STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabasso Restorative Care Center	660 Maple Street Wabasso, MN 56293

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 49336 Based on observation, interview, and document review, the facility failed to provide information to 5 of 5 residents (R1, R9, R15, R26 and R42) who attended the resident council group meeting regarding the Ombudsman services as advocates for residents residing in the facility. This had the potential to affect all 42 residents residing in the facility. Findings include: During the resident group meeting held on 11/07/24 at 3:30 p.m., with state surveyor, Ombudsman and R1, R9, R15, R26 and R42 were in attendance. Upon asking, R1, R9, R15, R26 and R42 indicated they were not aware of where to find the telephone number to contact the Ombudsman if needed and had not seen postings on the wall of her contact information. Review of resident council minutes from 6/06/24 through 11/07/24, revealed no information regarding how to contact the Ombudsman was found in the minutes. Observations on 11/13/24 at 4:29 p.m., identified the Ombudsman information was found posted on the wall next to the resident's grievance poster located by the main entrance of the building. Interview on 11/13/24 at 4:34 p.m., with Ombudsman confirmed the contact's name and number on the wall was not accurate. She stated she had visited the nursing home on several occasions and had asked the social service designee (SSD) to update the information with her current name and phone number for the residents. She added the Ombudsman contact information had listed an employee who no longer represented the facility in Redwood County. Interview on 11/13/24 at 4:35 p.m., with administrator identified all residents knew how to the contact the Ombudsman when admitted to the nursing home. Interview on 11/13/24 at 4:37 p.m., with SSD confirmed the current Ombudsman's name and contact information was not accurate on the board. Observation on 11/13/24 at 4:39 p.m., with the the administrator and the posted information identified she removed the poster from the wall that had outdated information. Email correspondence on 11/19/24 at 10:20 a.m., from the Ombudsman identified she was assigned to the nursing home May of 2021. (continued on next page)

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

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of August 2024 Facility Assessment identified the facility would establish and maintain contact information of State Licensing and Certification Agency, Office of the State Long-Term Care Ombudsman, and other sources of assistance. Review of Admission Packet, under Admission Agreement identified resident would be informed of the rights and procedures for filling complaints without fear of reprisal with the Office of Health Facility Complaints, the State Department of Health, the area nursing home Ombudsman, and the administrator of the facility and have been given the address and telephone numbers of those agencies and persons. Lastly, residents would receive the name and address of outside health care services, as well as a description of the services rendered.

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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. 47497 Based on observation, interview, and document review, the facility failed to follow up on a verbal grievance for 1 of 1 resident (R5). R5's 10/27/24 quarterly Minimum Data Set (MDS) assessment identified his cognition was intact and had diagnosis of stroke, heart failure, renal insufficiency, and diabetes mellitus. Interview on 11/12/24 at 10:45 a.m., with R5 identified that about 5 months ago he had some gel pens go missing. He reported it to the social service director (SDD) but reports nothing was done. He also reports he is missing the key to his locked drawer and a stylist that was kept on the same string that his key was on. Observation and interview on 11/18/24, at 12:45 p.m., with R5 in the hallway near the dining room, where the SSD director was walking down the hall, R5 stopped her and stated I told you about the gel pen's, can you tell her . R5 pointed to the surveyor. The SSD replied, I don't recall that. R5 asked the SSD, don't you remember I hung a big note on your door with one of the pictures I colored?. The SSD asked R5 if he filled out a grievance, he replied yes. The SSD said she would have to look and then walked away. The SSD director never provided any documentation and did not identify to the surveyor if she was able to find a completed grievance. Review of the facility grievance log dated May of 2024 through November 2024, identified no grievance had been completed on the behalf of R5 following a verbal complaint identifying he had missing personal property. A facility grievance policy was requested but was not provided by the end of the survey.

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not prohibit or in any way discourage a resident from communicating with federal, state, or local officials. 34083 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R18) was provided communication with the county care coordinator (CC) and those communications were not discouraged or obstructed, when multiple attempts were made to contact R18 without success. Findings include: Review of a 5/20/24, State Agency (SA) report identified on 5/26/24 the care coordinator (CC) for R18 had telephoned the facility and spoke with an unidentified charge nurse leaving contact information for R18 to return the call. The social services designee (SSD) then emailed CC that R18 had attempted to return her call, but she was on another line. The CC then received another email from the SSD, which stated, I have asked you repeatedly to direct these types of needs to me and only me, please honor and respect this. Our nurses are extremely busy providing cares to our resident and cannot be available to get resident for phone calls that are not time sensitive or family members. If I am out of the office, you will get a notification who to direct your request to. If you have any questions or concerns, I have cc' d our director of nursing (DON) on this message SSD. Interview and email correspondence review on 11/15/24 at 8:44 a.m. with the CC reported she had difficulty contacting her clients to review a change, and when she had attempted to contact the SSD as directed on 5/17/24 at 2:31 p.m, 3:42 p.m, 4:01 p.m., and 4:22 p.m. the SSD failed to answer and there was no notification of who should be contacted as she was out of the office. This resulted in R18 not being able to receive calls from his CC as there was no response. The CC reported she had attempted to call her client again on 5/20/24 at 9:27 a.m., and 2:43 p.m., there was no answer and she received the same voicemail as prior attempts. The 7th attempt to contact the SSD was transferred by unknown facility staff and the SSD was finally able to be reached at 2:51 p.m. and reported R18 was not available for the next half hour and contact information was left to have him return the call. The CC failed to receive a return call and as a result went to the facility later that afternoon to meet with R18 in person. R18 reported, only time I received a message to call you was last week. I just got your voicemail from [5/16/24]. R18 reported he had not received any notification of a call from the CC on 5/20/24, nor had he received any of the seven messages left by the CC. The CC expressed her frustration when her clients were not able to be accessed, or receive and make calls at the facility. She reported she believed her client was being denied access to services due to the call restrictions and it was possible this could also effect other residents in the facility. Review of the email dated 5/16/24 from the SSD to the CC identified she was informed by the SSD she was the only person to be contacted for follow-up to contact a client. The CC reported she had attempted to contact administration and left a message, but she had not received a return a call from the administrator either. Interview on 11/13/24 at 9:54 a.m. with R18 identified he was not aware of problems with making or receiving phone calls and identified he was not told about the repeated contact attempts from CC. He did have his own cell phone and was able to make or receive calls if aware he needed to call someone or receive a call. He was unaware if the CC had attempted to contact him on his personal cell or if they even had his personal cell information. (continued on next page)

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F 0586 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/13/24 at 10:32 a.m., interview with trained medication aid (TMA)-A reported phone calls were answered by nursing staff and a resident was able to take the call in the Salon room where there was privacy. R18 was independent with Activities of Daily Living (ADL) and no behaviors noted. She reported she was not aware of any directive to forward calls to the SSD from CC's. Interview on 11/12/24 at 1:30 p.m. interview with licensed practical nurse (LPN)-A reported nursing staff and other staff answer the phone and would inform the resident they had a call or they could return a call to the requested person on the private line in salon if they desired. LPN-A denied any requirement to refer a call to any staff or had been directed by the SSD to only leave a message with a specific facility staff person. Interview 11/13/24 at 3:43 p.m. with the SSD reported the facility had a resident phone line, and a resident could choose who they wanted to speak with. The SSD reported a CC, a guardian, etc could call and speak with anyone and she handled questions that pertained to areas she was responsible for. The SSD reported anyone could answer the phone and calls could also be forwarded to her if staff needed to do so. She reported Resident Rights were provided to residents in the admission packet and they had the right to receive phone calls, unless they identified someone they did not want to receive calls from. Case managers, county social workers, etc were to be able to call and speak with anyone. Resident rights are provided to residents at the time of admission. Review of the Resident Rights information provided in the Resident [NAME] of Rights identified residents may communicate privately with persons of their choice. There is to be access to a telephone where residents can make and receive calls as well as speak privately.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on interview and document review the facility failed to implement policies to ensure there was no fear of retaliation for 2 of 2 residents (R37 and R40) in addition to some resident council members who also voiced fear of retaliation from facility staff. Findings include: R37 R37's admission Minimum Data Set (MDS) assessment identified his cognition was intact, he was independent with activities of daily living (ADLs) and was receiving therapy services of Occupational (OT) and Speech (ST) therapies. R3 also was receiving physical therapy (PT) until the end of August 2024, when the facility no longer had available PT services. R37 was admitted [DATE] following acute hospitalization for diagnoses including metabolic encephalopathy, alcohol abuse, ADHD, degeneration of nervous system due to alcohol, cognitive communication deficit, history of falling, weakness, difficulty walking, hepatic encephalopathy, hypotension, alcoholic hepatitis with ascites, hypomagnesemia, and high blood pressure. Interview on 11/12/24 at 1:30 p.m. with R37 identified he had been admitted following acute hospitalization for therapies to regain his strength, and was attempting to find a job so he could be discharged , find a place to live and continue with his plan for an improved life style. He reported he was being careful to not cause any problems because he didn't want to be kicked out because he did not have any place he could go. R37 reported he was excited when he received his admission packet, which had the statement, Your Journey Starts Here and he felt that was a positive start for him. Interview on 11/14/24 at 3:30 p.m. interview with R37 with social services designee (SSD) in attendance regarding Arbitration agreements. R37 reported he was aware of what an Arbitration agreement was, and that he had signed the agreement at the time of admission. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/18/24 at 10:27 a.m. with R37 identified R37 wanted to apologize for lying when surveyor had come to his room with the SSD last week. He stated he was intimidated when the SSD had come into his room and he had been asked questions about Arbitration. He reported he had no idea what Arbitration was, and he was not in good shape when he had been admitted and had no idea what he had signed. He reported he would not have signed the agreement if he had known what he was signing. R37 stated the SSD had mouthed thank you when he said he understood what he had signed, but identified he did not know what we were talking about, but was afraid the SSD would get him kicked out of the facility and he had no where to go. R37 further stated shortly after he had arrived he had gone to the SSD's office to ask some questions, and had been feeling good about the facility and stated, My Journey Starts Here , to which the SSD looked at him with his perception of an expression of not wanting to be bothered. She reported to R37 she did not know what he was talking about, until he held up the admission packet with the words written on the cover to which she just looked at him with a perceived irritated expression. He reported he had attempted to speak with the SSD at a different time about concerns with what he could do about housing, paying bills, finding a job, etc., but she responded she was busy, and gave the impression his questions were an imposition. R37 reported the nursing staff were nice and attempted to help him, but he stated, I'm afraid she [SSD] could kick me out with the stroke of a key. He reported he was afraid as he only had this one chance to get better and make a change with his life and he did not know who he could talk with about his concerns as he felt very uncomfortable by the SSD demeanor. R40 R40's 10/9/24, admission MDS identified her cognition was intact, she was independent or needed some supervision with ADLs. She received both medication and non-medication intervention for pain which she described as almost constant. R40 wore an upper body brace due to back surgery, had a pressure reducing device for her bed, received surgical wound care, and medications that included antidepressant, antibiotic, and opioids. R40 had diagnoses which included Vertebrogenic low back pain, (chronic pain that occurs when the vertebral endplates of the spine are damaged), muscle spasm, sheltered homelessness, alcohol abuse, and other psychoactive substance abuse. Interview on 11/18/24 at 12:58 p.m. with R40 reported she was afraid of retaliation from staff and administration because she believed they would kick someone out if they felt there was a problem, but they didn't do anything about a resident that did cause problems. She did not feel she could voice a concern because it immediately went back to that person there was a concern with, and would make the situation worse. R40 stated she did not feel she was in a facility that would provide the services she needed to recover, and felt the facility had misrepresented the services they could provide. R40 stated she had requested to be seen by the MD who was making rounds in the facility on 11/18/24 and was told by the DON she could not because she had seen the Nurse Practioner the last week Interview on 11/18/24 at 5:08 p.m. with the facility administrator identified retaliation did not occur in the facility and her expectation was if there was a concern a resident or staff member would report it to her. She further stated she had not been made aware of any issues with retaliation or intimidation and did not believe it had occurred. The administrator voiced her expectation for all staff to follow the facility policy with regard to fear of retaliation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 10/15/24 Abuse, Neglect and Exploitation policy identified the facility provided information on reporting of concerns, without fear of retaliation. The facility would also respond to the resident concerns that were reported and assure there was no retaliation as a result of the report. The policy did not have avenues for what residents could do if they had experienced fears of retaliation from management. 49336 Resident Council During the resident group meeting held on 11/07/24 at 3:30 p.m., state surveyors and R1, R9, R15, R25 and R40 were in attendance. Interview with R1, R9, R15, R25 and R40 identified residents do not feel comfortable talking to the social service designee to voice their concerns or issues for fear of retaliation. Review of Admission Packet, under Admission Agreement and Acknowledgements identified resident would be informed of the rights and procedures for filling complaints without fear of reprisal with the Office of Health Facility Complaints, the State Department of Health, the area nursing home Ombudsman, and the administrator of the facility and have been given the address and telephone numbers of those agencies and persons. Residents were encouraged to participate in resident council meetings and decisions that would affect their lives in the facility. Lastly, residents would receive the name and address of outside health care services, as well as a description of the services rendered.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. 49336 Based on interview and document review, the facility failed to ensure the completed Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R26) reviewed for wounds. Findings include: The CMS Long-Term Care Facility RAI (resident assessment instrument) 3.0 User's Manual, dated 10/2023, indicates under Section M: Skin conditions to record any type of pressure ulcers and/or skin injuries the resident received during the 7-day observation period. R26 was admitted in September of 2023. R26's medical diagnosis form identified abscess (pus filled pocket that develops in the body's tissues of buttocks), non pressure chronic ulcer of buttocks with fat layer exposed, protein-calorie malnutrition, and end stage renal disease. R26's 9/21/24, Significant change Minimum Data Set (MDS) identified he was cognitively intact. Under section M, itidentified he had received an application of nonsurgical dressing other than to feet. There was no mention that R26 had a non-pressure skin ulcer on the MDS. R26's 9/29/23, History and Physical identified he had obtained a left buttock abscess and was prescribed antibiotics to treat his wound. R26's 10/09/24, Wound Care progress note, identified a diagnosis of skin ulcer of buttock with fat layer exposed and was a type 1 diabetic. Recommendations had include wound care orders, increase his protein intake, reposition every 1 to 2 hours, and use a pressure-relief mattress and chair cushion. R26's 10/29/24, Order Summary Report identified Left Buttock ulcer instructions: 1. Wash hands, apply gloves, remove dressings, clean wound bed with 4x4 gauze soaked in wound cleanser. 2. Place AG collagen within the wound bed. 3. Lightly pack the wound bed with lightly soaked Vashe gauze. 4. Secure with Adhesive foam dressing. 5. Change dressing daily with a start date of 10/10/24. Review of R26's undated care plan identified he had an acutal impairment to his skin integrity related to his cutaneous absecess of the buttocks. The goal was for R26 to maintain or develop clean and intact skin. Interventions for staff was to complete weekly documentation to include measurement of each area of skin breakdown, including the width, length, depth, type of tissue and exudate (fluid or pus from areas of infection) and any other notable changes or observations. Interview on 11/13/24 at 3:10 p.m., with R26 identified he was aware he had received daily wound dressing changes related to his wound,, however, he was unsure why his wound has not healed in the past 9 months. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/24 at 12:08 p.m., with registered nurse (RN)-A had identified R26 had a non-pressure ulcer that was identified on the wound care clinic progress notes and medical diagnosis sheet. She had accessed R26's medical record on Point Click Care (online medical record software), and confirmed she had placed his diagnosis under section I of the MDS and identified R26's wound was previously coded under section M for surgical wounds and had no longer used it for her MDS entries. She stated she had accurately coded the MDS according to the RAI manual. Interview on 11/18/24 at 4:33 p.m. with director of nursing (DON) identified she was not aware of the coding process related to MDS data entries. Review of MDS Coordinator job description identified the individual would monitor changes in resident's condition, complete assessments on residents that comply with Federal and State regulations, and would perform quality monitoring of data prior to submission to Federal and State databases. Review of October 2023 MDS 3.0 Completion policy identified the facility would assess and identifiy care needs the individual completing parts of the assessment would attest to the accuracy of the section they completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34083 Based on interview and document review, the facility failed to revise the care plan for 2 of 2 residents (R33 and R40). R33 to include daily weights and R40 to include target behaviors for monitoring. Findings include: R40 R40's 10/9/24, admission Minimum Data Set (MDS) assessment identified her cognition was intact, she was independent or needed some supervision with ADLs. She received both medication and non-medication intervention for pain which she described as almost constant. R40 wore an upper body brace due to back surgery, had a pressure reducing device for her bed, received surgical wound care, and medications that included antidepressant, antibiotic, and opioids. R40 had diagnoses which included Vertebrogenic low back pain, (chronic pain that occurs when the vertebral endplates of the spine are damaged), muscle spasm, sheltered homelessness, alcohol abuse, and other psychoactive substance abuse. Review of R40's current undated care plan failed to identify target behaviors to be monitored and documented. The care plan identified she received anti-anxiety medication and listed to monitor for adverse reactions, but failed to include behavioral symptoms associated with the use of an antianxiety medication. R40 was also receiving an antidepressant and the care plan listed to administer as ordered but failed to identify potential adverse reactions to the medication. R40's diagnosis list included a history of suicidal ideation, but the care plan failed to address signs of increased depression and/or suicidal ideation. 47497 R33's 10/25/24 quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she required extensive assist with dressing, toileting, and transfers, and had diagnosis of congestive heart failure, hypertension, diabetes myelitis, and coronary artery disease. R33's 6/5/24 discharge orders following hospital admission identified a diagnosis of congestive heart failure with orders to weigh R33 the morning after discharge and consider this weight as a goal weight. Report any change in shortness of breath/edema in legs or abdomen as well as weight changes of 2-3 pounds overnight, gain of 5 pounds in a week or loss of 5 pounds from goal weight and to call 911 if you feel you are having a medical emergency. R33's care plan identified she had congestive heart failure. Staff were to administer cardio medications and monitor for s/s of congestive heart failure. They were to report changes in lower extremity edema, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. The care plan did not identify staff were to obtain a daily weight on R33 or when to report to the physician per the hospital discharge order. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's June 2024 administration record identified the facility had not added the physicians order until 6/30/24, 25 days after the physician order was received. Review of R33's weight summary identified they had not recorded a goal weight as ordered by the physician and did not start obtaining daily weights consistantly until after 7/19/24. R33's 7/14/24 nursing progress note at 2:36 a.m., identified R33 again requested to be seen at the emergency room , physician was contacted and gave an okay to send resident via ambulance to ER. R33 was admitted to the hospital after evaluation with congestive heart failure. R33's 7/18/24 hospital discharge summary report identified R33 had presented in the ER with COPD, congestive heart failure, preserved ejection fraction, coronary artery disease, and a-flutter with a 60-pound weight gain over the past month after being discharged to the nursing home from the hospital. Patient had a NSTEMI (heart attack) thought to be secondary to CHF exacerbation. R33 was diuresed with intravenous (IV) Lasix and then switched to oral torsemide with good improvement in her breathing. She is down about 20 pounds. Her baseline weight is likely between 160 and 170 pounds. Interview on 11/18/24, at 10:18 a.m., with RN-A agreed the facility did not follow the hospital discharge orders to get a baseline weight the morning after R33 discharged back to the facility, did not complete daily weights, and did not report weight gain of more than 2.5 pounds overnight or 5 pounds weight gain in a week to the physician. She identified the MD-A had changed the order to complete daily weights for only one week and identified she had entered that order into administration record but did not add it to the care plan. She agreed they did not follow the second physician order from MD-A either.

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Wabasso Restorative Care Center	660 Maple Street Wabasso, MN 56293

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47497 Based on observation, interview and document review the facility failed to identify a significant change in condition and provide timely medical intervention for 1 of 1 resident (R33) who had increasing, significant weight gain and other symptoms consistent with congestive heart failure (CHF) exacerbation. This resulted in actual harm for R33 when physician orders were not followed and appropriate, timely interventions for significant weight gain were not implemented. R33 was eventually admitted to the local hospital for IV diuretics (medication to remove fluid from the body) caused by CHF exacerbation. Findings include: R33's 10/25/24 quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she required extensive assist with dressing, toileting, and transfers, and had diagnosis of congestive heart failure, hypertension, diabetes myelitis, and coronary artery disease. R33's current, undated care plan identified she had congestive heart failure. Staff were to administer cardiac medications and monitor for signs and symptoms of congestive heart failure. They were to report changes in lower extremity edema, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. R33 was a Full Code. R33's 6/5/24 discharge orders to the facility following hospital admission identified a diagnosis of congestive heart failure with orders to weigh R33 the morning after discharge and consider this weight as a goal weight. Staff were to report any change in shortness of breath/edema in legs or abdomen as well as weight changes 2-3 pounds (lbs)overnight, gain of 5 lbs in a week, or loss of 5 lbs from goal weight and to call 911 if R33 was having a medical emergency. R33's 6/6/24, order summary report identified the facility Medical Director wrote new orders to change the hospital discharge order to daily weights for only one week. R33's weight sR33's weights record reflected the following: 1) 6/5/24 at 1:36 p.m., (day of discharge from the hospital) 161.4 lbs. 2) 6/9/24 at 4:06 p.m., 163.4 lbs. 3) 6/12/24 at 1:13 p.m., 170 lbs. 4) 6/13/24 8:39 a.m., 171.2 lbs. 5) 6/18/24 at 7:59 p.m., 183 lbs. 6) 6/19/24 at 7:58 p.m., 185.8 (a gain of 24.4 lbs in 14 days) (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	7) 6/22/24 at 3:50 p.m., 186.8 lbs 8) 6/23/24 at 10:45 p.m., 188.4 lbs. 9) 6/24/24 at 12:22 p.m., 188.2 lbs. 10) 6/26/24 at 12:41 p.m., 192.4 lbs. 11) 6/26/24 at 10:10 p.m., 196.5 lbs. 12) 6/30/24 at 7:32 a.m., 200.8 lbs Further review of R33's weights identified R33 weights were as follows on: 1) 7/1/24 at 7:25 a.m., 205.2 lbs. 2) 7/2/24 at 7:07 a.m., 207.8 lbs. 3) 7/3/24 at 7:12 a.m., 210.8 lbs. 4) 7/4/24 at 7:11 a.m., 212.6 lbs. 5) 7/5/24 at 7:15 a.m., 213.8 lbs. 6) 7/6/24 at 12:56 p.m., 215.8 lbs. 7) 7/7/24 at 10:22 a.m., 216.4 lbs. 8) 7/8/24 at 9:13 a.m., 217 lbs. 9) 7/9/24 at 8:34 a.m., 218.2 lbs. 10) 7/10/24 at 7:02 a.m., 217.8 lbs. 11) 7/11/24 at 10:32 a.m., 221 lbs. 12) 7/12/24 at 10:37 a.m., 220.1 lbs. 13) 7/13/24 at 10:10 a.m., 223.2 By 7/13/24, R33 had a total weight gain of 61.8 lbs since re-admission on 6/5/24. Review of R33's nursing and physician progress notes lacked indication of provider notification or medical intervention related to weight gain from 6/5/24 (return from hospitalization) until 6/29/24. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	6/20/24, nursing progress note at 3:19 a.m., identified at 2:58 a.m., R33 had complained of shortness of breath. oxygen saturations were 84%, she described feeling like an elephant sitting on her chest. Oxygen supplementation was started at 2 liters (L per nasal cannula and a nitroglycerin (a medication used for treatment of chest pain (nitro)) 0.4 mg tab was given. R33 stated at 3:01 a.m., she was feeling better. Oxygen saturations came up to 95%. Staff documented no concerns at this moment. The medical record lacked indication that staff informed the physician of R33's weight gain at this time. 6/23/24, nursing progress note at 9:06 p.m., identified R33 had been on famotidine at hour of sleep (HS) for heartburn, GI distress. Famotidine (used to treat heart burn) was discontinued. She has been having chest pain, upper GI distress during the night and wants medication restarted. Will email physician these concerns. The medical record lacked evidence the physician had been notified of significant weight gain. 6/25/24, nursing progress note at 2:13 p.m., identified they received new order to restart famotidine and increase insulin. The record lacked indication of provider notification of weight gain. 6/29/24, nursing progress note at 9:00 p.m., identified R33 had been complaining of pain and has some edema in lower extremities. oxygen sats 99%, T 98.7, Blood pressure (BP) 112/76, pulse 89, weight 215.4. Physician called. Verbal order was given for a one-time dose of Lasix 40 mg and tramadol for pain. The MD ordered staff to start daily weights. 7/1/24, physician progress note at 10:28 a.m., identified R33 was seen during routine doctor rounds at the facility. Physician identified R33 had concerns of congestive heart failure and some lethargy over the weekend. The note identified she had been admitted to the nursing home for congestive heart failure and atrial fibrillation (A-fib) after a recent hospitalization . She had episode of lethargy with increased edema and shortness of breath. Some tightening in the chest. The MD ordered an increase in trazodone for sleep and increase Lasix to 40 mg daily and for staff to make cardiology appointment and labs. Although R1 was on 40mg of daily Lasix, she continued to gain weight between 1 to 7 pound each day which is a possible sign of excessive fluid in the body. 7/7/24, nursing progress note at 11:01 p.m., identified R33 had been complaining of shortness of breath and retaining fluid. Oxygen saturation is 97% on room air. She has had weight increase and requests oxygen supplementation. Oxygen started at 2 liters; resident reports much improved. There remained no indication staff identified the need for further evaluation. R33 had gained 11.2 lbs since last seen by the physician on 7/1/24. R1 continued to gain weight between 1 to 7 pound each day which is a possible sign of excessive fluid in the body. 7/9/24, nursing progress note at 1:33 p.m., identified the Minimum Data Set (MDS) registered nurse initiated a Significant Change assessment due to decline in activities of daily living, increase in incontinence, increased complaints of shortness of breath and increased weight gain. 7/9/24 dietary progress note at 2:56 p.m., identified diet was updated to a low sodium diet per dietitian recommendations. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	7/11/24, nursing progress note at 3:11 a.m., R33 short of breath, coughing up frothy sputum, states it hurts to breath, I'm scared! Crackles heard in bases, BP 143/88 pulse 90, respirations 22, oxygen 97%. R33 requests to sit in recliner. There was no indication staff identified R33's concerns for the need for immediate medical evaluation and treatment by a higher level of care hospital. 7/11/24, nursing progress note at 4:04 a.m., R33 has been resting in recliner now with less shortness of breath, will continue to monitor. Audible wheezing is heard with respirations at times. 7/11/24, nursing progress note at 3:56 p.m., identified the registered nurse (RN) completed a respiratory assessment, the note identified R33 reports shortness of breath at rest, with activity, and with head of bed flat. She has spent a few nights sleeping in recliner in the day room to help with her breathing. R33 is utilizing her scheduled and prn inhalers and nebulizer treatments with some relief. She has had to use supplemental oxygen via nasal cannula at night for increased shortness of breath. discussed using an incentive spirometer and the benefits of using this device. R33 agreed to try it. R3's 7/13/24 July 24 (registered dietician) RD Review resident list noted R33 was identified for an assessment to be performed by the RD for a weight gain of +50 lbs. in 30 days. 7/14/24 nursing progress note at 1:16 a.m., identified R33 had complained of shortness of breath and generalized body aches rated 9/10, she requested to be sent to the emergency room for care. Nursing called the facility medical director and was given an order to administer Lasix 40 mg and increase her current Lasix order from 40 mg daily to 60 mg daily. R33 was informed of the physicians' orders and agreed to try the medication change. 7/14/24 nursing progress note at 2:36 a.m., identified R33 again requested to be seen at the emergency room , physician was contacted and gave an okay to send resident via ambulance to ER. R33 was admitted to the hospital after evaluation with congestive heart failure. Review of the 7/18/24, hospital discharge summary report identified R33 presented in the ER with COPD, congestive heart failure, preserved ejection fraction, coronary artery disease, and atrial flutter with a 60-pound weight gain over the past month after being discharged to the nursing home from the hospital. Patient was noted to have had a NSTEMI (heart attack that happens when the heart does not get enough oxygen) thought to be secondary to CHF exacerbation. R33 was diuressed (given IV diuretic medication to remove fluid) with IV Lasix and then switched to oral torsemide with good improvement in her breathing. R33's weight decresed 20 lbs and she was discharged back to the facility on [DATE]. Hospital discharge summary indicated R33's baseline weight is between 160 and 170 pounds. Interview on 11/18/24, at 10:18 a.m., with RN-A agreed the facility did not follow the hospital discharge orders to get a baseline weight the morning after R33 discharged back to the facility, complete daily weights, and report weight gain of more than 2.5 pounds overnight or 5 pounds weight gain in a week to the physician. She identified the facility medical director had changed the order to complete daily weights for only one week and identified she had entered that order into administration record, but agreed staff did not follow that order either. Interview on 11/14/24 at 10:24 a.m., with R33's physician (MD)-A, identified the facility should have been updating him with any weight gain of 3 pounds in 24 hours or more then 5 pounds in a week. He agreed the facility should have been updating him of R33's weight changes more frequently. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/14/24 at 11:51 a.m., with attending physician from the local ED identified she believed in her professional opinion that had the facility sent R33 over to the clinic earlier on when she started experiencing weight gain and complaining of shortness of breath and chest pain, they likely could have treated her and avoided harm. The attending ER physician also identified that the clinic's heart nurse reached out to the facility in June to follow up with R33, she asked for an update on her over-all health status but never received a call back. Interview on 11/13/24 at 3:29 p.m., with the director of nursing (DON) identified she would have expected staff to update the physician with any weight gain of more than 3 pounds overnight or 5 pounds in a week. Staff should have called 911 for an emergency transport to the ER for evaluation when R33 had serious complaints of shortness of breath, chest pain, and found to have had a significant weight gain rather than calling or emailing the medical director. She identified that in most cases they advise nursing to call the medical director for guidance as they attempt to keep residents in house and use their own facilities own resources. She agreed MD-A was not updated regarding R33's weight changes timely. The DON identified they had no professional standards reference for nursing to utilize other than medication reference guides. A request was made to the facility to provide any training, or competencies completed related to recognizing a change of condition with the nursing staff that had entered progress notes identifying R33's symptoms of chest pain, shortness of breath, weight gain, and left arm pain. The facility provided training on identifying a change in condition for only 1 of the 5 licensed nurses on staff. Nothing more was provided by the end of the survey. The facility utilized no nursing standards of practice references for nursing staff to follow to assist in identifying medical emergencies or changes in condition. A policy on identifying and acting on a change in condition was requested but was later identified to not have any policy/procedure per management.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39988 Based on observation and interview the facility failed to ensure lighters were stored in a secured manner away from residents to prevent potential fire for 7 of 32 residents (R3, R5, R10, R16, R25, R32, and R38) that smoked in the facility. Findings include: Interview and observation on 11/12/24 at 2:15 p.m., with R10 identified there were some residents who kept their smoking materials at the nurse's station, but he kept his in his room. He reported he had a drawer that locked that he could keep his cigarettes and lighter in, he opened his drawer which was not locked and to show his cigarettes and lighter. Interview and observation on 11/13/24 at 9:15 a.m., with R32 who reported he normally kept his cigarettes and lighter in his shirt pocket during the day. At night he placed a couple napkins over them and then his baseball cap on top of that on his bedside table, he stated no one had ever come into his room at night. R32 had his cigarettes and his lighter laying on his bedside table as he laid in his bed. Interview on 11/13/24 at 2:48 p.m., with the director of nursing (DON) identified that residents who smoke are to bring their lighters to the nurse's station to be stored. Residents were not to keep their smoking materials in their room even in a locked drawer however, staff were not able to search the residents room either, so staff educate the resident. The facility does have a box in the medication room with lighters that have the residents name on it. She confirmed there was one resident who walked around the facility and has taken items from other resident rooms. Interview on 11/13/24 at 3:02 p.m., with trained medication aide (TMA)-B who identified residents were to turn in their lighters, but it was a hit and miss if staff were able to get them to do that. She reported residents will go out and buy more lighters and stick them in their pocket and staff cannot not search them or their room. Staff can ask residents to turn their lighter in but if they do not give it to staff there was not much staff could do. The resident lighters are to be keep at the nurse's station until the resident goes out to smoke. Interview on 11/14/24 at 8:00 a.m., with R32 while outside in smoking area reported he had never been asked to keep his lighter or cigarettes at the nurse's station. He stated he had always kept them in his room. R32 had never een asked to use the provided automatic wall mounted lighter outside. R32's care plan identified he was a smoker. Goal was that he would not suffer injury from unsafe smoking practices through the review date. Staff were to notify the nurse immediately if it was suspected resident had violated the facility smoking policy. Resident was able to smoke unsupervised. Interview on 11/14/24 at 8:03 a.m., with R38 who reported he did not need to turn his lighter or cigarettes into the nurse and he was able to keep them in his own room. He did not recall ever being asked to keep his lighter at the nurse's station for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/14/24 at 8:07 a.m., with R16 who reported he did not need to turn his lighter or cigarettes into the nurse. He stated he keeps them in his pocket or his room. R10's care plan identified he was a smoker. Goal was that he would not suffer injury from unsafe smoking practices through the review date. Staff were to notify the nurse immediately if it was suspected resident had violated the facility smoking policy. Resident was able to smoke unsupervised. Interview on 11/14/24 at 12:14 p.m., with R10 who reported he had never been asked to turn his cigarettes or lighter into the nurse and he has always kept his smoking materials in his room. Interview on 11/18/24 at 9:39 a.m., with R25 who was outside in the smoking area who confirmed the automatic lighter worked as he had just used it to light his cigarette. He stated that it depends on who you are if you are allowed to keep your cigarettes and lighter in your room. Interview on 11/18/24 at 12:59 p.m., with nursing assistant (NA)-A who identified that some residents in the facility are not able to keep their cigarettes mainly because others will steal them, so we keep them at the nurse's station. All the lighters are to be kept at the nurse's station and if staff see a resident with a lighter, staff are to ask for it and label it with their name and place it in the medication room. Interview on 11/18/24 at 4:11 p.m., with administrator identified she would expect resident lighters to be stored securely. If staff observed a resident with a lighter in their room to ask the resident to store that at the nurse's station. She confirmed that the facility had an automatic lighter attached to the building outside in the smoking area however, the residents continued to feel the need to have a lighter. 34083 R3's 9/7/24 quarterly Minimum Data Set (MDS) assessment identified she had severe cognitive impairment, and was independent with activities of daily living (ADLs). R3 had diagnoses which included alcohol abuse, Schizophrenia, anxiety disorder, and nicotine dependence. R3 was observed going to and from the outdoor smoking area with her smoking materials multiple times during the survey period. R3's current undated care plan identified she was independent with smoking and able to smoke unsupervised. A listed intervention was to notify the charge nurse immediately if it was suspected R3 had violated the facility smoking policy. R3's 5/8/24 at 11:20 a.m. progress note identified her room had a strong smell of smoke. When asked if she was smoking in her room she stated she was, and she did not feel well and did not want to go outside to smoke. Resident voiced she was aware of the facility policy on smoking and was provided education on policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's 5/16/24 at 1:31 p.m. incident report identified she was not in the approved smoking area and she was asked to move to the correct area. R3 responded this is my designated smoking area. R3 was educated on the designated smoking area, but refused to move to the the designated area. There was no indication of enhanced monitoring to ensure all residents were safe from fire hazards. An attempt to interview R3 on 11/13/24 at 10:00 a.m. as she sat in her room regarding her smoking was unsuccessful, as she refused to answer any questions. Interview on 11/13/24 at 10:32 a.m. with trained medication aid (TMA)-A reported R3 can smoke unsupervised at the present time. She reported R3 had previously attempted to smoke in her room, but since the smoking times had changed she was not aware of any further attempts to smoke in her room. TMA-A identified residents were supposed to turn in their lighters after use, but they just went out and purchased more and did not turn them in. All residents were asked to turn in their lighters to be stored at the nursing station, but they usually kept them in their possession and nothing was done about it. She was not aware if R3 currently had a lighter, but she was aware she did have cigarettes in her position. 47497 R5's 10/27/24, quarterly Minimum Data Set (MDS) assessment identified he was cognitively intact with diagnoses of stroke, heart failure, renal insufficiency, diabetes, anxiety, and depression. R5's care plan identified he was a smoker. The goal was that he would not suffer injury from unsafe smoking practices through the review date. Staff were to notify the charge nurse immediately if it is suspected he had violated the facility smoking policy. R5 was able to smoke independently. Interview on 11/12/24 at 10:45 a.m., with R5 identified he was a smoker and kept his cigarettes in a unlocked drawer in his room. He identified that he used to have a locked drawer but that someone took the key that he had hung on the back of his wheelchair before going to bed at night, so he now keeps them in an unlocked drawer. R5 identified staff had never asked him to turn in his lighter. Review of the 10/15/24, Resident Smoking policy identified smoking was prohibited in all areas except the designated smoking area. Safety measures for the designated smoking area included protection from weather conditions, ashtrays made of noncombustible material, metal containers with self-closing covers which ashtrays could be emptied, accessible fire extinguisher, prohibition of oxygen use in smoking area, and smoking had to occur 6 feet from the exits and common space. Residents who smoke will be assessed to determine whether supervision was required or if resident was safe to smoke. Smoking materials for resident who require supervision will be maintained by nursing staff. There was no mention that lighters will be stored securely at the nurses station.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47497 Based on interview and document review the facility failed to ensure 5 of 6 nursing staff were competnet to identify an emergent change in condition and the need to transfer to hospital for emergency medical evaluation for 1 of 1 resident (R33). The facility also failed to follow the facility assessment and/or develop policies and procedures and ensure staff had demonstrated competencies to perform care for residents. Findings include: Review of the [DATE], Centers for Disease Control, About Heart Attack Symptoms, Risk, and Recovery, located at https://www.cdc.gov/heart-disease/about/heart-attack.html#:~:text=The%20major%20symptoms%20of%20a%20heart%20attack%20are%3A,arms%20or%20shoulders.%205%20Shortness%20of%20breath.%20, identified a heart attack, also called a myocardial infarction, happens when a part of the heart muscle doesn't get enough blood. The more time that passes without treatment to restore blood flow, the greater the damage to the heart muscle. The major symptoms of a heart attack are: 1) Chest pain or discomfort. Most heart attacks involve discomfort in the center or left side of the chest that lasts for more than a few minutes or that goes away and comes back. The discomfort can feel like uncomfortable pressure, squeezing, fullness, or pain. 2) Feeling weak, light-headed, or faint. You may also break into a cold sweat. 3) Pain or discomfort in the jaw, neck, or back. 4) Pain or discomfort in one or both arms or shoulders. 5) Shortness of breath. This often comes along with chest discomfort, but shortness of breath also can happen before chest discomfort. Other symptoms of a heart attack could include unusual or unexplained tiredness and nausea or vomiting. Women are more likely to have these other symptoms. If you notice the symptoms of a heart attack in yourself or someone else, call [DATE] immediately. The sooner you get to an emergency room , the sooner you can get treatment to reduce the amount of damage to the heart muscle. At the hospital, health care professionals can run tests to find out if a heart attack is happening and can decide the best treatment. In some cases, a heart attack requires cardiopulmonary resuscitation (CPR) or an electrical shock (defibrillation) to the heart to get the heart pumping again. Bystanders trained to use CPR or a defibrillator may be able to help until emergency medical personnel arrive. The chances of surviving a heart attack are better the sooner emergency treatment begins. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabasso Restorative Care Center	660 Maple Street Wabasso, MN 56293

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the [DATE], article from Cleveland Clinic titled, Acute Heart Failure, located at https://my.clevelandclinic.org/health/diseases/21686-acute-heart-failure, identified acute heart failure (AHF) describes a heart that can't deliver enough oxygen-rich blood to the body. This happens because of a sudden, rapid decline in heart functioning and the amount of blood the resident's heart can pump to the rest of their body. Acute heart failure (AHF) is a life-threatening condition. Heart disease and certain medical conditions can make their heart work harder than usual. This extra effort leads to physical changes that can include: 1) Enlarged heart. 2) Decreased blood flow. 3) Narrow blood vessels, rapid or irregular heartbeat. 4) Stiff heart muscles. These changes are small at first and start long before AHF symptoms. Over time, the changes are worse. When the heart can not keep up, AHF occurs. AHF is one of the most common reasons for hospital stay for residents/patients over [AGE] years of age. Common symptoms include: 1) Shortness of breath 2) Heavy breathing 3) A sensation like suffocating. 4) Struggling to breathe while lying down. 5) Tight chest. 6) Abnormal heart rhythm, 7) Chest pain 8) Cough 9) Fluid retention in arms or legs. 10) Loss of consciousness. If any of those symptoms are noticed, the article directs staff to seek emergency medical care for the resident as quickly as possible. AFH can lead to organ dysfunction when they do not receive enough blood and oxygen and are life-threatening. Staff should perform a rapid assessment to include a resident's health history and a physical exam. Emergency treatment includes oxygen therapy, medications to open blood vessels, and diuretics (medications to remove excess fluids in the body). If a resident is in the hospital, they may be there for several days or even beyond one week. Once they have had AHF, they are at a higher risk of having it again and a higher risk of AHF becoming fatal if a resident's kidneys aren't working well. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's [DATE] quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she required extensive assist with dressing, toileting, and transfers, and had diagnosis of congestive heart failure, hypertension, diabetes myelitis, and coronary artery disease. R33's care plan identified she had congestive heart failure. Staff were to administer cardiac medications and monitor for s/s of congestive heart failure. They were to report changes in lower extremity edema, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate, lethargy and disorientation. R33 was a Full Code. R33's [DATE] discharge orders to the facility following hospital admission identified a diagnosis of congestive heart failure with orders to weigh R33 the morning after discharge and consider this weight as a goal weight. Staff were to report any change in shortness of breath/edema in legs or abdomen as well as weight changes , d+[DATE] pounds (lbs)overnight, gain of 5 lbs in a week, or loss of 5 lbs from goal weight and to call 911 if R33 was having a medical emergency. R33's [DATE], order summary report identified the facility Medical Director wrote new orders to change the hospital discharge order to daily weights for only one week. R33's weight summary identified the facility did not complete the hospital discharge order to obtain a weight on the first morning after returning from the hospital. R33's weights record reflected the following gains noted below: 1) [DATE] at 1:36 p.m., (day of discharge from the hospital) 161.4 lbs. 2) [DATE] at 4:06 p.m., 163.4 lbs. 3) [DATE] at 1:13 p.m., 170 lbs. 4) [DATE] 8:39 a.m., 171.2 lbs. 5) [DATE] at 7:59 p.m., 183 lbs. 6) [DATE] at 7:58 p.m., 185.8 (a gain of 24.4 lbs in 14 days) 7) [DATE] at 3:50 p.m., 186.8 lbs 8) [DATE] at 10:45 p.m., 188.4 lbs. 9) [DATE] at 12:22 p.m., 188.2 lbs. 10) [DATE] at 12:41 p.m., 192.4 lbs. 11) [DATE] at 10:10 p.m., 196.5 lbs. 12) [DATE] at 7:32 a.m., 200.8 lbs (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R33's weights identified R33 weights were as follows on: 1) [DATE] at 7:25 a.m., 205.2 lbs. 2) [DATE] at 7:07 a.m., 207.8 lbs. 3) [DATE] at 7:12 a.m., 210.8 lbs. 4) [DATE] at 7:11 a.m., 212.6 lbs. 5) [DATE] at 7:15 a.m., 213.8 lbs. 6) [DATE] at 12:56 p.m., 215.8 lbs. 7) [DATE] at 10:22 a.m., 216.4 lbs. 8) [DATE] at 9:13 a.m., 217 lbs. 9) [DATE] at 8:34 a.m., 218.2 lbs. 10) [DATE] at 7:02 a.m., 217.8 lbs. 11) [DATE] at 10:32 a.m., 221 lbs. 12) [DATE] at 10:37 a.m., 220.1 lbs. 13) [DATE] at 10:10 a.m., 223.2 (R33 had a total weight gain of 61.8 lbs since re-admission on [DATE]. Review of R33's nursing and physician progress notes identified: 1) [DATE], nursing progress note at 3:19 a.m., identified at 2:58 a.m., R33 had complained of shortness of breath. oxygen saturations were 84%, she described feeling like an elephant sitting on her chest. Oxygen supplementation was started at 2 liters (L per nasal cannula and a nitroglycerin (nitro) 0.4 mg tab was given. R33 stated at 3:01 a.m., she was feeling better. Oxygen saturations came up to 95%. Staff documented no concerns at this moment. The medical record lacked indication the physician or discharging hospital had been notified, or staff had identified an egregious weight gain from likely CHF exacerbation and sent R33 to the ED. 2) [DATE], nursing progress note at 9:06 p.m., identified R33 had been on famotidine at hour of sleep (HS) for heartburn, GI distress. Famotidine was discontinued. She has been having chest pain, upper GI distress during the night and wants medication restarted. Will email physician these concerns. There was no indication the physician had been immediately called or discharging hospital notified, or staff had identified new onset chest pain or egregious weight gain from likely CHF exacerbation and potential complications from the weight gain and sent R33 to the ED. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10) [DATE], nursing progress note at 3:11 a.m., R33 short of breath, coughing up frothy sputum, states it hurts to breath, I'm scared! Crackles heard in bases, BP ,d+[DATE] pulse 90, respirations 22, oxygen 97%. R33 requests to sit in recliner. There was no indication staff identified R33's concerns for the need for immediate medical evaluation and treatment by a higher level of care hospital. 11) [DATE], nursing progress note at 4:04 a.m., R33 has been resting in recliner now with less shortness of breath. will continue to monitor. Audible wheezing is heard with respirations at times. There is no indication staff identified a medical emergency warranting a trip to the ED for further exam, diagnostic testing, and treatment. 12) [DATE], nursing progress note at 3:56 p.m., identified the registered nurse (RN) completed a respiratory assessment, the note identified R33 reports shortness of breath at rest, with activity, and with head of bed flat. She has spent a few nights sleeping in recliner in the day room to help with her breathing. R33 is utilizing her scheduled and prn inhalers and nebulizer treatments with some relief. She has had to use supplemental oxygen via nasal cannula at night for increased shortness of breath. discussed using an incentive spirometer and the benefits of using this device. R33 agreed to try it. There was no mention staff consulted with the local ED, or a professional standards of practice to identify CHF exacerbation as an emergent condition. 13) [DATE] nursing progress note at 1:16 a.m., identified R33 had complained of shortness of breath and generalized body aches rated ,d+[DATE], she requested to be sent to the emergency room for care. Nursing called the facility medical director and was given an order to administer Lasix 40 mg and increase her current Lasix order from 40 mg daily to 60 mg daily. R33 was informed of the physicians' orders and agreed to try the medication change. It is unknown if staff or the MD had spoken with R33 on the signs and symptoms of an emergency condition of CHF exacerbation and informed R33 of risks and benefits so she could make an informed decision about her care and the risk of delaying ED assessment and treatment. 14) [DATE] nursing progress note at 2:36 a.m., identified R33 again requested to be seen at the emergency room , physician was contacted and gave an okay to send resident via ambulance to ER. R33 was admitted to the hospital after evaluation with congestive heart failure. There was no mention why staff did not immediately call 911 vs waiting for a call or call back from the MD who is not located nearby. Review of the [DATE], hospital discharge summary report identified R33 presented in the ER with COPD, congestive heart failure, preserved ejection fraction, coronary artery disease, and atrial flutter with a 60-pound weight gain over the past month after being discharged to the nursing home from the hospital. Patient was noted to have had a NSTEMI (heart attack that happens when the heart does not get enough oxygen) thought to be secondary to CHF exacerbation. R33 was diuressed (given IV diuretic medication to remove fluid) with IV Lasix and then switched to oral torsemide with good improvement in her breathing. She was down about 20 pounds. Her baseline weight is likely between 160 and 170 pounds. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 10:24 a.m., with R33's physician (MD)-A, identified the facility should have been updating him with any weight gain of 3 pounds in 24 hours or more then 5 pounds in a week. He agreed the facility should have been updating him of R33's weight changes more frequently. The physician did not identify R33's symptoms as a medical emergency and felt he had provided appropriate care. Staff should use professional judgement based off professional standards and call 911 if a medical emergency was suspected. Interview on [DATE] at 11:51 a.m., with attending physician from the local ED identified she believed in her professional opinion that had the facility sent R33 over to the clinic earlier on when she started experiencing weight gain and complaining of shortness of breath and chest pain, they likely could have treated her and avoided harm. She agreed that the s/s described in the ,d+[DATE] nursing progress note of chest pain, pain in the center of her back radiating down her left arm are s/s of a heart attack and R33 should have been immediately transferred to the ER for evaluation and treatment. The attending ER physician also identified that the clinic's heart nurse reached out to the facility in June to follow up with R33, she asked for an update on her over-all health status but never received a call back. Interview on [DATE] at 3:29 p.m., with the director of nursing (DON) identified she would have expected staff to update the physician with any weight gain of more than 3 pounds overnight or 5 pounds in a week. Staff should have called 911 for an emergency transport to the ER for evaluation when R33 had serious complaints of shortness of breath, chest pain, and found to have had a significant weight gain rather than calling or emailing the medical director. She identified that in most cases they advise nursing to call the medical director for guidance as they attempt to keep residents in house and use their own facilities own resources. She agreed MD-A was not updated regarding R33's weight changes timely. The DON identified they had no professional reference for nursing to utilize other than medication reference guides. Interview on [DATE], at 10:18 a.m., with RN-A agreed the facility did not follow the hospital discharge orders to get a baseline weight the morning after R33 discharged back to the facility, complete daily weights, and report weight gain of more than 2.5 pounds overnight or 5 pounds weight gain in a week to the physician. She identified the facility medical director had changed the order to complete daily weights for only one week and identified she had entered that order into administration record, but agreed staff did not follow that order either. A request was made to the facility to provide any training, or competencies completed related to recognizing a change of condition with the nursing staff that had entered progress notes identifying R33's symptoms of chest pain, shortness of breath, weight gain, and left arm pain. The facility provided training on identifying a change in condition for only 1 of the 5 licensed nurses on staff. Nothing more was provided by the end of the survey. The facility utilized no nursing standards of practice references for nursing staff to follow to assist in identifying medical emergencies or changes in condition. A policy on identifying and acting on a change in condition was requested but was later identified to not have any policy/procedure per management. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility Assessment identified they were prepared to provide care to residents with a diagnosis of CHF. The nursing staff were able to provide early identification of problems/deterioration, and management of medical symptoms and conditions such as heart failure. They consider the characteristics of their resident population to determine the skills and competencies required to meet each resident's needs as identified through resident assessments and care plans, and the staff training and education and competencies necessary to provide the level and types of care needed for residents. The training topics provided include identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life. A request was made to the facility for any training, or competencies completed with RN-A, RN-B, LPN-A, LPN-B, and LPN-C. The facility provided a document identifying one of the nurses listed (LPN-B), had attended training on [DATE] for Recognizing and Communicating Resident Change in Condition. No other training or competency documentation was provided. Interview on [DATE] at 5:55 p.m., with the administrator identified she would have expected nursing staff to call 911 for emergency transport to the hospital for a resident who is experiencing symptoms of shortness of breath, chest pain, and weight gain.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34083 Based on interview and document review the facility failed to comprehensively assess and identify target behaviors and non-pharmacological interventions for scheduled antidepressant and antipsychotic medication for 3 of 5 residents (R8, R42 and R246)) reviewed for unnecessary medication usage. Findings include: R8 R8's 10/29/24, significant change Minimum Data Set (MDS) assessment identified R8 had severely impaired cognition, he was independent with activities of daily living (ADLs), and he demonstrated behaviors including hallucinations, physical and verbal behaviors, and intruded on the privacy and activities of others. R8's behaviors have worsened compared to the previous assessment. His medications included antipsychotic, antianxiety, antidepressant, and antiplatelet medications. R8's current undated care plan identified he had a behavior problem related to mental health with interventions listed as anticipate and meet resident needs. If reasonable discuss the resident's behavior, explain/reinforce why behavior is inappropriate and/or unacceptable. The care plan identified R8 received antianxiety antipsychotic and antidepressant medications with monitoring for side effects and effectiveness. There was no mention of Target Behaviors to be monitored. R8's current physician orders identified medication orders including: Olanzapine (antipsychotic) 10 milligrams (mg) by mouth (PO) twice daily (BID) Trazodone (antidepressant) 100 mg PO at bedtime (HS) Buspirone (antianxiety) 15 mg PO three times daily (TID) Interview on 11/14/24 at 2:05 p.m., with the director of nursing (DON), agreed with the above findings and identified she would expect the resident care plans to be updated to include target behaviors and non-pharmacological interventions. Interview on 11/18/24 at 1:R15. with the MDS coordinator identified she had update resident care plan to include target behaviors and non-pharmacological interventions during the ongoing survey. 47497 R246 R246's face sheet identified he had diagnosis of anxiety disorder and major depressive disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R246's November 2024, administration record identified he was taking bupropion (antidepressant) extended release 300 mg by mouth daily, citalopram (anti-depressant) 20 mg by mouth daily for major depressive disorder and hydrocodone/acetaminophen 5-325 (an opioid analgesic) as needed for knee pain. R246's care plan identified he used an antidepressant, with a goal that he would be free from discomfort, or adverse reactions related to antidepressant therapy through review date. Staff were to administer antidepressant medications as order, monitor/document any side effects and effectiveness every shift. The care plan made no mention what non-pharmacological interventions staff should attempt. R246's care plan identified he had a diagnosis of anxiety disorder and takes an anti-anxiety medication; with a goal he would be free from discomfort, or adverse reactions related to anti-anxiety therapy through the review date. Staff were to administer anti-anxiety medication as ordered by the physician and monitor for side effects and effectiveness. The care plan made no mention of non-pharmacological interventions staff should attempt. Interview on 11/14/24 at 4:30 p.m., with the director of nursing (DON), agreed with the above findings and identified she would expect the interventions be added upon admission. She identified that they had updated the care plans after surveyors had pointed out the care plans were lacking the non-pharmacological interventions. 49336 R42 R42's 10/22/24, admission assessment Minimum Data Set (MDS) identified she had a diagnosis of anxiety, depression, and post-traumatic stress disorder (PTSD). R42 had moderate cognitive impairment and had no behaviors. R42 had little interest or pleasure in doing things, felt down, depressed, or hopeless never to 1 day. R42's 10/29/24, Order Summary sheet identified R42 had taken the following medications: 1) duloxetine (treats major depressive disorder and anxiety) 30 milligrams (mg) twice a day for anxiety with a start date of 10/16/24. 2) gabapentin (treats seizures and pain) 400 mg three times a day for anxiety and alcohol dependence with a start date of 10/16/24. Review of R42's October and November Medication Administration Record (MAR) identified she had taken both duloxetine and gabapentin on a routine basis. There was no mention of target behaviors it was prescribed to treat or alleviate. R42's undated, care plan identified she had taken anti-anxiety medications. The goal was to be free from discomfort or adverse reactions related to anti-anxiety therapy use. Interventions was to administer antianxiety meds as ordered by the physician and monitor for side effect and effectiveness. There was no mention of specific target behaviors or side effects of duloxetine and gabapentin medications or what the medication would be relieving. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/24 at 2:30 p.m., with nursing aide (NA)-A stated R42 was independent with her cares had exhibited irritability when she was low on cigarettes and could not identify any other specific behaviors. Interview on 11/14/24 2:32 p.m., with registered aide (RN)-A stated R42 had anxiety and forgetfulness for behaviors and stated it was not identified on her medication record or care plan. She had accessed the Point Click Care (PCC), which is an online medical record software, and stated nursing assistants were directed to chart on R42's behaviors and confirmed there were no specific target behaviors listed. She stated the care plan had lacked evidence of side effects and/or adverse consequences of her duloxetine and gabapentin medication use and should have been included in the care plan. Interview on 11/14/24 at 2:43 p.m., with trained medication aide (TMA)-C had accessed PCC and pulled up R42's behavior charting. She had clicked under the behavior chart and revealed the section was blank on the left side of the screen and identified she would need to click on the list of behaviors to document on R42. She confirmed she could not identify specific target behaviors to chart on R42 when she was not aware of what behaviors to look for. Interview on 4:22 p.m., with director of nursing (DON) was not aware of side/adverse effects related to psychotropic medication use and would plan to collaborate with the nursing team to identify and understand specific target behaviors for those residents. Review of 9/25/24 Psychotropic Medication policy identified the facility would document residents' response to medications and would include resident's presence, absence of adverse consequences in the resident's medical record. In addition, the residents' symptoms and therapeutic goals would be clearly and specifically identified and documented, and would assess the resident's underlying condition, signs, symptoms, expressions, preferences, and goals for treatment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34083 Based on observation, interview and document review the facility failed to ensure 2 of 2 opened vials of Tuberculin (TB) purified protein derivative (PPD) solution (used to detect tuberculosis)((TB)) were appropriately labeled according to manufacturer's guidelines with an open date. Findings include: Observation on 11/13/24 at 10:53 a.m. with licensed practical nurse (LPN)-A identified 2 open vials of PPD solution stored in the refrigerator of the medication room. The pharmacy labeled bag containing the vials was dated as dispensed from the pharmacy on 9/28/24. Neither of the 2 vials had been dated as to when they had been opened. Review of the provided pharmacy list for outdates after opening identified the solution was good for 30 days from the date opened. Interview on 11/13/24 at 10:55 a.m. with licensed practical nurse (LPN)-A reported medications were supposed to be dated when opened, and confirmed there was no date identifying when either of the 2 vials of PPD solution had been opened. LPN-A retrieved the facility list of medication outdates after opening and identified the solution was good for 30 days after opening. Interview of the director of nursing (DON) on 11/13/24 at 10:20 a.m. reported her expectation for medications to be dated and initialed on the date of opening. A policy on medication labeling and storage was requested but not provided by the time of exit.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 47497 Based on observation, interview, and document review, the facility failed to provide schedule routine dental services upon request for 1 of 1 resident (R5). Findings include: R5's 10/27/24 quarterly Minimum Data Set (MDS) assessment identified his cognition was intact and had diagnosis of stroke, heart failure, renal insufficiency, and diabetes militias. Interview on 11/12/24 at 10:48 a.m., with R5 identified he had requested a dentist appointment a long time ago when he had first admitted to the facility. He stated, I'm missing all my molars. R5 reported he thought he would benefit from a partial denture. Interview and observation on 11/18/24 at 12:36 p.m., R5 identified for the second time during the survey that he had requested a dental appointment, he stated look at all the teeth I'm missing. He opened his mouth and pointed to his upper molars. Surveyor observed R5 had all but 1 upper molar missing. R5's 6/4/24, 7/27/24, and 10/25/24, oral assessments completed by RN-A identified R5 had requested a dental appointment during each assessment. Interview on 11/18/24 at 1:47 p.m., with RN-A identified when she completes the oral assessment with residents she always asks if they would like a dental appointment, if the answer is yes, she either tells the social service director (SSD) verbally or she sends her an email requesting an appointment be made. RN-A identified that the facilities SSD is the person who is responsible for making appointments for the residents. Observation on 11/18/24 at 1:47 p.m., of an email dated 6/4/24 sent from RN-A to the facilities SSD. The email identified that R5 was requesting a dental appointment, that he had identified that he has several cavities but denies pain or difficulty chewing at this time. Interview on 11/18/24 at 2:10 p.m., with the SSD identified she did not recall R5 requesting a dental appointment. typically, she would have been notified via email by nursing or the would tell her verbally. The SSD reviewed the Email and stated, I must have missed it.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 34083 Based on observation, interview and document review the facility failed to provide physician ordered physical therapy (PT) services for 2 of 2 residents (R20 and R37). Findings include: R37 R37's admission Minimum Data Set (MDS) assessment identified his cognition was intact, he was independent with activities of daily living (ADLs) and received therapy services of Occupational (OT) and Speech (ST) therapies. R37 also had orders for physical therapy (PT) which he received until the end of August 2024, when the facility no longer had PT services available. R37 had diagnoses of metabolic encephalopathy, alcohol abuse, ADHD, degeneration of his nervous system due to alcohol, cognitive communication deficit, history of falling, weakness, and difficulty walking. R37's current, undated care plan identified he was dependent on staff for meeting emotional, intellectual, physical, and social needs due to his physical limitation. He had MD orders for PT/OT evaluation and treatment. Staff were to encourage R37 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility. Observation and interview on 11/12/24 at 2:12 p.m. with R37 identified he was admitted following hospitalization with a goal to receive therapies, regain his strength, find a job, and return to an independent living situation. R37 ambulated independently using a walker due to balance issues. He reported he had continued to receive Occupational (OT) and Speech Therapy (ST) but had not received PT since the end of August when the facility no longer had Physical therapy services available. R37's PT Evaluation and Plan of Treatment identified his certification period as 8/26/24 - 10/24/24. His treatment approaches included PT services 3 x weekly x 4 weeks. The Therapy Assessment Summary: Clinical Impressions- identified he presented with generalized weakness and decline in mobility following hospitalization . Reason for skilled services: Requires skilled PT services to analyze gait pattern, assess functional abilities, evaluate need for assistive devices. Facility independence with all functional mobility, increased activity tolerance, and increase independence with gait. Review of the 8/29/24, electronically signed PT notes identified skilled interventions were focused on transfer training to increase functional task performance, strengthening activities to increase functional task performance and dynamic balance actives while standing with minimal verbal instruction required due to compromised balance, functional activity tolerance, postural support/control, safety awareness and strength. Interview on 11/12/24 at 10:05 a.m. with the ST reported the facility did not currently have PT available, and she thought it had ended at the end of August. She reported she was not aware of any PT coverage at the present time. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/18/24 at 1:12 p.m. with the director of nursing (DON) identified R37 had a physician order dated 11/6/24 to continue PT services, but the facility did not currently have PT services available. She reported therapy requests were forwarded to OT assistant, but she was not certain what was done about it. Interview on 11/18/24 at 1:18 p.m. with registered nurse (RN)-A identified R37 was seen by OT but the facility did not currently have PT services available in house. RN-A reported she was not aware of any plan implemented since not having PT services in place since Aug/Sept of 2024. Interview on 11/15/24 at 4:31 p.m. With the administrator identified R37's most recent physician order dated 11/6/24 at 3:58 p.m. identified he was to continue receiving PT. The administrator confirmed PT services had not been provided as the facility did not currently have a PT provider available. A policy on the provision of skilled therapy services was requested but not provided by the end of the survey. 49336 R20 R20's 10/22/24, admission Minimum Data Set (MDS) had a moderate cognitive impairment and was substantial/maximum assist with toileting, showering and personal hygiene. R20's medical diagnoses sheet identified she had an left artificial knee joint, osteoporosis (bone disease that become brittle), and internal joint prosthesis. R20's 10/16/24, Orders Discharge Report identified R20 would receive physical therapy (PT) and occupational therapy (OT) to evaluate and treat. R20's 10/16/24, active orders identified she was to have assistance with toe touch, non weight bearing status for her mobility and transfers. R20's 10/16/24, OT evaluation and plan of treatment identified a treatment plan for therapeutic exercises, OT therapy evaluation and self care management training 5 times a week for 6 weeks. The facility could not provide documented evidence that R20 had been seen by a physical therapist. R20's undated care plan identified the following: 1) R20 was at risk for ADL self-care needs. The goal was to maintain R20's current level of function. Interventions was for staff to provide extensive assist of 1 to assist R20 for showers, personal lhygiene and to transfer to commode by pivot with walker, and for PT/OT to evaluate and treat per MD orders. 2) R20 was a high risk for falls related to limited weight bearing, back pain, hypertension and medication use side effects. The goal was to be free of falls. Interventions were for staff to anticipate and meet R20's needs and for PT to evaluate and treat as ordered or as needed (PRN). (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Email correspondence on 11/14/24 at 3:45 p.m., from Therapy Director identified the facility's PT therapist last day of work was 8/30/24. Interview on 11/14/24 at 3:00 p.m., with occupational therapist was treating R20 for occupational services with restrictions due to R20's central line (inserted into a large vein in the body to provide access to the bloodstream) on her right arm. She had reviewed R20's transfer status upon admission and was awaiting for a replacement for the physical therapist who had left their employment at the facility on august 30th. She was aware the facility had a plan to hire a new physical therapist before mid December of 2024. Interview on 11/18/24 at 11:15 a.m., with administrator had used the OT therapist in house to provide services to residents and was aware the facility had no physical therapist in house. Her plan was to hire a new physical therapist for the facility and had hired one last week. Email correspondence on 11/18/24 at 11:44 a.m., from the administrator identified physical therapist was hired on 10/28/24. However, the facility had no plan placed to ensure services were provided in the interim when no staff was available by the facility. Interview on 11/18/24 at 1:14 p.m., with R20 had worked with 2 physical therapist at the facility from her previous stay at the nursing home. She was readmitted back to the nursing home October 2024 and had asked where the previous physical therapists were. She was informed by OT they no longer worked at the facility. She confirmed she had been working with OT when admitted with therapy orders. She was aware staff did not know how to initially transfer her and had informed staff of her needs with her tip toe and pivot with assistance to the commode. Interview on 11/18/24 at 4:11 p.m., with administrator agreed that the facility assessment should be updated and current on what the facility provided for services. She confirmed that currently they did not have a physical therapist available to evaluate at this time, however they hired a physical therapist at end of Oct but he has not started at this facility yet. Review of August 2024 Facility Assessment identified the facility would provide ancillary services, including, activities occupational therapy, physical therapy and speech therapy. In addition, the facility's resources included, chemical dependency program, behavioral health and specfic rehabilitation therapy.

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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** 34083 R37 R37's admission Minimum Data Set (MDS) assessment identified his cognition was intact, he was independent with activities of daily living (ADLs) and received therapy services of Occupational (OT) and Speech (ST) therapies. R37 also had orders for physical therapy (PT) which he received until the end of August 2024, when the facility no longer had PT services available. R37 had diagnoses of metabolic encephalopathy, alcohol abuse, ADHD, degeneration of his nervous system due to alcohol, cognitive communication deficit, history of falling, weakness, and difficulty walking. R37's current, undated care plan identified he was dependent on staff for meeting emotional, intellectual, physical, and social needs due to his physical limitation. He had MD orders for PT/OT evaluation and treatment. Staff were to encourage R37 to participate in activities that promoted exercise, physical activity for strengthening and improved mobility. Interview on 11/12/24 at 10:05 a.m. with the ST reported the facility did not currently have PT available, and she thought it had ended at the end of August. She reported she was not aware of any PT coverage at the present time. Interview on 11/18/24 at 1:12 p.m. with the director of nursing (DON) identified R37 had a physician order dated 11/6/24 to continue PT services, but the facility did not currently have PT services available. She reported therapy requests were forwarded to OT assistant, but she was not certain what was done about it. Interview on 11/18/24 at 1:18 p.m. with registered nurse (RN)-A identified R37 was seen by OT but the facility did not currently have PT services available in house. RN-A reported she was not aware of any plan implemented since not having PT services in place since Aug/Sept of 2024. Interview on 11/18/24 at 4:11 p.m., with administrator agreed that the facility assessment should be updated and current on what the facility provided for services. She confirmed that currently they did not have a current PT staff available to evaluate residents and had recently hired a new PT staff at end of October but has not started working at the facility. 39988 Based on interview and document review, the facility failed to implement 1 of 1 facility assessment for the identified required number of staff deemed required to provide cares had been scheduled and maintained on the weekends. Additionally, the facility failed to update their facility assessment when they did not have physical therapy services available. The facility also failed to provide physical therapy as ordered for 2 of 2 residents (R20 and R37) reviewed for therapy services. This had the ability to affect all 32 residents. Findings include: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the August 2024, facility assessment identified the facility had 2 shifts day shift 6:00 a.m. to 6:00 p. m. and night shift 6:00 p.m. to 6:00 a.m., the staffing plan for basic number of staff was as follows: Day shift 6:00 a.m. to 6:00 p.m. RN or LPN charge nurse=2 TMA/NA direct care staff =3 Night shift 6:00 p.m. to 6:00a.m. RN or LPN =1 TMA/NA direct care staff =2 Review of the working schedules and timecards for weekend days during the facilities quarter 3 identified less than the amount of identified staff worked for 12 of 26 weekend dates during the day shift. Interview and observation on 11/14/24 at 11:10 a.m., with administrator identified weekend staffing was the same as during the week. Upon review of the facility assessment with the administrator it was confirmed that the staffing requirements identified the day shift was to have 2 licensed nurses scheduled. The administrator stated that was incorrect that the facility had never scheduled 2 licensed nurses on the day shift, and she was unaware that the facility assessment identified that and she would need to correct that information. 49336 Therapy R20's 10/22/24, admission Minimum Data Set (MDS) had a moderate cognitive impairment and was substantial/maximum assist with toileting, showering and personal hygiene. R20's medical diagnoses sheet identified she had a left artificial knee joint, osteoporosis (bone disease that become brittle), and internal joint prosthesis. R20's 10/16/24, Orders Discharge Report identified R20 would receive physical therapy (PT) and occupational therapy (OT) to evaluate and treat. R20's 10/16/24, active orders identified she was to have assistance with toe touch, non-weight bearing status related to her mobility and transfers. R20's 10/16/24, OT evaluation and plan of treatment identified a treatment plan for therapeutic exercises, OT therapy evaluation and self-care management training 5 times a week for 6 weeks. The facility could not provide documented evidence that R20 had been seen by a physical therapist. R20's undated care plan identified the following: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1) R20 was at risk for ADL self-care needs. The goal was to maintain R20's current level of function. Interventions was for staff to provide extensive assist of 1 with R20 for showers, personal hygiene and to transfer to commode by pivot with walker, and for PT/OT to evaluate and treat per MD orders. 2) R20 was a high risk for falls related to limited weight bearing, back pain, hypertension, and medication use side effects. The goal was to be free of falls. Interventions was for staff to anticipate and meet R20's needs and for PT to evaluate and treat as ordered or as needed (PRN). Email correspondence on 11/14/24 at 3:45 p.m., from Therapy Director identified the facility's PT therapist last day of work was 8/30/24. Interview on 11/14/24 at 3:00 p.m., with occupational therapist was treating R20 for occupational services with restrictions due to R20's central line (inserted into a large vein in the body to provide access to the bloodstream) on her right arm. She had reviewed R20's transfer status upon admission and was waiting for a replacement for the physical therapist who had left their employment at the facility on august 30th. She was aware the facility had a plan to hire a new physical therapist before mid-December of 2024. Interview on 11/18/24 at 11:15 a.m., with administrator had used the OT therapist in house to provide services to residents and was aware the facility had no physical therapist in house. Her plan was to hire a new physical therapist for the facility and had hired one last week. Email correspondence on 11/18/24 at 11:44 a.m., from the administrator identified a new PT was hired on 10/28/24. Interview on 11/18/24 at 1:14 p.m., with R20 was seen by 2 PT staff from her previous stay at the nursing home earlier this year. She was readmitted back to the facility on [DATE] with therapy orders and was informed by the OT staff that the previous PT staff had transferred to another location and the facility had no current PT staff. She stated she had been working with OT staff when admitted and was aware facility staff did not know how to appropriately transfer her, initially. She had verbally informed and had provided education to staff on how to transfer her safely for her toileting and mobility needs. Review of August 2024 Facility Assessment identified the facility would provide ancillary services, including, activities occupational therapy, physical therapy, and speech therapy. In addition, the facility's resources included, chemical dependency program, behavioral health, and specific rehabilitation therapy.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39988 Based on interview and document review the facility failed to ensure the binding arbitration agreement was fully explained in a manner that 16 of 32 residents (R1, R5, R9, R10, R15, R16, R18, R26, R30, R32, R33, R37, R40, R42, R148, and R246) and/or their representatives understood and had been explained their right to not sign the agreement. This had the potential to affect all 32 residents. Findings include: During the 11/12/24 entrance conference at 9:14 a.m., the social service designee (SSD) identified the arbitration agreement was not a pre-condition for admission and there had been no residents who had signed one. Review of Resident and Facility Arbitration Agreement identified it was not a condition of admission. The parties understood and agreed that this contract contained a binding arbitration provision which may be enforced by the parties, and that by entering into this arbitration agreement, the parties would be giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury, as well as any appeal from a decision or award of damages. The resident understood that (1) he/she had the right to seek legal counsel concerning this arbitration agreement, (2) that execution of this arbitration agreement was not a precondition to admission or to the furnishing of services to the resident by the facility, and (3) this arbitration agreement may be rescinded by written notice to the facility from the resident within 30 days of signature. If not rescinded within 30 days, this arbitration agreement shall remain in effect for all subsequent stays at the facility, even if the resident was to discharge and readmit to the facility later. The undersigned certified that he/she had read the arbitration agreement and that it had been fully explained to him/her, that he/she understood its contents, and had received a copy of the provision and that he/she was the resident, or a person duly authorized by the resident or otherwise to execute this agreement and accept its terms. Interview on 11/14/24 at 11:31 a.m., with social service designee (SSD) identified she completed the admission packet and during that time she explained to the resident what an arbitration agreement was. She reported the resident then signed the arbitration agreement however, there was no residents in an active arbitration. The SSD explained to the resident that by signing the arbitration agreement they agree that disputes would be handled by an arbitrator in a conference room verses the legal court system and a judge. She added that she also informed the resident that the fees are different, which she did not go into detail with the resident but rather just told them it was different. For the cognitively impaired resident the guardian or POA would sign the agreement. She revealed at the entrance meeting when she had reported no one had signed an arbitration agreement, she meant that no one was actually engaged in an active arbitration dispute. R148 was a new admission and had been at the facility less than 2 weeks, with no MDS completed at time of survey. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R148's medical record identified that the Resident and Facility Arbitration Agreement had been signed by the resident the day after admission to the facility and the SSD had signed as the witness. Interview on 11/14/24 at 12:05 p.m., with R148 identified SSD had never explained to him what an arbitration agreement was. He reported he had not received a copy of an arbitration agreement or any of his admission papers. He reported he did not realize he signed any kind of an agreement, and he did not want to sign an agreement. R10's 6/6/24, admission Minimum Data Set (MDS) identified R10's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15. Review of R10's medical record identified that the Resident and Facility Arbitration Agreement had been signed by the resident on admission day and the SSD had signed as the witness. Interview on 11/14/24 at 12:14 p.m., with R10 revealed he did not remember anyone ever talking with him about an arbitration agreement or what that was. He further stated, I don't know what that is. R32's 4/17/24, admission MDS identified R32's cognition was moderately impaired with a BIMS score of 10. Review of R32's medical record identified that the Resident and Facility Arbitration Agreement had been signed by the resident on admission day and the SSD had signed as the witness. Interview on 11/14/24 at 12:16 p.m., with R32 identified he did not know what an arbitration agreement was, and he did not remember anyone ever talking to him about any agreement. Interview on 11/18/24 at 4:11 p.m. with the administrator identified she would expect that the arbitration agreement would be explained in a manner that the resident would understand. If the resident did not understand she would expect that they would not sign the agreement. 49336 Resident Council During the resident group meeting held on 11/07/24 at 3:30 p.m., R1, R9, R15, R26 and R42 were in attendance. Upon asking, R1, R9, R15, R26 and R42 were not aware of signing an arbitration agreement on admission. R42 stated she had received a stack of papers and was informed to sign them all when admitted . The residents identified they were unaware what an arbitration agreement was and they had the option of not signing it. R26 was admitted on [DATE]. R26's face sheet identified R30 was his own power of attorney. R26's 9/21/24, Significant change Minimum Data Set (MDS) identified he was cognitively intact. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R26's 9/29/23, signed Resident and Facility Arbitration Agreement identified the agreement was explained to R26 and had understood the contents and was provided a copy of the agreement. R42 was admitted on [DATE]. R42's face sheet identified R26 was her own power of attorney. R42's 10/22/24, admission MDS identified she had a mild cognitive impairment. R42's 10/16/24 signed Resident and Facility Arbitration Agreement identified the agreement was explained to R42 and had understood the contents of the agreement and was provided a copy of the agreement. R30 was admitted on [DATE]. R30's face sheet identified R30 was his own power of attorney. R30's 9/05/24, quarterly MDS identified he was cognitively intact. R30's 2/29/24, signed Resident and Facility Arbitration Agreement identified the agreement was explained to R30 and had understood the contents and was provided a copy of the agreement. 34083 R37's admission Minimum Data Set (MDS) assessment identified his cognition was intact, he was independent with activities of daily living (ADLs) and was receiving therapy services of Occupational (OT) and Speech (ST) therapies. R3 also had orders for physical therapy (PT) which he received until the end of August 2024, when the facility no longer had available PT services available. Review of minutes of therapy provided included Therapy - Speech-85 minutes x 2 days, OT-43 individual minutes group 31 minutes. PT - 107 minutes 8/26/24 -ongoing at time of submission, but no additional minutes were documented for PT services. R37 was admitted [DATE] following acute hospitalization for diagnoses including metabolic encephalopathy, alcohol abuse, ADHD, degeneration of nervous system due to alcohol, cognitive communication deficit, history of falling, weakness, and difficulty walking. Interview on 11/14/24 at @2:30 p.m. with R37, and the SSD in attendance reported he was aware of what an Arbitration Agreement was and voiced the SSD had explained it when he was admitted . He voiced he was aware he had signed the agreement and had no concerns. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabasso Restorative Care Center	660 Maple Street Wabasso, MN 56293

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 11/18/24 at 10:27 a.m., with R37 who requested to speak privately with this surveyor when he saw her in the hall on the next day (11/18/24) of the survey process. Upon entrance to R37's room he stated, I want to apologize for lying. R37 reported he had no idea what an Arbitration agreement was, and he had felt intimidated by the SSD when he had been asked with her in attendance. He reported she was watching him, and he reported he had understood about the Arbitration agreement and agreed to sign the document, but he had no idea what we were talking about. R37 stated he would not have signed the agreement if he had understood what he was signing. R37 repeated he was NOT IN agreement with signing an Arbitration Agreement and was not aware he had signed one until interviewed with the SSD in attendance. R37 reported the SSD had mouthed, thank you when he had replied he was aware of what he had signed and that had also bothered him. R40 R40's 10/9/24 admission Minimum Data Set (MDS) assessment identified her cognition was intact and she was independent with activities of daily living (ADLs). R 40 reported she had come to the facility for therapy services following back surgery and was having a lot of pain for which she received both medication and non-pharmacological interventions. R40 had diagnosis of Vertebrogenic low back pain, muscle spasm, sheltered homelessness, alcohol abuse, and other psychoactive substance abuse. Subsequent interview on 11/18/24 at 12:58 p.m., with R40 reported she was fearful of retaliation from staff and administration, and she had not understood what an Arbitration agreement, was, and reported it was not something she would have signed if she had been aware of what she was signing. R40 reported she had been given paperwork at the time she was admitted and told by the SSD she needed to sign the forms for being admitted to the facility. R40 reported she had signed the documents but had not realized what she was signing.

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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 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** 39988 Based on observation, interview and document review the facility failed to implement enhanced barrier precautions for 1 of 1 resident (R148) who had surgical wounds and a PICC line. Additionally, the facility failed to have appropriate infection control surveillance to monitor infections through to resolution for 3 of 3 months reviewed. This had the potential to affect all 32 residents. Findings include: R148 was a new admission within the last 6 days prior to the survey. R148's 11/9/24, care plan identified risk for transmitting an infection, enhanced barrier precautions per CDC guidelines. Interview on 11/12/24 at 10:08 a.m., with R148 identified he had surgical wound on both feet from amputation of bilateral toes, partial left heel removed, he reported he had major infection and they surgically removed that. He reported all the surgery was related to him getting frostbite last winter and he spent months in the hospital. He also was observed to have an orthopedic metal pin device in his left lower shin which suspended his left foot due to the pin. He reported he was non-weight bearing at this time, he received an antibiotic twice a day at 9:00 a.m. and 9:00 p.m., through his PICC line (catheter inserted into a vein or artery directly into the blood stream for IV antibiotic use) that was visible in his right upper arm. Observation on 11/12/24 at 10:37 a.m. of R148's door to room had no sign indicating EBP. Observation on 11/12/24 at 2:06 p.m., of R148's door to room had no sign indication EBP. R148's history and physical identified osteomyelitis wound graft site, wound incision foot anterior left, wound incision removed foot anterior right, wound incision removed heel left, bilateral toes 1-5 dry gangrene status post bilateral 1-5 toe amputations, and orthopedic external skeletal fixation pin on left lower extremity. A PICC line placed in right upper arm for IV antibiotic use for course of antibiotic therapy. Observation on 11/13/24 at 9:00 a.m., of R148's door to room had no sign indicating EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on 11/13/24 at 1:34 p.m., with licensed practical nurse (LPN)-A who obtained supplies to complete the dressing changes for R148 bilateral feet. Upon entering R148's room it was noted he had no sign on his door indicating EBP. She knocked and we entered, she explained what she was going to do. She washed her hands, donned her gloves, and removed the old dressing, she changed gloves and washed the surgical wounds. She changed gloves and applied dressing and wrapped with kerlix. She talked through what she was doing and questioned R148 about his pain level throughout the procedure. LPN-A had provided R148 with a pain pill prior to the dressing changes. Once outside of room LPN-A was asked if R148 was on any type of precautions. LPN-A paused and then stated that is a good question, and she would check on that. She then reported that since R148 had wound R148 should be on enhanced barrier precautions (EBP). She revealed she typically relies on the signage on the resident's door to know if the resident was on any type of precautions. She confirmed that R148 had no signage on his door indicating any type of precaution. Interview on 11/13/24 at 2:05 p.m. with R148 confirmed there had been no staff that had ever put on a gown during his wound dressing changes. He revealed that the nurse changes the dressing on his feet every day and no staff had ever wore a gown. Interview on 11/13/24 at 2:07 p.m., with registered nurse (RN)-A identified she had added EBP to R148's care plan when he was admitted due to his surgical wounds. She stated, let me guess there is no sign on his door. She revealed that should have all been set up on admission day. Interview on 11/18/24 at 4:11 p.m., with administrator identified she would expect if a resident was identified as needing to be on EBP that a sign would be posted on the door to the room and PPE supplies readily available. Review of the 6/24/24, Enhanced Barrier Precautions policy identified EBP was an infection control intervention to reduce transmission of organisms. The facility would initiate EBP for wounds such as chronic, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers, and/or indwelling medical devices such as central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, and midline catheters. Even if the resident is not known to be infected or colonized with a MDRO. The facility should ensure gowns and gloves available immediately near or outside of the resident's room. EBP should be implemented during high-contact care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care, and wound care. 38687 SURVEILLANCE Review of the infection control surveillance from August 2024 through November 2024 provide identified columns as follows: 1) Resident 2) Admit/entry date 3) Onset date. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) Infection diagnosis (dx). 5) Site. 6) Healthcare acquired infection (HAI) to be checked yes or no. 7) Isolated: If Yes: Date, or No for selections. 8) Culture: If Yes: Date, or No for selections. 9) Organism. 10) Antibiotic. 11) Re-culture date. 12) X-ray date. 13) Date resolved. Interview and surveillance review on 11/18/24 at 3:35 p.m. with the director of nursing (DON)/infection preventionist (IP) identified the DON was new to her role as both DON and the IP. She had only been in her role as IP for approximately 2 weeks. The Minimum Data Set (MDS) coordinator, assisted in helping her with surveillance. She was enrolled in a course but had not taken it yet. The previous DON/IP left the faciity on [DATE]. The DON/IP was unsure what types of transmission based precautions (TBP) needed to be implemented, and upon review of the surveillance, agreed, several critical sections like Isolated had been left blank. She agreed there was no way to determine if TBP had been implemented timely or at all. She does input infections into the computerized system (Point Click Care) but was still utilizing the paper forms listed above for her surveillance. The DON remarked she was unsure how to perform surveillance and only had about 1 hour to devote to infection control (IC). Another staff at a sister facility was to oversee their program, but she has been out on vacation and prior to that, has had minimal interaction for oversight of the program. Further review of the above surveillance identified of the 45 entries from August 2024 through November 2024: 1) HAI was selected 1 x. 2) Isolated was selected 1 x. 3) R296 was identified having Clostridium Difficile (C-Diff). There was no indication when or what type of precautions were implemented, when TBP were removed, and if his symptoms resolved. The date resolved was the date R296 had finished the course of antibiotics. 4) 4 residents (R9, R26, R40, and R297) were identified with resistant bacteria strains in wounds and an infected surgical implant. It is unknown when or if they were placed into precautions, what type of precautions if any were utilized, or if they required enhance barrier precautions (EBP) long term. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) 33 residents (R18, R25, R15, R1, R39, R38, R27, R9, R20, R10, R22, R34, R12, R37, R21, R35, R41, R2, R17, R19, R36, R16, R6, R23, R31, R28, R8, R11, R43, R42, R29, R30 and R40) had been identified with COVID-19 and/or 7 had upper respiratory infections (URI). None showed if TBP had been implemented, the date TBP if any, had been placed, or the type of TBP utilized. There was no indication the facility analyzed data for residents infected with COVID-19 during a COVID outbreak (identified by the Centers for Disease Control as 1 or more residents) were quarantined, rooms changed or precautions placed to prevent further outbreak to other residents. Interview on 11/18/24, with the sister facility's IP who was reported to oversee the program was attempted, however was unable to be conducted as they were out of the office. Interview and surveillance review on 11/18/24 at 4:35 p.m., with the administrator identified she agreed the DON required extensive oversight of the IP at the facility until she had been trained and deemed competent to oversee the IP at the facility. She agreed the surveillance tracking needed to be comprehensive, include more data, and that data be analyzed to prevent potential spread of infection. The administrator noted she would follow up on the above identified concerns. Review of the 5/29/24, Infection Surveillance policy identified surveillance was to be an ongoing, systemic collection, analysis, interpretation, and dissemination of infection related data. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. Nurses were to participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. Examples of notification triggers include, but are not limited to: a. Resident develops signs and symptoms of infection. b. A resident is started on an antibiotic. c. A microbiology test is ordered. d. A resident is placed on isolation precautions, whether empirically or by physician order. e. Microbiology test results show drug resistance. All resident and infections were to be tracked. Separate, site-specific measures were to be tracked as prioritized from the infection control risk assessment. Outbreaks were to be investigated.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38687 Based on interview and document review, the facility failed to ensure 1 of 1 director of nursing (DON)/infection preventionist (IP) had appropriate training and oversight of the infection control program to management by performing surveillance activities, maintain documentation of incidents, findings, and any corrective actions required. Findings include: Review of the infection control surveillance from August 2024 through November 2024 provide identified columns as follows: 1) Resident 2) Admit/entry date 3) Onset date. 4) Infection diagnosis (dx). 5) Site. 6) Healthcare acquired infection (HAI) to be checked yes or no. 7) Isolated: If Yes: Date, or No for selections. 8) Culture: If Yes: Date, or No for selections. 9) Organism. 10) Antibiotic. 11) Re-culture date. 12) X-ray date. 13) Date resolved. (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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and surveillance review on 11/18/24 at 3:35 p.m. with the director of nursing (DON)/infection preventionist (IP) identified the DON was new to her role as both DON and the IP. She had only been in her role as IP for approximately 2 weeks. The Minimum Data Set (MDS) coordinator, assisted in helping her with surveillance. She was enrolled in a course but had not taken it yet. The previous DON/IP left the faciity on [DATE]. The DON/IP was unsure what types of TBP needed to be implemented, and upon review of the surveillance, agreed, several critical sections like Isolated had been left blank. She agreed there was no way to determine if TBP had been implemented timely or at all. She does input infections into the computerized system (Point Click Care) but was still utilizing the paper forms listed above for her surveillance. The DON remarked she was unsure how to perform surveillance and only had about 1 hour to devote to infection control (IC). Another staff at a sister facility was to oversee their program until she was properly trained and deemed competent, but she has been out on vacation and prior to that, has had minimal interaction with the DON for oversight of the program. Further review of the above surveillance identified of the 45 entries from August 2024 through November 2024: 1) HAI was selected 1 x. 2) Isolated was selected 1 x. 3) R296 was identified having Clostridium Difficile (C-Diff). There was no indication when or what type of precautions were implemented, when TBP were removed, and if his symptoms resolved. The date resolved was the date R296 had finished the course of antibiotics. 4) 4 residents (R9, R26, R40, and R297) were identified with resistant bacteria strains in wounds and an infected surgical implant. It is unknown when or if they were placed into precautions, what type of precautions if any were utilized, or if they required enhance barrier precautions (EBP) long term. 5) 33 residents (R18, R25, R15, R1, R39, R38, R27, R9, R20, R10, R22, R34, R12, R37, R21, R35, R41, R2, R17, R19, R36, R16, R6, R23, R31, R28, R8, R11, R43, R42, R29, R30 and R40) had been identified with COVID-19 and/or 7 had upper respiratory infections (URI). None showed if TBP had been implemented, the date TBP if any, had been placed, or the type of TBP utilized. There was no indication the facility analyzed data for residents infected with COVID-19 during a COVID outbreak (identified by the Centers for Disease Control as 1 or more residents) were quarantined, rooms changed or precautions placed to prevent further outbreak to other residents. Interview on 11/18/24, with the sister facility's IP who was reported to oversee the program was attempted, however was unable to be conducted as they were out of the office. Interview and surveillance review on 11/18/24 at 4:35 p.m., with the administrator identified she agreed the DON required extensive oversight of the IP at the facility until she had been trained and deemed competent to oversee the IP at the facility. She agreed the surveillance tracking needed to be comprehensive, include more data, and that data be analyzed to prevent potential spread of infection. The administrator noted she would follow up on the above identified concerns. (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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 5/29/24, Infection Surveillance policy identified surveillance was to be an ongoing, systemic collection, analysis, interpretation, and dissemination of infection related data. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. Nurses were to participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections. Examples of notification triggers include, but are not limited to: a. Resident develops signs and symptoms of infection. b. A resident is started on an antibiotic. c. A microbiology test is ordered. d. A resident is placed on isolation precautions, whether empirically or by physician order. e. Microbiology test results show drug resistance. All resident and infections were to be tracked. Separate, site-specific measures were to be tracked as prioritized from the infection control risk assessment. Outbreaks were to be investigated.