STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda	901 Southeast Willmar Avenue Willmar, MN 56201

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review the facility failed to follow the physician order to notify the medical provider of weight changes for 1 of 3 (R1) residents reviewed for change of condition. Findings include: R1's admission minimum data set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. R1's medications included a diuretic (medication to get rid of excess fluid). R1's Nutrition assessment dated [DATE], identified R1's admission weight was 177 pounds with usual body weight of 180 pounds. The assessment further identified R1's dehydration risk factors were use of a diuretic, thickened liquids/modified diet, total feeding assistance, dysphagia (difficulty swallowing), renal disease, and incontinence. R1's Orders Discharge Report dated 9/26/24, included the following orders: spironolactone 25 milligrams (mg) tablet daily for heart failure. (medication to remove excess fluid) torsemide 20mg tablet; take 1/2 tablet by mouth in the morning for heart failure May take additional tablets as directed by the HF [heart failure] clinic. (medication to remove excess fluid). Weigh daily and report change of three (3) pounds overnight or five (5) pounds in a week. R1's Treatment Administration Record (TAR) dated 10/1/24 to 10/31/24 indicated to weigh daily every day shift related to chronic systolic (congestive) heart failure and to report change of three (3) lbs. [pounds] overnight or 5 lbs. [pounds] in a week per heart failure clinic with a start day of 9/27/24. Weights were completed 10/1/24 to 10/18/24 and identified the following: 10/1/24 weight was 177.2 and 10/7/24 weight was 169.9 to reflect a 7.3-pound weight loss in a week. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/7/24 weight was 169.9 and 10/8/24 weight was 166.9 to reflect a 3-pound weight loss overnight. 10/8/24 weight was 166.9 and 10/15/24 weight was 160.1 to reflect a 6.8-pound weight loss in a week. R1's clinical record lacked notification to the physician or the heart failure clinic for the weight fluctuations as ordered. During an nterview on 11/5/24 at 9:15 a.m., the director of nursing (DON) verified R1's weight changes should have been reported to the medical provider but were not reported as ordered. During an interview on 11/5/24 at 10:00 a.m., R1's primary care physician (PCP) indicated he was not notified of R1's weight loss and usually would be notified of a significant weight loss. Further indicated R1's weights should have been reported to the heart failure clinic to adequately manage R1's diuretic and heart failure. During an interview on 11/5/24 at 10:28 a.m., registered nurse (RN) from the heart failure clinic verified they had not been notified of the weight fluctuations and should have been. The RN further indicated any weight fluctuations of three pounds in one day and five pounds in one week would require an evaluation and possible changes in medications to prevent fluid overload or too much fluid loss.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review the facility failed to ensure a comprehensive care plan was developed within the required timeline for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1's admission minimum data set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. The MDS also identified R1 was at risk for pressure ulcers, had a history of falls, was on a texture modified diabetic diet, and had unclear speech. The MDS further identified high risk medications as antianxiety, antidepressant, diuretic, and antiplatelet medications. R1's Communication Care Area Assessment (CAA) dated 10/8/24, identified R1 had expressive aphasia and unclear speech and was only able to answer yes or no questions and had attempted to use a whiteboard for making needs known. Also identified R1 was working with speech therapy (ST) and would proceed with care planning for continuity of care. R1's Cognitive Loss/Dementia CAA dated 10/7/24, identified R1 was not able to complete the brief interview for mental status (BIMS) because of R1's communication deficit. The CAA also indicated would proceed with care planning for continuity of care. R1's Visual Function CAA dated 10/8/24, identified R1 wore reading glasses and a possible right field vision cut related to cerebral vascular accident (CVA) and would proceed with care planning for continuity of care. R1's Urinary Incontinence CAA dated 10/8/24, identified R1 had bladder incontinence and needs were anticipated 24 hours a day. Further indicated R1 would have a routine toileting schedule to minimize incontinence and would proceed with care planning for continuity of care. R1's Falls CAA dated 10/8/24, identified R1 had right sided hemiplegia, was total assist with all activities of daily living (ADL)s, has difficulty verbalizing needs, and required assistance of a Hoyer (full body mechanical lift). The CAA also indicated the goal was to minimize the risk of falls and would proceed with care planning for continuity of care. R1's Pressure Ulcer CAA dated 10/8/24, identified R1 did not have any pressure ulcers but was at risk for developing pressure ulcers due to R1's impaired mobility, incontinence, and total assist of staff for transfers. The CAA indicated the goal was to minimize the risk and would proceed with care planning for continuity of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Psychotropic Drug Use CAA dated 10/8/24, identified R1 received antidepressant medications with new medications started during hospitalization . The CAA further identified R1 had a risk of complications related to medication use and would proceed with care planning for continuity of care. R1's baseline Individual Resident Care Plan developed on 9/26/24, identified R1 was a fall risk, had a wound on the inner right bicep, was on an anticoagulant, was at risk for dehydration, and was on a diabetic pureed diet. R1's nutrition care plan dated 10/2/24, identified R1 had a nutritional risk related to diagnosis diabetic diet with interventions identified. The care plan also identified R1 was independent in planning her leisure time with interventions identified. The care plan did not include any of the other potential or actual risk areas identified on the comprehensive assessments or the CAAs. The care plan did not identify any goals or interventions to mitigate the risks of the identified risk care areas. During an interview on 10/31/24 at 2:35 p.m., registered nurse (RN)-A indicated she was filling in as t R1's case manager and was not aware R1's care plan had not been completed but verified it was not comprehensive or complete. During an interview on 11/5/24 at 9:15 a.m., the director of nursing (DON) indicated a baseline care plan was completed but verified the comprehensive care plan was not comprehensive or complete. The DON indicated their team thought they had 21 days from admission and was not aware of the seven (7) day after CAAs were completed timeline. The facility policy titled, Care Planning dated 2/2024, indicated the purpose was to provide an individualized and comprehensive interdisciplinary plan of care for each individual that promote quality of care and lift. The policy identified the comprehensive care plan is developed with in 21 days of the admitted .

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39998 Based on interview and document review, the facility failed to identify, monitor, and comprehensively assess for dehydration and significant weight loss for 1of 3 residents (R1) reviewed for change of condition. The facility's failures resulted in harm for R1 who had a 20 pound weight loss in 18 days and was subsequently admitted to the hospital for dehydration, acute renal failure, and later died . Findings include: R1's admission minimum data set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. The MDS also identified R1 was at risk for pressure ulcers, had a history of falls, was on a texture modified diabetic diet, and had unclear speech. The MDS further identified high risk medications as antianxiety, antidepressant, diuretic, and antiplatelet medications. R1's baseline care plan dated [DATE] identified R1 was at risk for dehydration. The care plan did not identify associated interventions. R1's nutritional care plan dated [DATE], identified R1 was at nutritional risk related to diagnosis of diabetes with a goal of R1 will maintain weight at 177 pounds or gradual weight loss and would not show signs/symptoms of dehydration. Will meet nutritional needs through oral intake of >50% of most meals. Interventions included: diet and supplements per doctor order, honor food choices, hydration per facility protocol, record food and fluid intake, and obtain weights per facility policy. R1's physician orders included the following -Spironolactone (medication to remove excess fluid) 25 milligrams (mg) tablet daily for heart failure (start date [DATE]) -Torsemide (medication to remove excess fluid) 20mg tablet; take ,d+[DATE] tablet by mouth in the morning for heart failure May take additional tablets as directed by the HF [heart failure] clinic (start date [DATE]) -Weigh daily and report change of three (3) pounds overnight or five (5) pounds in a week (start date [DATE]). R1's Admission Note dated [DATE], identified R1 was admitted following hospitalization for a short-term rehabilitation stay. Further identified R1 had demonstrated decision-making capacity and participated in admission decisions. R1 had a goal to return home. R1's Progress Note dated [DATE], indicated R1 was alert and able to answer writer with short words. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Nutrition assessment dated [DATE], indicated R1's weight (wt) was 177 pounds (lbs) and was close to reported usual body weight. The assessment identified R1 was at risk for dehydration due to required staff assist with eating; diagnosis of diabetes, dementia, renal disease; diuretic and psychotropic medications; dysphagia (difficulty swallowing), thickened liquids, and modified texture diet. The assessment indicated R1's required an estimated ,d+[DATE] Kcals daily and required ,d+[DATE] milliliters (ml) of fluid daily. Interventions identified noted in the section Additional Nutritional Comments included but were not limited to: fluids offered and encouraged through the day. Water mug available at bedside. R1's weights recorded on the [DATE] treatment administration record (TAR) identified the following: On [DATE] wt. was 177.2 lbs. On [DATE] wt. was 175.6 lbs. On [DATE] wt. was 170.9 lbs. On [DATE] wt. was 170.7 lbs. On [DATE] wt. was 171.3 lbs. On [DATE] wt. was 170.1 lbs. On [DATE] wt. was 169.9 lbs., which identified R1 had 7.3 lb weight loss since [DATE]. R1's meal and fluid intake sheet for [DATE] included the direction; if a resident shows sign of decrease in appetite, let the supervisor know. R1's food and fluid consumption's between [DATE] through [DATE] identified the following: -[DATE] through [DATE] there was no recorded entries for food and fluid intake. -[DATE] total fluid intake 240 ml, a deficit of at least 1260 ml. Food intake: 25% for lunch. -[DATE] total fluid intake possibly ,d+[DATE] ml for breakfast (entry was not legible), a deficit of at least 1400 ml. Food intake: for 25% breakfast. -[DATE] total fluid intake 380 ml, a deficit of at least 1120 ml. Food intake: breakfast bites, 100% lunch and dinner. R1's Physician Visit Note dated [DATE], indicated R1 was seen by her primary care physician via video visit for hospital follow-up. R1 received a change in antidepressant medication with no other orders. The note did not address R1's fluid or nutritional status (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In review of R1's record between [DATE] through [DATE], it was not evident R1's physician and/or heart failure clinic had been notified of the 7.3 lb. weight loss. Although, it was identified R1 was at risk for dehydration and weight loss, the record did not identify a comprehensive hydration and nutritional assessment was completed to determine if the weight loss was contributed to nutrition or as a result of fluid loss secondary to diuretic medications and low fluid intake. Additionally, after the nutritional assessment was completed on [DATE], there was no indication interventions were implemented nor evident R1's fluid and food deficits were comprehensively assessed to determine appropriate interventions. R1's daily Focus Charting dated [DATE] to[DATE] did not indicate any concerns and noted R1 to be alert. The documentation did not address R1's low food or fluid consumption. R1's Skilled Note on [DATE], noted R1 to be alert on and off, no facial grimacing, smiled on and off, pleasant mood, no behaviors, no vision, or hearing concerns. The documentation did not address R1's low food or fluid consumption. R1's Focus Charting Note dated [DATE], noted R1 to be alert. The documentation did not address R1's low food or fluid consumption. R1's weights recorded on the [DATE] TAR identified the following On [DATE] wt. was 166.9 lbs; wt loss of 3 lbs from [DATE] On [DATE] wt. was 167.6 lbs On [DATE] wt. was 164.8 lbs On [DATE] wt. was 164.9 lbs. On [DATE] wt. was 162.9 lbs. On [DATE] wt. was 161.2 lbs. On [DATE] wt. was 160.1 lbs. On [DATE] wt. was 160.1 lbs. On [DATE] wt. was 158.6 lbs. On [DATE] wt. was 157.2 lbs.; identifying a total weight loss of 20.0 lbs in 18 days since [DATE]. R1's meal and fluid intake sheet for [DATE] included the direction; if a resident shows sign of decrease in appetite, let the supervisor know. R1's food and fluid consumption's between [DATE] and [DATE] identified the following: -[DATE], total fluid and food intake could not be calculated; no documentation was recorded for the evening meal. However the record identified for breakfast and lunch R1 did not have any fluid or food intake. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-[DATE], total fluid and food intake could not be calculated; no recorded entries for lunch and evening meal. However, the record identified for breakfast R1 consumed 180 ml of fluid and 75% of her meal. -[DATE], total fluid and food intake could not be calculated; no recorded entries for evening meal. However, the record identified R1 consumed 240 ml of fluid and ate 25% of lunch and 25% of evening meal. -[DATE], total fluid intake 520 ml; a deficit of 980 ml. Food intake breakfast ,d+[DATE] [sic], lunch-75%, and 100% for the evening meal. -[DATE], total fluid and food intake could not be calculated; no recorded entries for evening meal. However the record identified total fluid for breakfast and lunch was 600 ml. Food intake for breakfast 50% and lunch 100% was consumed. -[DATE], total fluid and food intake could not be calculated; no recorded entries for evening meal. However the record identified total fluid for lunch was 200 ml. Food intake for breakfast was 25% and zero (0) for lunch. -[DATE], total fluid and food intake could not be calculated; no recorded entries for evening meal. However, the recorded entries identified R1 did not consume any food or fluids for breakfast and lunch. -[DATE], total fluid and food intake could not be calculated; no recorded entries for the evening meal. However,the record identified R1 had zero (0) fluid intake for breakfast and zero (0) for lunch, R1 consumed 25% of lunch meal. -[DATE], total fluid intake 520 ml, a deficit of 980 ml. Food intake for breakfast was not legible, R1 ate 100% of her lunch and dinner. -[DATE], total fluid intake 520 ml, a deficit of 980 ml. Food intake recorded breakfast 75%, lunch 75%, and evening meal 100%. In review of R1's record between [DATE] through [DATE] revealed no indication the physician or the congestive heart failure clinic were notified of R1's continued weight loss and overall weight loss of 20 lbs in 18 days. Additionally, the record continued to not identify comprehensive assessments for fluid balance, dehydration, or nutrition nor evident the care plan was revised. R1's Focus Charting Note dated [DATE], noted R1 to be alert. R1's General Note dated [DATE] at 5:27 p.m., indicated a meeting was held with R1's family, nursing, and therapies to discuss R1's increased lethargy and weakness the past several days with minimal verbal responses. R1's family requested a urinary analysis (UA) to rule out urinary tract infection. R1's family reported R1 was uncomfortable, facial grimacing, restlessness. R1 was reported to not be progressing in therapies and discussed further options. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Focus Charting Note dated [DATE] at 1:58 p.m. noted R1 to be sleepy, less responsive, and not swallowing medications. Urine specimen obtained and sent to lab at 1:45 p.m. R1's urine was noted to be dark amber in color. R1's Speech Therapy discharge note dated [DATE], identified R1 participated and was demonstrating progress with improved efficiency of swallow phases and using left hand for drinking and eating at time but recently R1 had overall decline, decreased participation in therapies, lethargic. R1's Discharge Record dated [DATE] at 6:15 p.m. indicated R1 was transferred to the hospital and her condition was unstable. Resident sent to ER due to decline in condition. Decreased oral intake, sleeping more. admitted to the hospital for multiple conditions. R1's hospital emergency room note dated [DATE], indicated R1 presents with generalized weakness/ and fatigue secondary to dehydration. R1's family reported R1 had become weaker and not participating as much in the past week since [DATE]. R1's urine is dark and foul smelling and appears dehydrated upon arrival. R1's critical condition was renal failure (acute) and hypernatremia (critical high sodium levels in the blood) and required fluid resuscitation. Sodium level was 169 (normal range ,d+[DATE]), Creatinine 4.54 (normal range 0XXX,d+[DATE].11), and BUN was 157.0 (normal range 7XXX,d+[DATE].1) R1 was also noted to have a blood sugar of 659 (normal is approximately ,d+[DATE] according to www.cdc.gov) and urinalysis positive for an acute urinary tract infection (UTI). R1's death certificate indicated R1 died on [DATE] in the hospital. During an interview on [DATE] at 10:32 a.m., family member (FM-A) indicated around [DATE], R1 was less alert and appeared more depressed. On [DATE], R1 was not participating in therapy as much, had decreased fluid intake, and was not eating as well. FM-A stated on [DATE], R1's eyes were sunken in, mouth was dry, and lips were chapped and requested a urinary analysis (UA) as R1 had a history of UTI's. FM-A attended the care conference and indicated therapies reported that R1 was participating and improving until there was a shift on Monday ([DATE]). During an interview on [DATE] at 4:40 p.m., nursing assistant (NA)-A indicated R1 was alert during the first part of her stay and then a couple of weeks before R1 was hospitalized she would not eat much, slept more, stopped answering questions, and her urine would have a strong odor sometimes. NA-A reported telling the charge nurse about her increased sleepiness and not eating but was not sure what they did with that information. During an interview on [DATE] at 5:15 p.m., NA-B indicated R1 was alert and bubbly when she first arrived and communicated mostly with her facial expressions. NA-B indicated about a week before R1 went to the hospital things got weird and clarified R1 got super tired, would drop her head back and be difficult to arouse during meals, and just stopped eating. NA-A indicated the nurse was notified and they were directed to lay her down and monitor it for a few days. NA-A further explained R1 would let fluids run out of her mouth and not swallow anything and R1's family was concerned about a UTI and then R1 went to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 5:50 p.m., licensed practical nurse (LPN)-A indicated she worked as a charge nurse on all facility units and described R1 as making some overall progress and then started to decline and was more tired. LPN-A said the expectation was that NAs were to notify the charge nurse with any change of resident condition and the charge nurse was to assess the resident and their actions were dependent on their findings. LPN-A further explained if a resident's weight was three (3) pounds different from the previous one, the resident would be reweighed and if it was accurate, the nurse should notify the case manager, the doctor, and interdisciplinary team (IDT). LPN-A identified she was not aware if R1 was ordered to have daily weights or aware of R1's weight loss. During an interview on [DATE] at 2:15 p.m., registered nurse (RN)-B indicated the case manager for R1's unit was no longer employed at the facility and was assisting on R1's unit the day that R1's daughter brought up concerns about a possible UTI and requested an order. RN-B further indicated she was not aware of R1's weight loss or overall decline. During an interview on [DATE] at 11:20 a.m., the dietary manager (DM) stated the dietary staff was responsible for monitoring food and fluid intakes during mealtimes and were to document on the intake sheet. The DM verified that 21 meal and fluid intakes had not been documented during the period of [DATE] to [DATE] and stated, they were blank because someone was not doing their job. During an interview on [DATE] at 11:30 a.m., the registered dietician (RD) indicated she could not remember if she was notified of R1's weight loss. The RD further identified the nurses were to review the weights and report any weight changes to her. The RD indicated a weight loss of 20 pounds in 18 days was a significant weight loss and should have been reported to her. During an interview on [DATE] at 2:00 p.m., therapist (OT)-A indicated R1 initially was bright and alert and would answer yes and no questions but started to decline about a week prior to hospitalization . OT-A verified R1's decline was reported to nursing during that week but was unsure what additional assessment or follow up was done. During an interview on [DATE] at 2:05 p.m., physical therapy (PT)-A indicated R1 was more responsive and had a sense of humor but then started to decline, was refusing therapy, not tolerating sitting up, not eating as much. PT-A indicated their department was in constant communication with nursing and the decline was reported to nursing as it was occurring. During an interview on [DATE] at 3:30 p.m., the speech language pathologist (SLP) indicated R1 was initially participating and about a week before R1's hospitalization , R1 had a notable decline in her overall condition and was not participating in therapies, had a poor intake, and would not take medications during the final days before hospitalization . The SLP further indicated she told RN-A and the charge nurse about the decline. During an interview on [DATE] at 2:35 p.m., the assistant director of nursing (ADON) indicated the protocol for recognizing a change in condition is the nursing assistants (NA)'s or the med nurses bring their concern to the charge nurse, or the RN case manager and the resident would further be evaluated by a RN, then they would notify the physician and the family. The ADON indicated she was filling in as RN case manage on R1's unit during that time. ADON further identified during R1's last week in the facility, R1's intake decreased but denied any other possible changes of condition were reported to nursing until [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:05 a.m., the heart failure clinic RN indicated she reviewed R1's record and their clinic was not notified of R1's weight losses. The RN further stated, it would be important to know there was a weight loss because it would need to be evaluated and depending on what she [R1] was on for a diuretic, they [heart failure clinic] may want to change that. During an interview on [DATE] at 9:15 a.m., the director of nursing (DON) verified R1's weight changes should have been reported to the medical provider but were not reported as ordered. During an interview on [DATE] at 10:00 a.m., R1's primary care physician (PCP) reported conducting a video visit with R1 on [DATE] and changed some depression medication with hopes R1 would have a mood boost that would also increase her appetite. R1's PCP indicated he was not notified of R1's weight loss, decreased oral intake, or change of condition after that [DATE] visit. The PCP also indicated it would be an expectation that a significant change in condition would be reported to a physician Further indicated R1's weights should have been reported to the heart failure clinic to adequately manage R1's diuretic and heart failure. During an interview on [DATE] at 9:30 a.m., the medical director identified R1's primary drivers of the significant weight loss as dehydration, poor oral intake, and continued use of diuretics which should have been reported to R1's primary doctor. The medical director also stated, the facility should have intervened a few days earlier which would not have changed R1's demise but the clinical course would have been extended if R1's family wanted to do a feeding tube or constant intravenous (IV) fluids. The undated facility document titled Communication indicates NAs are trained to report any concerns or changes with residents directly to the nurse on duty, while nurses are instructed to report to their supervisor if there are any concerns or changes that need higher-level attention. This reporting structure ensures that issues are address in a timely and coordinated manner to promote resident safety and well-being. The facility policy titled Food and Fluid Intake Documentation last reviewed ,d+[DATE], indicated the facility will document the resident's food and fluid intake to assist in assessing the resident's current nutritional status. Food and fluid intake will be completed daily by nursing or culinary team members for all three meals, as assigned. It is the responsibility of the dietitian/culinary director to audit the intake documentation to assure that they are accurately and properly completed by staff. The facility policy titled Change in Condition Policy and Procedure last reviewed ,d+[DATE], indicated it is the policy of the facility to immediate inform the resident; consult with the resident's physician; and notify the resident's legal representative or emergency contact when there is: A significant change in the resident physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy further lists the procedure as follow: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda	901 Southeast Willmar Avenue Willmar, MN 56201

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Assess any changes noted through direct observation or through others' observations. Obtain any other data necessary for a complete assessment (blood sugar check, neurocheck, vitals, etc.) and as ordered by the physician. Notify the physician or nurse practitioner of the change. If unable to reach the physician, follow-up with another message. If unable to contact the physician, contact a MD (medical doctor) on-call at their clinic or call the hospital and/or 911 as appropriate. Notify the resident's legal representative or emergency contact of the change and actions taken. Notify the administrator, director of nursing, designed or building supervisor of the change as appropriate. Chart in electronic health record the assessment data, observations, discussions with the resident, physician notification (include the number of attempts made and when), any new orders, interventions, and family notifications. Follow up should continue as ordered by the physician or until the resident has stabilized. Continue to update the resident, physician, and resident legal representative of any deterioration or improvement.