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	10/25/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35992 Based on observation, interview and document review, the facility failed to ensure resident wheelchairs were kept in a clean and sanitary manner to promote resident well-being for 1 of 2 residents, (R17), observed for positioning. Findings include: R17's annual Minimum Data Set (MDS) of 5/24/24 identified R17 was dependent on staff to move from lying to sitting, sitting to standing, and chair/bed to chair transfer. The MDS indicated R17 no longer walked. R17's medical diagnoses included progressive neurological conditions, Parkinson's (a movement disorder of the the nervous system that impacts physical movement, which worsens over time), polyneuropathy (a disease that causes damage to multiple nerves in different areas of the body which impacts communication between the central nervous system, which included the brain and the spinal cord, and the rest of the body), low back pain, and repeated falls. R17's care plan, last revised 6/21/24, indicated R17's mode of locomotion (mobility) was a wheelchair. R17 had a potential for impaired skin Integrity related to uncontrolled movements of Parkinson's disease. R17 used a gel cushion in his rock-n-go wheelchair (a wheelchair which allowed a rocking type movement while wheelchair remains in a stationary position). R17's care plan identified R17 received altered texture diet with soft and bite size food. The care plan indicated R17 liked finger food snacks. On 10/21/24, at 1:50 p.m. R17 was observed seated in his wheelchair in the day room. On R17's wheelchair, on the fabric of outer aspect of the right side of the wheelchair, there was a worn area measuring 1/6 of the wheel (approximately 12 inches in an curved pattern) observed on the chair corresponding to the wheel of the wheelchair. The width of this area was noted to be 1/2 to one inche in width. In this worn area, approximately eight inches of the curve was noted to be no longer intact and shredded in appearance, with the fabric split and open areas present. On the left side of the wheelchair, a wear pattern of approximately eight inches in a curved pattern was noted, however, the fabric remained intact. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24, at 6:44 p.m., interview was held with registered nurse (RN)-E following observation of cares. During the observation of cares, RN-E was observed removing a napkin of soft food from the seat of the wheelchair prior to attempting transfer with R17. Upon review of the physical appearance of the wheelchair, RN-E identified the wheelchair had wear on both sides of the wheelchair and identified the right side was worse than the left. RN-E identified there was potential for impact of the wheelchair function, as well as potential injury to R17 on the shredded fabric. Upon review of the fabric, RN-E acknowledged the area not being intact limited the capability for cleaning well. RN-E acknowledged R17 fed him self independently at times, with food going onto the chair and the fabric not being intact posed a difficulty to maintain cleanliness. RN-E stated she was unaware of specific cleaning or maintenance schedule for wheelchairs. On 10/23/24, at 3:34 p.m. R17 was noted to remain in the same wheelchair previously viewed, which lacked repair to the impaired area. On 10/24/24, at 10:20 a.m., the director of nursing stated the wear on the wheelchair R17 posed a potential for injury to resident. DON also identified a concern regarding the ability to clean the wheelchair adequately, as cleaning of the fabric where it was no longer intact would be difficult. DON stated there were no current policies for routine cleaning and maintenance of wheelchairs. A review of an undated document, titled CNA (Certified Nursing Assitant) Day Shift Duties, directed staff to Clean wheelchairs after meals if needed. A second undated document, titled CNA Evening Shift Duties, also directed staff to Clean wheelchairs after meals if needed. A document, titled Bethesda Housekeeper Job Description, revised 9/01 indicated the housekeeping staff was to wash resident wheelchairs. All documents reviewed lacked indication as to ongoing maintenance and repair of wheelchairs in regards to physical structure.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20794 Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed and readily available to promote acceptable pain management for 1 of 4 residents (R199) reviewed for care planning. Findings include: R199's quarterly Minimum Data Set (MDS), dated [DATE], identified R199 had intact cognition and was admitted to the care center on 6/10/24 from the acute care hospital. The MDS outlined R199 was independent to setup assistance for most activities of daily living (ADLs) and had multiple medical conditions including malignant neoplasm of the left lower lung lobe, repeated falls, essential hypertension and bilateral primary osteoporosis of the knees. On 10/24/24 at 1:07 p.m., R199 was interviewed. R199 explained she admitted to the care center after being treated in the hospital for severe chest pain, and was diagnosed with the left lower lobe lung mass. R199 was noted to have tubes of Voltaren Gel (a nonsteroidal anti-inflammatory gel) on her bedside stand. R199 stated she had pain in both her knees, which she had been treating with the creams prior to her hospitalization . R199 stated she has been self-administering the creams, however, has the nurses apply it to areas when she is unable to reach them. R199 further stated she has had increasing pain in her left chest and shoulder due to her lung mass, and is receiving tylenol and tramadol, which helps. R199's initial Nursing Admission Assessment - Day 1 Club, dated 6/10/24, identified R199 had voice her pain level at a 0 on a scale of 0 - 10 (0 being no pain, 10 being excruciating pain. This assessment further documented resident reports occasional bilateral knee pain, recent cortisone injections [a synthetic hormone injected into the body to reduce pain, inflammation, and swelling] to knees. This assessment was supplemented with the Nursing Admission Assessment - Day 2 Club, also dated 6/10/24, due to R199 reporting history of pain. R199 reported her pain to be chronic and intermittent. In review of R199's significant change MDS (dated 6/28/24), the facility completed a Annual & Significant Change Assessment - 3.0 (dated 6/27/24, which indicated no change is pain reported. However, in review of R199's Quarterly Nursing Assessment - 2.0 (dated 9/19/24), the registered nurse (RN) Analysis for pain documented the following: resident did state that she has had occasional back pain, in the middle of her left side, over the past 5 days. The worst her pain has been is a 8 on a scale of 1-10. Does receive scheduled Tylenol as orders. Has also received Tramadol (a combination of a synthetic opioid and monoamine re-uptake inhibitors used to relieve moderate to moderately severe pain) PRN (as needed) as ordered. Both of them have been effective for her. A review of R199's current physician ordered medication listing (print date of 10/24/24) documented the following pain medication interventions: 8/08/24 - Diclofenac Sodium (Voltaren) External Gel 1% (Topical) - apply to left and or right knee topically as needed for pain. Apply 4 grams (g) up to 4 times a day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/08/24 - Diclofenac Sodium (Voltaren) External Gel 1% (Topical) - apply to left wrist topically as needed for pain. Apply 2g up to 4 times a day. 9/24/24 - traMADOL HCL oral table 25 milligrams (mg) - give 25 mg by mouth every 6 hours as needed for pain rated 6-10. Max Daily Amt: 100 mg. 9/27/24 - Acetaminophen 8 hour Oral Tablet Extended Release - give 1300 mg by mouth two times a day related to malignant neoplasm of lower lobe, left bronchus or lung. Maximum acetaminophen dosing of 4000 mg / day. 9/27/24 - Acetaminophen 8 hour Oral Tablet Extended Release - give 650 mg by mouth as needed for pain related to malignant neoplasm of lower lobe, left bronchus or lung. Maximum acetaminophen dosing of 4000 mg / day. BID (twice a day), PRN. In review of R199's Care Plan (print date of 9/24/24), noted the facility failed to identify R199's pain issues and interventions to assist in reducing pain. In an interview on 10/24/24 at 10:14 a.m., registered nurse / case manager (CM)-A reviewed R199's careplan and verified R199's pain issues had not been addressed on her care plan. CM-A stated it would be important to have R199's pain address on the care plan for continuity of care. During an interview on 10/24/24 at 10:21 a.m., assistant director of nursing for R199's unit (ADON)-A reviewed R199's physician's orders and care plan. ADON-A stated R199's pain issues should have been addressed on her care plan due to the diagnoses listed. In a further interview on 10/25/24 at 11:38 a.m., the director of nursing (DON) stated it would be her expectation that any resident with pain issues with interventions, be addressed in the care plan. DON further stated this was important so that the care plan and care sheets educate the direct care staff to the issues of pain and interventions prescribed. In review of the facility's policy, entitled: Bethesda Care Planning (dated 2/2024) documented the following: Purpose: To provide an individualized and comprehensive interdiction plan of care for each individual, that promotes quality of care and life. Responsibility: Interdisciplinary care team including: resident, family, physician and other appropriate medical professionals, nursing, social services, culinary, recreation, therapy and hospice when appropriate. Policy: > A plan of care is initiated for all residents within 48 hours of admission > A comprehensive care plan is developed within 21 days of admitted . > A registered nurse develops and oversees the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	> The plan of care is discussed during the resident's initial care conference, quarterly and with significant changes. >Each discipline is responsible for the following and established format for care planning. > Care plan reviews completed with OBRA [Omnibus Budget Reconciliation Act] assessments. > The initial 48 hour care plans are on paper. The comprehensive 21 day care plans are kept in the electronic record.

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F 0684 Level of Harm - Minimal harm or potential for 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** 35992 Based on observation, interview and document review, the facility failed to provide adaptive supports or assistive devices to ensure upright positioning for 1 of 2 residents, (R17), reviewed for positioning. In addition, the facility failed to ensure medications were administered per physician's order for 1 of 2 residents (R480) reviewed for respiratory care. Findings include: R17's annual Minimum Data Set (MDS) of 5/24/24 identified R17 had moderate cognitive impairment. The MDS identified R17 received substantial to maximum assistance with dressing, grooming, and bathing. R17 was dependent on staff to move from lying to sitting, sitting to standing, and chair/bed to chair transfer. The MDS indicated R17 no longer walked. R17's medical diagnoses included progressive neurological conditions, Parkinson's (a movement disorder of the the nervous system that impacts physical movement, which worsens over time), polyneuropathy (a disease that causes damage to multiple nerves in different areas of the body which impacts communication between the central nervous system, which included the brain and the spinal cord, and the rest of the body), low back pain, and repeated falls. R17's care plan, last revised 6/21/24, indicated R17 functional abilities varied, and at times, required assistance not at their usual level of performance. The care plan indicated R17's mode of locomotion (mobility) was a wheelchair. R17 had a potential for impaired skin Integrity related to uncontrolled movements of Parkinson's disease. R17 used a Gel cushion in his rock-n-go wheelchair (a wheelchair which allowed a rocking type movement while wheelchair remains in a stationary position). The care plan failed to identify positioning concerns while seated in the rock-n-go wheelchair, or potential positioning aides to be implemented. On 10/21/24, at 1:50 p.m. R17 was observed seated in a wheelchair in the day room area. R17 was leaning to the left side of the wheelchair, with his head resting on the arm rest. R17's eyes were closed, and R17 was not interacting with others. The wheelchair lacked lateral (side) support to maintain upright position, or to support R17's head, neck, and upper body. R17's wheelchair was tilted back at approximately a 45 degree angle, but lacked support of upper body, head and neck. On 10/22/24, at 10:06 a.m. R17 was observed to be seated in his wheelchair and was leaning to the left side of the chair, with no visible lateral support observed. R17 had his eyes closed, and was not interacting with others around him. During interview on 10/22/24, at 6:44 p.m., registered nurse (RN)-E stated R17 had been fitted with this rock-n-go wheelchair for a while. RN-E commented with R17's increased ataxic (poor muscle control that causes clumsy movements) the chair allowed R17 the opportunity for safe movement. When viewing R17 in the chair, RN-E acknowledged the potential need for lateral support, and identified there was no lateral support available for use. On 10/23/24, at 11:49 a.m., R17 was observed seated in his rock-n-go wheelchair, with a pillow placed on his left side to help maintain R17 in an upright position. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24, at 8:28 a.m. RN-E stated a referral had been sent for a therapy screen for positioning. On 10/24/24, at 10:20 a.m., the director of nursing (DON) stated it was her expectation for residents to be positioned in an upright position to promote comfort. If indicated, it was her expectation for a therapy referral to be submitted. The facility policy, titled Wheelchair Positioning Policy and Procedure, revised 1/24, indicated residents were to be positioned in good body alignment. The policy identified it was the responsibility of nursing staff to ensure resident was positioned properly. A Therapy screen was to be completed as needed to ensure proper wheelchair positioning. 48013 R480's quarterly Minimum Data Set (MDS) dated [DATE], identified R480 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R480's diagnoses included non-traumatic brain dysfunction, vascular dementia, hypertension, septicemia, non-Alzheimer's dementia, depression, psychotic disorder (other than schizophrenia), asthma (COPD) or chronic lung disease, insomnia, auditory and visual hallucinations, myalgia, and hypothyroidism. During review of R480's electronic health record (EHR), signed physician's order indicated an order for Advair HFA inhalation aerosol 115-21 mcg (microgram) two puffs inhale orally two times a day related to chronic obstructive pulmonary disease in the morning and in the evening. Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 10/22/24, indicated seven doses were documented as drug/item unavailable and four doses were documented as administered from 10/19/24 to 10/24/24. During interview on 10/24/24 at 7:37 a.m., trained medication aide (TMA)-A stated 480's Advair was not available as it had not been delivered from pharmacy yet. TMA-A stated she had faxed the pharmacy and ordered R480's Advair four times in the past several days and that she was going to place a call to the pharmacy today to see why medication had not been delivered. TMA-A stated she probably should have called pharmacy to follow up on it sooner and notified nurse. TMA-A confirmed she had documented on R480's MAR as not administered due to medication not being available. TMA-A stated it was important for R480 to receive medication to help her with breathing. During interview on 10/24/24 at 2:08 p.m., registered nurse (RN)-E stated TMA-A had updated her about R480's missing Advair inhaler, that it was unavailable however pharmacy is stating that it was delivered. During interview proceeded to check on available supply in medication and RN-E confirmed Advair inhaler was delivered by pharmacy and was available in medication cart. RN-E stated inhaler was the generic brand, so it had looked different than the previous inhaler. RN-E stated if a medication was unavailable, she would expect staff to fax the refill request to pharmacy and then would follow up with pharmacy to see if medication was available. If TMA was on the medication cart and medication was unavailable, RN-E would expect the TMA to update the nurse on duty and/or come and update the case manager. RN-E confirmed medication was signed off in MAR as administered three times, confirmed inhaler was dispensed from pharmacy on 10/10/24, and confirmed that cannister had not been used/medication administered since arrival from pharmacy RN-E viewed the cannister outside of the delivery system, which indicated there were 121 actuations available and the label stated 120 actuations were dispensed. RN-E stated this was a medication error as it had not been administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/24/24 at 2:33 p.m., director of nursing (DON) stated if medication was not available, she would first expect staff to check facility's supply to see if it is available in house and then would expect staff to call the pharmacy to order a refill of medication. DON confirmed documentation in the MAR was inaccurate and would be a medication error. The facility's Medication Administration policy and procedure was requested but was not received. The facility's Pharmacy Services policy, dated 10/22, indicated medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. During regular pharmacy hours, nursing will fax the emergency or stat order to the pharmacy and then call to alert the pharmacy that a stat order was just faxed. Such medications are delivered as soon as possible.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observations, interviews and document review, the facility failed to coordinate with dialysis, the nephrologist, and the primary physician when dialysis was discontinued for 1 of 1 resident (R102). This resulted in the potential for complications when R102 continued to maintain his dialysis central line with no routine dressing changes to prevent infection and continued on phosphorus binding medication, renal diet, and fluid restrictions. Findings include: R102's admission Minimum Data Set (MDS) dated [DATE], identified R102 had intact cognition and diagnoses of anemia, atrial fibrillation, hypertension, renal insufficiency, and depression. MDS also indicated R102 was receiving hemodialysis. R102's Physician's Order Sheet, print date of 10/22/24, included the following physician's orders: -Renal (dialysis) diet which consisted of regular texture, regular/thin consistency, low phosphorus, low potassium, and no added salt. -Dialysis: Check site - central line right (R) upper chest for bleeding and signs and symptoms of infection every shift -Fluid restriction (2000 mL (milliliter/day) Document all fluid intake from meals and what is given from nursing. -Sevelamer Carbonate (phosphorus binding medication) oral tablet 800 mg (milligram) two tablets by mouth with meals related to acute kidney injury. R102's mediation administration record (MAR) and treatment administration record (TAR) indicated all above orders and treatments were signed off as completed from 10/9/24 to 10/24/24. R102's progress note, dated 10/4/24, indicated facility received call from the dialysis clinic and was informed R102's kidney function had returned, and he would not need a dialysis treatment on 10/5/24 and 10/8/24. R102 would need lab work completed on 10/8/24 and pending those results may be able to discontinue port and dialysis. R102's progress note, dated 10/9/24, indicated facility received call from the dialysis clinic and was informed R102 was discharged from dialysis and would need to follow up in the clinic in three months. During interview on 10/21/24 at 4:05 p.m., R102 stated he had stopped dialysis about a month ago. During interview on 10/21/24 at 4:06 p.m., registered nurse (RN)-G stated R102's dialysis treatments had ended approximately one to two weeks ago and stated the droplet magnet on R102's door indicated R102 was on fluid restrictions. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/23/24 at 8:58 a.m., nursing assistant (NA)-A stated she thought R102 had quit dialysis so she would have to check with the nurse. NA-A stated R102 was currently on fluid restrictions where he was only able to have a certain number of fluids each day. During interview on 10/23/24 at 12:02 p.m., dialysis registered nurse (DRN)-A stated R102 was not receiving dialysis any longer as R102 had recovered. DRN-A stated R102 ended dialysis on 10/3/24 and a referral for the surgeon was sent for the removal of the central line and port. During interview on 10/23/24 at 4:42 p.m., R102 stated the central line and port was still in place and he thought it was getting removed on 10/24/24 or 10/25/24. During interview on 10/24/24 at 8:20 a.m., RN-A stated when dialysis gets discontinued for a resident the facility gets the okay from the dialysis clinic and lab work would be completed to confirm that discontinuation of dialysis could still occur. The facility would need to then set up appointment for resident's central line and port to be removed. RN-A stated R102's central line and port is scheduled to be removed on 10/29/24. RN-A could not think of anything else that would need to be done. When surveyor asked about the care plan and care sheet, RN-A stated she should probably check R102's and make changes on them. RN-A stated it would be important for the information on the care sheets was accurate for communication purposes with the staff. The nurses continue to check the central line site for signs and symptoms of infection. RN-A stated R102 is probably still on fluid restrictions and a renal diet, and he may not need to be. She would have to check with the dialysis center and provider about his fluid restrictions, renal diet orders and dressing change orders. She confirmed these should have been addressed by now, should have been addressed immediately after discontinuation of dialysis. RN-A stated R102 was the only resident that she had come off of dialysis and was not aware of the process. During interview on 10/24/24 at 8:36 a.m., assistant director of nursing (ADON)-A stated when dialysis is discontinued it is initiated by the provider/nephrologist. The dialysis clinic contacted the facility to make aware resident's dialysis was discontinued. That was taken as an order. Follow-up labs were done determine if port could be removed. ADON-A stated she was not sure of anything else that would need to be done as she has never had anyone come off of dialysis. The port should have been removed as soon as possible to minimize risk of complications and infections. ADON-A stated nephrologist should have been notified immediately following discontinuation of dialysis for medication orders, clarification of fluid restriction and renal diet orders. During interview on 10/24/24 at 9:16 a.m., director of nursing (DON) stated when a resident's dialysis is discontinued, communication should be done with the provider, resident, and family. She expected case managers to follow through with recommendations for follow-up. Case manager should have reached out to dialysis for any changes in orders at the end of dialysis such as port removal and site care, fluid restrictions, diet, and medication orders. DON stated removal of the port should be as soon as possible as it is an infection source and with the port not being used regularly, it could have caused complications and/or infections. During interview on 10/24/24 at 10:06 a.m., RN-A stated she received the referral for the port to be removed on the day R102 was discharged from dialysis. RN-A confirmed R102 was discharged from dialysis on 10/9/24. RN-A stated she was not sure if the facility called to set up the appointment or if the surgeon's office called as she handed it off to the medical secretary who scheduled all appointments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/24/24 at 10:18 a.m. medical secretary (MS) stated she was responsible for scheduling appointments for the transitional care unit (TCU). On 10/17/24 she received an email from RN-A stating, RN-A called the dialysis center in regard to removal of the port. RN-A informed her the order for the referral was in EPIC (medical software) and asked MS to call and schedule appointment. MS stated she called to make appointment and the soonest appointment available was on 10/29/24. During interview on 10/24/24 at 11:10 a.m., DRN-A stated Sevelamer should have been discontinued at the end of dialysis as it helps control calcium levels and could cause R102's calcium to become too low. When a resident came off dialysis, the resident no longer needed to be on fluid restrictions, renal diet and medications relating to dialysis. DRN-A stated a follow-up appointment at the dialysis clinic with the nephrologist is determined and nephrologist stated he would like to see R102 in three months. DRN-A confirmed R102 was discharged from dialysis on 10/9/24 and the removal of the port is scheduled for 10/29/24. During interview on 10/24/24 at 12:01 p.m., nephrologist stated orders that go with dialysis should be discontinued at the time of discontinuation of dialysis such as fluid restriction, renal diet, and medications. Sevelamer should have been discontinued when R102 was discharged from dialysis and would recommend that it be discontinued now if it had not been. Nephrologist stated R102 should be seen by provider (emergency room or urgent care), if R102 had not been eating a lot of protein, that could cause low albumin, and if R102's phosphorus level was low and he continued to not have adequate intake, medication could cause serious harm to R102. During interview on 10/24/24 at 12:15 p.m., RN-H stated R102's primary provider was contacted and informed facility that R102 should be sent to urgent care. RN-H stated family was transporting R102 to urgent care. When R102 was discontinued from dialysis, orders were not received to discontinue medications, change in diet or to stop fluid restrictions. RN-H stated on 10/18/24, R102 blood pressures started dropping and the physician discontinued amlodipine and ordered blood pressure monitoring, however, did not order any other medications to be held or discontinued. RN-H stated orders were received this morning from Nephrology to hold the Sevelamer. During interview on 10/24/24 at 12:36 p.m. consultant pharmacist (CP) stated side effects from the Sevelamer are usually stomach related. It would be important to monitor potassium and phosphate levels. Sevelamer was usually discontinued with discontinuation of dialysis. Symptoms depended on what R102's phosphorus level was, the medication binds the phosphorus. CP expected the provider to do labs to check level. During interview on 10/24/24 at 12:58 p.m. DRN-A stated site care of the port should be changed weekly and cleansed with betadine or chlorhexidine and then left to dry before recovering it with a sterile dressing. If dressing changes were not being done, an infection could occur. No treatment was required for the port, such as flushing, as it did not need to remain patent as it was no longer going to be used. (continued on next page)

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	245427	A. Building B. Wing	10/25/2024

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/24/24 at 1:44 p.m., medical director (MD)-A stated he expected the facility to follow up with the provider via fax with any clarification of orders such as port removal, changes in medication, when to check labs. He expected follow-up occurred within a few days of dialysis discontinuation and confirmed approximately four weeks would be too long to wait. He would not be concerned with treatment to the port but expected site cares to be completed until port is removed. If site cares were not completed, concern would be local infection risk. As long as there is a port, there is a theoretical entry point for bacteria. MD-A stated there was a risk medically if dialysis medications were received when not receiving dialysis, but it should be caught on rounds. MD-A stated he needed to refer to his nephrology colleagues for further side effects from Sevelamer. During interview on 10/24/24 at 1:45 p.m., CNA-D stated R102's appetite was poor when he first was admitted . However, since admission, R102 ate most of breakfast and 50% of most lunch and supper and that R102 did not drink many fluids. During interview on 10/24/24 at 2:03 p.m., RN-A confirmed there was no discussion with the dialysis clinic and/or the nephrologist in regard to site care/catheter care when R102's dialysis was discontinued. RN-A did not think about the site care as the facility was not supposed to touch it when R102 was receiving dialysis. When RN-A was asked what the facility does for other central lines, RN-A stated they changed the dressing as ordered. The orders for site care should have been clarified and/or addressed with dialysis clinic and/or provider but things fell through the cracks. Received additional information from nephrologist on 10/29/24 at 4:02 p.m., the letter included the following: this letter is to amend an earlier conversation I had last week in regard to R102's medication and clinical status. In our discussion, I mentioned that there was a potential harm for R102 to be receiving the medication Sevelamer while not eating. I would like to amend my assessment. Upon further investigation, two factors have come up that makes this medication prescription safe and appropriate. 1) R102 has been consistently eating his meals, When I first discussed this with the Department of Health, I had incorrectly received information that he was not eating. However, I was able to verify with the nursing staff at Bethesda that he is eating. 2) The medication is ordered appropriately to be given with meals. This is the appropriate way to order the prescriptions to avoid complications and time with meals. Received additional information from medical director on 10/29/24 at 4:02 p.m., the letter included the following: this letter is generated to further amend and/or clarify our previous conversation. I have had a chance to speak with our local (Willmar-based) nephrologist this weekend, to get his impression of this specific situation (understanding that we both had limited details) and on the standard management of patients coming off hemodialysis or peritoneal dialysis. We agreed that it is the responsibility of the clinician/nephrologist that discontinues the dialysis to manage and/or direct the care of those orders that are bundled with dialysis. If the nephrologist or nephrology APP does not communicate transitional orders directly to the care facility, they should communicate to the primary care physician to manage those medical orders based on the clinical situation and communicate/document those changes. In the interval, the preceding or previous orders would be expected to be followed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	From what you told me during our conversation, these included a renal diet (which would likely be continued, as the patient remains a renal patient), a fluid restriction (which may be continued or discontinued based on objective medical assessment of fluid status renal/cardiac output), the monitoring of the access catheter (which is the primary means to detect a skin or soft tissue infection which should prevent the risk of a systemic infection), and the management of phosphate binders to protect against hyperphosphatemia & secondary hyperparathyroidism. As you may know, these would be a very low risk medicines to continue as long as the patient is eating and drinking. Certainly, a laboratory evaluation of calcium/phosphate homeostasis could direct the continuation or discontinuation (more likely) of this non-absorbed medication. Other medication changes could also be indicated based on goals of care & nephrology opinion. Again, these would not be based on nursing assessment but on clinical status (medical) & nephrology opinion. From the information that has been given to you and others, the patient was NOT placed at significant risk of harm through this process. The facility's Dialysis policy, dated 2/24, indicated hemodialysis is performed to remove toxic wastes from the blood of residents in renal failure. Residents requiring hemodialysis may be admitted to Bethesda with the hemodialysis being done at Fresenius Kidney Care Outpatient Hemodialysis Unit. A copy of the agreement with is maintained in the administrator's office. A physician's order is required for hemodialysis. A plan of care will be developed and implemented on all residents receiving hemodialysis. 1. Dialysis schedule will be up with the dialysis unit. Every effort will be made to utilize Bethesda Transportation to and from dialysis appointment. 2. Each resident on hemodialysis has a communication book. This book is used to communicate between the facility and the Hemodialysis Unit. 4. Most hemodialysis residents are on a fluid restriction. The physician in conjunction with the hemodialysis dietician determines the amount of restriction. These guidelines will be on the eMAR. 5. Notify the Dialysis Unit of all medication changes. This can be done in the communication book.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures with the use of an antipsychotic medication for 1 of 5 residents (R134) reviewed for antipsychotic medications. Findings include: R134's quarterly Minimum Data Set (MDS) dated [DATE], identified R134 had severe cognitive impairment and required supervision/assistance with all activities of daily living (ADL)'s. R134's diagnoses included cancer, hypertension, non-Alzheimer's dementia, psychotic disorder (other than schizophrenia) and delusional disorders. MDS indicated R134 needed supervision with transfers and ambulation. R134's physician orders included orders for Quetiapine Fumarate (antipsychotic) 25 milligram (MG) by mouth in the morning and 50 mg by mouth in the afternoon and at bedtime for delusional disorders. R134's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R134 in the past six months. During observation on 10/22/24 at 4:36 p.m., R134 was independently ambulating around her room, hanging clothing on the back of her recliner. No staff present in room. During observation on 10/24/24 at 7:34 a.m., R134 was independently ambulating around her room fidgeting with different items. No staff present in room. During interview on 10/24/24 at 12:36 p.m., consultant pharmacist (CP) stated any resident on an antipsychotic medication should have orthostatic blood pressures obtained monthly. Pharmacist stated orthostatic blood pressures were important to monitor due to postural hypotension being one of the major side effects, especially in an older person, and would put the resident at a higher risk for falls when taking these medications. During interview on 10/24/24 at 2:08 p.m., registered nurse (RN)-E stated orthostatic blood pressures are to be obtained monthly for use of antipsychotic medications. RN-E stated R134's Quetiapine was started on 7/26/24 and confirmed orthostatic blood pressures had not been obtained for R134. RN-E stated it was important to monitor orthostatic blood pressures for side effects that could affect mobility. During interview on 10/24/24 at 2:33 p.m., director of nursing (DON) stated antipsychotic medications could cause side effects such as sleepiness, dizziness, and orthostatic hypotension. DON stated orthostatic blood pressures are to be done monthly to monitor for side effects. DON stated it should have be identified by the consulting pharmacist and/or the nurse manager. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Antipsychotic Medications policy, dated 4/2024, indicated all resident has the right to be free from unnecessary medications. Residents have the right to be from antipsychotic medications used for purposed of discipline or convenience and not require to treat medical symptoms.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R88) reviewed for immunizations was provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R88's face sheet, print date 10/24/24, indicated she was [AGE] years old. The immunization record, print date 10/24/24, indicated she received a PCV13 on 4/21/15 followed by the PPSV23 on 12/12/18 and that R88 refused the PCV20 on 12/20/23. During record review, vaccination consent form, signed on 8/19/24, indicated R88 gave consent to receive the PCV20 as she became eligible or was advised, however the record lacked evidence that R88 received PCV20. During interview on 10/24/2024 at 9:28 a.m., infection preventionist (IP) indicated immunizations are reviewed upon admission. IP stated she reviewed immunization record and eligible immunizations with resident upon admission and would administer any wanted vaccines/immunizations once reviewed with the provider. IP stated R88 had refused the PCV20 on 12/20/23 and during the facilities annual fall immunization fair, R88 must have changed her mind and now consented for the PCV20. IP stated RN case managers obtained the consent forms and notified her regarding the influenza and COVID-19 booster consent, but IP stated she was not notified of the updated consent for the PCV20. IP stated it was important to ensure residents are offered and provided all available and requested vaccinations to prevent hospitalization and the risk of developing symptoms to lead to acute illness as R88 is at a high risk. During interview on 10/25/24 at 11:38 a.m., director of nursing (DON) stated her expectation was that when RN case managers completed the annual vaccination consents with residents, all vaccination requests should be relayed to the IP. DON stated it was important for residents to receive the requested vaccinations as they are important for their health and to follow their request. The Pneumococcal Vaccination policy, dated 9/24, indicated all residents will be offered the Pneumococcal conjugate vaccines (PCV12, PCV15, or PCV30) and/or the pneumococcal polysaccharide vaccine (PPSV23), to aid in preventing pneumococcal infections (e.g. pneumonia). This will be a shared clinical decision between the resident and the resident's medical provider.