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	12/10/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to store food in accordance with professional standards for food safety in 1 of 2 refrigerators on the 100-units. This had the potential to affect all 40 residents that resided on the unit.Findings include:On 12/9/25 at 4:49 p.m., the refrigerator on the 101-120 unit was reviewed with dietary aide (DA)-A. Contents of the refrigerator included a square, foam take-out container, labeled with a resident's name. However, the container was not labeled with a date. DA-A verified the box was not dated, but should have been dated, to ensure the resident did not eat spoiled food.On 12/9/25 at 4:55 p.m., the refrigerator on the 121-140 unit was reviewed with DA-B. Contents of the refrigerator included a clear, plastic bag with approximately six peeled, hard-boiled eggs in it. However, the package was open and unlabeled. DA-B verified the package was not stored in a closed container and was not labeled with the opened date. DA-B stated the container should have been closed and labeled with the opened date to ensure safety.On 12/10/25 at 11:00 a.m., the Infection Preventionist (IP) stated all food stored in the unit refrigerators were expected to be labeled, sealed, stored, and discarded per facility policy to prevent foodborne illness.The facility's Storage of Food Policy, revised 7/2025, indicated all food would be stored in a safe and sanitary manner to ensure residents received safe meals, and all food stored in the refrigeration units would be covered in seamless containers or otherwise suitable protection.The facility's Date Marking Ready to Eat Potentially Hazardous Food Policy, revised 12/2024, indicated the facility would label and date potentially hazardous foods when opened and foods would be discarded after a 7-day period.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to implement proper enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) for 4 of 7 residents (R4, R16, R241, R55) and failed to implement proper enhanced respiratory precautions for 1 of 2 residents (R67) reviewed for transmission based precautions. In addition the facility failed to provide sanitary urinary catheter cares for 1 of 1 residents (R55) reviewed for catheter cares. Also the facility failed to complete appropriate hand hygiene for 1 of 1 residents (R67) observed for personal cares. R222's quarterly Minimum Data Set (MDS) dated [DATE], identified R222 had severe cognitive impairment and diagnoses which included Alzheimer's disease, anxiety and depression. R222 was dependent on staff for assistance with activities of daily living (ADL). R222's care plan revised 11/17/25, identified R222 received hospice services and was dependent on staff for dressing, personal and toileting hygiene, and transfers. During an observation on 12/9/25 at 12:12 p.m., nursing assistant (NA)-A and NA-B entered R222's room and began to assist R222 with transferring to bed from wheelchair with a gait belt. Once R222 was laying down in the bed, NA-A applied gloves, removed R222's brief, who had been incontinent of bowel. NA-A used wipes to clean R222's buttocks and perineal area, then removed gloves and applied new gloves. NA-A and NA-B applied a new brief, adjusted R222's clothing, then covered R222 with blanket and positioned R222 with pillows. NA-A removed gloves. NA-B left room, and NA-A opened the window blinds and moved R222's wheelchair away from the bed. At 12:25 p.m., NA-A left R222's room. NA-A walked in hall, entered room [ROOM NUMBER], picked up a paper from on the floor and placed it on the bedside stand next to the bed, then left room [ROOM NUMBER]. NA-A then returned to R222's room, fixed R222's call light which R222 had pulled from the wall, then left the room again. NA-A went to the dining room, approached R57 and asked if R57 wanted to go to her room. R57 said yes, so NA-A wheeled R57 to her room in her wheelchair. NA-B was in R57's room, then NA-A and NA-B assisted R57 to the commode. NA-A did not sanitize hands after incontinence cares with R222, or prior to R57's cares. During interview on 12/9/25 at 1:12 p.m., NA-A verified had not sanitized hands after incontinence cares with R222, or prior to entering room [ROOM NUMBER], or assisting R57 to her room and commode. NA-A indicated usual practice was to perform hand hygiene before and after cares. NA-A also indicated did not sanitize hands after removing gloves, or prior to applying gloves, as was not aware to do so. NA-A stated it would be easier if each room had hand sanitizer dispensers. NA-A indicated hand hygiene was important for hygiene purposes. During interview on 12/9/25 at 4:07 p.m., infection preventionist (IP)-A stated expectation was for hand hygiene to be performed before and after cares and before and after glove use. IP-A indicated it was important to prevent the spread of infections. During interview on 12/9/25 at 4:10 pm., director of nursing (DON) stated expectation was for hand hygiene to be performed before and after cares to decrease spread of germs, viruses and bacteria. The facility policy titled Hand Hygiene dated 7/25, identified hand hygiene continued to be the primary (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	means of preventing the transmission of infection. The policy included when hand washing was to be used verses alcohol-based hand rub, and hand washing techniques, but did not include when hand hygiene should be performed. R67 R67's quarterly MDS dated [DATE], identified R67 was cognitively intact and had diagnoses which included: heart failure, multiple sclerosis, and diabetes mellitus. R67 was dependent on staff for dressing, toileting, and required substantial/maximum assistance with personal hygiene. R67's care plan revised 10/23/25, identified R67 received assistance with dressing, hygiene, toileting and transfers. R67's progress note dated 12/6/25, identified R67's covid test was positive and R67 was placed in enhanced respiratory isolation. During observation on 12/9/25 at 11:44 a.m., R67's doorway had no signage identifying R67 was on enhanced respiratory precautions. Outside R67's doorway approximately four to six feet away was a three drawered plastic bin with personal protective equipment (PPE) inside. A precaution sign was on the wall above the plastic bin with instructions on what PPE should be worn during enhanced respiratory precautions. During interview on 12/10/25 at 10:25 a.m., infection preventionist (IP)-A indicated the nursing staff was responsible for getting enhanced respiratory precaution signage and supplies set up. IP-A confirmed R67 did not have signage on his door to identify R67 was on precautions. IP-A stated it was important to provide signage to prevent infection from spreading through the building. During interview on 12/10/25 at 11:13 a.m., director of nursing (DON) indicated signage for enhanced respiratory precautions was important to prevent those entering R67's room from becoming ill or spreading the infection to others. The facility policy titled Covid-19 Infection Prevention Policy And Procedure dated 7/25, identified any resident who exhibited signs or symptoms consistent with COVID-19, or who tested positive for COVID-19 would be placed on enhanced respiratory precautions and would be tested for COVID-19. The facility policy titled Infection Control Policy dated 9/25, identified transmission-based precautions was also known as isolation precautions. For isolation practices PPE and signage would be provided outside resident rooms, respecting privacy and confidentiality. Findings include: R4's admission minimum data set (MDS) dated [DATE], included R4 was cognitively intact, has pressure ulcers, had IV access, and had a feeding tube. R4's undated care plan, included R4 was on EBP due to having a wound, tube feeding and PICC line (a tube inserted into a small vein in the arm and guided to a large vein near the heart for long term use). Care plan intervention included to wear personal protective equipment (PPE) when completing high contact resident cares per policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 12/9/25 at 9:04 a.m., licensed practical nurse (LPN)-A was administering g-tube medications and providing drain cares. During observation, LPN-A was coming in contact with the bedding and bedside table in R4's room. LPN-A was not wearing a gown during this time. During interview on 12/9/25 at 9:15 a.m., LPN-A stated nurses did not typically wear gowns when providing tube feeding care and medication or drain cares and only gloves were required. LPN-A confirmed R4 was on EBP but stated gowns are usually only worn when doing wound care. R16 R16's admission MDS dated [DATE], included R16 was cognitively intact. R16 had an indwelling catheter and a feeding tube. R16's undated care plan, included R16 was on EBP due to having a feeding tube. Care plan intervention included to wear PPE when completing high contact resident cares per policy. During observation on 12/9/25 at 11:53 a.m., nursing assistant (NA)-E assisted R16 with transferring from his bed to the bathroom. NA-E was not wearing a gown. During interview on 12/9/25 at 11:56 a.m., NA-E stated she was unsure what the EBP precautions were for and was unsure where she would find PPE to wear if needed. NA-E confirmed she assisted R16 to the bathroom and did not wear a gown and did not usually wear a gown when helping with transfers or in the bathroom. R241 R241's order summary report dated 12/10/25, included an admission date of 12/6/25 and had diagnoses of retention of urine and infection due to indwelling urethra catheter. R241's undated care plan, included R241 was on EBP due to having a catheter. Care plan intervention included to wear personal protective equipment (PPE) when completing high contact resident cares per policy. During observation and interview on 12/10/25 at 11:31 a.m., NA-H was assisting R241 to the bathroom. NA-H was not wearing a gown during transfer. NA-H stated he had not noticed the EBP magnet on the door frame and was not aware R241 was on precautions. NA-H stated he did not know why R241 would be on EBP. NA-H stated R241 did have gowns available, but they were only worn when providing catheter cares. During interview on 12/10/25 at 8:10 a.m., infection preventionist (IP) confirmed all new hires receive training on EBP, along with ongoing training. Staff are trained to wear gown and gloves when preforming high contact cares for residents on EBP. High contact cares include transferring, assisting to the toilet, catheter cares, feeding tube tasks, wound care and device care. IP confirmed both R4 and R16 were on EBP and staff should have been wearing proper PPE during cares and contact. IP stated this was important to prevent the spread of infection. During interview on 12/10/25 at 11:31 a.m., director of nursing (DON) states it is her expectation that staff follow the training received on EBP and wear proper PPE during high contact cares, including feeding tube cares, catheter cares and assisting with toileting, dressing and bathing. The DON stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this was important to reduce the spread of infection from one person to another. Facility policy for EBP dated 2025, included staff must use EBP when performing high contact cares in the resident room, therapy gym and communal bathroom. R55's quarterly MDS dated [DATE] revealed R55 was cognitively impaired, needed assistance with activities of daily living (ADLs) such as dressing, toileting, and hygiene. R55 had an indwelling catheter and a diagnosis of Parkinson's disease. R55's care area assessment (CAA) dated 2/22/25, revealed R55 needed assistance with ADLs. R55 utilized an indwelling catheter for flaccid neuropathic bladder (nerve damage that controls the bladder), benign prostatic hyperplasia (BPH, a condition that causes urinary problems). R55's care plan was revised on 9/4/24, revealing R55 was on enhanced barrier precautions due to being at risk for infection and/or colonization with multidrug resistant organisms (MDRO) due to having a urinary catheter. Staff were to wear appropriate personal protective equipment when they are completing high-contact residents care activities per policy. R55 needed assistance with ADLs. R55's signed physician orders dated 11/13/25, revealed a urinary catheter 22 French, change every four weeks on Thursdays. Change the urinary catheter drainage bag every fourteen days. R55's residents care sheet dated 12/8/25, indicated R55 was on EBP and had a Foley catheter. During an observation on 12/9/25 at 8:06 a.m., R55's urinary catheter collection bag was laying on the fall mat next to the bed with approximately 100 cubic centimeters (cc) of yellow urine. The collection bag, tubing, and the drainage port was in contact with the fall mat. During an observation on 12/10/25 at 7:31 a.m., R55's urinary catheter collection bag was lying on the floor next to the bed with approximately 200 cc of dark yellow urine. During an observation on 12/10/25 at 7:42 a.m., NA-G did not apply a gown and went into R55 room to perform morning ADL's. NA-G applied gloves and assisted R55 with putting on pants, socks, and shoes. NA-G then assisted R55 to sit up and helped him wash his hands and face and apply a shirt and deodorant. NA-G applied a transfer belt and assisted R55 to stand up using the walker and transferred R55 into the wheelchair. NA-G wheeled R55 into the bathroom and assisted with oral care. NA-G then wheeled R55 to the breakfast table. During an interview on 12/9/25 at 8:16 a.m., nursing assistant (NA)-F indicated that gowns are normally worn by the nurses when they are changing the catheter tubing. NA-F indicated gowns are not worn when getting R55 dressed. NA-F verified the urinary catheter bag was on the fall mat and should have been hung on the side of the bed to prevent it from touching the floor for sanitary reasons. During an interview on 12/10/25 at 7:50 a.m., NA-G verified a gown was not worn during ADL cares and transferring R55. NA-G indicated that gowns are worn by the nurses during catheter cares. During an interview on 12/9/25 at 11:20 a.m., a registered nurse care coordinator (RNCC)-A, verified that the urinary collection bag should not be laying on the grown related to the possibility of an increased risk of infection and cleanliness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/25 at 8:29 a.m., infection preventionist (IP) all staff are to wear gowns during high contact activities such as bathing, transferring, wound care, and catheter cares. A urinary collection bag should not be touching the floor as it increases the possibility of introducing bacterial into the tubing. IP expectation would be to have a barrier between the catheter bag and the floor. During an interview on 12/10/25 at 10:11 a.m., director of nursing (DON) indicated the catheter urinary collection bag should not be touching the floor, related to infection control. EBP gowns should be worn by staff when performing high contact care and when a resident has an indwelling device, such as a urinary catheter. Review of the policy titled Indwelling Foley Catheter Policy and Procedure dated 11/15, revealed routine catheter care: enhanced barrier precautions will be utilized when handling catheter, or drainage bags . drainage bags are placed in privacy bags.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a self-administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 3 of 3 residents (R192, R151, R116) observed with medications at the bedside. R116 R116's quarterly MDS dated [DATE], identified R116 was cognitively intact and was dependent on staff with dressing, personal hygiene, and toileting. R166 had hypertension and was legally blind. R116 was frequently incontinent of urine and had skin issues related to moisture. R116 care area assessment (CAA) dated 7/18/25, identified that R116 was legally blind, had urine incontinence, and needed staff to assist with toileting, hygiene, and received nystatin (antifungal medication) to the groin twice a day to help with redness. R116 was occasionally incontinent of urine and needed assistance with toileting, personal hygiene, and transfers. R116's care plan, revised on 1/28/25, identified R116 as being legally blind and needing assistance with activities of daily living (ADLs). R116 preference was for staff to administer medications. R116's signed physician orders dated 12/3/25, revealed orders for nystatin powder to the groin folds topically every day and evening shift for redness. R116's resident care sheet dated 12/8/25, identified that R116 receives Nystatin to the groin area twice a day and was legally blind. R116's self-administration of medication assessment, dated 11/18/24, identified R116 had chosen to have nursing staff administer medication except for Orajel (gum and tooth pain). During an observation on 12/8/25 at 2:14 p.m., R116's nightstand had a nystatin powder, which directed staff to apply to groin folds, an open box of chocolates, saltshaker, and a pepper shaker. During an observation on 12/9/25 at 8:19 a.m., R116's nightstand had a pepper shaker and a salt shaker next to nystatin powder. During an interview on 12/10/25 at 9:31 a.m., nursing assistant (NA)-C indicated R116's groin had been red, and nystatin powder should be locked up in the nurse's medication cart. NA-C also indicated R116 was legally blind. During an interview on 12/9/25 at 12:20 p.m., registered nurse care coordinator (RNCC)-A confirmed R116 did not have self administration order for nystatin powder. RNCC-A confirmed nystatin powder was in the R116 room on the nightstand, and confirmed the nystatin powder should not have been left on the nightstand. R151 R151's significant change MDS dated [DATE], identified R151 as being cognitively intact and needed assistance with ADLs. Identified R151 had a diagnosis of diabetes and anxiety. R151's signed physician orders dated 12/5/25, revealed R151 had an order for miconazole nitrate (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	powder 2% to apply under the breasts topically as needed twice a day. R151's care plan, revised on 10/2/25, indicated R151 needed assistance with activities of daily living (ADLs). R151 took medication whole and wished to have the staff administer medications. During an observation on 12/9/25 at 8:59 a.m., R151 had miconazole nitrate powder 2%, on top of a small refrigerator that was located next to the bed. During in observation on 12/9/25 at 3:48 p.m., R151 had miconazole nitrate powder 2%, continued to be on the small refrigerator next to the bed. During an interview on 12/9/25 at 11:17 a.m., registered nurse care coordinator (RNCC-A) verified R151 did not have a self-administration order for medication. RNCC-A verified that R151 had miconazole nitrate powder in the room on top of the refrigerator. RNCC verified it should not be left in the room without a self-administration order. During an interview on 12/10/25 at 10:30 a.m., the director of nursing (DON) indicated that if a resident wanted to self-administer medications, a resident would be evaluated through an assessment to ensure they have the ability to safety administer medications. Staff would then add the self-administration to the care plan. DON stated her expectation would be for an assessment to do done before medications are left in a resident's room. A review of the self-administration of medication policy and procedure dated 2/2025, indicated that a resident may self-administer medications if the comprehensive assessment and plan of care indicate the practice is safe. All medications that are self-administered must have a medical doctor's order and be properly labeled. R192's admission minimum data set (MDS) dated [DATE], included R192 was cognitively intact and had diagnosis of chronic rhinitis (inflammation of the nasal lining) and chronic obstructive pulmonary disease (COPD) (a lung disease which leads to symptoms of shortness of breath, cough and wheezing). R192 R192's order summary sheet dated12/10/25, included an order for Breo Ellipta inhalation aerosol powder 100-25 MCG/ACT (a long acting inhaler used to treat COPD) 1 puff daily and fluticasone propionate nasal suspension 50 MCG/ACT (a nasal spray for chronic rhinitis) 2 sprays in each nostril 2 times a day. R192's care plan with initiation date of 11/25/25, included resident wished to have staff administer medications. During observation and interview on 12/9/25 at 8:42 a.m., R192 had an inhaler and nasal spray on his bedside table. R192 stated he keeps them there and uses them on his own. R192 stated the staff were aware he had them and explained how he took the inhaler once a day and the nasal spray twice a day. During interview on 12/9/25 at 11:27 a.m., registered nurse (RN)-A stated it would be listed at the top of a resident's chart if they were able to self-administer. A self-administration assessment and order would be needed before a resident was allowed to keep medications in their room and management (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them by themselves. RN-A confirmed medications were left in his room this morning unattended. RN-A confirmed R192 did not currently have a self-administration assessment completed or an order in his chart but did express interest in administering his own medications. During interview on 12/9/25 at 11:39 a.m., assistant director of nursing (ADON) confirmed an assessment and self-administration order would be needed before a resident was allowed to keep medications in their room. ADON confirmed R192 did not currently have a self-administration assessment completed but she was working on one as she was informed by a nurse that he was interested in self-managing some of his medications. ADON stated the Breo inhaler, and the nasal spray were signed off at 8:08 a.m. this morning in R192's chart, prior to being observed in R192's room unattended by nursing staff. During interview on 12/10/25 at 8:24 a.m., director of nursing (DON) stated self-administration of medications after assessment was on the standing order, but confirmed an assessment was necessary to determine the residents' ability, knowledge and safety prior to allowing self-administration. DON stated this was important to ensure the resident was able to manage and store the medication correctly.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain respect and dignity for personal possessions for 1 of 1 residents (R140) reviewed who had personal property missing. Findings include: R140's admission minimum data set (MDS) dated [DATE], revealed R140 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs) such as toileting, dressing, and personal hygiene. R140 had a diagnosis of multiple sclerosis (autoimmune disease) and anxiety. R140's care plan was revised on 11/19/25, revealing R140 needed assistance with dressing, toileting, and transfers. During an observation on 12/9/25 at 11:53 a.m., R140 had two long-sleeve shirts in his closet; there were no pants or underwear in the closet or dresser drawers. During an interview on 12/8/25 at 1:07 p.m., family member (FM)-B reported R140 moved to his room two weeks ago. FM-B indicated R140's clothing was labeled, but there was no clothing in his closet, and R140 did not have clothes to wear the following day. The socks R140 was currently wearing did not belong to him, but the other clothes he was wearing did belong to him. FM-B indicated R140 was missing seven long-sleeve t-shirts and five pairs of pants. Review of Lost/Found/Damaged resident property report dated 11/25/25, revealed R140's family member (FM)-B filled out the form indicating two long-sleeve shirts, one black and one maroon in color, were missing. Three pairs of underwear and one pair of pants were missing. FM-B indicated the items went missing around 11/12/25, and some of the items were labeled. R140's room, laundry room, and the unmarked clothing rack were all searched. One item was found in the unmarked clothes, and it was then marked. During an interview on 12/9/25 at 4:37 p.m., registered nurse care coordinator (RNCC)-B indicated the process when something went missing was to do a search and then fill out a lost and found form. The lost and found form includes questions about the missing items, and staff would report the missing items to the family. A family member could also fill out a lost and found form. RNCC-B indicated she was aware of R140's missing clothing. During an interview on 12/9/25 at 4:44 p.m., social service (SS)-A indicated she was aware that R140 was missing three shirts and two pairs of pants. SS-A indicated the process to mark clothing was to have family leave the items with nursing, then the items would be placed in a bin outside of the laundry room, once laundry places a label on the clothing, then it is brought back up. SS-A indicated if the facility was unable to find the missing clothing, then the administrator would be notified, and the facility would replace the missing items. During an interview on 12/9/25 at 5:46 p.m., administrator indicated she was notified of the missing clothing. The administrator's expectation would be to provide R140 with clothing while the facility was attempting to locate his clothing. Review of an email from the administrator sent to staff on 11/26/25, reminded staff of the labeling process, which included the directions to place clothing in a plastic bag, complete the laundry that needs to be labeled form, or attach a note with the resident's first and last name, room number, and attach securely to the plastic bag. All long-term units bring the bag down to the main laundry area. There is a tote placed outside of the laundry door next to the elevator with signage titled clean resident clothes that need to be marked. If the item is soiled, the bag should be brought to the back soiled laundry room door. There is signage that states: soiled resident clothes that needs to be marked. Policy titled Laundry Process dated 4/4/25, revealed the day a resident is admitted to Bethesda, all resident clothes they are not wearing need to be labeled. Staff to complete the laundry that needs to be labeled form and attached securely to the suitcase or bag. Social services will call the laundry at extension 1126. If on a weekend, the registered nurse supervisor will call. Laundry will come to the resident room to pick up the bags and will mark new admits clothing on the day of admit or the next day. Be sure when removing clothing the resident was wearing, to make sure they are marked; if not, follow instructions below for labeling. Labeling process: place clothing in a plastic bag, complete the laundry that needs to be labeled form and attach securely to the plastic bag. All (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	12/10/2025

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long-term units- bring the bag down to the main laundry area. There is a tote placed outside of the laundry door next to the elevator with signage titled clean resident clothes that need to be marked. If the item is soiled, the bag should be brought to the back soiled laundry room door. There is signage that states: Soiled resident clothes that needs to be marked. Policy titled Procedural Guideline Lost/Found/Damaged Resident Property Investigations, dated 9/25, revealed the person who first receives a report of missing or damaged property will complete the front page of the Lost/Found/Damaged form with help from his/her direct supervisor, where necessary. A copy of the form is to be placed at the nurse's station so that staff may become aware of the problem and assist in the investigation wherever possible. Ask the resident if they feel the item is misplaced/missing or intentionally stolen. If they feel it was stolen, immediately call the administrator for direction. The original Lost/Found/Damaged form will be given to the designated social worker on the day reported or the next business day. Social service staff will distribute a copy of the form to other departments as appropriate. Social service staff will also bring the form to the next interdisciplinary team (IDT) meeting. The Lost/Found/Damaged forms will be reviewed and discussed at the IDT meeting and quality assurance (QA) committee meeting as appropriate. All Lost/Found/Damaged forms will be kept in a separate file located in the social services office.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide assistance with grooming for 2 of 3 residents (R71, R177) reviewed for activities of daily living (ADLs). Findings include: R71 R71's quarterly Minimum Data Set (MDS) dated [DATE], indicated R71 was moderately cognitively impaired. Indicated R71 had diagnosis which included hypertension and cataracts. R71's care area assessment (CAA) dated 5/28/25, indicated R71 had mild cognitive impairment, had difficulties expressing himself, and had disorganized thinking. Staff were to assist as needed with daily decision-making and reminders. R71 needed supervision or touching assistance to maintain personal hygiene, such as combing hair and shaving. R71's Care plan, updated on 10/20/25, indicated R71 had a daily preference of shaving daily as facial hair preference was to be clean shaven. R71 at times may require assistance with ADL's and needed supervision for personal hygiene. R71's resident care sheet dated 12/8/25, identified R71 needed supervision and cuing for grooming. Staff were to set up and give reminders to perform hygiene. R71's care conference from 10/29/25, identified R71 wanted to be clean shaven. During an interview and observation on 12/8/25 at 12:46 p.m., R71 indicated staff does not assist with shaving and does prompt him for shaving. R71 indicated he would like more help than he was currently receiving with ADLs. R71 had approximately 2 centimeters (cm) of facial hair. During an observation on 12/9/25 at 8:32 a.m., R71 was in the dining room with approximately 2 cm of facial hair. 177 R177's significant change MDS dated [DATE], indicated R177 had moderate cognitive impairment. R177 was dependent on staff for ADL care, such as shaving, combing hair, and washing face. Indicated R177 had a diagnosis of arthritis, dementia, anxiety, and depression. R177's CAA dated 11/21/25 indicated R177 had physical limitations and needed assistant with dressing and hygiene cares. R177's care plan revised on 12/1/25, indicated R177 was dependent on staff for personal hygiene. R177 had a preference of shaving daily, R177 preference was to be clean shaven. R177's resident care sheet dated 12/8/25 indicated R177 was to be clean shaven every day. Staff to shave daily, and assist as needed. During an observation and interview on 12/8/25 at 2:42 p.m., R177 had approximately 1 cm of facial hair. R177 indicated that staff did not assist him with shaving. During an observation on 12/9/25 at 8:58 a.m., R177 was sitting at the table in the dining room and had approximately 1 cm of facial hair. During an interview on 12/8/25 at 12:43 p.m., licensed practical nurse LPN-A Indicated R71 was able to shave himself independently at times, and on other days, he would ask for assistance. LPN-A indicated R177 needed assistance with shaving and ADLs. During an interview on 12/9/25 at 11:30 a.m., family member (FM)-A indicated R177 preference was to be clean shaven. FM-A would prefer R177 to be shaven daily unless R177 refuses. During an interview on 12/10/25 at 9:31 a.m., NA-C indicated her understanding was that R71 was independent with ADLS as he was normally dressed when the shift started, and R71 would ask staff to take out his dirty laundry and clean his razor when needed. NA-C stated R177 was dependent on staff for all ADLs, including shaving, brushing teeth. NA-C indicated that the nursing assistances have a resident care sheet that indicates each resident's preference. NA-C indicated that the care sheets direct staff to assist R177 with ADLs. During an interview on 12/9/25 at 12:20 p.m., RNCC-A indicated that residents were asked on admission what their preferences were for shaving, and their preferences were care planned. RNCC-A stated she was aware of both R71 and R177 preferences for being shaved. RNCC-A verified R71 and R177 had not refused ADLs in the past week. RNCC-A verified R71 and R177 had long facial hair, and staff should have offered assistance with ADLS. During an interview on 12/10/25 at 10:10 a.m., the director of nursing indicated that residents were asked about their shaving preference on admission. The DON's expectation were for staff to complete ADLs depending on a person's preference during the morning cares. Review of the care plan titled Morning and Evening Cares Policy and Procedure, dated 2/2025, revealed that grooming (oral care, shaving, hair care, etc.) was provided according to the resident's care plan. The resident is encouraged to participate as much as he/she is (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able. Assist the resident with shaving as needed. Performed with an electric razor, shaving is part of the male's usual daily care and female's care as needed if applicable. Besides reducing bacterial growth on the face, shaving promotes resident comfort by removing whiskers that can itch and irritate the skin, and produces an unkept appearance.