STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victory Health & Rehabilitation Center	512 49th Avenue North Minneapolis, MN 55430

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R164) reviewed for dignity. Findings include: R164's admission Minimum Data Set (MDS) dated [DATE], indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with meals and a mechanically altered diet. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R164 had activities of daily living (ADL) self-care performance deficit related to stroke and was able to eat independent after set up by staff using a divided plate. R164's physician order dated 12/4/24, indicated, Resident is to be up in w/c for meals. Aides are to feed resident and check mouth for pocketing food. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 11:58 a.m., R164 was in the dining room in his wheelchair at a table by himself, and empty stationary chair sat next to him. Social services director (SSD) stood next to R164 while assisting him with his lunch. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/17/24 at 12:05 p.m., SSD stated not being an NA and just helping staff out since they seemed shorthanded. SSD stated never received any feeding assistance training and saw the empty chair next to R164 but assumed it was being saved for another resident. SSD stated R164 was not a feeder but had requested assistance so she wanted to help out. SSD was not aware that standing while assisting was considered undignified. During interview on 12/17/24 at 12:48 p.m., licensed practical nurse (LPN)-A stated staff should not stand over a resident while assisting with meals as it was not a dignified experience when they stood over them. During interview on 12/17/24 at 12:51 p.m., director of nursing (DON) stated expectation staff would sit next to a resident when assisting with meals to provide a dignified dining experience. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 was on a mechanical soft diet and required set up assistance and supervision with meals. ST-A stated staff were supposed to assist R164 with meals as needed with opening or arranging items until cleared by speech therapy. Facility policy Assisting the Impaired Resident with In-Room Meals dated 9/2013, instructed staff to check food for appropriate consistency prior to serving and to position a chair next to the resident where it would be convenient for staff and resident to assist with the meal. Facility policy Quality of Life-Dignity dated 2/2020, indicated, staff should not 'label' a resident or refer to them by their care needs. The policy indicated, Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity an assist residents.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure a call light was accessible for 1 of 3 residents (R164) reviewed for call lights. Findings include: R164's admission Minimum Data Set (MDS) dated [DATE], indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with most activities of daily living (ADL). R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R164 was at risk for falls r/t (related to) CVA (cerebral vascular accident) affecting right dominant side of body. The care plan instructed staff to ensure resident's call light was within reach and to encourage him to use it. During observation on 12/16/24 at 1:20 p.m., R164 door was open and visible from the hallway. R164 was awake in bed with call light inside the top drawer of his nightstand out of his reach. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. R164's call light was inside the top drawer of his nightstand out of his reach. During observation on 12/17/24 at 10:08 a.m., R164's door was closed. R164 was in bed , awake, and call light in top drawer of his nightstand out of his reach. During observation on 12/18/24 at 8:13 a.m., R164 was in bed, sitting up with breakfast tray in front of him. No staff present and call light in top drawer of nightstand out of his reach. His meal consisted of a whole omelet. When asked if he needed assistance with his meal, he just grunted. During interview on 12/18/24 at 8:26 a.m., nursing assistant (NA)-C stated R164 was capable of using the call light. NA-C confirmed R164's call light was in his top drawer of his nightstand, out of reach. NA-C stated the call light should be close to the residents and within reach. During interview on 12/19/24 at 10:15 a.m., director of nursing (DON) stated expectation that R164 would have call light within reach at all times. Facility policy Answering the Call Light dated 9/2022, indicated, Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 22580 Based on observation, interview, and document review, the facility failed to ensure food preferences of the resident were honored and implemented for 1 of 2 residents (R24) reviewed for choices. Findings include: R24's Medical Diagnosis form indicated the following diagnoses: multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves), type II diabetes mellitus with hyperglycemia (high blood sugar), major depressive disorder and adjustment disorder. R24's Clinical Physician orders form indicated a diabetic diet encourage fluids, regular texture, and thin liquids consistency. R24's dietary slip on the breakfast tray on 12/18/24 indicated Diet- CCHO - Regular (Consistent Carbohydrate Diet), Liquids - Thin . Orange juice, grits and sausage link were crossed out. Observation on 12/18/24 at 8:00 a.m., the staff brought R24's breakfast tray, which consisted of 8 oz orange juice, 8 oz of milk, a bowl of frosted flakes, a piece of toast and an omelet. Interview on 12/18/24 at 8:05 a.m., R24 indicated that R24 had requested no orange juice. R24 indicated it comes on the breakfast tray every morning even though he/she requests no orange juice. Interview on 12/18/24 at 8:30 a.m., the Food Service Director(FSD) indicated the dietary aide is responsible for verifying the resident menu slip. The FSD indicated residents should get what they want as long as it is within the ordered diet. R24's care plan dated 12/18/24 indicated a nutritional problem or potential nutritional problem related to Multiple sclerosis, and diabetes mellitus. Goal was to maintain adequate status as evidenced by maintaining weight within 5% of 146#, no signs and symptom of malnutrition, and consuming at least 50% of meals. Interventions indicated to provide and serve diet as ordered Review of the Resident Food Preferences policy dated 7/2017 indicated individual food preference will be assessed on admission, and when possible staff will interview the resident to determine food preferences.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure a resident was provided the appropriate therapeutic diet and meal supervision for 1 of 1 resident (R164) reviewed for nutrition. Further, the facility failed to ensure a resident was transferred from bed to wheelchair in a manner assessed safe for 1 of 2 residents (R164) observed during transfers. Findings include: R164's admission Minimum Data Set (MDS) dated [DATE], indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with most activities of daily living (ADL) including eating and transfers, and required a mechanically altered diet. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's care plan dated 12/5/24, indicated R165 had an ADL self-care performance deficit related to stroke and required total assist by one staff to eat and was totally dependent on one staff for transferring. R164's care plan Special Instructions indicated, Hoyer lift. R164's Nutrition assessment dated [DATE], indicated R164 required mechanically altered diet. R164's Falls assessment dated [DATE], indicated R164 was at moderate risk for falls. R164's physician orders included, Mechanical soft diet, Mechanical soft textures dated 11/30/24 and Aides are to feed resident and check mouth for pocketing for food dated 12/4/24. R164's Therapy to Nursing Communication-Resident Status Update dated 12/2/24, indicated R164 required mechanical lift-Hoyer transfers. R164's occupational therapy notes dated 12/12/24, indicated OT (occupational therapist) reminded aides R164 required set up to eat meals. R164's physical therapy notes dated 12/17/24, indicated, Nursing staff to continue to use Hoyer lift with pt [patient] for transfers. During interview on 12/16/24 at 2:48 p.m., family member (FM)-A stated R164 was receiving therapy to improve strength and independence but currently required assistance with transfers and meals. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg with one hand and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 8:51 a.m., NA-A re-entered R164's room and asked if he was done with his meal, picked up the tray and left the room. NA-A did not check R164's mouth for pocketing food. During observation and interview on 12/17/24 at 12:20 p.m., NA-A and NA-B into R164's room to transfer R164 from bed to wheelchair so maintenance could swap out his bed. NA-A and NA-B assisted R164 to a sitting position on the edge of the bed. NA-A and NA-B were on either side of R164 and assisted him to a standing position by grabbing R164's pants and guided him to pivot and lower onto the wheelchair. NA-A stated R164 was a pivot transfer and did not require a lift. During interview on 12/17/24 at 12:33 p.m., NA-B stated when they transferred R164 from bed to chair he did not require a lift or a transfer belt and only required a gait belt when actually walking. During interview on 12/17/24 at 12:33 p.m., director of rehabilitation services (PT)-A stated R164 had not been cleared for pivot transfers and still required a Hoyer lift for transfers. PT-A stated expectation that staff would be transferring R164 using a Hoyer lift. During interview on 12/17/24 at 12:38 p.m., NA-A reviewed R164's electronic health record (EHR) and confirmed R164's transfer status was Hoyer lift. During interview on 12/17/24 at 12:45 p.m., NA-D stated expectation for NAs to sit next to R164 and supervise during meals and transfer using a Hoyer lift. During interview on 12/17/24 at 12:48 p.m., licensed practical nurse (LPN)-A stated staff should be transferring him with a Hoyer lift until cleared by therapy for a pivot transfer. During interview on 12/17/24 at 1:06 p.m., LPN-A stated staff should be supervising R164 during meals since he was on a dysphagia diet. During observation on 12/18/24 at 8:13 a.m., R164 was in bed, sitting up with breakfast tray in front of him. No staff present and call light in top drawer of nightstand out of his reach. His meal consisted of a whole omelet. When asked if he needed assistance with his meal, he just grunted. During interview on 12/18/24 at 8:26 a.m., NA-C stated R164 did not need any supervision during meals and can be left alone in his room with a tray. During observation on 12/19/24 at 8:32 a.m., R164 was in bed with breakfast tray in front of him. No staff present. His meal consisted of scrambled eggs - which he was eating with his left hand fingers and not utensils, ground sausage, 2 whole muffins, and cream of wheat. During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 required a mechanical soft diet, with set up assistance and supervision throughout the meal. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/19/24 at 10:15 a.m., director of nursing (DON) stated expectation that R164 would have supervision with meals which meant staff would sit with him throughout the meal. DON stated R164's food should be ground or cut up and should not be served whole. An unpeeled hard boiled egg was inappropriate. DON further stated expectation for staff to use the appropriate transfer method for each resident. R164 should be transferred with a Hoyer lift until cleared by therapy for stand and pivot. During interview on 12/19/24 at 10:31 a.m., food service director (FSD) stated R164 should not have been served a whole hard-boiled egg. Facility policy, Assisting the Impaired Resident with in-Room Meals dated 9/2013, instructed staff to, Review the resident's care plan and provide for any special needs of the resident and Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. Facility policy, Safe Lifting and Moving of Residents dated July, 2017, indicated the goal was this facility uses appropriate techniques and devices to lift and move residents. The policy instructed nursing staff to work in conjunction with the rehabilitation staff to assess resident needs for transfer assistance. The care plan should reflect the resident transferring needs.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51578 Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to prevent weight loss for 1 of 2 residents (R1). The facility failed to ensure that the resident was set up with assistance for meals and failed to provide a nutritional supplement that was needed to implement interventions to prevent further weight lost for 1 of 2 residents (R1) who had a significant unplanned weight loss. Further finding includes: R1's admission record indicated, R1 was admitted on [DATE] with the following diagnosis: Vascular Dementia with sever agitation, Cardiomyopathy (enlargement of the heart), Dysphagia (difficulty swallowing), Major Depressive Disorder, Delusional Disorders (disorganized thoughts and actions), Psychosis, Crohn's Disease, Type 2 Diabetes Mellitius (controlled), Anxiety disorder, History of Transient ischemic attacks (TIA's), Atherosclerosis heart disease, Hypertension, Insomnia, and adult failure to thrive. R1's quarterly Minimum Data Set (MDS): BIMS 11, Severe cognitive impairment due to medical diagnosis. Resident was unable to interview due to mental status and severe sleepiness during the day and evening. R1's physician orders: 1) Trazodone HCl Oral Tablet (Trazodone HCl) 75mg by mouth every day. 2) Abilify Oral Tablet 5 MG (Aripiprazole)by mouth in the morning 3) Sertraline HCl Oral Tablet (Sertraline HCl) 150mg by mouth every day 4) Lansoprazole Oral Suspension 3 MG/ML (Lansoprazole)Give 10 ml by mouth two times a day for GERD (30mg) Before meals. 5) Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 3 tablet by mouth one time a day for HTN (75mg) Goal below 140/90 6) Memantine HCl Oral Tablet 10 MG (Memantine HCl) Give 1 tablet by mouth two times a day for Severe vascular dementia with agitation. 7) Donepezil HCl Oral Tablet 5 MG (Donepezil Hydrochloride) 1 tab PO at HS 8)Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 tabs capsules by mouth two times a day (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9) Monthly weight Notify provider if 5 pounds difference in re weight. (active 7/12/2024) Estimated. 10) Nutritional Needs: Calories: 1375 -1925 kcal (25-35kcal/kg) Protein: 44 -66 g (0.8-1.2g/kg) Fluids: 1375 -1925 ml (1ml/kcal) 11) Monitor Behaviors 1. yelling/screaming, 2. delusions 3. excessive crying. Interventions: A. try to redirect with 1:1 conversation, B. Take care of needs. After interventions was there I=improvement, N= no change, W=worsened in behavior. Quarterly Care Plan: On 11/17/24 the care plan stated that R1 is usually in bed and needs encouragement to get up. The resident has little or no activity involvement r/t Disinterest, resident wishes not to participate. The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date. Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Invite/ assist to activities of their choice. Remind the resident that they may leave activities at any time and is not required to stay for entire activity R1 requires assistance with setup for all meals. R1's dietary note dated 10/4/2024 10:27 a.m., indicated R1 has no significant weight changes noted. Weight fluctuations are expected related to psychosis and vascular dementia. R1 would like to maintain or slightly gain some weight, but also states are not concerned about it. Dietary Lead (DL) offered education, but R1 was not interested. DL notified R1 that there has been weight loss and encouraged R1 to keep trying to eat as much as she could including meals/snacks. R1 was informed they could ask to speak with the dietitian with any questions or concerns. No complaints of chewing or swallowing difficulties noted. R1 exhibits adequate nutrition as evidenced by stable weight and good intake records. Skin is monitored regularly by nursing staff with intakes appropriate for routine healing as needed. Potential for altered nutrition related to dx/hx. RD to follow per MDS or PRN. Reviewed new order for adding a house nutritional supplement three times a day between meals was placed by the MD on 10/17/2024 per recommendation of DL. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 a dietary note stated: Nutrition/ Hydration. R1 has a nutritional problem or potential nutritional problem r/t dx/hx of cerebral aneurysm (not ruptured), Crohn's disease, delusional disorders, dysphagia, HTN, hyponatremia, depression, DM2, psychosis, vascular dementia. R1 will maintain adequate nutritional status as evidenced by maintaining weight within 5% of 118# or gain 3-4#/month to 125#, no s/sx of malnutrition, and consuming at least 50% of meals. R1 will continue to take dietary supplements as ordered between meals. R1 has no significant weight changes noted. Weight fluctuations are expected related to psychosis and vascular dementia. R1 states she eats well at meals and does drink the supplement that is brought to her several times each day. R1 states that her clothes continue to fit the same as normal. R1 would like to maintain or slightly gain some weight, but also states she is not concerned about it. DL offered education, but R1 was not interested. DL notified R1 that she has lost some weight and encouraged her to keep trying to eat as much as she can at meals/snacks. Resident was informed she could ask to speak with the dietitian if she had any questions or concerns. No complaints of chewing or swallowing difficulties noted. Resident exhibits potentially inadequate nutrition as evidenced by continued weight loss with good intake records. Skin is monitored regularly by nursing staff with intakes appropriate for routine healing as needed. Potential for altered nutrition related to dx/hx. RD to follow per MDS or PRN. EATING: The resident requires set up assistance with eating. Monthly weight review: 12/5/2024 12:25 113.6 Lbs. Wheelchair 11/11/2024 14:09 115.6 Lbs. Wheelchair 10/8/2024 10:01 118.2 Lbs. Wheelchair 9/4/2024 12:59 120.8 Lbs. Standing 8/22/2024 11:38 123.2 Lbs. Wheelchair 7/30/2024 11:41 124.4 Lbs. Wheelchair 5/31/2024 12:48 122.8 Lbs. Standing 4/11/2024 09:13 125.4 Lbs. Standing 3/5/2024 12:23 127.8 Lbs. Standing Resident has had significant weight loss since 9/24 to 12/16/24 this has resulted in a -5/96 weight loss. During an observation on 12/16/24 at 02:03 p.m., R1 was in bed with the room lights off and blankets overhead. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/16/24 at 05:36 p.m., R1 was brought a dinner tray at approx. 5:25p.m. and it was sitting on side table. R1 was lying in bed with blanket over head. The nurse's aide (NA-C) brought the tray in and set it down on the side table. NA-C did not set up or encourage R1 other than stating here is your supper. During an observation on 12/16/24 at 06:01 p.m., R1 was still in bed and the dinner tray was taken out of R1 room by dietary and R1 didn't eat any food on dinner tray. Direct observation of the dinner tray showed that R1 had eaten 0% of meal. During an observation on 12/17/24 at 08:42 a.m., R1 still in bed with lights off and blanket over head. During an observation on 12/17/24 at 12:12 p.m., R1 is still in bed and does have tray in room. R1 dinner tray is still in room with all lids on and looks like it has not been touched. During an observation on 12/17/24 at 02:17 p.m., R1 is still in bed and has blanket over head, at this same time an interview with NA-C was conducted. NA-C explained that R1 doesn't like to get up normally, so they let R1 sleep. NA-C explained that it is R1's choice to get out of bed. NA-C was also interviewed on the dietary supplement and if they have ever seen it in R1 room and NA-C verified what a nutritional supplement was and stated no. During an interview on 12/17/24 at 02:47 p.m., the social service aide (SSA) noted that as far as diet and other concerns it seems that this should be addressed more by dietary and reviewed in R1 care plan. SSA was asked if they work with R1 as far as eating, mobility, or ADL assessment and SSA stated that they should try to get R1 up and moving. SSA stated that the few times that I spoke with R1 I think R1 understands but doesn't respond. During an observation on 12/18/24 at 08:22 a.m., R1 is again in bed currently with the light on and does have a breakfast tray in room and has eaten 20% of tray. During an observation on 12/18/24 at 09:58 p.m., R1 is still in bed with head covered in blanket. R1 food tray is still in room since breakfast and staff have not asked R1 about needing anything while constant observation from 8:22am till 10:00am. During an interview on 12/18/24 at 11:25 a.m., with NA-C they stated that they tried to go into R1 room early this am and get R1 to sit up and leave the room, but R1 refused. When interviewed about helping with setting up R1 tray specifically NA-C explained that they don't because R1 is independent. However, during this interview R1 breakfast tray is still in room from this am. NA-C did state that they usually get R1 up into a chair for lunch and bring R1 out to the table unless R1 refuses. When asked if they chart behaviors NA-C stated that they don't usually. During an interview on 12/18/24 at 11:37 a.m., SSA did state that a conversation had happened with R1 last night and staff are going to work on getting R1 more active and monitor R1 eating habits. Currently there is no current note addressing the concerns. (continued on next page)

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	245544	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 12:36 p.m., a phone call placed to the Dietary Lead (DL) and message was left to return phone call. D.L. returned phone call and explained that they are familiar with R1 and R1 usually tells me what R1 wants and is fine with current weight. D.L explained that they have her care planned for three dietary supplements between meals. R1 usually has them between meals because that is how R1 chooses to have them. D.L. explained that there has not been anything new about R1 weight changes and would expect the DON or nursing staff to tell the D.L. if weight loss continued. During an observation on 12/19/24 at 08:59 a.m., R1 is in bed and has been sleeping since breakfast. There has been no observation of a supplement in R1 room. During an interview on 12/19/24 at 09:03 a.m., with the food services director (FSD) concluded that the D.L. will provide them with the information if a supplement needs to be ordered for a resident. D.L. stated that all supplements usually come from nursing. Supplements are usually stored in the dry storage and nursing has some in their refrigerator for the residents that need them. When asked if she was familiar with R1 and being on a supplement she stated no, but FSD was able to name other residents that were currently on a supplement. During an interview on 12/19/24 at 09:07 AM, the licensed practical nurse (LPN-B) was asked if was aware if R1 was on a supplement and where they would chart this information. LPN-B is on explained that R1 was not on a nutritional supplement and was looking at the regular computer to see if it was given during med passed. LPN-B explained that is R1 is care planned for a supplement that nursing would provide it and chart it on the MAR/TAR. LPN-B did go to the director of nursing (DON) and came back and stated that R1 was on a house supplement, but he couldn't find it on the MAR/TAR where they would normally sign this off. LPN- B was asked if he can show me the MAR/TAR and see if R1 is scheduled for the supplement. LPN-B explained that he didn't have access to that part of the computer and did state that if it was placed as an order that the expectation is for staffing (nurse) to be provide the supplement (house supplement). During an interview on 12/19/24 at 09:21 a.m., the DON was asked about the house supplement order and how what is there process for monitoring weights. The DON stated that the supplements are in the MAR for the nursing staff to provide and sign off like an order. The DON noticed that the order for a house dietary supplement was placed on 10/23/2024 for three times a day between meals. When DON reviewed the MAR/TAR it was not present on the last 3 months since October when the order was originally placed. The DON did state I don't see it on there and I would expect that it would have been on the MAR/ TAR when the order was initated. When the DON noticed that the order was not followed, DON did state that the nursing staff wouldn't have known that R1 was scheduled for the supplement. The DON did state that the purpose of providing a nutritional supplement was to prevent weight loss and provide a nutritional supplement. During a chart review on 12/19/24 at 09:31 a.m., it was verified that there was no order or documentation on the October, November, and December (up until 12/19/24) of a house nutritional supplement to be provided between meals. During chart review of the daily/ monthly weight book R1 was not even listed in the book for monitoring weights or flagged for observing for significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a facility policy named Weight Assessment and Intervention (revised March 2022), resident's weights are monitored for undesirable or unintended weight loss or gain. The facility failed to follow the portions of the policy that included weights are to be recorded in weight chart and evaluation for weight gain or loss will be noted in the resident's care plan and interventions or orders will be carried out per dietician, nursing staff, and provider.

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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** 44647 Based on interview and record review the facility failed to ensure a PRN (as needed) psychotropic medication order included an end date for 1 of 1 residents (R16) reviewed for PRN psychotropic medications. Findings include: R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated R14 had moderate cognitive impairment and diagnoses of lung cancer and depression. Furthermore, R14's MDS indicated R14 received hospice care and had received psychotropic medications for anxiety. R14's provider order dated 12/13/24, indicated R14 required Lorazepam concentrate (psychotropic medication for anxiety) 0.25milliliters (ml) every 4 hours PRN for anxiety. The order did not include a stop date. R14's Medication administration record (MAR) dated 12/2024 showed R14 had received Lorazepam on 12/13/24. When interviewed on 12/18/24 at 11:16 a.m., licensed practical nurse (LPN)-C verified R14's Lorazepam order did not include a stop date. LPN-C stated the order should be used for 14 days unless the provider gave a reason. LPN-C stated R14 was received hospice care and usually the orders were written for longer time frame and wasn't sure why that wasn't included when entering the order. When interviewed on 12/18/24. At 8:31 p.m., the Director of Nursing (DON) expected all PRN psychotropic medications to have a stop date of 14 days. DON further stated Lorazepam could be used for longer than 14 days with provider justification. DON verified R14's order did not have a stop date and the hospice providers usually wrote for 90 days. DON wasn't sure where why R14's order did not reflect this and stated it would need to be corrected. When interviewed on 12/19/24 at 10:19 p.m., the consultant pharmacist stated all PRN psychotropic medications should be ordered for no longer than 14 days. If the medication is not an antipsychotic medication, the provider can order longer than the 14 days with documentation. However, the order still must include an end date. A facility policy titled Antipsychotic Medication Use revised 7/2022, directed PRN psychotropic medications needed beyond the 14 day use must include a documented rationale and the duration of use will be indicated in the order.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure residents with difficulty swallowing were assisted with meals only by qualified individuals. Findings include: R164's admission Minimum Data Set (MDS) dated [DATE], indicated R164 had severe cognitive impairment, upper and lower extremity impairment of one side of the body, required substantial/maximal assistance with meals and a mechanically altered diet. R146 had three days of speech therapy and four days of occupational therapy in the seven day lookback period. R164's diagnoses included stroke, aphasia (condition limiting speech and understanding), dysphagia (condition affecting ability to swallow), and right-sided hemiplegia (paralysis affecting one side of the body). R164's December Care Task sheet indicated, ADL [activities of daily living]-Eating: dependent of 1 watch for pocketing food. R164's physician order dated 12/4/24, indicated, Resident is to be up in w/c for meals. Aides are to feed resident and check mouth for pocketing food. During observation on 12/17/24 at 8:47 a.m., R146 was in bed in room with breakfast tray on bedside table in front of him. R146 had ground sausage, cream of wheat, two whole waffles, and an unpeeled hard-boiled egg. R146 struggled to peel the egg and used his left hand fingers to eat the sausage. Further, R164 attempted to open a plastic water bottle with his teeth. No staff were present to assist. During observation on 12/17/24 at 8:50 a.m., nursing assistant (NA)-A entered R164's room to drop off a watcher pitcher for his roommate and exited the room without acknowledging R146 or offering to assist. During observation on 12/17/24 at 11:58 a.m., R164 was in the dining room in his wheelchair at a table by himself. Social services director (SSD) stood next to R164 while assisting him with his lunch. R164's lunch included ground pork, mashed potatoes, diced squash and slice of bread. During interview on 12/17/24 at 12:05 p.m., SSD stated not being an NA and just helping staff out since they seemed shorthanded. SSD stated never received any feeding assistance training. SSD stated R164 was not a feeder but had requested assistance so she wanted to help out. During interview on 12/17/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated staff must be trained to be qualified to assist residents with meals. LPN-A stated R164 was on a dysphagia diet and anyone assisting him must be trained since he was at risk for choking. During interview on 12/17/24 at 1:17 PM, director of nursing (DON) stated SSD was not a trained feeding assistant and was not qualified to assist R164 with his meal since he was on a dysphagia diet. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/19/24 at 9:56 a.m., speech therapist (ST)-A stated R164 was on a mechanical soft diet and required set up assistance and supervision with meals. ST-A stated staff were supposed to encourage R164 to eat in the dining room where there would be supervision, assist as needed with opening or arranging items and to offer cues and reminders to chew and swallow. ST-A stated R164 was not to eat alone until cleared by speech therapy. During follow up interview on 12/19/24 at 10:15 a.m., DON stated R164 should have supervision throughout his meal, should be provided an appropriate diet with items cut in small pieces. DON stated expectation only qualified staff would assist residents with meals. Facility policy Assisting the Impaired Resident with In-Room Meals dated 9/2013, identified a procedure for staff to provide appropriate support for residents who needed assistance with eating, but did not identify the need for assistance to be provided by only qualified staff. Facility written statement regarding paid feeding assistants (PFA), undated, indicated, If the facility employs PFA, provide the following information: a) Whether the PFA training was provided through a State-approved training program by qualified professionals as defined by State law, with a minimum of 8 hours of training; b) A list of staff [including agency staff] who have successfully completed training for PFA, and who are currently assisting selected residents with eating meals and/or snacks; c) A list of residents who are eligible for assistance and who are currently receiving assistance from PDA: NONE.