STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245572	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing Home	403 Colonial Avenue Lakefield, MN 56150

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to follow their grievance process for missing personal property for 1 of 1 resident (R19) who reported missing property. Findings include: R19's significant change Minimum Data Set (MDS) assessment dated [DATE], identified R19 had moderately impaired cognition. On interview 11/18/24 at 1:54 p.m., R19 stated he has had multiple packs of handkerchiefs lost when sent to laundry along with a couple shirts since his admission to the facility January 2024. R19 stated he is not sure how many handkerchiefs come in a pack but he has told multiple staff about his missing items. On interview 11/20/24 at 9:41 a.m., nursing assistant (NA)-A stated when residents inform them of missing belongings including clothing, would tell the charge nurse. NA-A was unsure what happens after that. On interview 11/20/24, at 9:45 a.m., NA-B stated staff fill out a missing belonging sheet and inform the charge nurse of the missing belongings. NA-B added they also put the form in the binder at the nurse's station. On interview 11/20/24 at 9:45 a.m., the nursing department coordinator (NDC)-A stated there was no book of missing belongings at the nurses station. NDC-A was able to locate a form to complete for missing or damaged items but thinks they are turned into social services to follow-up on and file. On interview 11/20/24 at 9:48 a.m., registered nurse (RN)-A, stated social services would have the missing belongings binder with the completed forms. RN-A indicated they currently do not have a social worker and she would look for them in her office. On interview 11/20/24 at 9:54 a.m., R19 stated every time I get new hankies, they just disappear in laundry. R19 stated his wife just got him a new pack and he is already down to 1 or 2 of them. R19 also indicated he has told staff multiple times about them missing along with his shirts. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview 11/20/24 at 10:24 a.m., laundry (L)-D indicated she has been aware of R19's missing handkerchiefs for the last month or two but not of his shirts. L-D stated they have looked for the missing handkerchiefs but have not been able to locate them. L-D indicated social services follows up with the residents. On interview 11/20/24 at 4:08 p.m., the administrator stated social services does keep a binder of missing belongings forms, but there was no form for R19's missing shirts or handkerchiefs present. The administrator confirmed a missing belongings form should have been completed and the grievance process was not followed through. The administrator stated any missing belonging is a big thing. Facility Missing or Damaged Items policy dated 2/19, included: - Person told of missing item to gather as much information as possible and initiate search for item. - If item is not found, complete the Missing or Damaged Item report form, and report it to charge nurse. - Charge nurse to determine further action in attempts to locate missing item and notify other departments as necessary. - Original copy of missing or damaged item report to be given to Social Services. - Social Services maintains file of all pertinent information regarding missing or damaged items.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40614 Based on interview and document review, the facility failed to ensure allegations of abuse were reported to the administrator and the State Agency (SA) timely for 1 of 1 resident (R24) reviewed for allegations of abuse. Findings include: Review of the 11/13/24 at 10:50 a.m., report to the SA identified on 11/12/24, at 6:15 a.m., resident informed staff the nursing assistant stated You better start cooperating with me or I will tell your husband and he will yell at you and You better be nice or your husband will yell at you. On interview 11/18/24 at 1:47 p.m., R24 denied any recent alleged events with verbal abuse. On interview 11/18/24 at 4:46 p.m., family member (FM)-A stated the facility did notify her regarding an event that occurred last week sometime (unable to identify the date) with potential verbal abuse. FM-A indicated R24's memory is very poor and would not recall any events from the past week. On interview 11/19/24 at 9:58 a.m., the director of nursing (DON) indicated she was notified of the alleged abuse event on 11/13/24 regarding R24, and reported it that same morning. The DON confirmed the event occurred 11/12/24. On interview 11/19/24 at 11:32 a.m., nursing assistant (NA)-C stated she was working on 11/12/24 around 6:00 a.m., when NA-D came into the room to assist and told R24 he was going to tell her husband who will yell at her. NA-C stated she thought about the encounter through the day and around 1:30 p.m. discussed the event with her co-workers who informed her she needed to report the event to the charge nurse. NA-C indicated the charge nurse was not available, and the DON and administrator were not present at the facility so she notified the business office manager (BOM)-G around 2:30 p.m. On interview 11/20/24 at 10:36 a.m., the administrator confirmed the alleged event report was not made to the SA until the following day. The administrator stated she was out of the building the day of the alleged event and during investigation found out the event occurred in the morning but wasn't reported until later in the day from the staff member internally. The administrator stated she received notification from BOM-G on 11/12/24, in the afternoon and instructed her to have the DON report the event but she was out of the office also. The administrator attempted to get another staff member privileges to report to the SA but was unsuccessful so event wasn't reported until the next day by the DON. Facility Abuse Prevention Plan undated, identified the administrator and DON must be promptly notified of suspected maltreatment. All alleged incidents of maltreatment are reported immediately to the SA and to all other agencies as required and all necessary corrective actions, depending on the results of the investigation, are taken. Immediately means as soon as possible, but not more than 24 hours after discovery of the incident. Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to ensure a residents hospice status was accurately coded on the Minimum Data Set (MDS) assessment for 1 of 1 residents (R15) reviewed for hospice and end of life. Findings include: R15's facesheet printed on 11/20/24, included diagnoses of protein-calorie malnutrition and encounter for palliative care. R15's current, quarterly MDS assessment dated [DATE], indicated R15 had moderately impaired cognition, had clear speech, could understand, and be understood. Hospice was not marked on the MDS. R15's significant change MDS assessment dated [DATE], indicated R15 was receiving hospice care. A progress note dated 7/3/24, indicated the provider faxed an order requesting hospice admission. During a telephone interview on 11/20/24 at 9:29 a.m., hospice agency administrative assistant (AD)-F stated R15 was enrolled in hospice on 7/8/24. R15's certification of terminal illness (CTI) diagnosis was protein calorie malnutrition. During an interview on 11/20/24 at 9:54 a.m., registered nurse (RN)-A who was also the MDS nurse, looked in R15's electronic medical record (EMR) and acknowledged hospice was not marked in Section O which indicated special treatments, procedures, and programs, for the quarterly MDS assessment dated [DATE]. RN-A immediately made a modification to add hospice to R15's MDS and stated she inadvertently missed that. Facility policy for accuracy of MDS assessments was requested and not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to ensure a care plan was revised to include hospice care for 1 of 1 residents (R15) reviewed for hospice and end of life. Findings include: R15's facesheet printed on 11/20/24, included diagnoses of protein-calorie malnutrition and encounter for palliative care. R15's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R15 had moderately impaired cognition, had clear speech, could understand, and be understood. R15's progress notes dated 7/3/24, indicated the provider faxed an order requesting hospice admission. R15's care plan initiated on 5/1/23, had no reference to R15 receiving hospice or palliative care. During a telephone interview on 11/20/24 at 9:29 a.m., hospice agency administrative assistant (AD)-F stated R15 was enrolled in hospice services on 7/8/24. During an interview on 11/20/24 at 9:54 a.m., registered nurse (RN)-A who was also the MDS nurse, stated if a resident was receiving hospice services, it would be identified on his/her care plan. RN-A looked in R15's electronic medical record (EMR) and acknowledged neither hospice or palliative care was identified on the care plan. RN-A stated either she or the director of nursing could add updates to the care plan, as well as any nurse. RN-A stated she should have caught that omission. Facility Care Planning policy with revised date of 8/23, indicated the care planning process began pre-admission and continued on a regular and periodic basis throughout the residents stay. Care plans were updated with any changes.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 40614 Based on interview and document review, facility failed to document a complete recapitulation of stay for 1 of 1 resident (R28) reviewed for discharge. Findings include: R28's facesheet printed 11/20/24, identified an admitted to facility of 7/8/24 with diagnoses including: pressure ulcer of left foot (bedsore injury to the skin and tissue below the skin), depression, osteomyelitis (infection in bone) and paraplegia (paralysis that mostly affects the movement of the lower body). R28's discharge orders were dated 10/24/24, and signed by the provider. A progress note dated 10/25/24 at 9:51 a.m., by registered nurse (RN)-B included resident discharged to home with wife. Personal belongings, over the counter medication were taken home. Discharge orders reviewed with wife and resident and they state understanding. The medical record lacked a discharge summary. On interview 11/20/24 at 4:43 p.m., registered nurse (RN)-H, also identified as regional director of skilled care, confirmed she was not able to locate a discharge summary in the medical record and added there has been a turn over in staff so was unsure if it was completed but it should have been. On interview 11/20/24 at 4:47 p.m., RN-A, also identified as MDS coordinator, stated in the past social services was responsible for the discharge process and this was her first time doing a discharge. RN-A stated she was not aware she needed to fill out a discharge summary so this was not done but did send the orders with the resident upon discharge. Facility Death/Discharge Record Completion policy dated 8/23/24, included: On permanent discharge, nursing will complete discharge summary to the extent possible in the electronic health record (EHR). On permanent discharge, nursing will secure the signature and address of the responsible person to whom released, the signature and address of the resident. The signature and address is recorded on the admission and discharge record. The nurse will complete the discharge summary in the EHR. The physician will be notified via fax, phone call or in person of discharge.

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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** 40614 Based on observation, interview and document review, the facility failed to document and monitor weight loss for 1 of 1 resident (R24) who had weight loss. In addition, the facility failed to obtain accurate weights for 2 of 2 residents (R24, R4) who were evaluated for nutrition. Findings include: R24's facesheet printed on 11/20/24, included diagnoses of stroke affecting left side, Parkinsonism (movement related disorder), dementia, mild with anxiety, hypoglycemia (low blood sugar), hyponatremia (low sodium level), and dysphagia (difficulty swallowing). R24's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R24 had severe cognitive impairment, required setup help for eating and was dependent for transfers, mobility in wheelchair, dressing, and personal cares of activities of daily living (ADL's). No weight loss or gain. R24's care plan dated 10/23/24, indicated R24 was at risk for nutritional compromise related to right sided stroke and Parkinson's disease. Goals included resident will have adequate intakes of food and fluids with meals/snacks and resident will not have triggered weight loss of 5% in 30 days or 10% in 180 days. Interventions included allow resident to make meal choices, offer extra fluids between meals for hydration at activities and in common areas and room, resident will maintain ability to feed self, monitor monthly weights for any significant trigger, weigh and notify provider of weight changes per facility protocol. Additional interventions included monitor and record intakes of food and fluids, observe for any problems with chewing or swallowing and work with speech therapy for safest level of chewing and/or swallowing. R24's physician orders dated 7/18/24, indicated R24's diet included regular with cut up meats at meals, thin liquids. A nurse progress note dated 11/13/24 at 1:25 p.m., by licensed practical nurse (LPN)-B included provider here for house rounds and orders for speech therapy to evaluate for increased complaints of swallowing issues. A nurse progress note dated 11/18/24 at 6:49 p.m., by LPN-A included R24 has had a diet change: Soft and bite size recommended and take a sip of water after each bite to ensure food is fully chewed and swallowed. Crush all pills, and thin liquids as ordered by speech therapy. R24 weights in pounds recorded since admission on 5/10/24 included: 5/11/24 - 146.2 6/13/24 - 147.4 7/11/24 - 151.4 7/29/24 - 184.8 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/5/24 - 141.0 9/5/24 - 184.8 9/5/24 - 194 9/27/24 - 142.2 10/14/24 -140.2 11/4/24 - 135.2 11/11/24 - 123 11/14/24 - 121 - 17.24% change from admission 6 months prior. 10.5 percent change from 11/4/24. On interview 11/18/24 at 4:54 p.m., family member (FM)-A stated R24 has not had an appetite lately and will take bites and spit it out. FM-A indicated she was not aware of a weight loss but FM-B had informed her she isn't eating much if at all. During observation on 11/18/24 at 6:30 p.m., R24 was eating in her room with husband present. Ate 50% of her meal. During observation on 11/19/24 at 12:45 p.m., R24 refused her lunch. Review of meals documented from 10/20/24 to 11/19/24 included: None: 11 times 0-25%: 7 times 26-50%: 11 times 51-75%: 12 times 76-100%: 24 times A nutritional assessment dated [DATE], observation and completion date by registered dietician (RD)-I, included a score of 10 indicating R24 is at risk of malnutrition. Notes included: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24 has had variations to weights and it appears some are inaccurate. She was readmitted with stroke and history of Parkinson's Disease. Admission height taken from hospital records 65 and weight 146 pounds. Ideal body weight is 125 pounds. Estimated nutritional needs 1300-1500 calories, 60-70 grams protein and 1600 ml fluids. Review weight 135 pounds which is a decrease of 3.5% in 30 days and a decrease of 7.5% in 180 days. Both do not trigger for weight loss. Diet is regular, regular texture (cut up) and regular liquids. Intakes are generally adequate with small portions preferred. Her husband comes to feed her meals which are consumed in room for most part. Her husband brings her a donut for mid - morning snack. She has her own teeth and there are no problems with chewing or swallowing at present. Nursing notes that she had difficulty swallowing on 10/4/24, however this was also associated with anxiety and difficulty breathing. No other notes regarding problems. Medications pertinent to nutrition include laxatives with many medications recently discontinued. Mini Nutritional Assessment score: 9 - at nutrition risk NUTRITION DIAGNOSIS Inability to manage self care and physical inactivity related to stroke and Parkinson's disease as evidenced by requiring assistance with ADL's and structured meals to maintain nutrition status. NUTRITION INTERVENTIONS: Diet: regular, regular texture and regular liquids Cut up meat for ease of self feeding NUTRITION PLANS: Provide diet as ordered Snacks per facility protocol and resident preferences Monitor any difficulty with swallowing Monitor need for nutrition supplement if weights are accurately declining. Monitor intakes of food/fluids to ensure nutrition needs are being met. On interview 11/20/24 at 3:06 p.m., the registered dietician (RD)-I stated she has had issues with getting accurate weights or reweighs completed when requested. RD-I stated when she completed her recent nutritional assessment it was for the look back period dating from previous quarterly assessment 7/15/24 through 11/7/24. RD-I indicated if the weights for 11/12 and 11/14 were accurate, she should have been notified of the significant weight loss. RD-I indicated it has been difficult to complete accurate assessments when weights are sometimes inaccurate. RD-I stated she has requested re-weights but they are never completed. RD-I indicated she writes possible inaccuracy of weights in her reports which go to all the department heads, so they are aware of the request for re-weights and possible inaccuracy of weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview 11/20/24 at 3:16 p.m., licensed practical nurse (LPN)-A reviewed R24's weights and stated there are obvious operator errors present and R24 should have been reweighed with the inaccurate weights that struck out as errors. LPN-A added he has requested a lot of reweighs at the facility due to crazy weight difference since he has been at the facility at the end of September. LPN-A stated the most recent weight from 135 to 123 pounds in one week would require notification to the physician. LPN-A added R24 hasn't been eating much so the weights could be accurate. LPN-A reviewed the record and confirmed there is no documentation present of physician notification of the significant weight change. On interview 11/20/24 at 3:25 p.m. interim case manager (ICM)-K confirmed a 12 pound weight loss in one week is a significant weight loss and the physician should have been notified. ICM-K indicated weights that are obviously not accurate need to be reweighed and inaccurate weights struck out as error. On interview 11/20/24 at 3:29 p.m., nurse consultant (NC)-L confirmed the facility has had issues with the monitoring and accuracy of weights and it is on a list to address. On interview 11/20/24 at 3:32 p.m., the dietary manager (DM)-J indicated she has met with R24 and FM-B regarding her intake and snacks. DM-J indicated she has observed FM-B eating portions of R24's food so is not sure how accurate the intake documentation is. DM-J confirmed she has had difficulty getting accurate weights with some weights being obvious significant errors. When reweighs are requested, they don't happen. DM-J confirmed she, the RD and the physician should have been notified of R24's recent significant weight loss. 42073 R4's facesheet printed on 11/20/24, included diagnoses of severe protein-calorie malnutrition and dysphagia (difficulty swallowing). R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated R4 was cognitively intact and was dependent upon staff for activities of daily living (ADL's). R4's orders did not specify obtaining measured weights. R4's care plan with revised date of 10/2/24, indicated R4 was at nutrition risk due to history of poor intake and history of requiring a feeding tube. In addition, staff were to monitor monthly weights for significant changes, notify the provider of weight changes per policy, and to weigh R4 per facility protocol or provider orders. Review of R4's weights showed weights consistently over 100 pounds from 8/16/24, to 10/16/24, except for an aberrant weight on 9/30/24, of 82.6 pounds. Review of dietician progress notes indicated: --10/1/24: Weight listed in the EMR (electronic medical record) on 9/30/24, is 82.6 # (pounds). Question the accuracy of this. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--10/15/24: Weights appear inaccurate with weight on 9/16/24, 107# and weight on 9/30/24, of 82.6 #. During a telephone interview on 11/19/24 at 9:52 a.m., registered dietician (RD)-I stated she suspected some inaccurate resident weights but had not spoken to the nursing staff or director of nursing (DON) about it. RD-I stated she included this information in her nutrition reports which went to department leaders, so they were aware of the possible inaccuracies of weights. During an interview on 11/19/24, at 11:20 a.m., the DON stated she was aware of inaccuracies of weights; that it has been identified one or two months ago. The DON stated because of this, staff re-weighed resident wheelchairs and updated the wheelchair weight book. The DON stated she had then asked nurses to obtain residents weights rather than nursing assistants (NA's). The DON stated she would look for the written communication to the nurses regarding this change, but she used mostly verbal communication to inform them. During an interview on 11/19/24 at 12:27 p.m., licensed practical nurse (LPN)-B stated had not received communication from the DON indicating only nurses should be weighing residents. LPN-B stated she was aware of weight inaccuracies, adding a physician, Got after me about that one day. LPN-B stated each day she wrote in a small notebook which residents needed a measured weight. After a NA obtained the weight, the NA recorded it in the notebook, then LPN-B calculated the weight without the wheelchair and entered it into the EMR. While she had not seen evidence of it, LPN-B stated she wondered if NA's were weighing residents in a wheelchair with the oxygen tank attached, adding that could account for the weight fluctuations. During an interview on 11/20/24 at 8:56 a.m., the administrator was aware of inaccurate weights being recorded in resident records. The administrator stated the inaccuracies were sometimes due to staff not waiting for the scale to be fully turned on and therefore the weight was skewed. The administrator stated the maintenance director had calibrated the scale and the DON provided education to the nursing staff. The administrator stated she would look for the documentation of the education and stated it did not indicate (as the DON had stated), that only nurses would weigh residents rather than NA's. During an interview on 11/21/24, at 8:41 a.m., in the shower room with the wheelchair scale, NA-H stated NA's weighed a residents in their wheelchair, then gave the charge nurse the weight. NA-H stated she thought the nurse deducted the wheelchair weight. Observed a sign on the scale indicating to remove the oxygen tank [before weighing the resident]. During an interview on 11/21/24 at 9:16 a.m., LPN-B stated she got sick of inaccurate weights one weekend, so created a list of the weight of resident wheelchairs so that nurses could use that information when calculating weights. LPN-B stated she shared the list with the nursing staff and made the DON aware too. During an interview on 11/21/24 at 9:19 a.m., nursing assistant (NA)-F stated residents were weighed in the shower room. If a resident had an oxygen tank on their wheelchair, that was removed. NA-F stated she gave the total weight measurement (resident and wheelchair) to the nurse who wrote it down, but NA-F didn't know what happened after that. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Weighing and Weight Changes of Residents policy dated 4/22, included weekly weights are taken by nursing staff and entered into the electronic medical record. The DM or RN/LPN will review weights and request for reweighs if there is a change of plus or minus 3 pounds in a week. If reweigh confirms a weight change of 3 pounds gain or loss, daily weights will be requested by RN/LPN or DM for 7 days to observe resident's weight. The DM will evaluate for significant weight gains and losses. If significant weight charges are documented, the DM will report to the RD to review. If weight loss is confirmed and the resident's meal intakes are more than 50%, the DM will report to the RD and provider with confirmation of significant weight change. The DM will continue to observe resident's weight for another week before starting interventions, unless recommended to do otherwise by RD or provider. If weight loss is confirmed and the resident's meal intakes are less than 24-50%, the DM will report to the RD and provider with confirmed weight loss. The DM will start interventions as stated in the nutrition at risk policy and procedure.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 40614 Based on interview and document review, the facility failed to ensure that in the absence of a full-time registered dietician (RD), the dietary manager (DM) was certified to oversee nutrition and food services. This had potential to affect all 25 residents who resided in the facility. Findings include: During an interview on 11/18/24 at 12:25 p.m., dietary manager (DM)-J stated she had been employed at the facility since 12/18/23 and was not a certified dietary manager nor had she started any classes. DM-J stated she was notified today the administrator was going to get her signed up for the certification class. DM-J stated she does have a Food Safety Certificate, which she completed in 2019. During an interview on 11/20/24 at 10:45 a.m., the administrator was aware DM-D was not certified as a dietary manager. The administrator stated she understood the registered dietician coming once a week would be adequate until DM-J got her certification. The administrator stated, DM-J has not been signed up for her dietary certification classes. Dietary manager job description undated, skills/qualifications included, knowledge of state and federal food regulations, Serv-Safe Certified, current certification as a Certified Dietary Manager (CDM) or dietician preferred or willing. If not licensed as CDM will encourage the candidate to get obtain their CDM certificate.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 42073 Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 3, 2024), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: The CMS payroll-based journal (PBJ) staffing data report for quarter 3 of 2024, which included dates from 4/1/24, to 6/30/24, triggered for: Four or More Days Within the Quarter with <24 Hours/Day Licensed Nursing Coverage. The following infraction dates were identified: 5/25/24, 6/8/24, 6/9/24, 6/16/24, 6/1/24, 6/22/24, 6/23/24, 6/24/24, 6/29/24, and 6/30/24. Review of nursing staff schedules for each infraction date indicated a licensed nurse had been scheduled each of the three shifts (days, evenings, and nights). The daily staffing postings for each infraction date indicated a licensed nurse was scheduled on each shift. During an interview on 11/20/24 at 11:10 a.m., nursing department coordinator (NDC)-A who was responsible for scheduling nursing staff, stated there was always a licensed nurse working every day, on each shift - days, evenings, and nights. Together with business office manager (BOM)-G, timecards were reviewed for each infraction date. All shifts were identified as having been worked by a licensed nurse, either an employed nurse or an agency nurse. During an interview on 11/20/24 at 3:15 p.m., BOM-G stated she was responsible for entering data for the PBJ report and was not able to identify why the report triggered for four or more days within the quarter with <24 hours/day licensed nursing coverage. All nursing staff, including management and/or agency were entered into the report. During an interview on 10/20/24 at 4:00 p.m., the administer could not determine the reason the PBJ report triggered for four or more days within the quarter with <24 hours/day licensed nursing coverage. Facility PBJ policy was requested, and the administrator stated the facility followed the CMS PBJ - LTC (long term care) policy manual.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R26) who had a urinary ostomy Findings include: R26's facesheet printed on 11/20/24, included diagnoses of neuromuscular dysfunction of the bladder (when the nerves and muscles that control the bladder don't work properly), bladder-neck obstruction, and a urinary diversion device - a urinary ostomy (an opening in the abdominal wall to redirect the urine). R26's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R26 had moderately impaired cognition, clear speech, could understand and be understood. R26, who didn't walk, required staff assistance for most activities of daily living (ADL's), including toileting. R26's physician order dated 11/5/24, indicated to change two-piece urostomy pouch on Tuesday and Friday if leaking. During an observation on 11/19/24 at 1:20 p.m., observed an EBP sign hanging on R26's door which indicated staff were to don personal protective equipment (PPE) including gown, gloves, and mask, prior to providing care. Nursing assistant (NA)-F was observed taking a sit-to-stand mechanical lift into R26's room without donning PPE. NA-F assisted R26 from wheelchair to mechanical lift to toilet without PPE, then exited the room. During an observation and interview on 11/19/24 at 1:40 p.m., NA-F donned PPE - gown, gloves, and mask - to enter R26's room. NA-F stated she didn't don PPE to take R26 into the bathroom and assist him onto the toilet because she didn't touch him during that process. During an interview on 11/19/24 at 1:54 p.m., along with NA-F reviewed the EBP sign on the outside of R26's door. NA-F admitted she didn't wear PPE when toileting R26 with the sit-to-stand mechanical lift, adding, It's a fine line -- I can put the sling [for the lift] on him without touching him. During an interview on 11/19/24 at 1:58 p.m., the director of nursing (DON) stated whether or not staff donned PPE to care for a resident in EBP depended on the distance. When asked if there was a distance requirement, the DON stated would need to look at the policy. During an interview on 11/19/24 at 2:03 p.m., the DON provided the EBP policy and stated according to the policy, staff should wear PPE when toileting a resident in EBP. During an interview on 11/19/24 at 4:22 p.m., registered nurse (RN)-A, who was also the infection preventionist, stated nursing staff had a meeting on 11/11/24, where EBP was reviewed. A copy of sign-in sheet was provided and NA-F's signature was listed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Enhanced Barrier Precautions policy with revised date of 6/21/24, indicated EBP was used with residents who had indwelling medical devices; that an indwelling medical device provided a pathway for pathogens in the environment to enter the body and cause infection. EBP was used when performing high contact resident care activities such as toileting.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on interview and document review, the facility failed to implement a process for antibiotic review to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance for 4 of 5 residents (R9, R19, R20, R25) reviewed for antibiotics. This had the potential to affect any of the 25 residents who resided in the facility who might use antibiotics. Findings include: Review of the monthly infection control log dated 7/2024, 8/2024, 9/2024, 10/2024 and 11/2024, identified residents who had been identified as having an infection and had been administered an antibiotic and had included the floor plan of the facility. Review of 7/2024, surveillance log identified R20 had a urinary tract infection (UTI). R20 was admitted [DATE]. R20's face sheet had diagnoses of dementia with anxiety and traumatic brain injury. She was prescribed an antibiotic Macrobid that was started on 7/28/24. The surveillance log lacked indication of the antibiotic dosages and when or if the infection had resolved. Review of 9/2024, surveillance log identified R19 had a UTI infection. R19 was admitted [DATE]. R19's face sheet had diagnoses of dementia, UTI, obstructive reflux uropathy and benign prostatic hyperplasia (enlargement) with lower urinary tract symptoms. R19's 10/02/24, significant change Minimum Data Set (MDS) identified he had an indwelling catheter. R19 was prescribed an antibiotic ampicillin 500 milligrams (mg) on 9/16/24. The surveillance log lacked indication when or if the infection had resolved. Review of 9/2024, surveillance log identified R9 had a UTI infection. R9 was admitted [DATE]. R9's face sheet had diagnoses of functional urinary incontinence, retention of urine and chronic kidney disease. R9's 11/01/24, significant (MDS) identified he had an indwelling catheter. R9 was prescribed an antibiotic cefdinir 300mg on 9/24/24. The surveillance log lacked indication when or if the infection had resolved. Review of 10/2024, surveillance log :identified R25 had a UTI infection. R25 was admitted [DATE]. R25's face sheet had a diagnosis of joint replacement surgery, right artificial knee joint, and pruritis. R25 was prescribed an antibiotic macrobid on 10/28/24. The surveillance log lacked indication of the antibiotic dosages, as well as, when or if the infection had resolved. Review of 11/2024, surveillance log identified use of antibiotics for residents who had a UTI, however, the surveillance log lacked indication of what the infection were, did not identify if a time out had been completed, and did not indicate when or if the infection had resolved. During interview on 11/20/24 at 2:19 p.m., with registered nurse (RN)-A hired June 2024, and had not started her Infection preventionist (IP) training and was recently assigned to the duty as the facility's IP in September. RN-A stated the director of nursing (DON), who no longer worked at the facility, had a process in place for identifying antibiotic use for residents and would need to collaborate with the current facility administration to enforce consistency with the antibiotic stewardship program of tracking and logging all antibiotics. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 11/20/24 at 3:27 p.m., with administrator would expect the nursing team to identify, track and maintain monthly log updates of all residents who had received antibiotics. Review of April 2023, Antibiotic Stewardship Policy identified the facility licensed nurses would follow up on pending cultures within 48 hours and would contact lab services at 72 hours to verify culture results, as well as antibiotics used to treat infections or to prevent unnecessary antibiotic use. Review of April 2023, Infection Control-Antibiotic Stewardship Program policy identified the facility would promote appropriate use of antibiotics to treat infections and reduce adverse effects related to antibiotic use under evidence based practice guidelines aligned with Centers for Disease Control and Prevention (CDC). Secondly, the facility would monitor antibiotic usage patterns on a regular basis, review the antibiotic stewardship policy annually, would evaluate clinical signs and symptoms of residents who was suspected of having an infection and would use antibiotic time out forms to assess the ongoing need for antibiotics. Lastly, the IP would oversee the infection surveillance and would provide monthly reports, as indicated.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40614 Based on interview and document review the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 25 residents residing in the facility. Findings include: On interview on 11/19/24 at 10:29 a.m., the director of nursing (DON), indicated she started her employment at the facility in July 2024 and started doing the infection control role in October. The DON indicated she is enrolled in the Centers for Disease Control (CDC) infection preventionist course but has only completed one module so far and isn't very far into the training course. The DON added the role was going to be split between her and RN-A, also identified as Minimum Data Set (MDS) coordinator. On interview 11/19/24 at 10:23 a.m., RN-A indicated she is new to the infection preventionist role and has had no training at this time. RN-A stated she started at the facility at the end of June 2024 and was told to focus on MDS training first. RN-A indicated she is enrolled in a Boot Camp for Infection Control class the first week in December and is enrolled in the CDC infection preventionist course, but hasn't started it yet. On interview 11/19/24 at 10:59 a.m., the administrator stated she is aware the facility currently has no trained infection preventionist, but both the DON and the MDS coordinator are enrolled in the CDC course. Facility Infection Prevention and Control Program, dated 12/2022, included the early detection, prevention and management of infections are accomplished through effective oversight of the Infection Prevention and Control program that must include at a minimum, the following elements: To recognize and manage infections at the time of the resident's admission to the facility and throughout the stay; to follow recognized infection prevention and control practice while providing care that includes transmission based precautions and isolation; to provide program oversight including planning, organizing, implementing, operating, and monitoring; to maintain all of the elements of the program and ensuring the facility's interdisciplinary teams is involved in infection prevention and control practices; to develop and revise policies, procedures, and practices that promote consistent adherence to evidence-based infection control practices; to plan organize, implement, operate and maintain all the program elements; to define roles and responsibilities during routine implementation of practice and during unusual occurrences or times of potential risk of spread of infection or outbreak; to define and manage resident and employee health initiatives. The infection Prevention and Control Program components include the establishment of surveillance standards and frequency .; the development of the education component including the training in infection prevention and control practices that ensures compliance with facility requirements as well as State and Federal regulations.

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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** 40614 Based on interview and document review the facility failed to have records of the pneumococcal vaccinations for 1 of 1 resident (R19) and the influenza vaccine for 2 of 3 residents (R19, and R7) reviewed for immunization protocol for who had a signed agreement to receive the influenza vaccine. In addition, the facility failed to document for 1 of 1 resident (R19), the influenza vaccine had been offered and education on risks/benefits was completed. Findings include: R19's medical record identified R19 had been admitted to the facility on [DATE]. R19's medical record lacked documentation of receiving any pneumococcal or influenza vaccines. R19's medical record lacked documentation of education on risks/benefits or declination of vaccines. Upon request of R19's record of vaccinations or refusal along with education completed, registered nurse (RN)-A confirmed 11/19/24 at 10:23 a.m., R19's record lacked documentation of any vaccinations and stated she would look further into it. Upon second request for vaccinations 11/20/24 at 8:01 a.m., nothing further was received. R7's medical record identified R7 had not received influenza vaccine. A consent form was present in the medical record that included consent on 11/4/24, for Covid and influenza vaccine. Covid vaccine was administered 11/7/24 but R7's record lacked documentation of receiving influenza vaccine. R26's medical record lacked documentation the influenza vaccine had been offered, education/risks discussed or documentation of refusal. On interview, 11/20/24 8:01 a.m., RN-A indicated influenza vaccine shots have not been given at the facility yet this year. RN-A indicated the consents for vaccinations were sent to the families late and they haven't received them all back yet. RN-A had not completed follow-up with the families who had not returned the consent forms. RN-A stated the influenza vaccine had been at the facility for a few months but none had been given at this time. Facility Resident Vaccinations policy dated 6/2023, included all residents are provided with the opportunity and are encouraged to receive pneumonia and COVID-19 vaccinations. Vaccinations will be offered to all residents per Center for Disease Control (CDC) recommendations. The RN Case Manager and infection control coordinator will be responsible for researching resident medical record and history to determine if the vaccinations have been given. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Infection Control - Resident Vaccinations policy dated 4/2023, included to minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal pneumonia by assessing that each resident is informed about he benefits and risks of immunizations and has the opportunity to receive, unless medically contraindicated, resident refused or already immunized, for the influenza and pneumococcal pneumonia vaccine. Beginning in the fall of each year, residents will receive an educational handout on the inactivated influenza vaccine which is to include benefits and risks and possible side effects. Staff will receive consent from resident or responsible party. Staff then administer, per standard of nursing practice and document vaccine on resident's vaccination record. If vaccine not provided, staff will document as to why the vaccine was not provided, such as medical contraindications, refusal, or vaccine already given prior to admission. Influenza vaccine is offered October to March of each year. Pneumococcal is offered year around.