STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Care Center	600 Main Avenue South Baudette, MN 56623

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a significant change in status assessment (SCSA) was completed when two or more areas in resident status were identified on the Minimum Data Set (MDS) for 1 of 4 residents (R6) reviewed for MDS accuracy. Findings include: R6's quarterly MDS dated [DATE], identified R6 required maximum assistance with dressing both upper and lower body, was independent with bed mobility, and required maximum assistance with transfers and ambulation of ten feet. R6 was frequently incontinent of bowel. R6's quarterly MDS dated [DATE], identified R6 was dependent with dressing both upper and lower body, dependent with bed mobility and transfers and was unable to ambulate. R6 was always incontinent of bowel. The above assessments identified a change in status for dressing, bed mobility, transfers, ambulation and bowel incontinence. When interviewed on 6/24/25, at 3:00 p.m. nursing assistant (NA)-B stated R6 could stand and pivot with transfers. If R6 was having a really good day could do so with assist of one person, but otherwise required two-person assistance. During observation and interview on 6/24/25, at 4:27 p.m. NA-E and NA-F entered R6's room to assist her with toileting. After applying a gait belt the two aides assisted R6 to her bed to lie down. After gloving the aides removed R6's pants and brief and provided peri care. The aides rolled R6 from side to side to assist with peri care and applied a clean brief. R6's arms were crossed over her chest, and she made no attempt to assist with rolling back and forth in the bed. NA-E stated they have to assist R6 to turn side to side when assisting with toileting. During interview on 6/25/25, at 4:05 p.m. registered nurse (RN)-B stated she reviewed the completed resident assessments, aide and nurse documentation to complete a resident's MDS. R6's May MDS should have been a significant change MDS instead of a quarterly as R6 had some decline in her functional abilities and mobility, related to R6's disease process. RN-B was now trying to review the resident care plans when she completed the resident MDS assessments to make sure they matched and if a lot of change was needed to the care plan that would trigger with RN-B the resident could need a significant change MDS, and she would be able to catch those changes more easily. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CMS's (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3. 0 Manual pages 2-21 through 2-28 indicated 03. Significant Change in Status Assessment (SCSA). Assessment Management Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Any decline in an ADL physical function area where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual ' s functioning; Resident incontinence pattern changes or there was placement of an indwelling catheter. The policy Resident Assessment Instrument dated July 2019, identified at any time a resident had a significant change in status as defined in the RAI manual the RN would initiate a comprehensive assessment. A significant change was defined as a major decline or improvement in a resident's status that would not normally resolve itself without intervention, impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. A significant change in status MDS was required when a resident experiences a consistent pattern of changes with either two or more areas of decline or improvement from baseline.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a subset (i.e., discharge) Minimum Data Set (MDS) was completed and transmitted to the Centers for Medicare and Medicaid (CMS) database in a timely manner for 1 of 2 residents (R24) reviewed for resident assessment. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2023, identified all applicable MDS along with their completion and transmission dates required. This included, Discharge Assessment - return not anticipated, listed with a transmission date of, MDS Completion Date + 14 calendar days. R24's unsigned discharge MDS dated [DATE], identified discharged -return not anticipated. R24's progress notes identified R24's was admitted on [DATE], and discharged home with his son on 1/28/25. R24's electronic medical records identified the discharge MDS was in-progress. During an interview on 2/26/25 at 2:05 p.m., registered nurse (RN)-A, identified R24 had a planned discharge and the MDS was completed by an RN manager and then was reviewed by another RN or the director of nursing (DON). Once the MDS was reviewed it would be submitted to CMS. The discharge MDS should have been completed and submitted to CMS with-in 14 days of discharge. RN-A reviewed R24's medical record and identified R24's discharge MDS was not signed or submitted to CMS. It was missed and did not know why. During an interview on 6/26/25 at 2:22 p.m., the DON stated the RN managers completed the discharge MDS and then it would be reviewed by the other RN manager or the DON. R24's discharge MDS was missed somehow and was not completed or submitted. It was expected all MDSs would be completed and submitted per guidance from CMS. The facility's Resident Assessment Instrument policy dated 2025 did not identify handling of a discharge MDS.

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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** Based on interview and document review the facility failed to ensure weight loss was accurately coded on the Minimum Data Set (MDS) 1 of 2 residents (R22) reviewed for nutrition. Findings include: R22's significant change MDS dated [DATE], identified R22 had severe cognitive impairment. Under Section K: Swallowing/Nutritional Status, R22's weight was recorded as 96 pounds (lbs) and as having had no or unknown weight loss or gain since the last assessment period. R22's Weights and Vitals Summary dated 4/1/25 to 6/23/25 identified the following recorded weights for R22: - 4/1/25 R22's weight was 104.8 lbs. - 5/1/25 R22's weight was 100.2 lbs. - 6/2/25 R22's weight was 89.2 lbs., a 14.89% weight loss in nine weeks - 6/9/25 R22's weight was 96 lbs., a weight gain of 7 lbs. in one week - 6/16/25, R22's weight was 90 lbs. - 6/23/25, R22's weight was 87.6 lbs., a 16.41% weight loss in 12 weeks When interviewed on 6/24/25, at 3:24 p.m. the dietary manager (DM)-B stated she completed Section K: Swallowing/Nutritional Status for all the resident MDS assessments scheduled. DM-B had not realized she marked no for weight loss on R22's significant change MDS dated [DATE]. R22 had a weight loss and had been discussed at the facility's high risk team meetings. The MDS had been coded in error and should have been coded yes for a significant weight loss. During telephone interview on 6/25/25, at 8:30 a.m. the registered dietician (RD)-C stated she had not kept up with the comprehensive or significant change resident assessments. DM-B completed the MDS assessments for the residents and was the lead on monitoring resident weights. R22's intake was not good, and RD-C did not feel the weight obtained on 6/9/25, could be accurate, as it would be difficult for R22 to gain or lose that much weight in one week. R22's weight was 89.2 lbs. on the monthly report, which would represent a significant weight loss. During interview on 6/26/25, at 11:30 a.m. the director of nursing (DON) stated R22 had been on the facility's radar for weight loss and should have been coded as a significant weight loss on the significant change MDS completed on 6/12/25 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Medicare and Medicaid (CMS) Long-Term Care Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated October 2024, identified Section K: Swallowing/Nutritional Status which was intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. Further, the manual provided several coding instructions directing staff to select code 2/yes if the resident had experienced a weight loss of 5% or more in the past 30 days or 10% or more in the past 180 days and the weight loss was not planned or prescribed by a physician. The facility policy Resident Assessment Instrument (RAI) dated July 2019, identified federal requirements required that facilities use the RAI that has been specified by the state of Minnesota. The assessment system would provide a comprehensive, accurate, standardized, reproducible assessment of each resident functional capability and help staff to identify health problems.

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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** Based on interview and document review, the facility failed to ensure a resident's care plan was revised to include interventions for infection management for 1 of 1 resident (R18) reviewed for transmission-based precautions. Findings include: R18's quarterly minimum data set (MDS) dated [DATE], identified R18 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R18's diagnoses included diabetes, renal insufficiency and chronic obstructive pulmonary disease (COPD). R18's sputum culture results dated 5/30/25, identified R18 was positive for MRSA. R18's order summary report dated 6/9/25, identified R18 was to start the following medications related to diagnosis of pneumonia: - Prednisone 20 mg daily x 2 days, order date 6/9/25. - Azithromycin 250 mg daily x 3 days, order date 6/9/25. - Sulfamethoxozole-Trimethoprim 400-80 mg daily x 5 days, order date 6/9/25. - Early morning sputum culture status post antibiotic treatment, one time only, order date 6/18/25. R18's medication administration record dated 6/1/25 through 6/30/25, identified R18's last dose of Sulfamethoxozole-Trimethoprim was given on 6/14/25. R18's verbal Evaluation and Treatment of Suicidal Ideation dated 6/11/25, identified medical doctor (MD)-B ordered staff to stop wearing a gown when R18's 5 day course of antibiotics were complete. On 6/24/25 at 2:57 p.m., registered nurse (RN)-C stated R18 returned from the hospital on precautions for MRSA pneumonia. R18 stays in his room except when eating meals when he is allowed to sit at a table at an alcove across from his room. Staff sat with R18 while he ate meals. RN-C stated they had added EBP interventions to the care plan was so staff knew what was going on with the resident and what they were supposed to do when caring for him. she had not added interventions related to EBP to R18's care plan, although should have. On 6/25/25 at 10:21 a.m. nursing assistant (NA)-C stated staff were notified when a resident was on precautions through multiple ways, including by reviewing the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 8:48 a.m., RN-C stated upon R18's return from the hospital staff were supposed to wear full PPE when caring for R18. On 6/11/25, due to R18's mental health issue, MD-B was contacted and ordered to stop gowning upon R18's completion of antibiotics. R18's last antibiotic was 6/15/25, and modified precautions were initiated which included staff were to wear gown and gloves during direct cares, and R18 was allowed to sit in the hallway alcove with staff present and eat meals. RN-C was unable to determine the exact date modified precautions were started. RN-C stated the care plan was used by staff so they knew how to care for a resident. RN-C stated she had not added TBP precautions to R18's care plan although she should have. On 6/26/25 at 3:35 p.m., the director of nursing (DON) stated care plans were updated by the nurses and staff could review the care plans for changes. A care planning policy was requested and not received.

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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** Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to reduce or prevent continued weight loss for 1 of 2 residents (R22) reviewed for nutrition. Findings include: R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had severe cognitive impairment, required supervision with eating and had no weight loss of 5% or greater in the past month. R22's most recent Mini-Nutritional assessment dated [DATE], identified R22 had a severe decrease in food intake, had severe dementia and a weight loss of 2.2 to 6.6 pounds in the last three months. The assessment score was 4.0 which represented malnourished. The screening lacked assessment components such as review of R22's diet, chewing or swallow status, food preferences, nutrition needs, use of supplements or snacks, oral status, lab values, review of medications and relevant conditions and diagnoses. R22's physician Order Summary Report dated 6/25/25, identified order for mechanical soft texture diet, DDS #6, soft, bite sized food with regular fluids. On 6/24/25, during observation between 8:30 to 9:30 a.m. R22 was seated in the dining room with a plate of French toast with syrup cut into four triangle pieces. R22 made attempts to pick up the quartered toast and take bites and to cut the toast into bites to eat but was unsuccessful. Nursing assistant (NA)-A sat down at R22's table to assist her with eating at 9:05 a.m., thirty minutes after R22 had been served her breakfast. R22 did pick up a quartered French toast piece when prompted by NA-A, however, made no attempt to eat it, and placed it back on to her plate. NA-A returned R22's uneaten breakfast to the kitchen and returned to give R22 a bowl of watermelon cut into bite size pieces. R22 ate the watermelon with minimal prompting. R22's Weights and Vitals Summary dated 4/1/25 to 6/23/25 identified the following recorded weight for R22: -On 4/1/25 R22's weight was 104.8 lbs. -On 5/1/25 R22's weight was 100.2 lbs. -On 6/2/25 R22's weight was 89.2 lbs., a 14.89% weight loss in nine weeks -On 6/9/25 R22's weight was 96 lbs., a weight gain of 7lbs. in one week -On 6/16/25, R22's weight was 90 lbs. -On 6/23/25, R22's weight was 87.6 lbs., a 16.41% weight loss in 12 weeks (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's care plan last revised on 6/3/25, identified R22 had an unplanned weight loss related to poor food intake with a goal to regain 2 lbs. per month. Interventions included referral to dietician, to assist at each meal for two weeks, monitor food intake at each meal, offer substitutes as requested or indicated. R22 preferred soft finger foods, grilled cheese with crust cut off and sweet foods for breakfast. R22's medical record lacked any evidence R22 had been comprehensively assessed or evaluated for the weight loss and continued weight loss. During interview on 6/24/25, at 11:26 a.m. NA-C stated R22 used to eat pretty well but now staff had to feed her much of the time and R22 did not eat well at all now. R22 seemed to have a problem with chewing and NA-C noticed recently R22 would just take the tiniest little bird bites and needed a lot of coaching and reminders to eat. When interviewed on 6/24/25, at 11:39 a.m. NA-B stated R22 could eat on her own, but staff frequently had to load the food onto her fork and then prompt R22 to eat it. NA-B noticed R22 had trouble with eating bread and things like that, so NA-B just made sure not to give her any bread. If R22 refused to eat, the staff would just come back a little later and try again. During interview on 6/24/25, at 3:20 p.m. the dietary manager (DM)-B stated she had emailed the facility's consultant dietician regarding R22's weight loss, asking for recommendations. The dietician responded on 6/6/25, with a summary of her chart review from her hospitalization dietician consult and recommendations to trial clear nutritional supplement offered one ounce per hour when awake, consider a hospice plan of care and reaffirmation of tube feeding status in R22's advanced directives. DM-B stated she had spoken with R22's spouse regarding her weight loss, but if R22 did not want to eat the facility could not force her. DM-B stated she did not feel R22's spouse was ready for a conversation regarding hospice at the time, so did not bring it up to him. DM-B told R22's spouse that staff were trying to encourage food and fluids and DM-B felt he was able to see that, as he visited daily. DM-B had noticed R22 was having some trouble with chewing certain foods and DM-B would typically get a referral for a speech evaluation to see if something was going on there but had not done so for R22 yet. The mini dietary assessment that DM-B completed on admission and quarterly did not have much to it. The dietician had given DM-B a different dietary assessment form to use a couple of months ago, but DM-B had not had the chance to discuss the form with the dietician and so had not implemented it yet. R22's weight loss was discussed at the facility's high risk management meetings. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interview on 6/25/25, at 8:30 a.m. the consultant registered dietician (RD)-C stated she visited the facility at least one time per month and was in frequent contact with DM-B via email and calls, in which they discussed residents. RD-C always did an annual review on all the residents in the facility, which was last done on 6/26/24, however she had not kept up with the comprehensive and significant change assessments. DM-B did the initial assessments on new admissions, which was kind of like a screening. The mini nutritional assessment was not a comprehensive assessment and was considered more of a screening then an assessment. Dietitians were supposed to complete resident's comprehensive assessments, but RD-C had not been able to get them completed. When RD-C did complete the comprehensive assessments on residents she would chat with the resident and family, complete a comprehensive nutrition form, observe the resident eating and document a narrative note. RD-C had not done any resident assessments since the last year and RD-C felt she was missing some assessments for residents admitted during the winter as well as May and June of the current year. DM-B called her regarding R22's weight loss and they discussed R22 extensively because RD-C had received a dietary consult request on R22 from the hospital. RD-C had never seen R22 as DM-B had done the mini nutritional assessments and R22's MDS. When she had talked with DM-B, the general feeling of the team was the weight loss was related to R22's dementia diagnoses and not a swallowing issue. RD-C had not been aware R22 was not receiving the diet texture that was ordered. R22 needed a small bite size diet of foods she could put in her mouth without biting it. RD-A stated receiving the wrong textured diet could possibly contribute to R22's decrease in food intake. Further, one of the first things that needed to happen was to obtain a speech consult for R22 and possibly a dental consult. RD-C stated she held herself responsible for doing resident's comprehensive assessments and had just not been able to keep up with them. During interview on 6/26/25, at 11:30 a.m. the director of nursing (DON) stated the facility had high risk meetings to discuss resident concerns and looked at resident weight loss at those meetings. The team discussed the weight loss and tried to determine causes and interventions. R22 had been on the high-risk team's radar and they were trying to encourage food and liquids and find out favorite foods and preferences from her spouse. The facility did not have a qualified dietician on site every day because of their remote location and the DON knew DM-B had been in contact with RD-C regarding R22's weight loss. The facility staff had been incorporating interventions such as staff to sit with R22 at meals and try to assist her to eat. The facility policy Nutritional Assessment for Long-Term Care dated 9/2023, identified a Nutritional Assessment would be completed that may include all or any of the following: diagnoses, height and weight, body mass index (BMI), nutrition needs, diet order, food allergies, supplements and snacks as relevant, cultural and religious preferences, weight status; loss or gain, oral intake, medications; nutrition-related, physical and mental functioning, lab values, skin conditions as related to nutrition. and other relevant information. The Nutrition Risk Assessment would be updated quarterly or as need indicated.

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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. Based on interview and document review, the facility failed ensure a certified and credentialed dietary manager oversaw and supervised food preparation and services of the kitchens. This had the potential to affect all 25 residents, visitors and staff who consumed food from the kitchen. Findings include: On 6/23/25, at 12:19 p.m. cook (CK)-A stated the dietary manager (DM)-B oversaw the kitchen's day to day operations and was the team lead and the facility social worker (SW)-A was the managers supervisor. CK-A stated the facility's dietician came to the facility monthly. During interview on 6/24/25, at 2:31 p.m. DM-B stated her duties included new staff training, menu, scheduling, food and fluid intake for meals, follow up on dietary referrals from the hospital and sending the information to the dietician, care conferences, and meet with new admissions and families to discuss food preferences. DM-B stated she was the working manager or lead for the facility kitchen. DM-B did not have her qualifications to oversee the kitchen, but the facility was looking into classes because it was recommended that she complete the classes. DM-B had been in the kitchen lead/manager position for two years but had not yet enrolled due to having to cover dietary shifts in the kitchen. Registered dietician (RD)-C visited monthly, and DM-B was s able to get in touch with RD-A via email if there were concerns or for recommendations. The facility social worker oversaw DM-B daily job duties. During telephone interview on 6/25/25, at 8:30 a.m. RD-C stated she was the facility's consultant dietician, and her duties included to provide guidance, mentor and support DM-A in her role. DM-A was not yet enrolled in a CDM course as it had been a challenge for her to find time as DM-A frequently filled in for short shifts in the kitchen. RD-C visited the facility one time per month and was in contact by DM-A via email and chat on a regular basis. When interviewed on 6/26/25, at 11:30 p.m. the director of nursing stated because of the facility's remote location, they did not have access to a qualified dietician every day, however, DM-A was able to contact RD-C with any concerns and get recommendations. An undated Food and Nutrition Services Lead job description identified purpose to provide the nutritional needs and assist supervisor/dietitian in the day-to-day management of the dietary department. Job duties included assist with the day-to-day operations in the Nutrition Service Department, prepare employee work schedule, production and task lists, menus, recipes, food ordering, and determine dietary inventory needs. Know basics of therapeutic diets, properly perform nutrition assessments and care planning of residents, give input and work closely with dietitian regarding nutrition concerns and making suggestions in the operations of the dietary department and abide to the Minnesota Department of Health safety standards and facility policies. Minimum Qualifications section was not completed. (continued on next page)

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	245580	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Care Center	600 Main Avenue South Baudette, MN 56623

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dietitian Services Agreement dated 10/31/23, identified services to advise and assist personnel in food service systems and nutritional care of residents and patients as referred, evaluate, monitor all aspects of food service operation, making recommendations of conformance level that would provide nutritionally adequate, quality food in a regulatory compliant system of service, participate in orientation and in-service educational programs for food service personnel as requested, assess, develop, implement and evaluate nutritional plans of care for long term care residents providing follow-up as appropriate.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide the diet texture ordered to 1 of 3 residents (R22) reviewed for nutrition. Findings include: R22's significant change Minimum Data Set (MDS) dated [DATE], identified R22 had severe cognitive impairment and required supervision with setup assistance for eating. R22's Order Summary Report dated 6/25/25, identified an order for a modified reducing diet, mechanical soft texture, soft bite sized food and regular fluids. During observation on 6/24/25, between 8:30 a.m. to 9:30 a.m. R22 was seated in a reclining wheelchair at a table in the facility's dining area. R22 was served a plate of breakfast food. The plate had a slice of french toast cut into four triangle sections and pancake syrup over the toast, spilling onto the plate. R22 picked up a triangle section of french toast and put part of the slice in her mouth, attempting to bite off a small section. R22 was unable to break off a bite, sucked on the piece of toast and put the triangle slice back on the plate. R22 dipped her finger in the syrup and licked the syrup off her finger. R22 tried to cut the french toast on her plate with a fork and was unable. At 9:00 a.m. nursing assistant (NA)-A sat down next to R22 and gave her verbal prompts to pick up a piece of toast and take a bite. R22 brought a piece of the french toast to her mouth then returned it to her plate without attempt to bite off a piece. NA-A returned R22's meal to the kitchen and brought out a bowl of watermelon. R22 began to pick up and eat the bite size pieces of watermelon served to her with minimal verbal prompts. During observation on 6/24/25, at 5:35 p.m. R22 was seated in her wheelchair in the facility's dining area. R22 had a fish fillet sandwich served on a hamburger bun cut into four pieces with a large serving of tater tots on her plate. NA-B was seated next to R22 to assist her with her meal. NA-B immediately removed the fish fillet from the bun and began helping R22 eat the fish fillet. NA-B stated R22 had trouble with bread and things like that, so was not going to try to feed her the fish on the bun. During interview on 6/24/25, at 11:26 a.m. NA-C stated R22 did not eat well at all. R22 seemed to have a little problem with chewing her food and NA-C had noticed R22 would just take the tiniest little bird bites when eating. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/24/25, at 3:20 p.m. dietary manager (DM)-B stated R22 had the IDDSI#6 diet (International Dysphagia Diet Standardization Initiative-that provides a standardized framework for diet modification for individuals with swallowing difficulties) ordered which was supposed to be small and bite sized food that was easily mushed. R22 should not have been served french toast or hamburger buns that were not soft and bite sized. The facility needed to do a better job with following resident's diet orders. DM-B pointed to handwritten posters attached to a wall in the kitchen where resident meals were prepared. The posters listed resident names and the ordered diet each resident was to receive. Another poster listed all resident diets with a detailed description of what each diet entailed. DM-B stated all the dietary staff had been trained on resident diet orders and how to prepare food for each type of diet and could also refer to the posters on the wall for reference. During telephone interview on 6/25/25, at 8:30 a.m. registered dietitian (RD)-C stated R22 should be receiving the IDDSI #6 diet which was soft foods that would be easy to eat, cut into bite size pieces. Toast was not considered soft. Typically, the IDDSI #6 diet would require a speech language policy or physician consult to approve bread because bread and toast were considered gummy and very difficult to chew. The whole purpose of the diet was to be a bite that the resident could put in their mouth without having to bite it. Receiving bread on the IDDSI #6 diet could result in choking and the purpose of the IDDSI #6 diet was to prevent choking. During interview on 6/25/25, at 11:30 a.m. the director of nursing (DON) stated she had been made aware R22 had not been getting the correct diet texture. Further, completing a comprehensive dietary assessment would be a good idea but the facility did not have a qualified dietician on site everyday. The facility policy Nutrition Supplements dated August 2024, identified residents would be assessed to determine nutritional needs by the RD or designated personnel. Review of weight history, current diet, nutritional intake, diagnosis, medications, allergies, calorie and protein requirements, personal preferences and the need for assistance or adaptive equipment would be completed.

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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** Based on observation, interview and document review the facility failed to ensure a there was documentation to discontinuing transmission-based precautions (TBP) for respiratory Methicillin-resistant Staphylococcus aureus (MRSA) along with rationale for implementing enhanced barrier precautions (EBP)for 1 of 1 resident (R18) reviewed for respiratory infection. Findings include: R18's quarterly minimum data set (MDS) dated [DATE], identified R18 was cognitively intact and was dependent on staff for activities of daily living (ADL's). R18's diagnoses included diabetes, renal insufficiency and chronic obstructive pulmonary disease (COPD). R18's sputum culture results dated 5/30/25, identified R18 was positive for Methicillin-resistant Staphylococcus aureus (MRSA). R18's order summary report dated 6/9/25, identified R18 was to start the following medications related to diagnosis of pneumonia: - Prednisone 20 mg daily x 2 days, order date 6/9/25. - Azithromycin 250 mg daily x 3 days, order date 6/9/25. - Sulfamethoxozole-Trimethoprim 400-80 mg daily x 5 days, order date 6/9/25. - Early morning sputum culture status post antibiotic treatment, one time only, order date 6/18/25. R18's medication administration record dated 6/1/25 through 6/30/25, identified R18's last dose of Sulfamethoxozole-Trimethoprim was given on 6/14/25. R18's verbal Evaluation and Treatment of Suicidal Ideation dated 6/11/25, identified medical doctor (MD)-B ordered staff to stop wearing a gown when R18's 5-day course of antibiotics were complete. R18's medical record lacked evidence when precautions were implemented and discontinued and rationale for discontinuing them. Along with what interventions the facility had determined to be implemented. The facility infection control case detail log dated 6/26/25, identified R18 had a lower respiratory tract infection positive for MRSA. On 6/10/25, R18 was started on EBP, and staff were to wear personal protective equipment (PPE) including gloves, gown and surgical mask for all high contact activities. On 6/25/25 at 8:52 a.m., R18's room was observed there was no signage for EBP and no PPE outside the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 9:52 a.m. through 10:20 a.m., R18 was seated at a table in a small alcove area in the hallway across from his room. R18 was coughing and spitting phlegm into a tissue. While coughing, R18 was not covering his mouth. During interview on 6/25/25 at 10:21 a.m. nursing assistant (NA)-C stated staff NA-C had not worn PPE the last week when caring for R18 and was told this week R18 should stay at the table and not eat meals in the dining room. On 6/25/25 at 10:38 a.m., NA-D stated precautions were determined by the nurses and staff were notified when precautions were started or stopped through shift-to-shift report, a sign on the door, a cart outside the room, and a red biohazard bin in room. R18 was not able to eat in the dining room although R1 was able to sit in the alcove outside of his room and was able to feed himself. R18 was not on any precautions. On 6/25/25 at 11:05 a.m., NA-G stated staff were notified when a resident was on precautions in multiple ways including shift-to-shift report, carts outside the room and signs on the door. R18 had been hospitalized for approximately two weeks due to a lung infection and MRSA in his saliva. When R18 returned to the facility staff were instructed to wear PPE for about 2 weeks. Staff were told staff they didn't have to wear PPE unless they wanted too, and R18 was allowed to sit outside his room for meals. R18 was not allowed to go into the dining room. On 6/25/25 at 11:51 a.m., the medical director (MD)-A, who was also R18's primary physician, stated the facility should have a procedure in place for MRSA and the facility should keep the resident on precautions until the infection was resolved. On 6/26/25 at 8:48 a.m., RN-C stated upon R18's return from the hospital staff were supposed to wear full PPE when caring for R18. On 6/11/25, due to R18's mental health issue, MD-B was contacted and ordered to stop gowning upon R18's completion of antibiotics. R18's last antibiotic was 6/15/25, and modified precautions were initiated which included staff were to wear gown and gloves during direct cares, and R18 was allowed to sit in the hallway alcove with staff present and eat meals. RN-C was unable to determine the exact date modified precautions were started. RN-C stated the care plan was used by staff so they knew how to care for a resident. RN-C stated she had not added TBP precautions to R18's care plan although she should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/25 at 8:48 a.m., RN-C stated the following R18 had returned from the hospital on 6/9/25. On 6/11/25, R18 had mental health issues related to staff wearing PPE and threats of suicide. MD-B was notified and ordered precautions to be discontinued after the resident's antibiotic course was complete. MD-A was not contacted because he was hard to reach. RN-C had not previously encountered a similar situation and reached out to the corporate regional director of infection control for further guidance. The guidance identified precautions were not recommended for residents with respiratory MRSA, and further determination could be made by the infection control staff and physician. R18's last antibiotic was 6/15/25. The anticipated end date for precautions was 6/18/25. RN-C stated she set the end date for precautions by the antibiotic end date plus a few extra days for follow up/clarification from the corporate regional director of infection control. Staff were supposed to document in the medical record when precautions were started or discontinued. RN-C thought contact precautions were formally discontinued on 6/18/25, however, could not find documentation in the resident's progress notes. Due to R18's psychological issues and uncertainty if the infection was resolved, the facility determined they would continue modified precautions including allowing R18 to eat meals in the hallway alcove with staff present, separate from other residents, and continue EBP while resident was in his room. There was not a PPE cart outside of R18's room, there was not a sign on his door, and interventions of PPE was not added to R18's care plan. RN-C was uncertain if precautions should've been discontinued and wanted to determine if R18's infection was active MRSA. On 6/26/25 at 11:29 a.m., the director of nursing (DON) stated on 6/9/25, R18 was readmitted with diagnoses including aspiration pneumonia and MRSA in his sputum the resident was placed on precautions. R18 had orders for an antibiotic for 3 days, another for 5 days, and a steroid for 2 days. R18 was placed on isolation precautions including gown, gloves and mask. On 6/11/25, R18 became very upset and adamant regarding not wanting staff to wear gowns, did not want to be stuck in his room and R18 made suicidal threats. The nurses contacted the DON and the emergency room doctor (MD-B) regarding suicidal ideation protocol. MD-B ordered to discontinue gowning when the 5-day antibiotics were completed. MD-A, who was the medical director and R18's primary physician had not been notified of the situation. The infection control nurse, RN-C, reached out to the facility resources regarding MRSA pneumonia and what to do including if precautions should be started, when to retest, and when precautions could be discontinued. RN-C discussed the findings with staff at the high-risk meeting. The DON had not talked to R18 about staff gowning or isolation and was uncertain if it was documented in R18's medical record. The DON was aware, but not involved in discontinuing precautions for R18. The DON was uncertain if R18 was clear of MRSA or the exact date precautions were removed, however, thought they would have been lifted after the resident's antibiotics were complete and staff should have documented in the progress notes. The facility MDRO Infection policy reviewed 3/2/23, identified MDRO's as bacteria and other microorganisms that have developed resistance to one or more classes of antimicrobial drugs. Infections with MDRO's are difficult to treat and are associated with increase mortality rates. Common MDRO's found in nursing homes include MRSA. Staff will use contact precautions in addition to standard precautions when caring for a resident with MDRO infection. Signage at entry of the resident's room shall indicate Contact Precautions, and the type of PPE is required upon entry into the room. Contact precautions will be discontinued when the physician and Infection Preventionist review the situation and determine the resident is no longer infectious, or is colonized, and is at low risk of transmitting the organism to others. Care considerations related to MRSA include the following: - MRSA is a drug-resistant strain of bacterium found on people's skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- It is usually spread by contact with infected wounds or from direct contact with contaminated objects. - Implement strategies to reduce device and procedure related health-care associated infections (i.e. central lines, urinary catheter, surgical sites, hemodialysis, and ventilator). - Follow local, state, regional, or national recommendations for treatment and precautions. The Containment of Novel or Targeted MDRO's policy revised 11/23, did not address long term care facilities. The facility Enhanced Barrier Precautions policy revised 2/25, identified EBP are sued in conjunction with standard precautions and expands the use of PPE to wearing gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDRO)'s to staff hands and clothing. EBP are indicated at the discretion of the facility for residents infected or colonized with a non-CDC targeted MDRO without a wound, indwelling medical device, or secretions or excretions that are unable to be covered or contained. The policy included the Infection Prevention Manual for Hospitals The Centers for Disease Controls Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions dated 2/7/25, identified Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant S. pneumoniae) required contact and standard precautions.