STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245581	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Nursing & Rehab LLC	201 Shady Lane Drive Wadena, MN 56482

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 resident (R26) who utilized an indwelling catheter. Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], identified cognitive portion of the MDS was not completed. Identified R26 had diagnoses which included Alzheimer, neurogenic bladder (a condition that affects the bladder's ability to function properly due to damage or dysfunction in the nerves that control it), and benign prostatic hyperplasia (BPH) (enlarged prostate). MDS lacked information regarding R26's indwelling catheter. R26's annual Care Area Assessment (CAA) dated 9/11/24, identified R16 required required extensive assistance with toileting. Indicated R7 had an indwelling catheter related to urinary retention (unable to completely empty the bladder) and BPH. R26's care plan revised 4/1/24, identified R26 had an indwelling catheter due to urinary retention. Care plan identified catheter bag should have been covered at all times for dignity. R26's care sheet undated, identified R26's had an indwelling catheter. Further identified R26's catheter was to be covered at all times for dignity. During an observation on 2/10/25 at 11:35 a.m., R 26 was seated in his recliner in his room and R26's uncovered catheter bag was attached to the lower part of the recliner with 200 cubic centimeters- a unit of measurement for volume (CC) of clear urine in the drainage bag visible to anyone that walked by. During an observation on 2/12/25 at 12:00 p.m., R26 was lying in bed and R26's uncovered catheter was attached to the lower bed frame with about 300 cc of clear yellow urine in the drainage bag. R26's door was open, the uncovered catheter bag was visible and a visitor walked by R26's room. During an interview on 2/12/25 at 12:05 p.m., family member (FM)-A stated she was unsure if it would have bothered R26 to have his catheter drainage bag uncovered. FM-A further stated R16 was able to decide if having his catheter bag uncovered bothered him. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12./25 at 12:10 p.m., R26 stated he would have preferred to have his catheter bag covered. During a joint interview on 2/12/25 at 12:15 p.m., nursing assistant (NA)-C and registered nurse (RN)-A verified R26's catheter drainage bag was not covered and visible to others. Verified the expectation was that R26's catheter drainage bag was covered. During an interview on 2/12/25 at 1:39 p.m., director of nursing (DON) verified R26 was able to be interviewed and had an indwelling catheter. Verified R26 required extensive staff assistance with his indwelling catheter bag. DON stated her expectation would have been R26's indwelling catheter bag would have been covered. Review of a facility policy titled Foley Catheter Management revised 1/28/25, identified proper care was to be provided for the management of a Foley catheter to drain urine from the bladder and to prevent reflux of urine back into the bladder. Identified catheter bags were to be covered at all times.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on interview and record review, the facility failed to provide the resident council with responses, actions, and rationale taken regarding their concerns 4 of 4 (R14, R30. R20 and R3) resident council members in the facility. This deficient practice had the potential to affect all 49 residents residing in the facility. Findings include: On 2/11/25 at 11:01 a.m. a resident council meeting was held with surveyors and four residents present which included R14, R30, R20 and R3. Residents stated they had concerns of the facility's lack of providing follow-up responses when concerns were expressed during resident council meetings. All four residents expressed they did not receive any answers after concerns were expressed. Review of resident council meeting minutes provided by the facility from 7/9/24, to 1/7/25, identified the following: -7/9/24, concerns identified on resident council meeting minutes: would like more shower stalls, lack of respect for residents from aids, beds not getting made timely, would like something for watching baseball and spray for bugs outside. Concerns were marked resolved, partially resolved or not resolved and resident council action forms were completed however, follow-up information was not provided to the residents in resident council. -8/13/24, concerns identified on resident council meeting minutes: would like more outside activities, more information about appointments, aids talking about other aids, and a light out in the bathroom by day room. Concerns were marked resolved, partially resolved or not resolved resident council action forms were completed however, follow-up information was not provided to the residents in resident council. -9/10/24, concerns identified on resident council meeting minutes: not getting socks off at night, staff using cell phones, not emptying catheter timely, and shower on wrong day. Concerns were marked resolved, partially resolved or not resolved resident council action forms were completed however, follow-up information was not provided to the residents in resident council. -10/8/24, concerns identified on resident council meeting minutes: pills not being given on time, long time for call lights, supper coming in late, and fixing light in dining room. Concerns were marked resolved, partially resolved or not resolved resident council action forms were completed however, follow-up information was not provided to the residents in resident council. -11/12/24, concerns identified on resident council meeting minutes: not getting finger nails clipped, needing room numbers, room [ROOM NUMBER] call light taped together, not making beds, cold food, food being served late and garbage left in the room with soiled products. No follow-up response was identified with earlier concerns or current concerns brought up. Resident council action forms were completed however, follow-up information was not provided to the residents in resident council. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/10/24, concerns identified on resident council meeting minutes: no lotion on feet, not always given food alternatives, like to do knitting, crafts, painting and movies. No follow-up response was identified with earlier concerns or current concerns brought up. Resident council action forms were completed however, follow-up information was not provided to the residents in resident council. -1/7/25, concerns identified on resident council meeting minutes: bed not being made, garbage's overflowing, staff loud at night and entryways dirty. No follow-up response was identified with earlier concerns or current concerns brought up. Resident council action forms were completed however, follow-up information was not provided to the residents in resident council. During an interview on 2/12/25 at 3:09 p.m. social worker (SW) confirmed the above findings and indicated she did not have documentation of concerns being resolved. SW further indicated pervious concerns were not discussed with residents in resident council after a resident council action forms were filled out by each department. During an interview on 2/12/25 at 5:01 p.m., director of nursing (DON) stated the SW was in charge of resident council meetings and documentation for resident council meetings. DON indicated follow-up on concerns were to be documented on resident council meeting minutes and action plans. DON stated her expectations were resident council concerns were reviewed and brought to the correct department for resolution. DON further stated she would expect follow-up information be provided to the residents at resident council for each concern. Facility policy titled resident council last revised 2/26/20, the facility would provide residents with the opportunity to air any grievances that they may have and to give suggestions on what they would like. Along with any changes they think should be made. Staff Member would take minutes of meeting using the Resident Council Meeting form. Grievances aired during the meeting should be addressed within the proper department (ex: a nursing concern should be brought to the DON). Record any follow-up, to grievances, so they can be addressed at the next Resident Council meeting.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 37905 Based on observation, interview and document review, the facility failed to ensure all three years of survey results were readily accessible for residents or visitors. This deficient practice had the potential to affect all 49 residents currently residing in the facility. Findings include: During an observation on 2/10/25 at 3:53 p.m., the facility survey results were located in a white binder on a table near the entrance. The last survey results noted in the binder was for a standard abbreviated survey dated 8/16/24. The facility lacked the survey results for the following surveys completed from 8/17/24, to 2/9/25. -abbreviated survey completed on 10/21/24. -abbreviated survey completed on 1/14/25. During an interview on 2/10/25 at 4:53 p.m., director of nursing (DON) confirmed the last survey in the binder was from 8/16/25, and that other surveys had been completed since then. DON stated all surveys should have been included in the binder, so residents, visitors, and staff could look at them, and for facility transparency. A policy was requested however, was not provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to ensure a clean and sanitary environment when a visibly soiled commode bucket was stored next to a night stand for 1 of 4 residents (R25) and soiled bedpans were left out for 2 of 4 residents (R3, R42) reviewed for environment. In addition, the facility failed to store ADL supplies in a clean and discreet manner for 2 of 4 residents (R16, R25). Further, the facility failed to maintain standing lifts shared by residents in a clean and sanitary manner. Findings include: WASH BASINS & COMMODE BUCKET: R16 R16's Admission Minimum Data Set (MDS) dated [DATE], identified R16 had severe cognitive impact and diagnoses which included anxiety, depression and end stage renal disease (ESRD) (loss of kidney function). Identified R16 required extensive assist with activities of daily living (ADL's) which included toileting, transfer, and dressing. R16's care plan revised 11/14/24, indicated R25 had activities of daily living (ADLs) self-care performance deficit related to weakness. R16's goal was to receive staff assistance with ADLs, have no skin breakdown, have a well-groomed appearance, and no odor present. R16's care area assessment (CAA) dated 11/14/24, indicated R16 had congestive loss and dementia. The CAA further indicated R16 required extensive assistance with bed mobility, transfers, toileting. R25 R25's quarterly MDS dated [DATE], identified R25 had moderate cognitive impairment and diagnoses which included diabetes mellitus (DM), dementia and a pressure ulcer of the right heel. Identified R34 required moderate assistance with ADLs which included toileting, transfer, and dressing R25's care plan revised 2/1/25, indicated R25 had ADLs self-care performance deficit related to pain and weakness. R25's goals were to improve current level of function in bathing/showering and personal hygiene. R25's CAA dated 9/27/24, indicated R25 had cognitive loss and dementia. The CAA further indicated R25 required moderate assistance with bed mobility, transfers, toileting. During an observation on 2/10/25 at 12:22 p.m., R16's room (room [ROOM NUMBER]) had a pink wash basin dated 2/8/25, with R16's name written on the side sitting on the floor under the sink to the right of the doorway. The pink wash basin could be seen from the hallway when walking by. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/10/25 at 12:19 p.m., R25's room (room [ROOM NUMBER]) had three white unused briefs and a pink wash basin dated 2/8/25, with the initials DD written on the side sitting on the floor under the sink to the left of the doorway. The white briefs and pink wash basin could be seen from the hallway when walking by. In addition, there was a grey commode bucket with a white toilet hat (a container used to collect urine) sitting on the floor to the right of R25's night stand. There was a darkened ring on the inside of the grey commode bucket. Also, there was a flaky yellow ring, a cotton ball and a leaf inside the white toilet hat. On the right edge of the white toilet hat was a black power box with a cord plugged into the outlet and a cord going to R25's television. During an observation on 2/10/25 at 6:26 p.m., R16's room remained the same. During an observation on 2/10/25 at 7:01 p.m., R25's room remained the same. During an observation on 2/11/25 at 10:37 a.m., R16 and R25's room remained the same. During an interview on 2/11/25 at 11:20 a.m., housekeeping aid (HA)-B agreed R25 had a grey soiled commode bucket with a white toilet hat sitting on the floor. HA-B indicated it was not housekeeping's responsibility to clean the grey commode bucket up. HA-B further indicated it was the responsibility of nursing to clean the grey commode bucket. HA-B stated R25's room was cleaned and HA-B mopped around the grey commode bucket. During an interview on 2/11/25 at 11:23 a.m., nursing assistant (NA)-E agreed R25 room had a soiled grey commode bucket with a white toilet hat sitting on the floor. NA-E indicated R25 used to use the sit to stand lift and was toileted using the commode. NA-E further indicated R25 no longer used a commode. NA-E stated the grey commode bucket should have been removed when R25 no longer required the use of a commode. NA-E looked into the grey commode bucket and white toilet hat stated whatever is in there is kind of gross. During an interview on 2/11/25 at 12:20 p.m., NA-D went into R16 and R25's rooms and agreed both pink wash basins were on the floor and R25 had 3 white briefs on the floor. NA-D stated the pink wash basins and briefs are to be stored in the night stand drawers. STANDING LIFTS: During an observation on 2/10/25 12:33 p.m., one of the standing lifts located in the hallway on the memory care unit of the facility had a large amount thick amount of white substance and black/brown substance on the standing lift plate of the lift. During an observation on 2/11/25 10:51 a.m., the same lifts located in the hallway on the memory care unit continued to a large amount thick amount of white substance and black/brown substance on the standing lift plate of the lift. During an interview on 2/11/25 11:20 a.m., housekeeping aid (HA)-B stated HA-B had never cleaned the standing lift and had never been told to clean the standing lift. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/11/25 at 11:23 a.m., NA-E stated it was housekeeping's responsibility to clean the standing lift plate. NA-E further stated cleaning of the lifts had never been nursing staffs responsibility. NA-E looked at the lift standing plate and agreed that it was dirty and needed to be cleaned. 37905 BED PANS R42 R42's MDS dated [DATE], identified R42 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis, anxiety and depression. Identified R42 was dependent on staff for oral cares, hygiene, dressing and bathing. R42's CAA dated 12/22/24, identified R42 had a self-care performance deficit related to weakness. R42's CAA identified R42's care plan would be completed for self-care deficit and impaired mobility and staff would assist with ADL completion. R42's care plan revised 1/13/25, identified R42 had an ADL self-care performance deficit related to weakness. R42's interventions included personal hygiene/oral care assist of one. R3 R3's quarterly MDS dated [DATE], identified R3 was cognitively intact and had diagnoses which included heart failure, peripheral vascular disease (restricted blood flow to limbs) and depression. Identified R3 was dependent on staff for dressing, bathing, and toileting and personal hygiene. R3's CAA dated 9/19/24, identified a toileting program would be initiated if indicated and evaluated it was appropriate at that time due to incontinence, and would continue to monitor quarterly as needed. Staff would assist with toileting needs and would follow toileting plan. Staff would review and update care plan as needed. R3's care plan revised 12/16/24, identified R3 had an ADL self-care performance deficit related to immobility and related to amputation of one lower extremity. R3 required assistance of one for toilet use, personal hygiene, dressing and bathing. During an observation and interview on 2/12/25 at 7:37 a.m., NA-F was completing morning cares for R3. In R3's and R42's shared bathroom, there was a bed pan, with some tan and brown spots on it, face up sitting on the toilet riser in the bathroom. There was a second bed pan, lying on the floor, upside down on the left side of the toilet, with the leg of the toilet riser sitting in the middle of the bedpan. The bedpan on the floor had R42's initials written on the bottom of the bedpan. NA-F verified the bed pans were left out and stated R3 and R42 both used bed pans. NA-F stated the bedpans were supposed to be stored in a clean plastic bag, either on top of a garbage can or on a shelf in the bathroom. NA-F indicated R3 and R42 did not have a garbage can in their bath room, and the shelves were too small to hold them however, they should have been in bags, put on top of a garbage can, and not left out, or left on the floor. NA-F completed R3's cares, left the room, and did not remove the left out bed pans from the bathroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45844 STANDING LIFTS: During an observation on 2/10/25 at 12:24 p.m., two of the standing lifts located in the hallway on the main unit of the facility had a large area of dried, yellow/brown food like substance on the lower ends of the standing lift plate of the lifts. During an observation on 2/11/25 at 10:36 a.m., the same two lifts located in the hallway on the main unit continued to have a large area of dried yellow/brown food like substance on the lower ends of the standing lift plate of the lifts. During a joint interview on 2/11/25 at 11:01 a.m., housekeeper (HK) and nursing assistant (NA)-A confirmed the presence of a dried yellow/ brown food like substance on the lower ends of the lift plates on the two standing lifts. HK and NA-A both stated they were unsure who was responsible for cleaning the lifts. During an interview on 2/12/25 at 8:35 a.m., director of nursing (DON) stated all staff should ensure that lifts were wiped between every use including the foot plates when needed. DON stated her expectation was that all lifts would have been cleaned per policy. During a follow-up interview on 2/12/25 at 1:18 p.m., director of nursing (DON) stated expectation were for staff to put away bed pans in a bag in the resident's drawer or closet, and not to leave out or on the floor for infection control reasons. During a follow-up interview on 2/12/25 at 4:46 p.m., DON stated she was unaware of the above findings. DON stated her expectations were the wash bins and briefs were stored in the proper locations and the commode bucket was cleaned and stored in the proper location. DON further stated the white toilet hat should have been thrown away and the power box should not have been sitting on the side of the white toilet hat. Review of a facility policy titled Cleaning and Disinfection of Resident Care Equipment revised 5/8/24, identified reusable equipment such as mechanical lifts would be cleaned and disinfected after use of one resident and before use of another resident.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to ensure a complete and comprehensive assessment was completed for 1 of 1 residents (R16) reviewed for braces. Findings include: R16's Admission Minimum Data Set (MDS) dated [DATE], identified R16 had severe cognitive impact and diagnoses which included anxiety, depression and end stage renal disease (ESRD) (loss of kidney function). Identified R16 required extensive assist with activities of daily living (ADL's) which included toileting, transfers, and dressing. R16's face sheet identified R16 had a diagnosis of Parkinson's disease (disease of the nervous system). R16's care plan revised 11/14/24, indicated R25 had an ADL self-care performance deficit related to weakness. R16's goal was to receive staff assistance with ADLs. R16's care plan lacked information regarding R16's ankle-foot orthosis (AFO) brace (to support the ankle and keep the toes aligned with the rest of the foot). R16's care area assessment (CAA) dated 11/14/24, indicated R16 had congestive loss and dementia. The CAA further indicated R16 required extensive assistance with bed mobility, transfers and toileting. R16's electronic health record lacked a comprehensive assessment for R16's AFO brace. R16's signed physicians orders dated 1/14/25, lacked an order for R16's AFO brace. Review of therapy recommendations to nursing dated 11/18/24 and 11/19/24, lacked information regarding R16's AFO brace. Review of R16's treatment administration record (TAR) dated 1/1/25 to 2/12/25, lacked a treatment plan related to R16's AFO brace. Review of R16's progress notes dated 11/7/24 to 2/12/25, lacked documentation related to R16's AFO brace. During an observation on 2/10/25 at 2:30 p.m., R16 was laying in bed with a sock on the right leg underneath the white AFO brace. AFO brace was on the right leg extending from mid calf down the back over the outside of the ankle to the tip of R16's toes. AFO brace was made of hard plastic and was secured with a white velcro strap. During an observation on 2/11/25 at 10:42 a.m., R16 was sitting in her wheelchair in her room. R16 had AFO brace on right leg. R16 did not have a sock on underneath the AFO brace. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/11/25 at 5:17 p.m., R16 continued sitting in her wheelchair. R16 had AFO brace on the right leg. R16 had a blue gripper sock on underneath AFO brace that only extended approximately two inches above R16's ankle. R16's sock did not extend the entire length of R16's leg and AFO brace rested on R16's bare skin. During an observation on 2/12/25 at 1:38 p.m., R16 was sitting at the table with nursing staff eating ice cream. R16 did not have AFO brace on at that time. During an interview on 2/12/25 at 1:22 p.m., nursing assistant (NA)-I stated NA-I did not know why R16 had an AFO brace or when the AFO brace should applied/removed. NA-I further stated R16 did not have orders for the AFO brace. NA-I indicated NA-I had not been trained how to properly apply R16's AFO brace and was not aware R16 should have a sock underneath the AFO brace. During an interview on 2/12/25 at 1:51 p.m., licensed practical nurse (LPN)-A indicated R16 had an AFO brace for her right leg. LPN-A stated R16 used the AFO brace for her Parkinson's disease to help R16's right leg from dropping and retracting. LPN-A identified NA's were responsible for putting R16's AFO brace on. LPN-A indicated R16's spouse brought in the brace for R16 from home. LPN-A further indicated R16 did not have an order for the AFO brace and the AFO brace was not in R16's care plan. During an interview on 2/12/25 at 2:22 p.m., physical therapy assistant (PTA) indicated physical therapy had been working with R16 one time a week. PTA stated R16 had an AFO brace to help with ankle stability when R16 walked. PTA further stated there were no orders for R16 to have the AFO brace. During a follow-up interview on 2/12/25 at 2:45 p.m., PTA confirmed with physical therapy director R16 did not have any orders and no assessment was completed for R16's AFO brace. PTA further confirmed nothing had been communicated to nursing staff on when R16 was to be wearing the brace or how to correctly apply R16's AFO brace. During an interview on 2/12/25 at 4:55 p.m., director of nursing (DON) confirmed the above findings and stated R16 did not have the AFO brace care planned. DON further stated R16 should have been properly assessed and an order should have been received for R16 to have the AFO brace. Facility policy titled resident assessment and examination revised 3/13/24, to assess the resident for any abnormalities in the residents health status to enable the care team to implement interventions to address concerns. Facility policy titled MDS - Quarterly/Annual therapy screens issued 5/1/20, therapy should screen each resident listed as appropriate.

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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** 45844 Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) correctly for 1 of 1 residents (R26) reviewed for resident assessment. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2024, identified Section . C 0100: to C 0500 Should Brief Interview for Mental Status Be Conducted? SECTION C: COGNITIVE PATTERNS Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions. Section H 0100: Appliances Item Rationale Health-related Quality of Life It is important to know what appliances are in use and the history and rationale for such use. Code this section if an indwelling catheter including a supra pubic catheter is used. R26's quarterly Minimum Data Set (MDS) dated [DATE], Section C Cognitive Patterns Questions C 0100: to C 0500 were blank Sections H 0100 identified R26 did not have a catheter. Identified R26 had an ostomy. R26's care plan revised 9/7/24, identified R16 had a supra pubic catheter (a tube that drains urine from the bladder through a small incision in the lower abdomen). Review of R26's progress notes dated 10/3/24, identified R16 had a foley catheter in place. During an interview on 2/10/25 at 7:30 p.m., R26 stated he has had a catheter for quite some time because he was not able to empty his bladder. During an interview on 2/11/25 at 3:03 p.m., MDS Coordinator verified R26 had a suprapubic catheter and did not have an ostomy. MDS Coordinator verified section H of R26's MDS dated [DATE], had not been coded correctly. MDS Coordinator stated her expectation was the MDS would have been coded correctly. During an interview on 2/12/25 at 1:43 p.m., social worker (SW) verified R26 was able to be interviewed. SW verified section C of R26's MDS dated [DATE], was blank. SW stated she must have forgotten to do section C. SW stated her expectation was that section C would have been completed to ensure a current cognitive score for R26 was documented. During an interview on 2/12/25 at 1:55 p.m., director of nursing (DON) verified R26 was able to be interviewed and had an indwelling catheter. DON confirmed R26's MDS dated [DATE], section C was blank and section H had not been coded accurately. DON stated her expectation would have been for staff to complete the MDS and code it correctly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Review of a facility policy titled MDS 3.0 Process revised 2/18/22, identified full MDS assessments will be completed on residents newly admitted , those experiencing a significant change in status and annually. Quarterly MDS assessments will be completed per RAI schedule between full MDS assessments. Indicated each individual who completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment he/she completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to follow the comprehensive care plan for 1 of 1 residents (R37) whose care plan was reviewed. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and had diagnoses which included: Alzheimer's disease, dementia, anxiety and was currently receiving hospice services. R37 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and eating. R37's care plan revised 11/15/24, indicated R37 had an altered nutritional status related to dementia with a history of vascular dementia. R37 was to have soft cut up foods and pureed foods when needed. R37's intervention included: R37 was to have supervision when eating and staff were to encourage R37 to eat in the dining room sitting upright in R37's wheelchair. Review of R37 kardex undated, indicated R37 was a level four pureed, heart healthy diet and R37 required supervision with eating. It further indicated R37 was to be encouraged to eat in the dining room sitting upright in R37's wheelchair. During an observation on 2/12/25 at 8:01 a.m., R37 was laying in bed covered up with a blanket. Nursing assistant (NA)-E entered R37's room and placed R37's breakfast tray on the bedside table and left R37's room. During an observation on 2/12/25 8:03 a.m., NA-E returned to R37's room and asked R37 if he was hungry. R37 shook head up and down to answer NA-E's question. NA-E told R37 NA-E would assist R37 with eating his breakfast. NA-E set R37's bed up into an approximately 35 degree angle and moved the bedside table next to R37's bed. NA-E left R37's room to grab a straw and then returned to R37's room. NA-E continued to feed R37 breakfast in bed. When R37 was finished eating, NA-E removed R37's breakfast tray from the room. During an observation on 2/12/25 at 8:20 a.m., R37 continued to lay in his bed covered up with a blanket. R37's head of bed was lowered approximately 10 degrees and R37 remained in a slightly elevated position. R37 had finished eating and was resting prior to getting up. During an interview on 2/12/25 at 8:23 a.m., NA-E indicated R37 did not like to get out of bed until after breakfast. NA-E further indicated R37 was fed breakfast in bed. NA-E stated NA-E was not aware R37 was to be sitting upright in R37's wheelchair for all meals. NA-E further stated NA-E was unaware it was documented on R37's kardex to be up in R37's wheelchair for all meals. During an interview on 2/12/25 at 1:47 p.m., licensed practical nurse (LPN)-A stated R37 used to be sat straight up to be fed but lately staff had been feeding R37 in bed. LPN-A confirmed R37's care plan indicating R37 should have been up in R37's wheelchair for all meals. LPN-A stated R37's care plan needed to be updated to reflect the current changes for R37. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 4:50 p.m., director of nursing (DON) confirmed the above findings and indicated R37 did not like to get up much. DON stated R37's care plan should have been updated to reflect R37's current wishes. DON stated her expectations were care plans were updated on a continuous basis to ensure each resident was getting the care they required. Facility policy titled Care Plan - Baseline and Comprehensive revised 6/20/23, to ensure that each resident receives care individualized to him or herself and that goals and approaches for care are communicated to all parties including caregivers, the resident, and the resident's representative. Throughout the course of rehabilitation and the resident's stay in the facility, the identified risk factors, goals, interventions, and outcomes on the care plans would be evaluated at least quarterly and revised as necessary. Areas of concern that were identified during the resident assessment would be evaluated before interventions were added to the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48583 Based on interview and document review, the facility failed to update the care plan for 3 of 3 residents (R42, R41 and R15) reviewed for discharge planning. In addition the facility failed to update the care plan for 1 of 1 residents (R37) reviewed for activities. Findings include: R41 R41's significant change Minimum Data Set (MDS) dated [DATE], indicated R41 had diagnoses which included cancer, epilepsy (seizure disorder), anxiety and depression and was severely cognitively impaired. R41 required minimal assistance with activities of daily living (ADL's) which included bed mobility, transfers, and eating. R41's care plan revised on 9/9/24, indicated R41's discharge plans were undecided. R41 or R41's representative would meet with care plan team to identify discharge potential on a quarterly basis. R41's care plan conference summary dated 1/21/25, indicated R41's spouse would like R41 moved closer to spouse or R41's brothers. Review of R41's progress notes dated 12/12/24 to 2/12/25, lacked discharge planning documentation. R15 R15's quarterly MDS dated [DATE], indicated R15 had diagnoses which included cancer, anxiety and depression and had mild cognitive impairment. R15 required extensive assistance with ADL's which included bed mobility and transfers. R15's care plan revised on 9/11/24, indicated R15's discharge plans were to return to assisted living facility (ALF) if able. R15 required a discharge care conference needed closer to discharge and expected to be discharged to another facility. R15's care plan conference summary dated 2/6/25, indicated R15 required assistance 24/7. Review of R15's progress notes dated 12/12/24 to 2/12/25, lacked discharge planning documentation. R37 R37's quarterly MDS dated [DATE], identified R37 had severe cognitive impairment and had diagnoses which included Alzheimer's disease, dementia, anxiety and was currently receiving hospice services. R37 required extensive assistance with ADL's which include bed mobility, transfers, and toileting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R37's care area assessment (CAA) dated 9/16/24, indicated R37 had concerns with cognition and dementia. R36's CAA further indicated R36 did not communicate often and was not responding to conversations as much. R37's care plan revised 11/15/24, indicated R36 had a diagnoses of frontotemporal and vascular dementia with a history of alcoholism with limited R36's ability in leisure involvement. R37's goals were to maintain leisure abilities by actively engaging in structured leisure opportunities once daily three days a week. It further indicated R37 enjoyed music, games, music trivia and animals. Staff interventions were to break down tasks, give praise and provide music in R37's room. R37's care plan conference summary dated 1/21/25, stated R37's spouse offered additional activities that R37 would enjoy. These activities included, music (country, 50's and 60's), one to ones, and conversations. R37's spouse requested staff communicate with R37 even if R37 did not respond. R37's Kardex undated, indication R37 enjoyed music and singing however, preferred to listen to music in room instead of coming out to join a group of people. During an interview on 2/12/25 at 2:42 p.m., activity director (AD) indicated AD was responsible for updating the activities section of the care plan. AD stated AD attended R37's care conference and was aware of R37's spouse's requests. AD stated AD did not update R37's care plan to reflect spouses wishes. AD further stated AD did not know how to update the section in the care plan and would need to work with the MDS coordinator for assistance. 37905 R42 R42's admission MDS dated [DATE], identified R42 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis, anxiety, and depression. Identified R42 was dependent on staff for oral cares, hygiene, dressing and bathing. Identified R42 participated in goals and had an overall goal to discharge to the community at time of assessment. R42 had no active discharge plan and R42's expected discharge date was three or fewer months away. R42's CAA dated 12/22/24, identified R42 had a self-care performance deficit related to weakness. R42's CAA identified R42's care plan would be completed for self-care deficit and impaired mobility and staff would assist with ADL completion. R42's care plan revised 1/13/25, identified R42 had an ADL self-care performance deficit related to weakness. R42's interventions included personal hygiene/oral care assist of one. Discharge Planning, R42 planned to return home when R42 was stronger. R42's goal- to return to prior living situation upon completion of rehab. Interventions included to coordinate and assist in communication with outside or home services, and to discuss with family and resident discharge options. R42's care plan had not been revised to include discharge planning for long term care placement. During an interview on 2/10/25 at 1:11 p.m., R42 stated no one had talked to her about her wishes to move to the Mahnomen nursing home to be closer to family. R42 indicated a family member had informed her she was second in line on their admission list at the Mahnomen facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R42's Initial Care Conference form dated 12/12/24, identified information was collected from R42. R42 previously lived at home with spouse prior to hospitalization . R42 would like to go back home however, realized had a lot of work to do to go home. R42 was willing to look at long term placement closer to home. Review of R42's progress notes from 12/16/24 to 2/12/25, identified the following: -12/16/24 4:18 p.m., discharge planning: R42 was living with spouse at home prior to hospitalization . R42 is willing to look for long term placement closer to home. -1/16/25 1:04 p.m., nurses note: writer received call from Mahnomen nursing home requesting information, as spouse would like resident closer to home. Writer called back and left message that they needed a from sent and gave licensed social worker (LSW) name as contact as LSW facilitated discharges. During an interview on 2/12/25 at 1:13 p.m., licensed social worker (LSW) confirmed R42's care plan indicated R42 planned to return home. LSW indicated that was R42's ultimate goal, and it was her alternate goal to go home when she spoke to her a week ago. LSW indicated she had sent out a referral to Mahnomen nursing home last Friday and had not updated R42's care plan. During a follow-up interview on 2/12/25 at 3:20 p.m., LSW stated the discharge planning process started when residents were admitted into the facility. LSW further stated discharge goals were set based on resident's needs and services prior to admission. LSW indicated discharge planning continued throughout the residents stay and was discussed at all care conferences. LSW further indicated she was responsible to update the discharge planning section in the care plan and confirmed LSW did not always update the care plans. LSW verified R41's and R15's care plans had not been updated to reflect R41's and R15's current discharge plans. During an interview on 2/12/25 at 4:36 p.m. director of nursing (DON) confirmed R42's care plan had not been updated to include current discharge planning interventions and goals. DON stated the expectation was care plans would be revised to include any changes or follow up completed regarding discharge planning. Facility policy titled Care Plan - Baseline and Comprehensive revised 6/20/23, to ensure that each resident received care individualized to him or herself and that goals and approaches for care were communicated to all parties including caregivers, the resident, and the resident's representative. Throughout the course of rehabilitation and the resident's stay in the facility, the identified risk factors, goals, interventions, and outcomes on the care plans would be evaluated at least quarterly and revised as necessary.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on interview and document review, the facility failed to ensure continuation of appropriate discharge planning was implemented for 4 of 4 residents (R42, R41, R15 and R13) who remained at the facility. Findings include: R41 R41's significant change Minimum Data Set (MDS) dated [DATE], indicated R41 had diagnoses which included cancer, epilepsy (seizure disorder), anxiety and depression and was severely cognitively impaired. R41 required minimal assistance with activities of daily living (ADL's) which included bed mobility, transfers, and eating. R41's care plan revised on 9/9/24, indicated R41's discharge plans were undecided. R41 or R41's representative would meet with care plan team to identify discharge potential on a quarterly basis. R41's care plan conference summary dated 1/21/25, indicated R41's spouse would like R41 moved closer to spouse or R41's brothers. Review of R41's progress notes dated 12/12/24 to 2/12/25, lacked discharge planning documentation. R15 R15's quarterly MDS dated [DATE], indicated R15 had diagnoses which included cancer, anxiety and depression and had mild cognitive impairment. R15 required extensive assistance with ADL's which included bed mobility and transfers. R15's care plan revised on 9/11/24, indicated R15's discharge plans were to return to assisted living facility (ALF) if able. R15 required a discharge care conference needed closer to discharge and expected to be discharged to another facility. R15's care plan conference summary dated 2/6/25, indicated R15 required assistance 24/7. Review of R15's progress notes dated 12/12/24 to 2/12/25, lacked discharge planning documentation. During a telephone interview on 2/10/25 at 5:01 p.m., family member (FM)-B indicated FM-B had requested R41 to be moved closer to FM-B however, had not heard back from the social work (SW) regarding placement options for R41. 37905 R42 (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R42's admission MDS dated [DATE], identified R42 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis, anxiety, and depression. Identified R42 was dependent on staff for oral cares, hygiene, dressing and bathing. R42's Identified R42 participated in goals and had an overall goal to discharge to the community at time of assessment. R42 had no active discharge plan and R42's expected discharge date was three or fewer months away. R42's Care Area Assessment (CAA) dated 12/22/24, identified R42 had a self-care performance deficit related to weakness. Identified R42's care plan would be completed for self-care deficit and impaired mobility and staff would assist with ADL completion. R42's care plan revised 1/13/25, identified R42 had an ADL self-care performance deficit related to weakness. R42's interventions included personal hygiene/oral care assist of one. Discharge Planning, R42 planned to return home when R42 was stronger. Interventions included to coordinate and assist in communication with outside or home services, and to discuss with family and resident discharge options. During an interview on 2/10/25 at 1:11 p.m., R42 stated no one had talked to her about her wishes to move to the Mahnomen nursing home to be closer to family. R42 indicated a family member had informed her she was second in line on their admission list at the Mahnomen facility. R42's Initial Care Conference form dated 12/12/24, identified information was collected from R42. R42 previously lived at home with spouse prior to hospitalization . R42 would like to return back home, and realized had a lot of work to do to go home. R42 was willing to look at long term placement closer to home. Review of R42's progress notes from 12/16/24 to 2/12/25, identified the following: -12/16/24 4:18 p.m., discharge planning: R42 was living with spouse at home prior to hospitalization . R42 was willing to look for long term placement closer to home. -1/16/25 1:04 p.m., nurses note: writer received call from Mahnomen nursing home requesting information, as spouse would like resident closer to home. Writer called back and left message that they needed a from sent and gave licensed social worker (LSW) name as contact as LSW facilitated discharges. R42's medical record lacked further follow up on R42's wishes to be moved to Mahnomen facility. 49620 R13 R13's quarterly MDS dated [DATE], identified R13 had intact cognition with diagnoses of chronic obstructive pulmonary disease (COPD), (an ongoing lung condition caused by damage to the lungs), atrial fibrillation (abnormal heart rhythm), lymphedema (swelling caused by build up of too much fluid), hypertension (high blood pressure), obesity. Identified R13 required extensive to total assistance with ADL's such as bathing, toileting, transfers, and personal hygiene. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's care plan revised 9/11/24, identified R13's discharge plan from the facility was to discharge to a different facility closer to family. The care plan identified staff were to assist/arrange for tours of facilities and discuss with family and resident discharge options. R13's care plan created 4/4/24, identified R13 had an actual/potential psychosocial well-being problem due to being in a nursing home away from family and friends. The care plan identified staff would initiate referrals as needed. R13's Care Plan Conference Summary dated 12/13/24, identified R13 would like to discharge from the facility to be closer to family. The summary lacked documentation on a discharge plan for R13 to move to a facility closer to family. R13's significant change comprehensive CAA dated 8/29/24, lacked documentation on discharge planning. During an interview on 2/12/25 at 12:53 p.m., licensed social worker (LSW) stated she had sent R42's referral to Mahnomen nursing home right after R42 was admitted , which was before Christmas, and she had also sent them an updated referral form last week. LSW stated the first referral they rejected, because they did not have a bed. LSW stated she had called Mahnomen nursing home 1/16/25, and they were unable to meet R42's needs at that time. LSW confirmed she did not document any follow up to discharge planning for R42. LSW also confirmed she did not always discussed the discharge planning progress with R42. During a follow-up interview on 2/12/25 at 3:20 p.m., LSW stated the discharge planning process started when residents were admitted into the facility. LSW further stated discharge goals were set based on resident's needs and services prior to admission. LSW indicated discharge planning continued throughout the residents stay and was discussed at all care conferences. LSW further indicated she did not always put a note in the resident's chart regarding discharge planning. LSW verified R41's and R15's electronic medical chart lacked current discharge plans. During an interview on 2/12/25 at 4:36 p.m., director of nursing, confirmed she was aware LSW had not documented follow up regarding R42's discharge planning, and she expected LSW to document all progress regarding discharge planning in R42's medical record. DON indicated they had been aware that discharge planning and follow up was a concern the facility was aware of, and was important to document so others may follow up, and it was important because discharge planning should begin when residents were admitted . The facility policy titled Charting And Documentation revised 11/13/24, identified it's purpose to maintain a medical record to serve as a legal document that details the services provided to the resident, or any changes in the resident's medical or mental condition, through charting and documentation. Documentation would include information on assessment, notifications, interventions and evaluations which included: status updates/summaries as required. Requested facility policy on discharge planning however, one was not received.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview, and document review, the facility failed to ensure oral cares were performed for 1 of 3 residents (R42) who required assistance with hygiene, and were reviewed for activities of daily living (ADL). Findings Include: R42's admission Minimum Data Set (MDS) dated [DATE], identified R42 was cognitively intact and had diagnoses which included: diabetes mellitus, arthritis, anxiety and depression. Identified R42 was dependent on staff for oral cares, hygiene, dressing and bathing. R42's Care Area Assessment (CAA) dated 12/22/24, identified R42 had a self-care performance deficit related to weakness. Identified R42's care plan would be completed for self-care deficit and impaired mobility and staff would assist with ADL completion. R42's care plan revised 1/13/25, identified R42 had an ADL self-care performance deficit related to weakness. R42's interventions included personal hygiene/oral care assist of one. During an interview on 2/10/25 at 1:15 p.m., R42 indicated staff had never once asked her to wash her mouth out. During a follow up interview on 2/12/25 at 7:11 a.m., R42 indicated staff did not do any oral cares, including offering oral swabs or mouthwash and she would like that. R42 stated her dentures were at home. During an observation on 2/12/25 at 7:18 a.m., nursing assistant (NA)-F entered the room wearing gown and gloves. At 7:21 a.m. NA-G entered the room also wearing gown and gloves. NA-F folded up a blanket and placed in chair as R42 requested, then NA-G and NA-F assisted R42 from her bed to recliner with a mechanical lift. NA-G left the room with the lift, then NA-F assisted R42 by combing her hair, getting her a box of facial tissues and her call light. NA-F stated they were done with cares and exited the room. During an interview on 2/12/25 at 10:11 a.m., NA-H indicated R42 had a lot of anxiety, would have panic attacks, and required total assistance from staff. During a phone interview on 2/12/25 at 1:30 p.m., NA-F stated R42 did not have any dentures, and she completed oral cares only when R42 asked and stated otherwise R42 just drank water. NA-F indicated she had only completed oral cares for R42 maybe twice since she had been admitted . NA-F indicated she had not provided R42 oral cares that morning. NA-F indicated she was unaware of what oral cares should have been done when residents wore dentures. During an interview on 2/12/25 at 2:03 p.m., director of nursing (DON) stated expectation for oral cares were for staff to be complete every morning and at bed time. DON stated if residents wore dentures, she would expect the dentures be brushed and oral cares be completed with a toothette (sponged oral swab) with mouthwash or have them swish and spit, to remove food and buildup, which could cause mouth sores and for their dignity. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Oral Assessment And Management revised 3/13/24, identified every resident would have a complete, accurate and comprehensive assessment of oral status and needs. The residents' care plans would include assistive oral care devises, and would include alternative means to address the needs identified in the assessment process if a resident refused oral care. The policy did not include instructions for oral cares.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on observation, interview and document review, the facility failed to provide meaningful and engaging activities for 1 of 1 residents (R37) reviewed for activities. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and had diagnoses which included Alzheimer's disease, dementia, anxiety and was currently receiving hospice services. R37 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R37's care area assessment (CAA) dated 9/16/24, indicated R37 had concerns with cognition and dementia. R36's CAA further indicated R36 did not communicate often and was not responding to conversations as much. R37's care plan revised 11/15/24, indicated R37 had a diagnosis of frontotemporal and vascular dementia with a history of alcoholism with limited R37's ability in leisure involvement. R37's goals were to maintain leisure abilities by actively engaging in structured leisure opportunities once daily three days a week. It further indicated R37 enjoyed music, games, music trivia and animals. Staff interventions were to break down tasks, give praise and provide music in R37's room. R37's care plan conference summary dated 1/21/25, stated R37's spouse offered additional activities that R37 would enjoy. These activities included, music (country, 50's and 60's), one to ones, and conversations. R37's spouse requested staff communicate with R37 even if R37 did not respond. R37's Kardex undated, indication R37 enjoyed music and singing and preferred to listen to music in room instead of coming out to join a group of people. Review of weekly memory care activities schedule for 2/9/25 through 2/15/25, revealed the following: -Monday 2/10/25: 10:00 Card Game: Uno. 10:30 Exercise: Morning Stretches. 11:00 Building Legos. 1:30 Folding Towels. 2:30 Daily Chronicles with Beverages. -Tuesday 2/11/25: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:00 Folding Towels. 10:30 Exercise: Morning Stretches. 11:00 Pattern Shape Blocks. 1:30 Movie: [NAME] and Hooch. 2:30 Daily Chronicles with Beverages. -Wednesday 2/12/25: 10:00 Card Game: Go Fish. 10:30 Exercise: Morning Stretches. 11:00 Manicures. 1:30 Bingo. 2:30 Daily Chronicles with Beverages. During an observation on 2/11/25 at 2:12 p.m., R37 was sitting in his recliner in his room with his feet elevated and the television was on. Activities were not offered as noted on activity schedule. During an observation on 2/11/25 at 3:45 p.m., R37 continued in the same position as noted above. Activities were not offered as noted on activity schedule. During an observation on 2/12/25 at 1:41 p.m., R37 was sitting in his recliner in his room with his feet elevated and the television was on. R37's television was faced towards the bed and R37 was not able to see the tv. Activities were not offered as noted on activity schedule. During an observation on 2/12/25 at 1:57 p.m., bingo was being offered in the activity room on the memory care unit. R37 remained in his recliner in his room and was not offered to attend bingo. R37's television remained facing away and R37 was not able to see the television. During a telephone interview on 2/10/25 at 4:27 p.m., family member (FM)-A stated R37 sat in his room most of the time. FM-A also stated it had been requested by FM that staff play music and read to R37 during the day. FM-A indicated FM-A had requested the facility to get R37 a white board to help communicate with R37 as R37 had difficulties speaking. FM-A further indicated R37 did not have a white board as requested. During an interview on 2/12/25 at 8:23 a.m., nursing assistant (NA)-E stated activity aids were responsible for the actives on the memory care unit. NA-E further stated activities seldom happened on the memory care unit. NA-E indicated nursing staff were told they needed to complete activities on the unit however, nursing staff did not have the time to complete them. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 8:30 a.m., NA-I stated many times activities did not occur on the memory care unit. NA-I stated there was an activities schedule posted however, often times activities did not get completed. NA-I further stated nursing staff were told they could complete activities however, nursing staff did not have the time to complete activities. During an interview on 2/12/25 at 2:42 p.m., activity director (AD) indicated activity aids were responsible for completing activities on the memory care unit. AD further indicated at times activities did not get completed due to being short staffed. AD stated there was no documentation regarding activities and when residents were invited or attended. AD further stated she would be working on ensuring activities were completed as posted on the memory care unit. During an interview on 2/12/25 at 4:50 p.m., director of nursing (DON) confirmed the above findings and stated she was not aware activities were not being completed on the memory care unit. DON further stated her expectations were that all residents be invited to activities and activities were being completed as scheduled. DON indicated her plan was to have a full time activity aid on the memory care unit from 9am to 5pm Monday through Friday. DON further indicated activities were important especially on the memory care unit. Facility policy titled Activities issued 2/28/20, the facility will provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility failed to provide assistance to ensure hearing aids were available to maintain hearing/communication needs for 1 of 1 resident (R3) reviewed for hearing. Findings Include: R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 was cognitively intact and had diagnoses which included heart failure, peripheral vascular disease (restricted blood flow to limbs) and depression. Identified R3 was dependent on staff for dressing, bathing, and toileting and personal hygiene. Identified R3 had moderate difficulty with hearing, and used hearing aide or other hearing appliance. R3's Functional Abilities Care Area Assessment (CAA) dated 9/19/24, identified R3 was dependent for toileting hygiene, to shower/bathe self, upper and lower body dressing, and required substantial/maximal assistance with personal hygiene. Staff would review and update care plan as needed. R3's care plan revised 12/16/24, identified R3 had an activities of daily living (ADL) self-care performance deficit related to immobility and related to amputation of one lower extremity. R3 required assistance of one for toilet use, personal hygiene, dressing and bathing. R3's care plan did not include use of hearing aides or interventions for hearing aide use. During an interview on 2/10/25 at 2:26 p.m., R3 stated her hearing aides needed to be sent to be cleaned, and the facility staff had not done this for her. R3 said she could send them herself if she had a box to mail them in, which she had asked staff for. R3 was not wearing her hearing aides. During a follow-up interview on 2/12/25 at 8:18 a.m., R3 stated she did not wear her hearing aides, because they were broken and they needed to be sent for repair. R3 indicated she had informed four to five different staff members about a month ago, and they have not assisted her to get her hearing aides fixed. In addition, R3 said she had asked for a box, so she could mail them herself however, she had not been provided a box either. R3 stated her hearing aides had not been working well for about two months. During an interview on 2/12/25 at 12:08 p.m., licensed social worker (LSW) stated her usual practice was to call the company to get items repaired, and to discuss with the interdisciplinary team (IDT) to see who was responsible for the cost of repair or replacement. LSW indicated she was unaware that R3 needed her hearing aides repaired. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 2/12/25 at 12:50 p.m., LSW stated she had spoken to R3 about her hearing aides. LSW indicated R3 informed her she had informed multiple nurses and nursing assistants that her hearing aides were broken. R3 informed her she told a nursing assistant her hearing aides were not working then gave the hearing aides to the nursing assistant, who gave them to the nurse. The hearing aides were kept in the nursing cart for awhile, then R3 finally took them back to her room. LSW stated it was important for R3 to have her hearing aides repaired, so she could hear and communicate with others. LSW stated she would have expected staff to inform her or director of nursing (DON) that they needed to be repaired. LSW stated she would investigate why R3's hearing aides were not repaired, and would have them repaired. During an interview at 2/12/25 at 1:18 a.m., DON stated she expected if staff were aware a resident's hearing aides were broken, they would inform someone so they could be repaired as soon as possible. DON stated she had been informed R3's hearing aides were broken in passing. DON stated LSW or herself could have them repaired as soon as possible, for R3's dignity, respect, and ability to communicate. If R3 had told four to five staff, and no one did anything to fix her hearing aides, it could potentially make R3 feel like no one cared about her. A policy was requested however, was not provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to implement a system to ensure medications were available to administer as ordered for 1 of 1 residents (R14) identified who did not receive medications as ordered. Findings include: R14's admission Minimum Data Set (MDS) dated [DATE], identified R14 had intact cognition and diagnoses which included: hypertension (elevated blood pressure), neurogenic bladder (a condition where people lack bladder control due to a brain, spinal cord or nerve problem), and constipation. During an observation on 2/11/25 at 8:29 a.m., registered nurse (RN)-A set up R14's medications. RN-A indicated R14 was to receive Myrbetriq (medication for overactive bladder) and Psyllium (medication for constipation) however neither med was available to administer, and had not been available for several days so she would have to contact pharmacy to order it again. R14's current Order Summary sheet dated 2/4/25, included the following: -Myrbetriq 50 mg oral tablet, take one tablet daily for kidney stone. -Psyllium 0.52 mg capsule, take 2 capsules daily for constipation. R14's February 2025, Electronic Medication Administration Record (EMAR) identified the following: -Myrbetriq Oral Tablet Extended Release 24 Hour 50 MG (Mirbetriq)1 tablet by mouth one time a day for Kidney stone, R14 missed seven doses. -Psyllium Oral Capsule 0.52 GM (Psyllium) 2 capsules by mouth one time a day for constipation, R14 missed seven doses. Review of R14's progress notes from 2/4/25, to 2/11/25, identified the following: -2/5/25 at 8:03 a.m. Myrbetriq Oral Tablet Extended Release 24 Hour 50 MG 1 tablet by mouth one time a day for Kidney stone waiting for delivery. -2/5/24 at 8:04 a.m., Psyllium Oral Capsule 0.52 GM 2 capsule by mouth one time a day for Constipation related to constipation, new med on order. -2/6/25 at 10:18 a.m., Myrbetriq Oral Tablet Extended Release 24 Hour 50 MG 1 tablet by mouth one time a day for Kidney stone (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not available -2/6/25 at 2:01 p.m., Psyllium Oral Capsule 0.52 GM 2 capsule by mouth one time a day for Constipation Not available, has been ordered. -2/11/25 at 8:51 a.m., Myrbetriq Oral Tablet Extended Release 24 Hour 50 MG 1 tablet by mouth one time a day for Kidney stone Not available. -2/11/25 at 8:47 a.m., Psyllium Oral Capsule 0.52 GM 2 capsule by mouth one time a day for Constipation related to constipation, Not available. R14's progress notes lacked documentation R14's provider had been notified R14's Mybetriq and Psyllium were not available. During an interview on 2/11/25 at 8:45 a.m., RN-A confirmed R 14's Mybetriq and Psyllium were not available and had not been administered since 2/5/25. RN-A stated she had not worked on that unit in a while and was not aware R14 was out of her medication. RN-A stated the usual process was to call the pharmacy when a medication was not available. RN-A stated the director of nursing (DON) should have been notified R14 had not received her medication. During a telephone interview on 2/11/25 at 2:24 p.m., pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. PC-A stated it was important for R14 to receive medication as ordered to prevent further complications. During an interview on 2/12/25 at 8:40 a.m. DON verified R14 had missed seven doses of Mybetriq and Psyllium. DON further verified the provider had not been notified and no orders to hold the medication or to obtain a different medication was obtained. DON stated her expectation was that staff would have contacted the pharmacy and the provider regarding R14's medications that were not available. During an interview on 2/13/25, at 4:22 p.m., medical director (MD) stated he did not recall being contacted regarding R14's medications that were not available. MD stated most of the time when a medication was not available it was related to needing a prior insurance authorization. MD stated when that happened, his expectation was that the facility would have contacted his office and one of the nurses at the clinic would have helped to obtain a prior authorization to get the medication paid for by insurance. MD stated in the mean time, his expectation was that the facility would have contacted him so that he could have decided to hold the medication or replace it with another medication for R14. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Administering Medications revised 1/22/24, identified the policy was to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Further identified should a medication be withheld or refused, the physician would be notified when three (3) consecutive doses or a pattern of frequent withholding or refusal is noted. Documentation identifying the explanation of withholding or reason for refusal would be documented in the medical record. .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility had a 6.25% percent medication error rate for 1 of 7 residents (R14) observed during medication administration. Findings include: R14's admission Minimum Data Set (MDS) dated [DATE], identified R14 had intact cognition and diagnoses which included: hypertension (elevated blood pressure), neurogenic bladder (a condition where people lack bladder control due to a brain, spinal cord or nerve problem), and constipation. R14's current Order Summary sheet dated 2/4/25. included the following: -Myrbetriq 50 mg oral tablet, take one tablet daily for kidney stone. -Psyllium 0.52 mg capsule, take 2 capsules daily for constipation. During an observation on 2/11/25 at 8:29 a.m., registered nurse (RN)-A set up R14's medications. RN-A indicated R14 was to receive Myrbetriq(medication for overactive bladder) and Psyllium (medication for constipation) however neither med was available to administer, so she would have to contact pharmacy to order it again. During an interview on 2/11/25 at 8:45 a.m., RN-A confirmed R 14's Mybetriq and Psyllium were not available and had not been administered since 2/5/25. RN-A stated she had not worked on that unit in a while and was not aware R14 was out of her medication. RN-A stated the usual process was to call the pharmacy when a medication was not available. RN-A stated the provider should have also been contacted regarding the missing medications. RN-A further stated the director of nursing (DON) should have been notified R14 had not received her medication. During a telephone interview on 2/11/25 at 2:24 p.m., pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. PC-A stated it was important for R14 to receive medication as ordered to prevent further complications. During an interview on 2/12/25 at 8:40 a.m. DON verified R14 had missed seven doses of Mybetriq and Psyllium. DON further verified the provider had not been notified and no orders to hold the medication or to obtain a different medication was obtained. DON stated her expectation was that staff would have contacted the pharmacy and the provider regarding R14's medications that were not available. (continued on next page)

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Fair Oaks Nursing & Rehab LLC	201 Shady Lane Drive Wadena, MN 56482

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25, at 4:22 p.m., medical director (MD) stated he did not recall being contacted regarding R14's medications that were not available. MD stated most of the time when a medication was not available, it was related to needing a prior insurance authorization. MD stated when that happened, his expectation was that the facility would have contacted his office and one of the nurses at the clinic would have helped to obtain a prior authorization to get the medication paid for by insurance. MD stated in the mean time his expectation was that the facility would have contacted him so that he could have decided to hold the medication or replace it with another medication for R14. Review of a facility policy titled Administering Medications revised 1/22/24, identified the policy was to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Medications would be administered per provider's (MD, NP, PA) written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications were identified, and the medication is labeled according to accepted standards.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to maintain sanitary conditions for mechanical lifts for 2 of 2 residents (R20, R31) observed who used a mechanical lift. In addition, the facility failed to implement hand hygiene for 3 of 3 residents (R1, R3, R20) observed during cares. In addition, the facility failed to ensure safe delivery of beverages during dining observation. In addition, the facility failed to ensure proper signage for 1 of 3 residents (R25) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings include: LIFTS AND HAND HYGIENE R20, R31 During an observation on 2/10/25 at 1:12 p.m., nursing assistant (NA)-A took the mechanical lift without sanitizing it before into R20's room. NA-A and NA-B R20 hooked R20's lift pad to the lift and lifted R20 out of the wheelchair and placed R20 into her recliner and unhooked R20's lift sheet from the mechanical lift. During the transfer, R20 touched the mechanical lift. NA-A took the mechanical lift into R31's room. NA-A and NA-B did not sanitize their hands or the mechanical lift During an observation on 2/10/25 at 1:18 p.m., NA-A and NA-B assisted R 31 to roll onto her side while touching R31's back. NA-B placed the hoyer sheet under R31. NA-A and NA-B hooked the hoyer sheet to the mechanical lift and lifted R31 into her wheelchair. During the transfer,r both R31's arms came into contact with the lift. NA-A and NA-B unhooked the hoyer sheet from the mechanical lift. NA-A took the mechanical lift into the hallway and walked to R1's room with the mechanical lift. NA-A and NA-B did not sanitize their hands or the mechanical lift. During a joint interview on 2/10/25 at 1:28 p.m., NA-A and NA-B verified they had not sanitized their hands or the mechanical lift after assisting R20 and R31. NA-A and NA-B both stated they should have sanitized their hands and the lift to prevent the spread of infection. NA-A stated she would sanitize the lift prior to using it for R1. 37905 R3 R3's quarterly Minimum Data Set (MDS) dated [DATE], identified R3 was cognitively intact and had diagnoses which included heart failure, peripheral vascular disease (restricted blood flow to limbs) and depression. R3's MDS also identified R3 was dependent on staff for dressing, bathing, and toileting and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Functional Abilities Care Area Assessment (CAA) dated 9/19/24, identified R3 was dependent for toileting hygiene, to shower/bathe self, upper and lower body dressing, and required substantial/maximal assistance with personal hygiene. Staff would review and update care plan as needed. R3's care plan revised 12/16/24, identified R3 had an activities of daily living (ADL) self-care performance deficit related to immobility and related to amputation of one lower extremity. R3 required assistance of one for toilet use, personal hygiene, dressing and bathing. During observation on 2/12/25 at 7:37 a.m. nursing assistant (NA)-F, wearing a gown and gloves, was assisting R3 while in bed with morning cares. NA-F had a basin of water on bedside stand next to R3's bed, rinsed it out with water, then offered the washcloth to R3 to wash her face and offered her a towel to dry. NA-F proceeded to remove R3's shirt, washed R3's chest and underarms with soap and water and used a washcloth to dry the areas. NA-F assisted R3 to apply a sweater top and asked R3 if she wanted lotion on her leg, which R3 said yes. NA-F applied lotion with her gloved hands to R3's foot and leg and asked her if she wanted any on her hands. NA-F did not sanitize hands or apply new gloves and NA-F applied lotion to R3's hands. NA-F assisted R3 to roll to her side, after unfastening R3's brief tabs. NA-F proceeded to use the soap and water from basin on the washcloth, and proceeded to wash R3's perineal area. NA-F then proceeded with same washcloth used on perineal area, to wipe buttocks, wiped incision scar area and wiped away the ointment from that area. NA-F did not sanitize hands or change gloves after washing R3's perineal area, or change washcloth. NA-F called for a nurse to come to room using her walkie talkie, while she wore the same gloves. At 7:47 a.m. registered nurse (RN)-A entered the room wearing gown and gloves and applied powder to R3's skin folds. RN-A removed gloves, washed hands, applied new gloves, then applied an ointment to R3's incision scar. NA-F continued to wear same gloves, applied a new brief to R3, pulled up R3's pants and placed a mechanical lift sling under R3. NA-F called for assistance to come to the room for transfer assistance using her walkie talkie. NA-F took R3's basin to the bathroom, and put R3's soiled linen in a bag. At this point, NA-F removed her gloves and sanitized her hands. NA-F informed R3 she was going to leave to get the mechanical lift. At 7:58 a.m. NA-F returned to room with the mechanical lift after applying a gown and gloves. NA-F assisted R3 to put in her dentures, removed her gloves and applied new gloves. NA-F did not sanitize her hands between glove use. At 8:09 a.m. NA-H entered the room wearing a gown and gloves and NA-F and NA-H assisted R3 from her bed to her wheelchair using a mechanical lift. During a phone interview on 2/12/24 at 3:54 p.m., NA-F indicated her usual practice was to change her gloves after assisting residents after washing, before brushing their teeth, or if they had to apply a cream. NA-F indicated it was a habit to just leave on the gloves during resident cares. NA-F confirmed she left the same gloves on while assisting R3 with bathing, lotion application, perineal cares, and dressing. NA-F also verified she had washed R3's perineal area and washed R3's incision area with same gloves and washcloth. NA-F stated she had not received any education on how to wash using clean to dirty, verses dirty to clean areas. NA-F indicated not sanitizing hands or changing gloves when needed could be a problem, because the gloves and hands could be considered soiled. 48583 EPB: According to the Centers for Disease Control and Prevention (CDC) dated 4/2/24, EBP are required for residents who receive wound care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25 R25's quarterly MDS dated [DATE], identified R25 had moderate cognitive impairment and diagnoses which included diabetes mellitus (DM), dementia and a pressure ulcer of the right heel. Identified R34 required moderate assistance with ADL's which included toileting, transfer, and dressing R25's care plan revised 2/1/25, indicated R25 had an alteration in skin integrity related to pressure. Care plan directed staff to administer treatments and assess/monitor skin integrity weekly. R25's care plan lacked documentation related to R25 being on EBP. R25's comprehensive CAA dated 9/27/24, indicated R25 had an unhealed pressure ulcer on the right heal. The CAA further indicated R25 required moderate assistance with bed mobility, transfers, toileting. R25's wound assessment dated [DATE], identified R25 had a pressure ulcer that measured 1.5 centimeters (cm) by 1.9 cm by 1.4 cm. The wound assessment further indicated R25's pressure ulcer had moderated exudate (fluid released from the wound) and it was unknown how R25 obtained the pressure ulcer. During an observation on 2/10/25 at 12:19 p.m., there was no PPE located near R25's room for staff to wear while providing care for R25 (who was on EBP). Further, there was no sign to identify R25 was on EBP. During an observation on 2/10/25 at 7:01 p.m., a three drawer bin containing PPE was located outside R25's door for staff to wear while providing cares for R25 (who was on EBP). Further, there was a sign attached to R25's door that identified R25 was on EBP and provided guidance on what PPE staff were required to wear while providing cares for R25. During an interview on 12:20 p.m., NA-D stated R25 had a wound on her right heel and R25 was on EBP. 49620 DINING OBSERVATION During an observation on 2/10/25 at 4:40 p.m., dietary aide (DA)-A and (DA)-B delivered two food carts to the memory care unit and placed them near the kitchenette area. The food carts were setup with a tray for each resident labeled with the resident name, food preferences, silverware and meal. DA-B removed two clear plastic drink glasses from the kitchenette area, filled the glasses with juice, milk or water and carried the glasses holding the top rim with his bare hands back to the tray on the cart. DA-B removed a coffee cup from the kitchen, filled the coffee cup with coffee and carried the cup holding the top rim with his bare hands back to the tray on the cart. DA-B filled a glass with milk, handed the glass to DA-A who proceeded to carry the glass holding the top rim with her bare hands back to the tray on the cart. DA-B filled another glass with juice, handed the glass to DA-A who proceeded to carry the glass holding the top rim with her bare hands back to the tray on the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/25 at 4:56 p.m., DA-A and DA-B confirmed they both touched the top rim of the glasses with their bare hands and DA-B confirmed he touched the top rim of the coffee cup with his bare hands. DA-A and DA-B stated this practice could spread bacteria to the residents and cause illness. During an interview on 2/10/25 at 5:04 p.m., dietary manager (DM) confirmed the expectation of staff was to hold onto the handle of a coffee cup and to not touch the rim of the glasses or coffee cup with bare hands. DM verified that was important not to touch the top rim of glasses to prevent cross contamination and the spread of germs. Review of facility policy titled Hospitality and Dining Services effective 1/1/20, indicated the facility would provide safe and sanitary storage, handling and consumption of all foods. The policy indicated servers would handle eating utensils and plates, utilizing sanitary precautions; glasses handled by base, flatware by handles, plates kept away from clothing or aprons when serving. During an interview on 2/11/25 at 2:38 p.m., infection preventionist (IP) verified R25 should have been on enhanced barrier precautions. IP stated her expectation was that proper signage was posted for all residents on transmission based precautions(TBP), lifts were sanitized between residents, hand hygiene to be performed when appropriate and staff not to touch the top of glasses during meal service to prevent the spread of infection. During an interview on 2/12/25 at 8:31 a.m., director of nursing (DON) verified mechanical lifts were to be sanitized between residents. Further verified staff were to sanitize hands when appropriate. DON stated her expectation was that lifts were sanitized between residents and hand hygiene was performed to prevent the spread of infection. During a follow-up interview on 2/12/25 at 4:43 p.m., DON stated her expectation was that staff washed their hands before and after glove use. DON also stated she would expect gloves to be changed after going from a dirty task, such as changing a brief. DON stated residents should always be washed from clean to dirty, and to use different gloves and wash cloths for infection control purposes. During a follow-up interview on 2/12/25 at 5:01 p.m., DON indicated she was unaware R25 did not have an EBP sign on the door and no PPE near R25's room prior to 2/10/25 at 7:01 p.m. DON indicated R25 was to be on EBP due to the open wound. Review of a facility policy titled Disinfection of Resident Care Equipment revised 5/8/24, identified Reusable equipment will be cleaned and disinfected after use of one resident and before use of another resident Review of a facility policy titled Hand Hygiene revised 5/8/24, identified Staff will perform hand hygiene by washing hands for at least twenty (20) seconds with antimicrobial soap and water should be performed after providing direct resident care. Review of a facility policy titled Personal Cleanliness and Hygienic Practices revised 11/28/22, identified all plates, utensils and drinking cups would be handled in a way to avoid touching eating surfaces.

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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** 45844 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R5, R44, and R46) were offered or received pneumococcal vaccinations based on shared clinical decision-making in accordance with the Center for Disease Control (CDC) recommendations reviewed for immunizations. Finding include: Review of the current CDC recommendations 10/26//24, revealed The CDC identified Adults [AGE] years of age or older received the (PCV13) at any age and who have received the PPSV23 before the age of 65 and had not received the Pneumo 20-valent conjugate Vaccine (PCV20) should receive a dose of the PCV 20 or the PCV21 five years after the most recent PPSV23 or PCV13 vaccine. Review of R5's facesheet identified R5, age 68 was admitted tot he facility on 1/13/25. Review of R5's Minnesota Immunization Information Connection (MIIC) record undated, identified R16 received the PPSV23 on 1/18/2011, and the PCV13 on 2/5/2019. R5's medical record lacked evidence R5 had been offered the PCV20 or PCV21 five years after the most current dose of the PPSV23 or the PCV13. Review of R44's facesheet identified R44 age 78 was admitted to the facility on [DATE]. Review of R44's MIIC record undated, identified R44 received the PPSV23 on 12/7/2011, and the PCV13 on 12/10/2015. R44's medical record lacked evidence R44 had been offered the PCV20 or PCV21 five years after the most current dose of the PPSV23 or the PCV13. Review of R46's face sheet identified R46 age 73 was admitted to the facility on [DATE]. Review of R46's MIIC record undated , identified R46 received the PPSV23 on 8/14/17, and the PCV13 on 3/6/19. R46's medical record lacked evidence R46 had been offered the PCV20 or PCV21 five years after the most current dose of the PPSV23 or the PCV20. During an interview on 2/11/25 at 2:38 p.m., infection preventionist (IP) confirmed R5, R44,, and R46 had not been offered or received the pneumococcal vaccines as recommended by the CDC. IP stated her expectation was the facility would offer and administer all vaccines per CDC recommendation. During an interview on 2/12/25 at 8:31 a.m., director of nursing (DON) confirmed R5, R44, and R46 had not been offered or received the pneumococcal vaccinations as recommended by the CDC. DON stated her expectation would have been that all residents were offered and received all pneumococcal vaccines per CDC recommendations. Review of a facility policy titled Pneumococcal Vaccination revised 9/19/24, identified all residents would have received vaccine to protect them form pneumonia upon Center for Disease Control (CDC) recommendation. Further identified residents age [AGE] years or older who had: Previously received both PCV13 and PPSV23 but have not completed the recommended series: one dose of PCV20 was offered after the last pneumococcal vaccine dose or complete the recommended PPSV23 series as described on the Pneumococcal Vaccine Timing for Adults (CDC.GOV). The facility lacked the most current recommendations provided by the CDC.