STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. Building B. Wing	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moorhead Restorative Care Center	2810 Second Avenue North Moorhead, MN 56560

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview, and document review, the facility failed to ensure preferences for shaving were honored and implemented for 1 of 2 residents (R2) reviewed for choices. Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had intact cognition and had diagnosis which included dementia without behavioral disturbance and bipolar disorder. The MDS indicated R2 required extensive assistance for activities of daily living (ADL's) which included bed mobility, transfers, toileting and personal hygiene tasks which consisted of::combing hair, brushing teeth and shaving. R2's care plan dated 7/8/22, identified R2 required extensive assistance with personal hygiene and oral cares. The care plan indicated R2 had intact cognitive and had to request facial hair removal when desired. During an observation on 11/28/22, at 2:46 p.m. R2 was lying on his back in bed and was observed to have thick facial stubble noted on his chin and upper lip which extended to the jaw line. During an observation on 11/29/22, at 9:02 a.m. R2 was in the dining room eating breakfast and continued to have thick facial stubble on his chin and upper lip which extended to the jaw line. During an interview on 11/29/22, at 10:56 a.m. R2 indicated staff typically only shaved him once a week when he received his bath. R2 stated he wanted staff to shave him at least every other day without having to ask. R2 indicated he had informed the staff his shaving preferences several times however, they continued to only offer shaving weekly. During an interview on 12/1/22, at 10:22 a.m. nursing assistant(NA-D) indicated R2 required assistance from staff to shave. NA-D stated staff shaved R2 weekly during his bath. NA-D indicated male residents should have been offered to shave daily. During an interview on 12/1/22, at 10:27 a.m. trained medication aide (TMA-A) indicated she had assisted R2 with cares earlier that morning and confirmed she had not offered shaving to R2. TMA-A stated staff typically had only offered R2 assistance with shaving weekly with his bath unless the resident asked. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/22, at 10:31 a.m. clinical manager (CM) confirmed R2 required extensive assistance with shaving and had only been offered shaving weekly with his bath. CM stated her expectation would be staff would have offered R2 to be shaved daily. During an interview on 12/1/22, at 10:47 a.m. director of nursing (DON) confirmed R2 required extensive assistance from staff to shave. DON stated her expectation was R2 should have been offered to be shaved daily without having to request it from staff. A facility policy titled Self Determination and Participation revised 2/21, identified each resident was allowed to choose activities, and schedule health care and healthcare providers, that were consistent with his or her interests, values, assessments and plans of care, including: daily routine such as sleeping walking,eating, exercise, and bathing schedules; personal care needs, such as bathing methods, grooming styles and dress. .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34088 Based on interview and document review, the facility failed to ensure resident advanced directives were accurately documented in the resident's paper and electronic medical record (EMR) to reflect the residents current wishes for 1 of 1 resident (R23) reviewed for advanced directives. Findings include: R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had diagnoses which included diabetes, congestive heart failure, chronic obstructive pulmonary disease and end stage renal disease. The MDS identified R23 had intact cognition. Review of R23's Order Summary Report signed [DATE], revealed an order dated [DATE], which identified R23 was a DNR (do not resuscitate). Review of R23's care plan revised [DATE], identified he had a POLST (physician orders for life sustaining treatment) and had signed DNR orders. Review of R23's POLST form signed [DATE], identified R23 wanted CPR (cardiopulmonary resuscitation), however further on the form, it was revealed R23 requested comfort-focused treatment which was to allow for a natural death. During an interview on [DATE], at 3:50 p.m. R23 stated he did not want any life saving measures to be implemented if needed. R23 stated he wanted to be a DNR and had signed the form identifying his desire when he was admitted to the facility several months ago. During an interview on [DATE], at 9:59 a.m. the director of social services indicated she was responsible for obtaining a resident's life sustaining wishes. She confirmed she had met with R23 upon his admission and he had requested to be DNR. The director confirmed R23's POLST form had an x marking the box to provide CPR. She indicated she had accidentally checked that box instead of the one below which identified DNR request. During an interview on [DATE], at 10:19 a.m. the director of nursing (DON) indicated it was part of the facility's social service directors' admission process to obtain a resident's POLST wishes. The DON stated she would have expected each resident's POLST to accurately reflect the resident's wishes and would also correlate with the doctor's orders. Review of a facility policy titled, Advanced Directives revised [DATE], identified advanced directives would have been respected in accordance with state law and facility policy. The policy revealed upon admission, residents would have been provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chose to do so.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34088 Based on observation, interview and document review, the facility failed to ensure the physician and power of attorney were notified of newly developed pressure ulcers for 1 of 1 resident (R33) reviewed for facility acquired pressure ulcers. R33's admission Minimum Data Set (MDS) dated [DATE], identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair and was not on a turning and repositioning program. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers at the time of the assessment. R33's admission skin assessment dated [DATE], revealed R33's skin was intact. R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied. During an interview on 11/30/22, at 9:05 a.m. with nurse manager (NM)-A, stated R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. NM-A confirmed R33 currently had facility acquired pressure ulcers, one stage two on his sacrum and pressure ulcers to both heels which were unstagable due to deep tissue injury. NM-A stated she was not aware if R33's family had been notified of the pressure ulcers. During an interview on 11/30/22, at 9:16 a.m. Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. NP-A confirmed she had not been notified R33's sacrum was noted to have an open area on 11/25/22, and had not been notified of R33's bilateral heel deep tissue injury. R33's medical record lacked any documentation R33's practioner or family member/power of attorney had been notified of his pressure ulcers. During an interview on 12/1/22, at 10:29 a.m. the director of nursing (DON) indicated she would have expected R33's practioner and family member to be notified of any changes in R33's condition, which included newly developed pressure ulcers. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/1/22, at 10:44 a.m. R33's family member (FM)-A indicated she was not been notified R33 had any pressure ulcers. FM-A stated she would have wanted to have been notified of any changes in R33's condition. Review of a facility policy titled, Change in a Resident's Condition or Status reviewed 11/30/21, identified it was the purpose of the policy the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the residents's medical/mental condition and/or status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to immediately report, no later than 2 hours, an allegation of abuse to the State Agency (SA) for 3 of 3 residents (R4, R13, R26) reviewed for abuse. Findings include: R4 R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had diagnosis which included cerebral vascular accident (CVA), hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms. legs, and facial muscles) and seizure disorder. Indicated R4 had severe cognitive impairment and required limited assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R4's care plan revised 9/3/22, revealed R4 had a mood problem related to feeling unsafe with another resident at the facility. The care plan directed staff to limit exposure to the resident R4 felt unsafe around. The facility SA report dated 9/2/22, at 7:08 p.m. indicated R4 stated there was unwanted kissing between R4 and R14. The report identified R4 and R14 were placed on frequent checks to ensure well-being. During an interview on 12/1/22, at 9:24 a.m. registered nurse (RN-D) stated on 9/2/22, while R4 was eating breakfast around 8:00 a.m. RN-D noticed three red marks on R4's neck. RN-D stated she asked R4 what happened to her neck and R4 stated R14 had placed hickeys on her neck and she did not like it. RN-D was unsure of what time the allegation of abuse was reported to the administartor. During an interview on 12/1/22, at 9:41 a.m. trained medication aide (TMA-B) indicated she noticed three red marks on R4's neck around 8:30 a.m. on 9/2/22. TMA-B indicated she had informed RN-D R4 identified the red marks were from R14 and R4 did not like having the red marks present on her neck. During an interview on 12/1/22, at 9:55 a.m. administrator stated he had been made aware of the allegation of abuse before 10 a.m. on 9/2/22. Administrator confirmed the allegation of abuse had not been reported to the SA within two hours. Administrator stated his expectation would have been the allegation of abuse would have been reported to the SA within two hours. 37905 R13 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's quarterly MDS dated [DATE], identified R13 was cognitively intact and had diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. Indicated R13 was independent with activities of daily living (ADLs). identified R13 had received insulin injections seven of past seven days and antidepressant medication seven of seven days. R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and was able to make his needs known. Indicated R13 had some behavioral symptoms which included social inappropriateness. R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan indicated R13 had behavioral problem which included fixation on specific staff followed by repeated allegations of perceived retaliation of unknown origin that could not be substantiated. During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. During a follow up interview on 11/28/22, at 2:40 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A. R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her. Administrator confirmed the facility had not completed a SA report of alleged abuse. During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A confirmed the facility had not filed an abuse allegation report to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13. During an interview on 11/30/22, at 11:41 a.m. director of nursing (DON) indicated she was aware of R13's allegation of abuse and the facility had interviewed RNIP-A and R13. DON stated as a result of the allegation, the facility now had another nurse administering R13's medications. DON-A stated she had been aware R13 refused medication from RNIP-A and had been aware of his accusation regarding eye drops placed in his water for about a month. DON confirmed if R13 said he had been mistreated and felt afraid of RNIP-A, it would have been considered an allegation of abuse and it should have been reported to the SA. During a follow-up interview on 12/1/22, at 1:05 p.m. administrator confirmed the facility had not submitted a vulnerable adult report to the SA within the required time frames and stated they had submitted a vulnerable adult report today to the SA. Administrator indicated after further review of R13's grievance form, he felt it was more of an allegation of abuse than they thought in the beginning since R13 had expressed he did not feel safe. 34088 R26 R26's significant change in status assessment (SCSA) Minimum Data Set (MDS) dated [DATE], identified R26 had diagnoses which included knee replacement, arthritis, anemia and hypertension. Indicated R26 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and dressing. R26 had other behaviors directed towards others four (4) to six (6) days but not daily, which interfered with her care and/or disrupted her living environment (these could include hitting, scratching self, rummaging, or verbal symptoms like screaming). R26's care plan revised 10/25/22, revealed R26's safety was at risk, was a potential for abuse due to current medical conditions, need for assistance with cares, mobility and her husband had had escalated behaviors towards resident. The care plan revealed when R26's husband visited, frequent checks were to be completed. Review of facility state agency (SA) report dated 11/29/22, at 9:43 a.m. identified on 11/27/22, at 12:00 in R26's room, she had received verbal abuse from her husband. The report identified a witness as nursing assistant (NA)-A. The report identified when staff heard verbal altercations in the residents room, they would intervene, and if necessary ask the husband to leave. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/22, at 8:28 a.m. NA-A indicated R26's husband visited daily and she had heard R26's husband yell at her in the past once, when she did not remember something he had said. NA-A indicated on 11/27/22, she had passed by R26's room and noticed she had looked upset. NA-A indicated she had asked R26 if anything was wrong, and R26 told her to forget about it. NA-A indicated she felt R26 was upset by her husband at times and was concerned he was verbally abusing her. She indicated she had not observed R26 crying or any changes in her mood, however she indicated R26 appeared upset when her husband visited. NA-A indicated she had not reported her concern to anyone until morning report on 11/29/22, as R26 had declined to say anything. NA-A indicated she completed frequent checks on R26 when her husband was at the facility and encouraged her to keep her door open. During an interview on 12/1/22, at 9:49 a.m. the director of social services stated she was made aware of an allegation R26's husband had verbally abused R26 on 11/27/22. She indicated she had met with R26 regarding the allegation and R26 denied any abuse or concerns. She indicated R26 has had no observed changes in her mood or behavior within the last few weeks. The director indicated she had met with R26's husband on several occasions when he had become verbally aggressive towards her, and had hit a wall out of frustration during a conversation with her. She stated she had never seen R26's husband act aggressive towards her or yell at R26 in the past and had not observed R26 appear fearful when her husband was visiting. The director of social services indicated she had met with R26 to assess her psychosocial needs, the facility had implemented frequent checks for R26 while her husband was visiting, and immediately after he left. She indicated she was reaching out to see if R26 would talk with a mental health practioner in addition to working with the county regarding concerns with R26's husbands cognitive status and safety in the community. During an interview on 12/1/22, at 10:22 a.m. the director of nursing (DON) stated she was notified of the allegation of verbal abuse of R26 by her husband on 11/29/22, during morning report. The DON stated she would have expected to be notified immediately when facility staff observed the concern. The DON indicated R26's husband visited daily, and had not observed R26's husband acting abusive towards her. During an interview on 12/1/22, at 12:58 p.m. the facility administrator stated he had been made aware of the allegation during morning report on 11/29/22, and had submitted a report to the SA immediately. The administrator stated he expected to be notified of all allegations of abuse immediately and indicated a SA report should have been completed within two hours of the allegation. However, he indicated he had not been aware of the allegation until two days afterwards. A facility policy titled Abuse Prevention Program revised 6/22/22, indicated all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were to be reported immediately, but no later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the state agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview, and document review, the facility failed to complete a thorough investigation to assure residents were safe, following an allegation of abuse, for 1 of 3 residents (R13) investigated for abuse. In addition, the facility failed to prevent further potential abuse by allowing the alleged perpetrator (AP) to continue to have access to R13 and other vulnerable adults following the allegation of abuse. Findings Include: R13's quarterly Minimum Data Set, dated dated [DATE], identified R13 was cognitively intact, with diagnoses which included: diabetes mellitus type two, hypertension and chronic kidney disease. R13 was independent with activities of daily living (ADLs). R13 had received insulin injections seven of past seven days and antidepressant medication seven of seven days. R13's Care Area Assessment (CAA) dated 5/27/22, identified R13 was cognitively intact and and was able to make his needs known. R13 had some behavioral symptoms which included social inappropriateness. R13's care plan revised 6/13/22, identified R13 was independent with bed mobility, transfers, dressing and toilet use. R13's care plan identified R13 had a behavioral problem which included fixation on specific staff followed by repeated allegations of perceived retaliation of unknown origin that could not be substantiated. On 11/29/22, at 8:27 a.m. RNIP-A was observed passing medications on R13's hallway, and was standing in front of the medication cart, two doors down from R13's room. During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. During a follow up interview on 11/28/22, at 2:40 p.m. with an interpreter present, R13 identified he was afraid of RNIP-A. R13 stated he believed RNIP-A was trying to poison him as he had witnessed her place eye drops in his water the last Sunday morning of September. R13 indicated he had been refusing medications from RNIP-A. R13 stated he just wanted to stay in his room because he was afraid and felt the facility had not done anything to resolve the issue. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/29/22, at 8:27 a.m. administrator indicated the director of social services (DSS)-A and himself interviewed R13 with an interpreter present on the evening of 11/28/22. A grievance form was completed after the interview and both the administrator and DSS-A interviewed RNIP-A. Administrator stated the plan going forward was to have another nurse administer R13's eye drops. Administrator confirmed R13 alleged during their interview RNIP-A placed eye drops in his water and was afraid of her. During an interview on 11/29/22, at 8:41 a.m. DSS-A confirmed when interviewed, R13 had reported he believed RNIP-A had placed eye drops in his water and stated he was afraid of taking medications from her. DSS-A stated the facility was unsure if the allegation was accurate and indicated R13 was not always truthful. DSS-A stated RNIP-A stated she had not placed eye drops in R13's water and indicated R13 and RNIP-A did not like one other. DSS-A confirmed she had been aware R13 had been refusing medications from RNIP-A prior to the surveyor reporting the allegation. DSS-A confirmed R13 requested a grievance form be filed. DSS-A indicated no other staff or residents had been interviewed. Review of R13's Concern Or Problem Resolution Form dated 11/28/22, identified R13 had a concern RNIP-A placed eye drops in his water to poison him. R13 identified the date of occurrence on 9/27/22. R13 was now afraid to take medications from RNIP-A. The form identified a different staff member would now provide medications to R13. During an interview on 11/30/22, at 11:00 a.m. RNIP-A confirmed she had remained working in the facility after R13's allegation of abuse however she had been instructed to not administer R13's medications. RNIP-A confirmed she continued to have contact with R13 and other residents in the facility and was never removed from the facility's schedule while the investigation ensued. During an interview on 11/30/22, at 11:41 a.m. DON stated R13 and RNIP-A were interviewed after the allegation of abuse was received and confirmed no other residents or staff had been interviewed. DON indicated RNIP-A continued to work in the facility and was never removed from the facility's schedule. DON indicated her usual practice was to suspend a staff member during an investigation. DON stated she would normally choose three other residents at random to interview to determine if they felt safe or had concerns. During an interview on 12/1/22, at 1:03 p.m. administrator confirmed the facility had not originally completed a thorough investigation however now the facility were beginning to further investigate the allegation. The facility policy titled Grievances/Complaints, Filing reviewed 6/22, identified the social service director of designee was the grievance officer. The policy identified the grievance officer would coordinate actions with appropriate state and federal agencies, dependent upon the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property would have been reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. The policy indicated the grievance officer, administrator and staff would have taken immediate action to prevent further potential violations of resident rights while the alleged violation was being investigated.

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	245052	A. Building B. Wing	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moorhead Restorative Care Center	2810 Second Avenue North Moorhead, MN 56560

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47497 Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 3 residents (R24) reviewed for activities. Finding include: R24's admission Minimum Data Set (MDS) dated [DATE], indicated R24's had diagnoses which included depression, anxiety disorder, bipolar disorder and was cognitively intact. R24 required extensive assistance of one or two staff for all activities of daily living (ADL's). R24's activities that were very important to her were listening to music and being around animals. R24's activities that were somewhat important to her were going outside for fresh air, doing her favorite activities, and keeping up with the news. R24's least favorite activities were reading books, news papers, magazines, doing group activities, and religious activities. Review of R24's care area assessment (CAA) dated 5/11/22, indicated R24 preferred group activities and being active in activities. The CAA indicated R24's activity functional status would be addressed in her care plan with overall objectives to maintain her current level of functioning. Review of R24's Activity Data Collection (Admission) dated 5/9/22, indicated R24's leisure activities were reading, watching TV drama shows, listening to 80's music, visiting with family, going to church and enjoyed being with dogs. Review of R24's careplan revised on 11/10/22, lacked any documentation of what R24's activity preferences, approaches, or goals were for activities. During an interview on 11/29/22, at 2:30 p.m. with director of activities (DA) she confirmed the above findings and indicated the activity/preference assessments were to be completed within seven days of a residents admission. The DA indicated the information from the the assessment was shared with only activity staff and indicated most of the residents were able to tell staff what they wanted to do for activities. The DA verified R24 currently did not have a activity careplan developed due to not having the training when she was hired. The DA indicated she did not know how to complete a care plan and was currently not doing them. The DA indicated most residents were only in the facility for a few weeks and did not require a care plan. During an interview on 11/29/22, at 2:55 p.m. the activity aid (AA)-A indicated she documented all activity participation under the progress notes in the medical record. AA-A confirmed she had no written direction or activity careplan to follow and indicated she just knew what each resident enjoyed for activities. During an interview on 12/01/22, at 2:07 p.m. with director of nursing (DON) confirmed R24's care plan lacked any documentation of R24's activity focus, goals, or interventions. DON indicated she would expect staff to do a base line care plan within 48 hours of admission and a comprehensive care plan done within fourteen days after the assessment had been completed. She stated she would expect staff to complete care plans and to include activities focus, goals and interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Activity Evaluation undated, indicated staff would have evaluated residents within 14 days of admission and would develop an individual activities care plan (separate or as part of the comprehensive care plan). The policy identified each resident's activity care plan would have been related to his/her comprehensive assessment and would reflect his/her individual needs and the care plan would have identified if the resident was capable of pursuing activities without intervention from facility. The policy indicated the activity evaluation would have been part of the resident's medical record and should have been updated as necessary, but at least annually.

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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** 47497 Based on observation, interview and document review, the facility failed to provide meaningful activities for 1 of 3 residents (R24) who was dependent on staff for activities. Findings include: R24's admission Minimum Data Set (MDS) dated [DATE], indicated R24's had diagnoses which included depression, anxiety disorder, bipolar disorder and was cognitively intact. R24 required extensive assistance of one or two staff for all activities of daily living (ADL's). R24's activity preferences that were very important were listening to music and being around animals. R24's preferences that were somewhat important were going outside for fresh air, doing favorite activities, and keeping up with the news. R24's least favorite activities were reading books, news papers and magazines, group activities, and religious activities. Review of R24's care area assessment (CAA) dated 5/11/22, indicated R24 preferred group activities and being active in activities. The CAA indicated R24's activity functional status would be addressed in her care plan with overall objectives to maintain her current level of functioning. Review of R24's Activity Data Collection (Admission) dated 5/9/22, indicated R24's leisure activities were reading, watching TV drama shows, listening to 80's music, visiting with family, going to church and enjoyed being with dogs. Review of R24's Activity Participation Review dated 10/26/22, indicated R24 preferred one on one activities and enjoyed live music events. The review identified R24's activities remained appropriate, goals were met and to continue until next quarter. Review of R24's careplan revised on 11/10/22, lacked any documentation of what R24's activity preferences, approaches, or goals were for activities. Review of R24's Progress Notes from 9/1/22, to 12/1/22, revealed the following: - 10/19/22, activity aid visited with R24 about the show she was watching while nursing assistant (NA) did her nails. - 10/25/22, activity aid stopped in and asked R24 if she would like to attend bingo and R24 declined. - 11/3/22, activity director (AD) indicated R24 was confused and required one to one supervision while in activity today. The progress notes lacked documentation R24 offered or attended activities on a routine basis. During observation on 11/28/22, from 1:52 p.m. to 7:15 p.m. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 1:52 p.m. R24 was laying in bed on her back covered with a blanket, bed in low position, mat on floor next to bed, call light in reach and the TV was on. - at 5:41 p.m. R24 remained the same. Review of the facility November 2022, activity calendar, indicated staff were to have a beach ball activity at 2:00 p.m. and one on one visits at 3:30 p.m. R24 was not observed attending any activities through out the evening. During observation on 11/29/22, from 8:17 a.m. to 3:56 p.m. - at 8:17 a.m. R24 was seated in her wheelchair in the dining room and was eating her breakfast independently. - at 10:05 a.m. R24 was laying in bed covered with a blanket, bed in low position and call light within reach. - at 2:09 p.m. R24 was laying in bed covered with blanket, had her cell phone in her hand, bed in low position, head of bed elevated, mat on floor and was independently eating chips. - at 2:17 p.m. R24 remained the same and continued to eat her chips. - at 2:46 p.m. R24 remained the same while a housekeeper cleaned her room and R24 told the housekeeper she was hungry. - at 3:02 p.m. R24 remained in her room while lying in bed, bed in low position, mat on floor, call light within reach and was talking to herself repeatedly. - at 3:28 p.m. R24 remained lying in bed, when licensed practical nurse (LPN)-A entered her room and gave R24 a snack and immediately left the room. - at 3:47 p.m. R24 was yelling out loudly, when registered nurse (RN)-C entered R24's room and began talking with R24 about taking her blood pressure. RN-C proceeded by taking R24 blood pressure and immediately left the room. - at 3:56 p.m. R24 was yelling out loudly, when RN-C entered her room asking R24 if she would like to get up, go to the dining room, or if she wanted a cup coffee and R24 declined. Review of the facility November activity calendar, indicated staff were to have this day in history/daily devotions at 9:30 a.m., board/card games at 10:00 a.m., bingo at 2:00 p.m., and one on one activities at 3:30 p.m. R24 was not observed attending any activities through out the day or having one on one activities with staff. During observations on 11/30/22 from 7:20 a.m. to 1:30 p.m. -at 7:20 a.m. R24 was laying in bed, bed was in low position, call light within reach and R24 was talking to herself repeatedly. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 8:23 a.m. R24 remained the same and was yelling out loudly while talking to herself repeatedly. - at 8:31 a.m. R24 remained the same, when the director of social services (DSS) entered R24's room and asked R24 if she would like to eat breakfast in her room or the dining room. R24 indicated she would like to eat in her room and the DSS immediately left R24's room. - at 8:34 a.m. R24 was seated on the edge of her bed, when the dietary manager (DM) entered R24's room with a room tray, set the tray on the bedside table, assisted R24 as needed and immediately left the room. - at 8:37 a.m. R24 remained the same, when the director of rehab (DR) entered R24's room and asked R24 if she would like to get up. R24 yelled at the DR to get out of her room and DR immediately left her room. While DR was walking down the hallway, R24 then yelled at her to shut the door. The DR turned around and proceeded to shut R24's door. - at 8:50 a.m. R24 door remained closed and and she continued to talk to herself. - at 10:54 a.m. R24 was laying in bed on her back, bed in low position, mat on floor and appeared to be resting. - at 11:05 a.m. R24 remained the same. - at 1:30 p.m. R24 remained the same. Review of the facility November activity calendar for 11/30/22, indicated staff were to have shopping lists at 9:30 a.m., shopping for residents at 10:00 a.m., bowling at 2:00 p.m., and one on one visits at 3:30 p.m. R24 was not observed attending any activities through out the day or having one on one activities with staff. During an interview on 11/30/22, at 2:15 p.m. nursing assistant (NA)-D indicated R24 enjoyed visiting, having her hair and make up done. NA-D indicated R24 had recently had an increase in behaviors with yelling out and staff would offer her a snack, to watch videos on her phone or call her son. NA-D indicated R24 did not like to go to the activity room and usually stayed in bed. During an interview on 11/30/22, at 2:30 p.m. with director of activities (DA) confirmed the above findings and indicated R24 preferred one on one activities. The DA indicated facility staff completed one to one activities daily, although the DA could not identify which activities R24 preferred. The DA stated resident activity/preference assessments were to be completed within seven days of admission and were shared verbally with activity staff only. The DA indicated most of the residents could inform staff what they wanted to do for activities and confirmed staff documented activity participation in the resident's progress notes. The DA stated activity staff did not have a schedule for doing one on ones activities for residents and her expectation were for staff to offer residents activities daily and residents should have been receiving one on one activities on a daily basis. (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 11/30/22, at 2:55 p.m. the activity aid (AA)-A indicated R24 liked to visit about her son, write letters and enjoyed being out and about within the facility. AA-A stated R24 was receptive to activities however would occasionally refuse. The AA-A indicated all activity participation was documented under progress notes in the medical record. AA-A confirmed she had no written direction or activity careplan to follow and indicated she just knew what each resident liked for activities. During an interview on 12/01/22, at 2:07 p.m. with director of nursing (DON) confirmed the above findings and indicated she would expect staff to offer the residents activities and to follow the careplan. Review of facility policy titled, Activity Evaluation undated, indicated staff would have evaluated residents within 14 days of admission and would have developed an individual activities care plan (separate or as part of the comprehensive care plan). The policy identified each residents activities care plan would have been related to his/her comprehensive assessment and would have reflected his/her individual needs. The policy indicated the care plan would have identified if the resident was capable of pursuing activities without intervention from facility. The policy indicated the activity evaluation would have been part of there resident's medical record and should have been updated as necessary, but at least annually.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34088 Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions to promote healing and prevent worsening of pressure ulcers for 1 of 1 resident (R33) reviewed with a current stage two pressure ulcer on the sacrum (tailbone area) and two deep tissue injury pressure ulcers on both heels. R33 sustained actual harm when the facility failed to assess and monitor his skin which resulted in the development of two deep tissue injuries to his bilateral heels. Stage two pressure ulcer: partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister. Deep Tissue Injury (DTI) : is an injury to a patients underlying tissue below the skin's surface that results from prolonged pressure in an area of the body. Similar to a pressure sore, a deep tissue injury restricts blood flow in the tissue causing the tissue to die. Findings include: R33's admission Minimum Data Set (MDS) dated [DATE], identified R33 had diagnoses which included debility (physical weakness), atrial fibrillation, and hypertension. Identified R33 had moderately impaired cognition and required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, toileting and bathing. Identified R33 was always incontinent of bowel and bladder and was not on a toileting plan. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair and revealed R33 was not on a turning and repositioning program. Identified R33 was at risk for pressure ulcers and had a pressure relieving device for his bed and chair however was not on a turning and repositioning schedule and incorrectly identified R33 had a current pressure ulcer at the time of admission. R33's admission Care Area Assessment (CAA) dated 11/6/22, revealed R33 had moderate cognitive impairment which limited his abilities to recognize his needs. Identified R33 required extensive assistance with ADL's, and was not able to remember the need to change position. Revealed R33 preferred to be lying in his bed or seated in a wheelchair and was to have a pressure relieving device on his bed and his wheelchair. Identified R33 was at risk for developing pressure ulcers and had no pressure ulcers present at the time of the assessment. Review of R33's care plan revised 11/22/22, revealed R33 had a potential/actual impairment to his skin and identified the following interventions: barrier cream, pressure reducing devices for his chair, bed and heel protectors to protect his skin. R33's admission skin assessment dated [DATE], identified R33's skin was intact. Review of R33's Braden scale (an assessment tool for predicting the risk of pressure ulcers, based on the total scores given in the categories of sensory perception, moisture, activity, mobility, nutrition, and friction and shear) dated 10/31/22, identified R33 was at low risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R33's weekly skin review form dated 11/25/22, identified R33 had a small open area on his sacrum in which barrier cream was applied. The form lacked identification, staging, measurements, tissue characteristics or causative factors of R33's open area. R33's medical record lacked any further skin assessments or identification of any other open areas. During an observation on 11/28/22, at 2:44 p.m. R33 was lying in bed on his back, his face was pale gray in color, his eyes were closed and he was covered with a yellow blanket. During an observation on 11/28/22, at 5:36 p.m. R33 was observed lying in bed on his back, his face was pale gray in color, his eyes were closed. He was covered with a yellow blanket from his feet to his mid chest. -at 5:56 p.m. R33 was observed lying in the same position, his face was pale gray in color, his eyes were closed and he was covered with a yellow, fuzzy blanket. At that time, nursing assistant (NA)-B and NA-F entered his room, indicated to R33 it was time for him to eat. NA-B and NA-F removed the yellow blanket, which revealed R33's bilateral heels had been resting directly on the standard mattress with no off-loading (heels hovered over the bed by a pillow or use of pressure relieving heel protectors) devices in place. R33 was boosted up in bed by NA-B and NA-F, covered with a yellow blanket and the head of bed was elevated to a sitting position. R33's meal tray was placed on an over the bed table, which was then moved in front of R33. On 11/29/22, at 2:56 p.m. R33 was observed lying in bed on his back, his eyes were closed and he was covered from his feet to his mid-chest with a fuzzy yellow blanket. -at 3:22 p.m. R33 remained lying in the same position, his eyes were closed and he was covered from his feet to his mid-chest with a fuzzy yellow blanket. During an observation on 11/30/22, at 7:00 a.m. R33 was lying in bed on his back, his eyes were closed, and he was covered with a yellow blanket from his feet to his mid-chest. - at 7:30 a.m. R33 was observed to lying in the same position, his eyes were closed and he was covered with a yellow blanket from his feet to his mid-chest. R33 was not observed to make any independent changes in position. -at 7:56 a.m. R33 was observed to remain lying in the same position, his eyes were closed and he was covered with a yellow blanket. At that time, NA-B and NA-K entered his room, indicated they were going to assist him with morning cares. At 8:00 a.m. registered nurse manager (NM)-A entered R33's room and indicated she was there to assist with morning cares. NA-B removed the yellow blanket, which revealed R33 wore a hospital gown, gripper socks and both of his heels rested directly on the standard mattress. At that time, NM-A confirmed R33 had a standard mattress with no pressure relieving devices. R33 was assisted to turn to his right side by NM-A who held onto R33's body, while NA-B removed R33's urine soaked soiled incontinent brief. R33 had an open area on his sacrum and redness which completely surrounded the open area. At that time, NM-A stated she was unaware R33 had a pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- At 8:17 a.m. the NM-A assessed and measured R33's sacral pressure ulcer which revealed R33 had a stage two (2) pressure ulcer which measured a surface area of 3.1 centimeters (cm). NM-A stated the redness surrounding R33's stage 2 pressure ulcer was non-blanchable (reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device), on the lower right side of the wound, extending several cm's from the open area. She confirmed R33's non-blanchable skin was indicative of further skin breakdown. NM-A proceeded to cleanse the wound, applied Cavalon Barrier Cream (cream used to help protect and repair the skin of anyone suffering from incontinence), to R33's open area and applied a Cavilon wand (transparent film designed to protect intact or damaged skin from urine, feces, other body fluids, adhesive trauma and friction), to the surrounding redness. -At 8:33 a.m. NM-A picked up R33's right foot, palpated the entire area of his heel (approximately the size of golf ball) and confirmed R33's entire right heel, was completely and significantly boggy (refers to abnormal texture of tissues characterized by sponginess, indicative of a deep tissue injury/unstagable pressure ulcer). NM-A then picked up R33's left heel, which revealed a forming blister with hardened edges, that measured approximately 2.0 cm in length and 3.5 cm in width. NM-A palpated the inside the blister which revealed bogginess. NM-A confirmed R33 had bilateral unstagable (suspected deep tissue injury) pressure ulcers on his heels. NM-A then proceeded to check the rest of R33's skin for any further pressure ulcers and none were found. On 11/30/22, at 9:05 a.m. during an interview with NM-A, confirmed R33 had no pressure ulcers when he was admitted to the facility approximately one month prior. She indicated R33 had been declining in the past few weeks and had required increased assistance. NM-A stated she was not aware R33 had any skin breakdown on his sacrum or heels. NM-A indicated R33 should have been assisted to reposition every two hours, his heels should have been off-loaded and his skin should have been checked weekly for signs of breakdown. On 11/30/22, at 9:16 a.m. during an interview, R33's Certified Nurse Practioner (NP)-A, stated she had met with R33 several times since his admission and was familiar with him. She indicated R23 had experienced a decline in the last few weeks with dizziness, low blood pressures and has had some bloody stools which the facility had been monitoring. NP-A indicated R33 had been in bed more often than when he was first admitted and seemed to prefer to be in his room. NP-A stated she had not been aware R33 had a pressure ulcer on his sacrum, and she was not aware R33 had DTI to his bilateral heels. NP-A indicated she had been notified approximately a week ago R33 had redness on his buttocks, and felt it was due to R33's bowel and bladder incontinence. She indicated barrier cream should have been applied routinely to prevent further breakdown. NP-A stated she had not assessed R33's sacrum at that time. NP-A stated she expected R33's skin to be assessed weekly, and she expected R33 to have pressure relieving interventions in place such as routine repositioning, the use of heel protectors or Prevalon boots to his heels. NP-A confirmed R33's boggy heels were indicative of deep tissue injuries, as they were not able to stage the pressure ulcers since they had not opened yet. On 11/30/22, at 8:10 a.m. during an interview, NA-B indicated R33 required extensive assistance with bed mobility, and used a full mechanical lift for transfers. NA-B stated R33 was always incontinent of bowel, bladder and did not typically use his call light for assistance. She indicated R33 was supposed to be repositioned every two hours and confirmed that morning he had last been checked and changed at approximately 5:00 a.m., a total of 2 hours and 56 minutes from when she entered his room that morning. NA-B stated she was not aware R33 had a pressure ulcer on his buttocks and was not aware of the DTI to his heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 12/1/22, at 8:40 a.m. during an interview, NA-A indicated R33 had required assistance with bed mobility, transfers, and dressing since his admission. She stated R33 was assisted with repositioning and was to be checked and changed every two hours as he was totally incontinent of bowel and bladder. NA-A stated she felt R33 refused assistance with cares frequently and indicated he needed a lot of encouragement to allow staff to assist him. NA-A indicated she was not aware R33 had any pressure ulcers and was not aware of any pressure relieving interventions for his heels. Review of R33's progress notes from 10/31/22, to 12/1/22, revealed the following: - 10/31/22, revealed R33 was seen by NP-A for an initial visit for his admission following a 30 day inpatient hospital stay. The note indicated R33 had been hospitalized with a recent heart attack which required surgical intervention. The note revealed R33 complained of dizziness, had weakness and would have therapy work with him to improve his mobility and ADL function. The note indicated NP-A completed a comprehensive review R33 and identified his skin was intact and free of ulcers. -10/31/22, an admission summary note revealed R33 had declined to have his skin checked and had agreed to have the nurse complete a skin assessment the following day. - 11/11/22, a nursing note revealed R33 had refused a shower, skin check and was sleeping. -11/12/22, a nursing note revealed R33 was in bed all day, required extensive assistance with turning and repositioning, toileting and personal hygiene. Review of R33's medical record lacked any documentation of R33's bilateral heel DTI's. On 12/1/22, at 10:29 a.m. during an interview, the director of nursing (DON) indicated she expected a skin assessment to have been completed when R33's stage two pressure ulcer was first observed on 11/25/22, per the skin note. The DON confirmed R33's Braden scale which was completed upon admission revealed R33 was at minimal risk for skin breakdown. She indicated R33 had declined in the past few weeks related to his medical condition, which the facility had been monitoring. The DON indicated R33 had been in his bed more often than when he was first admitted . The DON confirmed R33's admission MDS incorrectly identified he had a pressure ulcer upon admission, medical record lacked routine skin monitoring and indicated she would expect his skin to be checked weekly. She indicated R33 should have had pressure relieving interventions in place for his heels, to include Prevalon boots and to off-load his heels from the bed as needed. The DON confirmed she was not aware R33 had any pressure ulcers and indicated NM-A had recently returned to the facility and would be implementing weekly wound/skin rounds. On 12/1/22, at 10:44 a.m. during a telephone interview, R33's family member (FM)-A indicated she was not aware R33 had any pressure ulcers and had recently been notified R33 was transferred to the hospital. FM-A stated she would have wanted to be notified of any changes in R33's condition. Review of a facility policy titled, Prevention of Pressure Ulcer Injuries reviewed 9/29/21, revealed it was the purpose of the procedure to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy revealed resident's skin was to be comprehensively assessed upon admission, and should be inspected daily with cares. The policy identified the following prevention strategies; prevention, nutrition, mobility/repositioning, support surfaces and pressure redistribution, device related pressure injuries and monitoring. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled, Pressure Ulcer/Skin Breakdown - Clinical Protocol, revised 7/12/22, identified nursing staff and practioner would assess and document an individuals significant risk factors for developing pressure ulcers. In addition, the nurse should complete a full assessment of newly admitted residents, identify cause of any skin breakdown, implement treatment/management measures and monitoring the effectiveness and healing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R8) residents identified at risk for falls to prevent further falls. Findings include: R8's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderate impaired cognition and had diagnoses which included diabetes mellitus, borderline personality disorder (a mental illness characterized by a distorted self-image, impulsiveness, unstable and intense relationships, and extreme emotions) and depression. Indicated R1 required limited assistance for transfers and extensive assistance for toileting. R8's fall assessment dated [DATE], identified R1 was at high risk for falls due to impaired cognition, medications, and previous falls. R8's fall assessment indicated R8 was incontinent of bladder and required staff assistance with transfers. Review of R8's care plan revised 10/20/22, revealed R8 was at high risk for falls related to immobility and weakness. The care plan revealed fall interventions which included call light in reach, bed in low position at night and a fall mat next to the bed. Review of 8's adverse event reports from 10/13/22, to 11/29/22, revealed the following: -10/13/22, R8 had an unwitnessed fall at 10:30 p.m. The event report identified staff found R8 on the floor The report revealed another resident informed staff R8 had self transferred from her bed and fell on to the floor. The report identified R8 had been sent to the emergency room (ER) to be evaluated related to R8 having an unwitnessed fall. The report further reveled R8 had not received any injuries from the fall. The report lacked immediate interventions to prevent future falls. -10/17/22, R8 had a witnessed fall at 9:30 p.m. event report revealed R8 had call light on and when staff entered the room R8 was standing by her bed and was starting to sit down so staff lowered R8 to the floor. The report lacked immediate interventions to prevent future falls. -10/18/22, R8 had an unwitnessed fall at 4:20 a.m. The report revealed R8 was found on the floor next to her bed. The report revealed R8 stated I don't like this bed it is possessed I'm not going back. The report revealed an immediate intervention to place a fall mat on the floor next to the bed. During an observation on 11/28/22, at 7:00 p.m. R8 was lying in bed. No fall mat next to the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/29/22, at 3:12 p.m. R8 was lying on her stomach in bed and slid to the floor to her knees next to the bed. No fall mat next to R8's bed. Surveyor alerted licensed practical nurse (LPN-A) that R8 was on the floor. When LPN-A arrived R8 had gotten to a standing position and was attempting to get back into bed so LPN-A assisted R8 into bed. R8 was assessed by nurse practioner (NP) and was sent to the ER for bilateral knee pain. X-ray report dated 11/29/22, revealed R8 had a contusion to her right knee. During an interview on 11/29/22, at 3:22 p.m. LPN-A indicated R8 was suppose to have a fall mat on the floor next to her bed due to R8 frequently puts herself on the floor and has had falls out of bed. LPN-A confirmed R8 did not have a fall mat next to the bed prior to her fall. During an interview on 11/30/22, at 1:01 p.m. nursing assistant (NA-D) indicated R8 has placed herself on the floor and has had some falls. NA-D further indicated she had not been aware R8 was supposed to have a fall mat on the floor next to the bed and stated she had never seen a mat on the floor next to R8's bed. During an interview on 11/30/22, at 1:13 p.m. clinical manager (CM) stated R8 has placed herself on the floor and has had falls out of bed. CM confirmed R8 was to have a fall mat on the floor next to her bed. CM confirmed there was no fall mat next to R8's bed at the time of the fall. During an interview on 11/30/22, at 1:29 p.m. director of nursing (DON) stated R8 had placed herself on the floor and has had falls. DON verified R8 was to have a fall mat next to her bed. DON confirmed R8 had not had a fall mat next to her bed during her fall on 11/29/22. DON stated her expectation was R8's fall interventions including the fall mat would have been implemented. A facility policy titled Falls and Fall Risk, Managing reviewed 10/22, indicated according to the MDS, a fall was defined as: unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. The policy indicated in conjunction with the attending physician , staff would identify and implement relevant interventions, to try to minimize serious consequences of falling.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on interview and document review, the facility failed to ensure newly admitted residents received 30 day physician visits for the first 90 days for 1 of 1 residents (R22) reviewed for physician visits. In addition, the facility failed to ensure long term residents received routine physician visits (every 60 days) for 1 of 3 residents R2 reviewed for routine physician care. Findings include: R22 Review of R22's face sheet indicated R22 was admitted on [DATE], with a diagnosis of unspecified severe protein calorie malnutrition. R22's medical record indicated R22 was seen by a nurse practioner (NP) on 10/6/22, 10/14/22, and 11/17/22. The record lacked documentation R22 had been seen by a physician during her stay at the facility. R2 Review of R2's face sheet indicated R2 was admitted on [DATE], with a diagnosis of acute bronchitis. R2's medical record indicated R2 was seen by a physician for routine rounds on 6/2/22, and 11/21/22. The medical record lacked documentation of an alternating physician visit between the NP visits which should have occurred in 10/2022. The visit was longer than a month overdue. During an interview on 12/1/22, at 11:00 a.m. clinical manager (CM) stated new admissions were required to be seen by a physician every 30 days for the first 90 days and then at least every 60 days thereafter. CM indicated a nurse practioner (NP) can alternate visits under the direction of a physician. CM stated it was the registered nurses (RN's) and the health unit coordinator (HUC) who were responsible for setting up physician rounds and confirmed R2 and R22 had missed being seen by a physician within the required time frames. During an interview on 12/1/22, at 11:10 a.m. director of nursing (DON) confirmed the requirement was for residents be be seen by a physician at least every 30 days for the first 90 days after admission and alternating every 60 days with a NP thereafter. DON stated her expectation was the regulation would have been followed accordingly. A facility policy titled Physician visit policy reviewed 12/21, indicated the medical care of each resident was supervised by a physician. The policy further identified the residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter per regulations.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34088 Based on interview and document review, the facility failed to ensure resident blood pressure medication was held as ordered by the physician for 1 of 1 resident (R23) reviewed for unnecessary medications and who had parameters to to hold blood pressure medication based on his blood pressure results. Findings include: R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had diagnoses which included hypertension, congestive heart failure (CHF), hyperkalemia (high potassium) and anemia. Identified R23 had intact cognition and was independent with his activities of daily living (ADL's). R23's Order Summary Reports signed 11/1/22, identified an order for Lisinopril (medication used to lower blood pressure) tablet five (5) milligrams (mg) by mouth one time a day for hypertension, hold for SBP (systolic blood pressure (top number)) less than 90 or DBP (diastolic blood pressure (bottom number)) less than 60. Review of R23's Medication Administration Record (MAR) from August 2022, through November 2022, revealed the following: - August 2022, MAR revealed on 8/19/22, R23's DBP was below 60, however his Lisinopril was not held. - September 2022, MAR revealed on 9/10/22, and 9/14/22, R23's DBP was below 60, however his Lisinopril was not held. - October 2022, MAR revealed on 10/13/22, and 10/22/22, R23's DBP was below 60, however his Lisinopril was not held. - November 2022, MAR revealed on 11/13/22, 11/16/22, and 11/25/22, R23's DBP was below 60, however his Lisinopril was not held. During an interview on 11/30/22, at 1:11 p.m. licensed practical nurse (LPN)-A stated R23 had an order to hold his Lisinopril based upon what his blood pressure was. She indicated she checked R23's blood pressure prior to administering his Lisinopril and if his DBP was below 60 she would have held the medication. LPN-A indicated she had not had to hold R23's Lisinopril due to a low blood pressure. During an interview on 12/1/22, at 11:18 a.m. registered nurse (RN)-A indicated he would have checked R23's blood pressure prior to giving him his blood pressure medication, and would hold the medication based on the parameters identified in the order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/22, at 1:41 p.m. the director of nursing (DON) confirmed R23's physician orders directed nursing staff to check R23's blood pressure prior to being administered his Lisinopril. The DON confirmed R23's physician orders had parameters to hold R23's Lisinopril when his blood pressure was low. The DON stated she would have expected the medication to be held as ordered. During a telephone interview on 12/1/22, at 1:38 p.m. the facility's consulting pharmacist (CP) stated she had recently reviewed R23's electronic medical record (EMR), and on 11/28/22, she had identified his Lisinopril had not been held as ordered on several occasions. The CP indicated she had reviewed R23's EMR since his admission in August 2022, and had not identified any concern with his Lisinopril being given when his blood pressure was outside of the parameters prior to her November review. The CP stated she would expect R23's Lisinopril to have been held when his DBP was below 60. She indicated R23's blood pressure could go too low if he received the medication when his BP was below the recommended parameters. Review of a facility policy titled, Medication Administration reviewed 5/2022, revealed medication should have been administered in a safe and timely manner and as prescribed. The policy identified medications must be administered in accordance with the orders. The policy identified vital signs (which would include blood pressure) must have been checked prior to administering medication when ordered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to complete timely tardive dyskinesia (TD) screenings (assessment for involuntary movements) for 1 of 3 residents (R17) reviewed for unnecessary medications, who received a routine dose of an antipsychotic medication. Findings Include: R17's significant change Minimum Data Set (MDS) dated [DATE], identified R17 had moderate cognitive impairment with disorganized thinking that fluctuated and had diagnoses which included: dementia, depression and diabetes mellitus. Identified R17 required extensive assistance with transfers, dressing, personal hygiene and toilet use. Indicated R17 had verbal behavioral symptoms daily, and rejected cares four to six days. Identified R17 received antipsychotic medication six of the last seven days routinely. Review of R17's Care Area Assessment (CAA) dated 10/26/2, identified R17 received antipsychotic medication. Identified an actual psychotropic drug use problem/need. R17's CAA identified R17 took the medications for depression and dementia with behavioral disturbances and a referral to psych was warranted. R17's care plan revised 7/26/22, identified R17's activities of daily living (ADL) self-care needs were related to confusion and limited mobility and R17 required extensive assistance with bed mobility, bathing, dressing and personal hygiene. R17's care plan identified R17 had impaired cognitive function/dementia or impaired thought processes, and to administer medications as ordered and monitor/document for side effects and effectiveness. R17's care plan indicated R17 used anti-anxiety medications and antidepressant medication however lacked identification of R17's antipsychotic medication use. Review of R17's Order Summary Report signed 10/18/22, identified the following: -Seroquel 25 milligram (mg) give 0.5 tablet by mouth at bedtime related to major depressive disorder, order date 10/17/22. -Seroquel 25 mg give 0.5 tablet by mouth every six hours as needed for agitation, order date 10/17/2. Review of R17's medication administration record (MAR) dated 11/1/22, to 11/29/22, identified the following: -Seroquel 50 mg, give 50 mg by mouth two times a day, related to major depressive disorder, single episode unspecified, encephalopathy unspecified, start date 10/24/22, end date 11/2/22. -Seroquel 50 mg, give 75 mg by mouth two times a day for depression, start date 11/3/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's medical record identified the record lacked a tardive dyskinesia assessment had been completed prior to start of antipsychotic medication use. During a telephone interview on 12/1/22, at 1:32 p.m. pharmacist consultant (PC)-A confirmed she was aware R17 did not have an tardive dyskinesia assessment completed and indicated her usual process was to allow the facility about a month to complete the assessment. PC-A stated she would expect tardive dyskinesia assessments to be completed on admission, every six months and with a medication change. PC-A indicated she had made a recommendation for the facility to complete a tardive dyskinesia assessment on 11/28/22. During an interview on 11/30/22, 3:05 p.m. director of nursing (DON) confirmed R17 did not have an Abnormal Involuntary Movement Scale (AIMS) (an assessment used to assess tardive dyskinesia) completed. During a follow up interview on 12/1/22, at 1:49 p.m. DON indicated her expectation was for staff to complete an AIMS assessment upon admission and with any medication changes. DON confirmed R17 should have had one completed when his Seroquel was started, to get a baseline tardive dyskinesia assessment. The facility policy titled Antipsychotic Medication Use, undated, identified nursing staff should monitor and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician which included: tardive dyskinesia. The policy failed to identify what assessment would be used and frequency to monitor for tardive dyskinesia.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47497 Based on observation, interview, and document review, the facility failed to maintain a clean and sanitary condition of the kitchen floor, ceiling ventilation system, walk in cooler and freezers to promote sanitation in the kitchen. In addition, the facility failed to maintain the water and ice machine to prevent potential contamination for all 39 of 39 residents who currently resided in the facility. Findings include: On 11/28/22, at 1:05 p.m. during an initial tour of the facility kitchen area with dietary manager (DM) the following concerns were identified: Floor: - the entire kitchen floor coverings and directly underneath the freezers, coolers, cabinets, stove area, and counter top food preparation areas were noted to be sticky and dirty. In addition, the floor coverings had several dust particles, dirt particles and dried food particles present on the entire surface of the kitchen floor. Walk in cooler: - upon entering the walk in cooler, the ceiling had visible droplets of water hanging and was dripping onto the floor. The floor had a large puddle of water on the walk way from the ceiling which was observed to be continuously dripping water. Chest freezer: - the chest freezer had a heavy build up of frost around the upper part of the freezer which extended all the way around the back and the sides of the freezer. The bottom of the freezer had large amounts of debris and food particles on the bottom of the freezer and was unclean. Inside the chest freezer was a half of a box of carmel rolls, which was uncovered, exposed to the elements and had freezer burn present on some of the carmel rolls. Meat freezer: - The bottom of the freezer had large amounts of debris and food particles present and was unclean. Ceiling vent: - the large ceiling vent located in the middle of the kitchen by the clean dishes had moderate buildup of gray/brown dust and dirt particles on the grates of the vent. Ice/water machine: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- the water and ice machine located in the main dining room of the facility had encrusted black substance around the water dispenser. On 11/30/22, at 9:11 a.m. during the kitchen tour of the facility kitchen area with DM the following concerns were identified: Floor: - the entire kitchen floor coverings and directly underneath the freezers, coolers, cabinets, stove area, and counter top food preparation areas were noted to be sticky and dirty. The floor coverings had several dust particles, dirt particles and dried food particles present on the entire surface of the kitchen floor. Walk in cooler: - upon entering the walk in cooler, the ceiling had visible droplets of water hanging and was dripping onto the floor. The floor had a large puddle of water on the walk way from the ceiling which was observed to be continuously dripping water. Chest freezer: - the chest freezer had a heavy build up of frost around the upper part of the freezer which extended all the way around the back and the sides of the freezer. The bottom of the freezer had large amounts of debris and food particles present and was unclean. Inside the chest freezer was a half of a box of carmel rolls, which were uncovered, exposed to the elements and had freezer burn present on some of the carmel rolls. Meat freezer: - The bottom of the freezer had large amounts of debris and food particles on the bottom of the freezer and was unclean. Ceiling vent: - the large ceiling vent located in the middle of the kitchen by the clean dishes had moderate buildup of gray/brown dust and dirt particles on the grates of the vent. Ice/water machine: - the water and ice machine located in the main dining room of the facility had encrusted black substance around the water dispenser. Review of daily cleaning schedule undated, indicated staff were to sweep/mop the kitchen floor and the walk-in cooler. Review of monthly cleaning schedule dated 2022, indicated staff were to clean behind and under major appliances, wash vents and wipe down walk in cooler. (continued on next page)

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	245052	A. Building B. Wing	12/01/2022

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DM confirmed the above findings during the kitchen tour and indicated the above areas should be cleaned daily. During an interview on 11/30/22, at 9:32 a.m. the DM confirmed the above findings and indicated dietary staff had daily cleaning assignments, although the assignments had not been completed on a routine basis. The DM confirmed the walk in cooler had been leaking water since last March 2022. DM verified he had notified the maintenance director and administrator of the leaking cooler at that time and was directed to deal with it. The DM indicated he had not been trained on how/when to defrost the freezers and verifed it had been about seven months since the chest freezer had been defrosted and cleaned. The DM indicated he would expect staff to complete their daily check lists for cleaning, sweeping/mopping the floors and maintaining and cleaning the freezers. The DM stated he would expect the walk in cooler to be fixed and maintained. During an interview on 11/30/22, 10:30 a.m. the maintenance director (MD) confirmed he had been notified of the leak in the walk in cooler about six months ago or longer. The MD indicated he had notified the owner of the leaking walk in cooler and was told he would seek contractors to repair the leak in the cooler. The MD stated he was not certain who was responsible for maintaining and cleaning the kitchen equipment and ice/water machine. Review of facility policy titled, Cleaning and Sanitation of Dining and Food Service Areas undated, indicated the nutrition and food service staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. On 11/30/22, a policy for cleaning ice/water dispenser was requested however was not provided.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 34088 Based on interview, and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities, develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 39 residents which resided in the facility. Findings include: The facility's QA program lacked a process for reporting, investigation, in depth analysis, improvement activities, and action plans to address deficient practices. The facility lacked a system for documentation demonstrating the development, implementation and evaluation of corrective actions or performance improvement activities. During an interview on 12/1/22, at 3:05 p.m. the director of nursing (DON) stated the facility's QA committee and processes were currently undergoing some changes which included adding a QAPI director who oversees the committee and projects in the future. The DON indicated at the current time, she felt the facility lacked a formal QA process and the facility was reactive vs pro-active in identifying and addressing quality concerns. The DON indicated the facility was currently working on a couple QA projects which included call light response time, falls, staff general orientation and reporting to the state agency. She indicated the current mechanism to obtain information for current projects was from information shared during morning report which was held Monday through Friday by facility leadership. The DON indicated there was no formal method of monitoring, data collection, or analysis of the aforementioned QA projects in place to ensure resident needs were consistently met. The DON was not able to provide evidence of actions plans with measurable goals and monitoring/auditing and evaluation of the identified projects. The facility provided an undated, 17 page document titled, QAPI Meeting Agenda, MRRC, which was identified as the facility's most recent QA meeting minutes. The QA meeting minutes identified the facility's most recent recertification survey was conducted on 8/17/21, however, the facility's most recent recertification surveys had been conducted on 6/16/22, and 12/22/21. The form listed data and information regarding infection however, the form listed staff responsible for infection control was not identified as an employee of the facility. Further, the form revealed resident council meeting had been held on June 27, 2022, listed an activity director who was not listed as an employee of the facility. The document revealed several sections for outstanding and current items which included topics of falls, OHFC (Office of Health Facility Complaints) and staff competency-training. However, the form lacked accurate, thorough data, method or means to track the data, comprehensive analysis, trends or actions. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled, QAPI reviewed 12/5/19, identified the purpose of the policy was the facility was to maintain a Quality Assurance and Performance Improvement (QAPI) Committee for continuous quality improvement of overall performance. The policy identified the committee was to monitor, sustain operational performance in clinical and non-clinical systems through self-identification and improvement areas where opportunities for improvement have been identified. The policy identified the critical functions of the QAPI committee included; review of operations, identify opportunities for improvement, prioritize opportunities for improvement, determine root cause, implement performance improvement projects. The policy identified the committee would conduct performance improvement projects, identify action items, collect and analyze data and implement corrective action.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34088 Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee met on a quarterly basis throughout the past calendar year to work on improving patient care and correcting any identified areas of concern. This had potential to affect all 39 residents residing in the facility. Findings include: Review of an undated QAPI (Quality Assurance Performance Improvement) Meeting Agenda [NAME] RHCC identified several members of the committee had been present at the meeting, however lacked documentation the infection preventionist had been present. The agenda did not identify when the facility's committee had last met. During an interview on 12/1/22, at 3:05 p.m. the director of nursing (DON) indicated the facility's QA committee had met in July or August of 2022, though was unsure of the date. The DON indicated she was unsure of when the facility's QA committee had met prior and stated they planned to be meeting quarterly going forward. The DON stated the facility recently hired a QA director who would be overseeing the facility's QAPI program and ensure the committee met quarterly. Review of facility policy titled, QAPI reviewed 12/5/19, identified the purpose of the policy was the facility to maintain a Quality Assurance and Performance Improvement (QAPI) Committee for continuous quality improvement of overall performance. The policy identified the committee was to meet monthly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37905 Based on interview and document review, the facility failed to maintain an on-going infection control program, which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility, including identification of any patterns in residents, locations or pathogens in real time to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 39 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted on 11/30/22, at 1:04 p.m. with registered nurse infection preventionist (RNIP)-A. The infection logs included the following columns: resident name, room number, admitted , type of infection, surveillance definition met, symptoms, onset date, antibiotic name, class, dose, route, frequency provider, antibiotic start date, antibiotic end date, transmission on based precautions required, and date symptoms resolved. The infection logs lacked necessary documentation for adequate surveillance of illnesses in the facility which should include: identification of all illnesses tracked, diagnostics preformed, test dates, type of tests, specimen source, results, if antibiotic resistant organism, time outs preformed, and dates resolved were not identified. A staff surveillance log was requested to determine possible communicable diseases in the facility including COVID-19, however was not provided. During an interview on 11/30/22, at 1:04 p.m. review of the facility's infection control plan and surveillance log was completed with RNIP-A. RNIP-A confirmed no surveillance, tracking or trending had been completed since October 2022, and indicated she was not provided the time required to maintain the infection control program. RNIP-A confirmed no diagnostic testing was tracked on her surveillance logs, or time outs, or infection results. RNIP-A confirmed the surveillance log was not kept up to date and stated no other staff member was responsible for tracking infections in the facility. RNIP-A verified she had not been tracking viral or other illnesses not treated with anti-infective agents. RNIP-A confirmed the facility residents had viral or other illnesses not treated with anti-infective agents occasionally. Additionally, RNIP-A confirmed she had not tracked any of the staff illnesses, however indicated the facility had no COVID-19 positive residents or staff in the past four weeks. During an interview on 12/1/22, at 11:10 a.m. DON confirmed RNIP-A was responsible for tracking all infections in the facility. DON indicated she was not aware of how the facility should conduct their surveillance of infections in the facility however stated she was aware the facility was expected to track all illnesses. DON confirmed not all necessary components were being tracked with the infection control surveillance program. The facility policy titled Infection Control Policy, undated, identified a system of surveillance was designed to identify possible communicable diseases or infections before they could spread to other persons in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Surveillance For Infections, reviewed 1/18/22, identified the infection preventionist would conduct ongoing surveillance for health care associated infections and other epidemiological significant infections that had substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The policy identified the infections would include routine surveillance which would include evidence of transmissibility in a healthcare environment, processes and procedures that prevent or reduce the spread of infection, and pathogens associated with serious outbreaks. The policy indicated the surveillance should include any or all of the following information to help identify possibly indicators of infections which included; laboratory records, including culture result, and multi-drug-resistant reports that required immediate attention. The policy identified for residents with infections, to collect the following data which included: identifying information, diagnoses, date of onset, infection site, pathogens, invasive procedures, and treatment measures. The policy identified targeted surveillance should use facility-created tools for a daily recording on individual infection report, monthly collection from individual reports and monthly summarization of data by unit and pathogen.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R24, R5, R19) were offered or received pneumococcal and/or influenza vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC recommendations, Recommended Adult Immunization Schedule for ages [AGE] years or older, United States, 2022, located at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#table-age, identified the following: -Adults age 19 of age or older should receive the influenza vaccination annually. -Adults [AGE] years of age or older should receive 1 dose PCV15 followed by PPSV23 or 1 dose PCV20. R24, age 74, was admitted to the facility on [DATE]. R24's medical record lacked documentation a pneumococcal or influenza vaccination was offered or received. R5 age 86, was admitted to the facility on [DATE]. R5's medical record lacked documentation a pneumococcal or influenza vaccination was offered or received. R19 age 72, was admitted to the facility on [DATE]. R19's medical record lacked documentation a pneumococcal or influenza vaccination was offered or received. During an interview on 12/1/22, at 3:34 p.m. director of nursing (DON) confirmed her expectation was for all residents on admission to be offered the influenza and pneumococcal vaccinations if eligible. DON confirmed she would expect the facility would follow their policies of vaccinations offered and to document results. DON confirmed she was aware R19 had refused all immunizations however was not certain if R19 had been provided education or offered the vaccinations. The facility policy titled Vaccination Of Residents reviewed 1/18/22, identified all residents would be offered vaccines that aid in preventing infectious diseases unless the vaccine was medically contraindicated or the resident had already been vaccinated. The policy identified certain vaccines, example influenza and pneumococcal vaccines, may have been administered per the physician-approved facility protocol (standing orders) after the resident had been assessed by the physician for medical contraindications for each vaccine. The policy identified the resident's attending physician must provide a separate written order for any other vaccination, and such orders would be recorded in the resident's medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Pneumococcal Vaccine, undated, identified all residents would be offered pneumococcal vaccines to aid in prevention of pneumococcal infections. The policy identified prior to admission, residents would be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated would be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident had already been vaccinated. The policy indicated before receiving the vaccine, the resident or legal representative would receive information and education regarding the benefits and potential side effects of the vaccine. The policy identified residents had the right to refuse vaccination, and if refused, appropriate entrees would be documented in each residents' medical record indicating the date of the refusal. The facility policy titled Influenza, Prevention, And Control of Seasonal, undated, identified the infection preventionist would promote and administer seasonal influenza vaccine and unless contraindicated, all residents would be offered the vaccine.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to provide Centers for Disease Control And Protection (CDC) recommended COVID-19 testing of 2 of 2 residents (R238, R89) newly admitted to the facility during time when community transmission rates were high. This practice had the potential to affect all 39 residents and staff who resided at the facility. Findings Include: The CDC COVID-19 Integrated County View community transmission rate as of 11/16/22, was high. The Centers For Medicare And Medicaid Services (CMS) QSO-20-38-NH revised 9/23/22, identified to enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities were required to test residents and staff based on parameters and frequency set forth by the health and human services (HHS) secretary. The memo indicated testing information of residents who were newly admitted or readmitted to the facility and those who left the facility for 24 hours or longer. The memo referred to the managing admissions and residents who left the facility section of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic webpage. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, revised 9/23/22, included managing admissions and residents who left the facility section which identified: Testing was recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. In general, admissions in counties where Community Transmission levels were high should have been tested upon admission. R238 Review of R238's medical record identified R238 was admitted [DATE]. Review of R238's hospital COVID Screening and Lab Report identified R238 had a SARS-CoV-2 completed 11/15/22, with results not detected. R238's medical record lacked further testing as recommended by CDC for residents newly admitted to the facility in an area of high community transmission rate. R89 Review of R89's medical record identified R89 was admitted [DATE]. Review of R89's hospital COVID Screening and Lab Report identified R89 had a SARS-CoV-2 completed 11/18/22, with results not detected. R89's medical record lacked further testing as recommended by CDC for new residents newly admitted to the facility in a an area of high community transmission rate. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/1/22, at 3:34 p.m. director of nursing (DON) indicated most residents were tested prior to entering the facility. DON confirmed R238 and R89 had not completed all necessary COVID-19 testing. DON stated she would expect newly admitted residents would be tested on day one, three and five to prevent COVID-19 to be spread in the facility. The facility policy titled COVID-19 Facility Guidelines, revised 11/2/22, identified residents would be tested per state and local guidance and updated on their results in a timely manner. The facility policy titled F886, revised 4/27/22, identified to enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities were required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to ensure COVID-19 vaccinations were offered and received for 1 of 5 resident (R19) reviewed for COVID-19 vaccination status. Findings Include: R19 age 72, was admitted to the facility on [DATE]. R19's medical record lacked documentation a COVID-19 vaccination was offered or received. On 12/1/22, at 3:34 p.m. director of nursing (DON) indicated she would expect COVID-19 vaccination would be offered when residents were admitted . DON confirmed R19's medical record lacked documentation a COVID-19 vaccination had been offered. DON indicated she had been aware R19 had refused all vaccinations, however would expect nursing staff to follow the facility's policy regarding vaccinations. The facility policy titled Vaccination Of Residents reviewed 1/18/22, identified all residents would be offered vaccines that aid in preventing infectious diseases unless the vaccine was medically contraindicated or the resident had already been vaccinated. The policy further identified certain vaccines, may be administered per the physician-approved facility protocol (standing orders) after the resident had been assessed by the physician for medical contraindications for each vaccine. The policy identified the resident's attending physician must provide a separate written order for any other vaccination, and such orders would be recorded in the resident's medical record.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 37905 Based on interview and document review, the facility failed to ensure abuse and/or vulnerable adult (VA) training was completed upon hire as directed by facility policy for 1 of 1 employees (registered nurse infection preventionist (RNIP)-A) identified as an alleged perpetrator (AP) in an allegation of potential verbal abuse. Findings Include: During an interview on 11/28/22, at 2:30 p.m. R13 stated he had made a report to a nurse, unidentified, who had filed a report with the facility regarding concerns with registered nurse Infection preventionist (RNIP)-A who had mistreated him and placed something in his water. Review of the SA reports and grievance log provided by the facility lacked documentation of a report filed related to R13's allegation. On 11/28/22, at 7:28 p.m. surveyor reported to administrator R13 indicated he had been mistreated by a staff member and was afraid of her. Administrator confirmed no SA report had been filed regarding R13's allegation and stated he would interview R13. During an interview on 11/30/22, at 7:45 a.m. business office manager (BOM)-A confirmed RNIP-A started employment at the facility on 2/8/22. BOM-A indicated RNIP-A had been transferred to the facility from a sister company facility where she began work on 7/6/20. Review of RNIP-A's personnel file lacked documentation abuse and/or vulnerable adult (VA) training had been completed since RNIP-A began work in the facility on 2/8/22. During an interview on 11/30/22, at 11:00 a.m. RNIP-A indicated she had completed abuse prevention and vulnerable adult training at the previous facility, however could not remember how long ago. During an interview on 11/30/22, at 3:45 p.m. director of nursing (DON) confirmed RNIP-A had not completed abuse prevention training at the facility. DON indicated she believed since RNIP-A transferred from a sister facility, the training was not required. The facility policy titled Abuse Prevention Program revised 1/22/22, identified comprehensive policies and procedures had been developed to aid their facility in preventing abuse, neglect or mistreatment of their residents. The policy indicated the facility program mandated a staff training/orientation program that included such topics as abuse prevention, identification and reporting of abuse, stress management, dealing with violent behavior or catastrophic reactions, etc. (and so on).