STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. Building B. Wing	01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview and document review the facility failed to assist with ambulation for 1 of 3 residents (R47) reviewed for activities of daily living (ADL). Findings include: R47's quarterly Minimum Data Set (MDS) dated [DATE], identified R47 was cognitively intact and required assist of two staff for activities of daily living including transfers and did not walk in the room or corridor. R47 used a wheelchair for locomotion and had no functional limitation in range of motion of the upper or lower extremities. Diagnoses included acute transverse myelitis (a demyelinating disease of central nervous system), and transient ischemic attack (commonly called a mini-stroke; a temporary blockage of blood flow to the brain). R47's care plan dated 6/15/22, directed staff to ambulate R47 to the dining room with assist of 1 or 2 staff and walker three times daily. The facility undated nurse aide care sheet directed staff to walk R47 daily. R47's therapy orders were requested and not received. The facility Therapy Lite Assessment (Therapy and Restorative Minutes) Results dated 11/10/22 through 1/2/23, identified R47's total walking minutes and total walking distance was 0. The restorative therapy orders were requested but not provided. During interview on 1/9/23, at 1:44 p.m. R47 stated she was recently discharged from therapy and wanted staff to walk with her to lunch. R47 stated the last time she walked was on 1/6/22. During interview on 1/12/23, at 12:23 p.m. the physical therapist (PT) stated when R47 was discharged from therapy, orders were written for nursing staff to ambulate R47 to meals. The orders were written for nursing staff to complete the task because she knew the restorative nurses were not always working. The PT stated the nursing staff knew and should be walking R47. During interview on 1/12/23, at 1:40 p.m. nursing assistant (NA)-B stated staff were supposed to walk with R47 every day to lunch. NA-B did not walk R47 because the resident was not on her care group. (continued on next page)

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/12/23, at 1:51 p.m. NA-G stated R47 was on her care group and did walk a few steps to and from the bed and wheelchair but did not walk to the bathroom or elsewhere in the room or outside of her room. It was on the care sheet to walk R47 every day but did not identify the frequency or distance and R47 did not ask, nor had she offered to walk R47 farther. During interview on 1/12/23, 2:14 p.m. NA-I stated R47 wanted to walk to get stronger and the last time NA-I walked with R47 was on 1/6/23, to the dining room for evening meal. During interview on 1/12/23, at 2:19 p.m. registered nurse (RN)-A stated she or another staff updated resident care plans and NA care sheets. Nursing staff were aware they were supposed to walk R47 to meals. RN-A stated she expected staff to ambulate R47 as ordered by therapy and per the NA care sheet. During interview on 1/12/23, at 3:52 p.m. the director of nursing (DON) stated R47 recently was discharged from therapy with orders for staff to ambulate resident to meals. Staff was supposed to ambulate resident 1 to 3 times per day and she expected staff to complete the task. The facility's undated Walk to Dine Ambulation Program identified the program to promote a more homelike and enhanced dining experience for residents, meanwhile maintaining their strength and ambulation abilities. The program included resident encouragement to walk, staff monitoring of distance and/or time walked, monitoring participation and if declined, offering another time during the day.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview, and document review the facility to comprehensively assess, develop interventions and ensure consistent clinical monitoring was completed for 3 of 3 residents (R53, R36, R4) who had experienced a change in condition. his resulted in actual harm for R53, who was hospitalized with sepsis and expired. Findings include: R53's quarterly Minimum Data Set (MDS) dated [DATE], identified R53 was cognitively intact, diagnosis included diabetes mellitus type 2, and required assist with activities of daily living (ADL's). R53's undated face sheet, identified diagnoses including history of clostridium difficile (C.diff - an infection in the colon which symptoms including diarrhea, belly pain and fever), diarrhea and nausea with vomiting. R53's care plan dated [DATE], directed staff to monitor R53 for changes in abilities, report loose foul-smelling stools and to monitor stool consistency. R53's Medication Administration Record (MAR) dated [DATE] through [DATE], identified the following: - Staff monitored R53's daily fluid restriction of ,d+[DATE] cc although the total daily fluid intake was not documented. - R53's daily weight was documented all but four days and ranged from 203 lbs on [DATE], to 207.5 lbs on [DATE]. On [DATE] through [DATE], and on [DATE], R53's vital signs (blood pressure, pulse, oxygen saturation (O2 sats), respirations and temperature) was documented at least once daily. Staff had not documented vital signs from [DATE], [DATE], or [DATE] through [DATE]. [DATE] evening shift: ,d+[DATE], R20, O2 sats 97% RA, P88, T 97.7F [DATE] evening shift: ,d+[DATE], R20, 99% RA, P88, T 98.6F [DATE] evening shift: ,d+[DATE], morning shift: ,d+[DATE], R20, 99% RA, P 97, T 97.5F, [DATE] evening shift: ,d+[DATE], R20,99% RA, P 92, T 97.2F, [DATE] evening shift: ,d+[DATE]. R20, 99% RA, P113, T 97.8F, [DATE] evening shift ,d+[DATE]. R20, 93% RA, P93, T 98.2F, [DATE] evening shift ,d+[DATE], R18, 91% RA, P 100, T 97.7F, [DATE] evening shift ,d+[DATE], R20, 97% RA, P84, T 97.9F, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] morning shift: ,d+[DATE], other VS not documented - R53's blood pressure was not documented on [DATE], [DATE] or [DATE] through [DATE]. - R53's Respirations were not documented from [DATE] through [DATE]. - R53's O2 sats were not documented from [DATE] through [DATE] - R53's pulse or temperature were not documented from [DATE] through [DATE]. - Medication(s) including Loperamide (medication used to decrease the frequency of diarrhea) as needed four times daily was administered and documented as not effective on [DATE] and [DATE]; administered with no effectiveness documented on [DATE]; and administered and documented as effective on [DATE], [DATE], [DATE]. - Gastrointestinal (GI) distress including nausea, vomiting or abdominal pain was documented on [DATE], [DATE], and [DATE]. Specific symptom(s), severity or frequency were not documented. - Body aches or headaches on [DATE], [DATE], [DATE], and [DATE] were documented but specific symptom(s) were not. R53's pain rating was documented on [DATE] as #,d+[DATE], and on [DATE] was #, d+[DATE]. R53 had received Acetaminophen 650 mg on [DATE] and [DATE]. R53's Progress Notes dated [DATE] through [DATE], included the following: - On [DATE], R53 requested imodium for loose stools. Effectiveness was not documented. - On [DATE], R53 complained of sore throat, feeling tired and not able to smell very good. R53 was afebrile and had a negative rapid COVID test. - On [DATE], at 5:00 a.m. R53 had a low blood sugar of 31. Snacks were provided, and blood sugar recheck at 5:45 a.m. was 145. - On [DATE], at 2:05 p.m. note stating res is being transferred to hospital with diagnosis of sepsis. - On [DATE], at 2:06 p.m. change of condition note documented stating R53 was in the dining room for breakfast, then went back to room and resident started complaining of not feeling well. Vitals sign's were completed showing a BP: ,d+[DATE]. R53 was having a difficult time with formulating words and sentences and had complaints of chest pain. Ambulance was called and R53 sent to the emergency department (ED). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R53's emergency department (ED) record dated [DATE], identified R53 presented to the ED for evaluation of increased fatigue and lethargy. The ED medical doctor (ED MD) identified R53 was ill-appearing, toxic appearing, was tachycardic with heart rate of ,d+[DATE], and shallow respirations at 30. Treatments included intravenous (IV) fluids, Levophed (IV medication used to treat life-threatening low blood pressure), panculture (testing of the blood, urine, sputum, or stool to identify infection), and IV antibiotics. The final diagnoses included sepsis due to unspecified organism, unspecified whether acute organ dysfunction present and the plan had been to transfer R53 to another facility for critical care management. R53's hospital progress notes identified the following: - [DATE], R53 presented to the ED due to feeling weak, lethargic, and decreased blood pressure. R53 had diarrhea for about a week, dysuria (painful urination), and abdominal pain. There was abnormal lab work and CT (medical imaging tests that take pictures of selected areas inside the body) scans. Diagnoses included septic shock due to a combination of UTI and colitis as well as acute kidney injury, anemia, low potassium, and low magnesium. At 6:25 p.m. the provider addend the progress note and included an additional diagnosis of acute respiratory failure with treatment including 12 liters of oxygen, additional antibiotic for potential atypical pneumonia and one dose of Lasix (medication used to prevent the body from absorbing too much salt and allows the salt to be passed out of the body through the urine). - [DATE], continue Levophed (medication used to treat life-threatening low blood pressure that can occur with certain medical conditions), continue IV antibiotics and continue oral antibiotics. - [DATE], continue Levophed and antibiotics. At 5:34 p.m. the provider addend the progress note and identified throughout the day R53 had not produced any urine and required increased oxygen resulting in multiorgan system failure. - [DATE], R53 was non-responsive, on bipap (a type of ventilator that helps with breathing), not producing urine, was acidotic (a medical condition in which too much acid is produced in the body and/or the kidneys cannot remove enough acid through the urine. The medical condition may lead to confusion, shock or even death), had fluid overload and prognosis was very poor. The provider discussed with family and decided on comfort cares and no further escalation of treatment. R53's hospital discharge summary dated [DATE], identified R53 continued to decline and expired at 12:53 a.m. During interview on [DATE], at 7:43 p.m. registered nurse (RN)-A stated she was not familiar with R53. On [DATE], at 7:45 p.m. during joint interview with RN-C and RN-D, who is also the infection preventionist, RN-D stated R53 was sickly, was a drug seeker and always had something going on. RN-C stated R53 tested negative for COVID-19 on [DATE] and was monitored for GI issues on [DATE], [DATE], and [DATE]. RN-C and RN-D stated staff should have further monitored and assessed R53 prior to going to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During interview on [DATE], at 8:02 p.m. nursing assistant (NA)-E stated R53 had always been sick, had always complained of not feeling well and had diarrhea all the time. NA-E stated R53 had been confused the week before she went to the hospital. A few days prior to R53's transfer to the ED R53 became pale, yellowish in color, became weak and her ability declined from a 2-person stand-by-assist to a total mechanical lift. NA-E stated she reported R53's changes to the nurse. On [DATE], at 8:21 p.m. left a message requesting MD-A return call. During interview on [DATE], at 3:06 p.m. medical doctor (MD)-A stated R53 was a very complicated resident and had diagnoses including anemia, diabetes, thyroid disorder, and atrial fibrillation; all of which were stable at the time of R53's evaluation on [DATE]. R53's exam had been non-specific (normal) and residents only symptoms were fatigue and feeling tired. When R53 was at baseline, R53 had been able to communicate her needs. MD-A stated she expected staff to assess R53, respond appropriately, and notify MD-A of any changes. MD-A stated she had been unable to find any communication (via fax, computer messages or phone calls) from the facility beginning after the [DATE] evaluation through the ED admitted [DATE]. MD-A stated she would expect the facility to notify herself or her nurse of any change in condition. - MD-A stated upon review of R53's emergency department (ED) note dated [DATE], R53 was hypertensive, tachycardic and was admitted to the hospital. The final diagnoses were Clostridioides difficile (C-diff) colitis (an infection in the colon which symptoms including diarrhea, belly pain and fever) and septic shock (a life-threatening condition caused by an infection. Symptoms include low blood pressure, pale and cool arms and legs, chills, difficulty breathing, decreased urine output, mental confusion, and disorientation). MD-A stated R53 was admitted to the hospital and according to the hospital notes had declined quickly. Signs and symptoms of septic shock included any signs of infection, diarrhea, cellulitis, fever, tachycardia, an increase in blood pressure and then a drop in blood pressure. Further, MD-A stated the nurses should have assessed R53 and should have been able to tell something was wrong. R53's medical record did not identify comprehensive assessment(s) were completed after identification of R53's confusion, weakness, diarrhea and change in color, nor identify interventions implemented to stabilize R53's mental and physical status, or evidence of ongoing monitoring. Further, it was not evident the MD-A had been notified of the change in R53's cognition, mental status, or GI status. 41575 R36's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderate cognitive impairment, required supervision or setup for most activities of daily living (ADLs) and used a walker for mobility. R36's care plan dated [DATE], identified R36 had shortness of breath related to chronic obstructive pulmonary disease (COPD) and asthma and directed staff to monitor her shortness of breath and oxygen levels. R36 had short term memory problem and/or periods of confusion. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During observation and interview with R36 and family member (FM)-A on [DATE], at 12:10 p.m. R36 was sleeping soundly and did not respond to the knock on her door or her name being called. FM-A stated R36 had frequent periods where she was unresponsive and was unable to be aroused from sleep. R36 had frequent low oxygen saturations and was requiring oxygen more and more frequently. R36's Physician Orders dated [DATE], identified R36 received Ipratropium bromide nasal solution, xopenex inhaler, and Trelegy Ellipta for respiratory failure and COPD. R36 also received Xarelto (a medication to prevent blood clots). The physician orders did not identify the use of oxygen. R36's progress notes identified the following: -[DATE], R36 felt weak and complained of no strength. She fell on to her left arm. Was alert and orientated and assisted up with assist of two staff. The doctor was notified of the fall. -[DATE], R36 was confused and wandered into another resident's room. -[DATE], R36 reported she had fallen off her toilet the day before and hit her head. R36 stated she had gotten herself up and did not notify anyone at the time of her fall. -[DATE], R36's physician was notified of her reported fall. Orders were received to monitor her mental status. -[DATE], R36 was very sleepy during the evening shift. Staff will continue to monitor for COVID-19 symptoms. Oxygen saturation was 92% on room air. -[DATE], R36 was very sleepy through out the evening shift. FM-A requested staff assess her vital signs. R36 oxygen saturation was 92% on room air. -[DATE], R36 was on leave of absence (LOA) with FM-A. FM-A called the facility at 12:00 p.m. and again 2:30 p.m. to report he was unable to awaken R36. He was told to take R36 to her physician to be evaluated. -[DATE], R36 went by ambulance while on LOA with family. Returned to the facility at 7:00 p.m. Direction to follow up with primary physician with no new orders. Will continue to monitor. -[DATE], FM-A requested staff to assess R36 vital signs. Vital signs were taken and oxygen saturation was 80%. Oxygen was applied and oxygen saturation was rechecked 45 minutes later. Oxygen saturation was 89%. The medical record lacked evidence of further assessment for R36's unusual lethargy, confusion, abnormal oxygen saturations, and new utilization of PRN oxygen. During interview on [DATE], at 3:30 p.m. the director of nursing (DON) stated more assessment would be needed when R36 was difficult to arouse or when exhibits low oxygen saturations. The DON would expect further assessment and vital signs as well as report to next shift for ongoing assessments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R4's significant change MDS dated [DATE], identified R4 had moderate cognitive impairment, received antipsychotic, antianxiety and antidepressant medications on a daily basis, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment. During interview on [DATE], at 2:40 p.m. R4 stated her feet were really swollen and she was concerned about it. She was not taking diuretic medications. The staff did have her elevate her feet in the afternoons. The swelling bothered her and her daughter had ordered some elastic stockings for her to try but they had not been delivered yet. R4's progress notes identified the following: -[DATE], hospice note. Noted 3+ edema (swelling) to right lower leg and foot and 2+ to the left. Orders received to try Lasix (a diuretic medication to decrease fluid retention) 20 milligrams (mg) daily for seven days. Will reevaluate in seven days. -[DATE], hospice note. Gradual weight gain in past months. is back to her baseline weight of 190 to 200 pounds. R4 has significant edema to her feet. Encourage to elevate her legs. -[DATE], hospice note. R4 has ,d+[DATE]+ edema to both feet. Encouraged to elevate during the day. She does have compression wraps on at this time. R4's Physician Order Review, dated [DATE], identified R4's current signed orders. These included medications: Lasix (a diuretic medication) 20 mg every day for 5 days with start date [DATE] and end date [DATE], for localized edema. R4's most recent Physician Progress Note, dated [DATE], identified the current visit was for medication recheck. The progress note lacked evidence R4's diuretic medication and edema had been addressed, or if the physician was aware the medication ordered for five days ended [DATE], with need for further evaluation. R4's weights were reviewed [DATE] through [DATE] and indicated the following: -[DATE], R4's weight was 200 pounds. -[DATE], R4's weight was 186 pounds. -[DATE], R4's weight was 181.8 pounds. -[DATE], R4's weight was 192 pounds. -[DATE], R4's weight was 198 pounds -[DATE], R4's weight was 182 pounds. ' (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The recorded weights identified R4 had a significant weight gain of 5% in less than a two week period between [DATE] and [DATE]. R4's diuretic medication was ordered [DATE], with end date of [DATE], however, the medical record lacked evidence R4's weight gain was assessed after the discontinuation of the medication. When interviewed on [DATE], at 11:50 a.m. registered nurse (RN)-G stated the physician came to the facility to see patients. Medications were discussed verbally on rounds. R4 did have Lasix ordered for 5 days as recommended by hospice, as R4 had developed ,d+[DATE]+ pedal edema in her lower extremities. The medication was for a limited time and then would be reevaluated. Staff did try to have R4 lie in a recliner with her feet elevated in the afternoon as an intervention for her edema. She was not aware R4 had a weight gain after the diuretic was stopped. The staff obtained the resident weights on their bath days but had difficulty with putting the information in the electronic medical record, so RN-G had to rely on staff verbal reports if they noticed resident weight gains or losses. The unit has been actively weighing all the residents this week to obtain current weights and getting them documented in to the each residents medical records. RN-G had not done any type of assessment for R4 when her diuretic was discontinued because R4 was a hospice patient and she felt the hospice nurse should have assessed R4. R4's ten pound weight gain was not reported by the nursing assistants who did the weights and because they had not tracked resident weights in the computer the significant weight gain was missed. RN-G was not aware R4 had gained ten pounds in the two weeks after discontinuing her diuretic, but thought it could have been due to her increased appetite. When interviewed on [DATE], at 3:15 p.m. the DON stated when a resident was prescribed a diuretic medication she would like to see their weight come down and watch their fluid intake. The DON remembered R4 had been pretty fluffy and hospice was trying to get some of the fluid off for comfort. Staff would need to assess weights to find out if the diuretic ordered was effective and weights should be done weekly. The DON did not feel a ten pound weight gain in a two week period could be attributed to appetite alone. Assessments were expected to be conducted when needed, regardless if the resident was under hospice care. A policy on assessing for a change of condition was requested and not provided. The facility's Weight Monitoring Program policy dated [DATE], identified the purpose was to provide guidance to staff for monitoring weights to maintain or improve the overall health of residents. The policy defined a medically significant weight gain as a weight gain of 5 or more pounds within one week could indicate a change in health status per the plan of care (i.e. diuretics, cortcosteroids, etc). Staff were directed to weigh residents weekly, as needed, or as ordered by the physician. Weight data would be assessed, tracked and entered into the electronic health record weekly. The physician would be contacted for any resident with a medically significant weight gain of 5 pounds or more.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to implement and complete routine weight monitoring to ensure caloric needs were being met to prevent weight loss and promote health and failed to complete a comprehensive nutritional assessment for 1 of 1 resident (R36) reviewed with significant weight loss. Findings include: R36's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderate cognitive impairment, required supervision or setup for most activities of daily living (ADLs). R36's care plan dated 1/5/23, identified R36 had short term memory problem and/or periods of confusion. R36 was independent with eating. Staff were directed to monitor her weight weekly, and offer her food and drinks per her preference. On 1/9/23, at 12:10 p.m. R36 was observed sleeping soundly and did not respond to the knock on her door or her name being called. Family member (FM)-A stated R36 had frequent periods where she was unresponsive and was unable to be aroused from sleep. During continuous observation 7:00 a.m. through 8:40 a.m. on 1/11/23, R36 was observed sleeping soundly on her bed. Staff entered the room at 8:30 a.m. after knocking and placed R36's breakfast tray on her bedside table approximately four feet from the side of the bed and out of R36's reach. The unidentified staff made no attempt to awaken R36 to eat and left the room without speaking to R36. R36 remained sleeping on her bed and made no attempt to sit up or eat. R36's Physician Orders dated 1/12/23, identified R36 received a regular diet. A multi-vitamin was ordered daily, as well as vitamins C, D3 and an Occuvite vitamin daily. Nutritional supplements were not listed on R36's orders. R36's most recent dietary assessment dated [DATE], identified R36 was 64 inches in height and weight was 123.4 pounds from 5/25/22. Estimated daily nutrition needs were 56 grams of protein and 1290 calories. The dietary note identified R36 was at lower nutrition risk. R36's goal range for the next 90 days was 120-130 pounds. R36 was able to get adequate nutrition via meals and snacks offered. No new nutrition recommendations. Continue with current nutrition plan of care and contact dietitian with any nutritional concerns or questions. R36's progress notes identified the following: -12/7/22, R36 slept all shift. R36 did not eat supper as she was not alert enough. -12/9/22, care conference was held on 11/16/22. Reviewed information from the past quarter, including weights and meal intakes. No new concerns noted. Will continue with current plan of care and observe for changes. -12/31/22, R36 would not wake up to eat or take her medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record of R36 meal intakes was requested, however, was not received. R36's record of weights from May 25, 2022 through 1/10/22, identified the following: - 5/25/22, R36 weighed 123 pounds. -11/3/22, R36 weighed 125 pounds. -11/9/22, R36 weighed 126.8 pounds. -1/10/23, R36 weighed 114 pounds. R36's medical record lacked evidence of weekly weights as directed and did not identify any additional documentation. R36 demonstrated an unidentified weight loss of 12.8 pounds (10%) in the two months between 11/9/22 and 1/10/23. R36's medical record also lacked evidence of any nutritional assessments, evaluation of her oral intake at meals, or notification of the RD or R36's provider related to this unidentified significant weight loss. During interview on 1/12/23, at 11:50 a.m. RN-G stated weights were not being recorded in the resident's medical record. The bath aide obtained resident weights on their bath days but had trouble documenting in the new electronic medical record. The facility was currently educating the staff on how to enter data, like weights, into residents electronic records. RN-G just went by what was reported to her by the bath aide. RN-G was currently having the nursing assistants weigh all the residents in her unit so they could enter current weights in all the resident's medical records. When interviewed by telephone on 1/12/23, at 4:25 p.m. the registered dietitian (RD)-M stated he did come to the nursing facility periodically. RD-M completed resident dietary assessments based on the information he was given. When weights were not recorded RD-M emailed the resident's case manager for the information. When RD-M completed R36's dietary assessment on 10/5/22, he had notified the case manager via email he did not have a current weight, however did not receive a response. He completed the assessment using the weight he did have, from May 2022, five months previous. It was more limited but he wanted to do something, rather than nothing. RD-M had her diagnoses list and her heights and the resident progress notes were reviewed to glean information. RD-M wondered if he should wait to do his assessment until he had a more current weight The weight from May was more limited but he wanted to do something and could not properly assess her nutritional status. RD-M did not complete the dietary section of resident MDS's and thought maybe RN-C completed them. RD-M only completed resident dietary assessments which were documented in the medical record under a progress note. R36's 10/5/22, progress note was the most recent dietary assessment completed and RD-M was unsure if any other dietary assessments were completed. He was not contacted further regarding concerns pertaining to R36. During interview on 1/12/13, at 4:40 p.m. the MDS coordinator, RN-C stated the dietitian wrote his dietary Cassessment in the resident's progress notes but did not complete any part of the MDS assessment or the Care Analysis Assessments (CAA). RN-C completed the dietary section of the MDS and the nutrition CAA. He had staff weigh R36 when he needed to enter her weight into the MDS, which was why R36 had weights documented on 11/3/22, and 11/9/22. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/12/23, at 3:30 p.m. the director of nursing (DON) stated she would expect further assessment and vital signs as well as report to next shift for ongoing assessments. Resident weights should be done weekly. A policy for physician notification was requested, however, was not received. The facility's Weight Monitoring Program policy dated 1/18/21, identified the purpose was to provide guidance to staff for monitoring weights to maintain or improve the overall health of residents. The policy defined a medically significant weight gain as a weight gain of 5 or more pounds within one week could indicate a change in health status per the plan of care (i.e. diuretics, corticosteroids, etc). Staff were directed to weigh residents weekly, as needed, or as ordered by the physician. Weight data would be assessed, tracked and entered into the electronic health record weekly. The physician would be contacted for any resident with a medically significant weight gain of 5 pounds or more.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the consulting pharmacist (CP)-A failed to identify irregularities related to the use psychotropic medications for 1 of 5 residents (R4), the facility failed to ensure irregularities identified by CP-A were addressed timely by the medical provider for 1 of 5 residents (R4) and failed to ensure the medical provider documented a rationale for the extended use of an as needed (PRN) psychotropic medication for 2 of 3 residents (R20 R28) reviewed for unnecessary medications. Findings include: R4's significant change Minimum Data Set (MDS) dated [DATE], identified R4 had moderate cognitive impairment, consumed antipsychotic, antianxiety and antidepressant medications daily, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment. R4's Physician Order Review, dated 9/20/22, identified R4's current signed orders. These included but was not limited to the following medication: Abilify (an antipsychotic medication) 2 milligrams (mg) by mouth (po) at bedtime, R4's Physician Progress Note, dated 10/18/22, identified R4 had a recent emergency room visit and had been given Zyprexa (antipsychotic medication). Staff reported R4 was like a different person when on the medication with improved mood and behavior. The physician indicated R4's Abilify would be discontinued and Zyprexa 5 milligrams at bedtime initiated. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included medications but were not limited to: lorazepam (an antianxiety) 0.5 mg by mouth (po) every four hours as needed (PRN) with start date 10/19/22, and Zyprexa (an antipsychotic medication) 5 mg po at bedtime, with start date 10/18/22. The orders failed to identify an end date for the PRN lorazepam ordered, as required. R4's Pharmacy Summary Report dated 11/8/22, indicated irregularities were identified and to see report. The corresponding report titled Nursing Report for November 2022, directed nursing staff to address ASAP but no later than 7 days, R4's lorazepam 0.5 mg tablet. The report read PRN psychotropics were limited to a 14-day duration based on updated CMS guidance and rules, unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. A recommendation was made to re-evaluate the appropriateness of continuing the current therapy. If treatment was to be continued add an appropriate stop date and document the duration of treatment and clinical evaluation/rationale of the resident. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. Staff reported R4 had been a little lethargic during the day and felt a decrease in her dose of Zyprexa would be beneficial. Staff reported R4's mood had been stable and no issues with mood swings, depression, or anxiety symptoms. R4 was tired during the day but had appropriate behaviors. The physician indicated R4's morning dose of Zyprexa would be decreased to 2.5 milligrams mg, however, R4 did not currently receive Zyprexa in the morning. R4's current order had been for Zyprexa 5 mg at bedtime only which was not changed or decreased. Further, the progress note lacked evidence the pharmacist recommendations made on 11/8/22, to evaluate R4's PRN lorazepam was brought to the physician's attention or addressed. R4's undated Face Sheet identified R4's current physician ordered medications. These included medications: Zyprexa 2.5 mg po in the morning, with start date 11/18/22, and Zyprexa 5 mg po at bedtime. R4 was currently receiving Zyprexa in the morning as well as her bedtime dosage. The medical record lacked documentation the physician had been contacted to confirm the increase to R4's Zyprexa by 2.5 mg daily was an intentional increase in medication. R4's Pharmacy Summary Report dated 12/8/22, indicated no irregularities were identified, despite the previous month's recommendation regarding the PRN lorazepam had not yet been addressed and the recent conflicting increase of R4's antipsychotic medication Zyprexa. When interviewed on 1/12/22, at 11:50 a.m. registered nurse (RN)-G stated she had not received any pharmacy reports from the physician since September 2022. The pharmacy reports were physically brought over to the physician's office right after the CP's monthly visit and the physician would fax the signed forms to the facility after review. RN-G wished the process was more timely. The forms were brought to the physician office and the recommendations did not get addressed again until they were returned from the physician. At that time the nurse managers reviewed the forms to check if any medication or treatment changes were ordered. RN-G stated R4's pharmacy recommendations, as well as other residents, should be addressed in a more timely fashion. During interview on 1/12/23, at 1:36 p.m. CP-A stated he did not feel it was unusual for the physician's late response to his recommendations. The nursing staff was supposed to re-evaluate PRN psychotropic medications with the provider, for the required 14-day window. When a PRN psychotropic medication was first identified during monthly medication review, he would fill out a Consultant Pharmacist Medication Review form. CP-A filled out the form for R4 because the medication had a 14-day window and needed to be addressed. CP-A did not typically reiterate previous recommendations month to month. CP-A remembered wondering about the increase with R4's Zyprexa but did not read the physician's progress note when the provider had initiated the increase. It was a small dose, so there was nothing to really trigger a recommendation from him. When interviewed on 1/12/23, at 3:15 p.m. the director of nursing (DON) stated the facility did not have a process to check if the physician had addressed monthly pharmacy recommendations. 40943 R20's significant change Minimum Data Set (MDS) dated [DATE], identified R20 had diagnoses that included major depressive disorder and generalized pain. R20 exhibited behaviors that included physical and verbal behaviors towards others and refusing cares. R20 received antianxiety medication 2 out of the 7 days of the assessment period. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's physician orders dated 12/2/22, included an order for lorazepam (antianxiety, psychotropic medication) 1 mg by mouth two times per day as needed (PRN) due to disorientation, pain/anxiety from 12/2/22 to 3/20/23. R20's physician notes from 12/2/22 to 1/12/23, lacked documentation regarding R20's extended use of antianxiety medication and lacked documentation of contraindications for gradual dose reduction of lorazepam R20's Consultant Pharmacist's Medication Review dated 12/8/22, identified R20 had an order for lorazepam 1 mg tablet 1 tablet by mouth twice daily PRN for anxiety. The pharmacist comments included: since this medication was used for a psychological condition and due to Centers for Medicare and Medicaid Services (CMS) guidelines, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. On 12/20/22, the physician responded the medication was to be continued for 90 days. Will have a routine visit in about 4 weeks. However, the form lack rationale/justification for continuation. R28's annual MDS dated [DATE], identified diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and paranoid personality disorder. R28 utilized antianxiety medications but did not exhibit behaviors during the assessment period. R28's Psychotropic Drug Use CAA dated 10/10/22, identified R28 was prescribed lorazepam 0.5 mg PRN daily due to a diagnoses of paranoid personality disorder. R28 did not utilize the medication during the assessment period. R28's physician orders dated 7/5/22, included an order for lorazepam 0.5 mg by mouth everyday PRN for anxiety from 7/5/22 to 7/10/23. Target behaviors: exit seeking, paranoid behaviors, confusion, being scared, and not sleeping. R28's physician notes from 7/6/22 to 12/17/22, lacked documentation regarding R28's extended use of PRN antianxiety medication and lacked documentation of contraindications for gradual dose reduction of lorazepam. R28's Consultant Pharmacist's Medication Review dated 6/9/22, identified R28 had an order for lorazepam 0. 5 mg tablet 1 tablet by mouth everyday PRN for anxiety. The pharmacist comments included: since this medication was used for a psychological condition and due to Centers for Medicare and Medicaid Services (CMS) guidelines, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. On 6/21/22, the physician responded, 6 months. However, the form did not identify a justification for continued use. During an interview on 1/12/23, at 1:42 p.m. RN-A stated the interdisciplinary team (IDT) did not review PRN lorazepam administrations, documentation, nor physician progress notes prior to making GDR recommendations. The process was more of a discussion between the nurse manager and the consultant pharmacist than chart review to determine what was best for the resident. RN-A used to make sure the physician completed all documentation to ensure compliance with guidelines but the physician would not do it. Because of this, RN-A stated she gave up trying. However, RN-A had not brought this concern to administration to address. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 1/12/23, at 3:08 p.m. the consultant pharmacist stated he looked for the initial 14-day evaluation whenever a PRN psychotropic medication was started. Then, he would review if the resident was using the medication and how often. From there, if the resident had not used a medication for approximately 3 months, he would recommend the medication be discontinued. Sometimes, the consultant would review progress notes to make sure there was a rationale but the facility had implemented a new electronic medical record system, and it was more of a process to look at progress notes. He usually visited with the nurse manager to determine a resident's chart included a rationale for use. During the IDT meeting, the team would review the residents who had MDS assessments that month; however, the team did not review administrations, documentation nor physician progress notes. The consultant pharmacist hoped the physician would provide a clear, concise documentation why a medication was ordered, but this was more of a nursing responsibility and his role was to review how often a medication was given. Once his recommendations were made, he did not review the following month to ensure it was addressed. During an interview on 1/12/23, at 4:55 p.m. the director of nursing (DON) stated she was new to her role at the facility and was aware documentation for administration of a psychotropic medication needed to be more robust. She received emails with the pharmacist reviews, and they discussed potential GDR during IDT meetings she attended. Staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for the resident. The facility policy Psychotropic Medications issued 10/1/15, identified physicians and other providers (nursing practitioners and physician assistants) would order psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The policy further identified the consultant pharmacist would: 1. Monitor psychotropic drug use in the facility to ensure that medications were not used in excessive doses or for excessive duration, monthly basis. 2. Participate in the IDT quarterly review of residents on psychotropic medications. 3. Notify the physician and the nursing unit if a psychotropic medication was due for review. Additionally, the Physician would: 1. Order psychotropic medication only for the treatment of specific medical and/ or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non- pharmacologic approaches. 2. Document rationale and diagnosis for use and identify Target Behavior symptoms for the reason the medication is being used. 3. Document discussion with the resident and/or responsible party regarding the risk versus benefit of the use of these medications included in the discussion and documentation must be the presence of any black box warning or off label use of the medication affecting the prescribing of the medication to the resident. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Evaluate with the interdisciplinary team, effects, and side effects of psychoactive medications within one month of initiating, increasing, or decreasing dose and during routine visits thereafter. 5. Monitors the resident for lack of drug efficacy clinically and in discussions with the interdisciplinary team within one month of initiating and during routine visits. 6. Attempt a gradual dose reduction (GDR) decrease or discontinuation of psychotropic medications after no more than 3 months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants. 7. Review Sedative/ hypnotics quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated. 8. New orders for PRN psychotropic medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances. 9. Obtain psychiatric consultation as resident's clinical condition requires.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41575 Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted and/or medical justification was provided to support an increase dosage of Zyprexa (an antipsychotic medication) for 1 of 5 residents (R4) reviewed and ensure as needed (PRN) psychotropic medication use was limited to 14 days or medical justification was provided to support ongoing use for 1 of 5 residents (R4) who had PRN psychotropic medications ordered. The facility failed to provide evidence non-pharmacological interventions were provided prior to administration of as needed (PRN) psychotropic medication for 3 of 4 residents (R8, R28, R20). Findings include: R4's significant change Minimum Data Set (MDS) dated [DATE], identified R4 had moderate cognitive impairment, consumed antipsychotic, antianxiety and antidepressant medications on a daily basis, and required extensive assistance to complete activities of daily living (ADLs). The MDS outlined a section to record R4's mood. R4 was unable to be interviewed, however, staff assessment of R4's mood severity scored 3, as minimal. No hallucinations, rejection of care or behaviors were recorded and no change in R4's mood and behavior had occurred since her last assessment. R4's Physician Order Review, dated 9/20/22, identified R4's current signed orders. These included but were not limited to the following medication: Abilify (an antipsychotic medication) 2 milligrams (mg) by mouth (po) at bedtime, R4's Physician Progress Note, dated 10/18/22, identified R4 had a recent emergency room visit and had been given Zyprexa. Staff reported R4 was like a different person when on the medication with improved mood and behavior. The physician indicated R4's Abilify would be discontinued and Zyprexa 5 mg at bedtime initiated. R4's Pharmacy Summary Report dated 11/8/22, indicated irregularities were identified and to see report. The corresponding report titled Nursing Report for November 2022, directed nursing staff to address ASAP but no later than 7 days, R4's lorazepam 0.5 mg tablet. The report read PRN psychotropics were limited to a 14-day duration based on updated CMS guidance and rules, unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. A recommendation was made to re-evaluate the appropriateness of continuing the current therapy. If treatment was to be continued add an appropriate stop date and document the duration of treatment and clinical evaluation/rationale of the resident. R4's Physician Order Review, dated 11/15/22, identified R4's current signed orders. These included but were not limited to the following medications: lorazepam (an antianxiety) 0.5 mg po every four hours PRN with start date 10/19/22, Zyprexa (an antipsychotic medication) 5 mg po at bedtime, with start date 10/18/22. The orders failed to identify an end date for the PRN lorazepam ordered, as required. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's most recent Physician Progress Note, dated 11/15/22, identified the current visit was for medication recheck. Staff reported R4 had been a little lethargic during the day and felt a decrease in her daytime dose of Zyprexa would be beneficial. Staff reported R4's mood had been stable and no issues with mood swings, depression or anxiety symptoms. R4 was tired during the day but had appropriate behaviors. The physician indicated R4's morning dose of Zyprexa would be decreased to 2.5 mg, however, R4 did not currently receive Zyprexa in the morning. R4's current order had been for Zyprexa 5 mg at bedtime only which was not changed or decreased. Further, the progress note lacked evidence the pharmacist recommendations made on 11/8/22, to evaluate R4's PRN lorazepam was brought to the physician's attention or addressed. R4's undated Face Sheet identified R4's current physician ordered medications. These included but were not limited to the following medications: Zyprexa 2.5 mg po in the morning, with start date 11/18/22, and Zyprexa 5 mg po at bedtime. R4 was currently receiving Zyprexa in the morning as well as her bedtime dosage. The medical record lacked documentation the physician had been contacted to confirm the increase to R4's Zyprexa by 2.5 mg daily was an intentional increase in medication. When interviewed on 1/12/23, at 11:50 a.m. registered nurse (RN)-G stated the physician came to the facility to see patients. Medications were discussed verbally on rounds. The physician had stopped R4's Abilify and started Zyprexa on 10/18/22. RN-G indicated she was unable to find documentation in R4's medical record to justify the increase in the Zyprexa in November and thought maybe the physician had noticed something with R4 that the facility staff had missed. RN-G reviewed the physician progress notes on 11/15/22, and verified R4's physician had dictated to decrease R4's Zyprexa, not increase the medication. RN-G had written the verbal order and transcribed the morning Zyprexa order to R4's medication administration record. RN-G indicated the nurses reviewed resident behaviors quarterly by review of the nurse progress notes incidental charting and if a resident's behaviors changed it would be in the progress notes. RN-G was unable to find documentation to warrant an increase in R4's Zyprexa. RN-G stated she would review R4's increased Zyprexa dose next week when R4's physcian was at the facility for rounds. During telephone interview with the consulting pharmacist (CP)-A on 1/12/23, at 1:35 p.m. CP-A indicated it was not unusual for the medical provider to have a late response to his monthly recommendations. The nursing staff were suppose to evaluate his recommendations with the primary provider within 14 days. After that it could wait for 30 or 60 days for formal response documented by the physician. CP-A did not reiterate his former recommendations and it was just because of the 14 day window with the PRN psychotropic that he wanted his recommendations addressed for R4. CP-A had noted the increase Zyprexa in November, but it was a small dose and he had not read the physician progress notes and so had not addressed it during his monthly medication review. When interviewed on 1/12/23, at 3:15 p.m. the director of nursing (DON) stated she was aware behavior documentation in the facility's current electronic medical record system was a problem. The nurses were directed to do a weekly summary of behaviors and behavior audits. The documentation of behaviors would be needed before adjustment of resident medications. When R4's Zyprexa was increased, the nurse should have asked for an order clarification immediately. 40943 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's annual Minimum Data Set (MDS) dated [DATE], identified R8 had severe cognitive impairment and had diagnoses that included vascular dementia with behavioral disturbance. R8 utilized antianxiety (a type of psychotropic) medications but R8 did not exhibit behaviors during the assessment period. R8's Psychotropic Drug Use CAA dated 12/2/22, identified R8 utilized lorazepam (psychotropic medication used to treat anxiety) 0.5 milligram (mg) once daily as needed (PRN) after 2:00 p.m., if R8's scheduled dose of gabapentin (an anticonvulsant that was used with other medications to prevent and control seizures. It was also used to relieve nerve pain following shingles (a painful rash due to herpes zoster infection) in adults) did not help with target behaviors which included yelling, anxiety, refusing to eat, hitting at staff. No PRN doses were given during assessment period. R8's non-pharmacological interventions were as follows: 1:1, music, cinnamon toast, drink. Staff were directed to take things slow and speak softly to R8 during that time. R8 continued to have behaviors such as uncontrolled yelling which cannot be redirected and issues with bathing, hitting out at staff, and yelling. R8's care plan dated 1/4/23, identified R8 exhibited behaviors of yelling, hitting, and swearing. Staff were directed to use non-pharmacological interventions including: 1:1, music, cinnamon toast, food/drink, leave and reapproach. Staff were also directed to observe for changes and report. R8's undated, nursing assistant care sheet did not identify R8 had any behaviors nor did it direct staff on R8's behavioral triggers or non-pharmacological interventions. R8's physician orders dated 3/2/22, included an order for lorazepam 0.5 mg by mouth once daily PRN from 3/22/22 to 2/2/23. Special instructions included: Never to be given before 1:00 p.m. dose of gabapentin. Utilize and document redirection interventions prior to giving lorazepam. R8's target behaviors included: yelling, banging on table, and hitting. R8's August 2022 Electronic Medication Administration Record (EMAR) identified R8 did not receive any PRN doses of lorazepam. R8's September 2022, EMAR identified the following: - On 9/5/22, at 3:48 p.m. R8 received 0.5 mg of lorazepam. The administration notes field identified the medication was administered due to given as PRN. However, the notes did not identify any behaviors, or any non-pharmacological interventions attempted. Additionally, it identified the medication was not effective. - On 9/27/22, 4:17 p.m., R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R8's October 2022, EMAR identified on 10/11/22, at 3:05 p.m. R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered or if any non-pharmacological interventions were attempted prior to the administration. R8's December 2022, EMAR identified on 12/5/22, at 11:57 a.m. R8 received 0.5 mg of lorazepam. The EMAR did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. (continued on next page)

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	245252	A. Building B. Wing	01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/10/23, at 9:28 a.m. R8 was sitting in her wheelchair next to the medication cart. Licensed practical nurse (LPN)-C encouraged R8 to drink approximately 2 ounces (oz) of a supplement drink from a disposable plastic cup. LPN-C used a calm, reassuring voice. R8 drank the supplement drink, and no behaviors were exhibited. During an observation on 1/10/23, at 10:00 a.m. R8 sat at a table in the common area. R8 sat quietly and watched the other residents. Family member (FM)-A approached and greeted R8. R8 was calm and smiled. FM-A then assisted R8 to her room for a visit. During an interview on 1/11/23, at 10:20 a.m. nursing assistant (NA)-B stated when she worked with R8, R8 really didn't understand. R8 did not get mad or angry. R8 just didn't do anything when you asked her. NA-B did see R8 have behaviors in the morning once during morning cares. Staff just walked away and let R8 eat her breakfast, then R8 calmed down. The rest of the morning went fine. NA-B reiterated staff needed to stay calm and reapproach R8 when she was having a bad day. R8 was usually happy and smiling. R8 wasn't always able to make sense when she spoke, but she tried. During an interview on 1/11/23, at 5:19 p.m. LPN-D stated R8's bath days were really bad. R8 would yell and scream. Sometimes, R8 had to eat in the activity room because she was so upset. Staff never knew what R8 needed. Staff offered toileting or eating, but sometimes R8 just had to calm herself. These behaviors could last hours, minutes or not at all. LPN-D then stated R8 had an order for as needed lorazepam and LPN-D would speak with the other nurse and nursing assistants before giving it to make sure it was a good choice. LPN-D would then document all the non-pharmacological interventions staff had tried and would continue to monitor for effectiveness. However, LPN-D then stated she would forget to document in a progress note most of the time. LPN-D would put a note in the EMAR when she administered the medication. For example, on 9/5/22, LPN-D stated she entered for pain on R8's lorazepam administration. LPN-D stated she had administered Tylenol as well because she thought R8 was having neck/shoulder pain and R8 wasn't able to tell her. R8 wouldn't calm down. However, LPN-D stated it had occurred four months prior and she could not identify what behaviors if any, R8 was exhibiting. LPN-D additionally could not identify what non-pharmacological interventions had been attempted prior to the lorazepam administration. LPN-D continued to state lorazepam was more for calming R8 down. Staff were not able to tell if it was pain or behaviors but if the Tylenol did not help R8's pain at least she would calm down. LPN-D then stated she knew she needed to do better documentation, but she was a new LPN and was learning every day. During an interview on 1/12/23, at 9:45 a.m. registered nurse (RN)-B stated behavior monitoring needed to be documented on any resident that exhibited a behavior. Some common behaviors were yelling, hitting, and screaming. R8 did exhibit behaviors of yelling, screaming, and hitting. Staff were directed to provide cinnamon toast, distraction and sometimes she needed the quiet of her room. R8 also had a photo album that she liked to look at. However, sometimes the non-pharmacological interventions did not help, and she needed an as needed dose of lorazepam. However, lorazepam would only be given as a last resort when every other non-pharmacological intervention did not work. Staff were additionally directed to document the administration on the EMAR, document behaviors and interventions in the nursing progress notes, and document a follow up as well that identified if the medication was effective or not. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/12/23, at 1:29 p.m. RN-A stated R8 had scheduled lorazepam on her bath days, but sometimes bathing continued to be difficult for R8. R8 had an additional order for lorazepam 0.5 mg once daily PRN. Before this was to be given, staff were directed to provide non-pharmacological interventions such as cinnamon toast, minimal bath water, calm approaches, start with one nursing assistant and ask for help if needed, quiet places and 1:1. However, R8's exhibited behaviors and responses to non-pharmacological interventions were all over the place. RN-A stated neither R8's EMAR, nor progress notes, identified why PRN medications were given nor did they identify what non-pharmacological interventions had been attempted prior to the administration. Staff were expected to document all interventions that were attempted in the nursing progress notes. Additionally, staff were expected to do a follow up note that described the effectiveness of the medication. During an interview on 1/12/23, at 4:55 p.m. the director of nursing (DON) stated she had recently begun her role at the facility. She knew the interdisciplinary team (IDT) had a conversation about R8 and her medications because R8 yelled at night. The DON stated she needed to investigate to determine when R8 had received PRN lorazepam and why. Staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R8. R28's annual MDS dated [DATE], identified a severe cognitive impairment and diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and paranoid personality disorder. R28 utilized antianxiety medications but did not exhibit behaviors during the assessment period. R28's Psychotropic Drug Use CAA dated 10/10/22, identified R28 was prescribed lorazepam 0.5 mg PRN daily due to a diagnoses of paranoid personality disorder. R28's target behaviors included: exiting seeking and paranoid behaviors. R28 did not utilize the medication during the assessment period. R28's care plan dated 12/29/22, identified R28 utilized antianxiety medication related to diagnosis of anxiety as exhibited by: exit seeking and wandering that was not redirectable. Staff were directed to administer medications per order and observe for side effects, work with a psychiatric team, monitor mood and response to medications. R28's non-pharmacological interventions included: 1:1, offer food/drink and give a toy dog to distract. R28's undated, nursing assistant care sheet did identify R28 was an elopement risk but did not identify any other target behaviors nor directed staff on R28's behavioral triggers or non-pharmacological interventions. R28's physician orders dated 7/5/22, included an order for lorazepam 0.5 mg po everyday PRN anxiety from 7/5/22 to 7/10/23. Target behaviors: exit seeking, paranoid behaviors, confusion, being scared, and not sleeping. R28's September 2022 , EMAR identified the following: - On 9/4/22, at 1:22 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 9/23/22, at 6:47 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 9/30/22, at 7:31 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R28's October 2022, EMAR identified R28 did not receive PRN lozepam R28's November 2022, EMAR identified the following: - On 11/4/22, at 7:20 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/5/22, at 7:26 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/6/22, at 7:41 p.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/9/22, at 4:04 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 11/22/22, at 1:14 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. R28's December 2022, EMAR identified the following: - On 12/3/22, at 7:25 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/4/22 at 7:26 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/12/22, at 7:24 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/17/22, at 6:53 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/20/22, at 3:24 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. - On 12/31/22 at 2:34 a.m. R28 received 0.5 mg of lorazepam. R28's medical record did not identify why the medication was administered nor non-pharmacological interventions were attempted prior to the administration. During an observation on 1/12/23, at 8:32 a.m. R28 was in the dining room. R28 was clean, well-groomed, and eating his breakfast. No behaviors were exhibited. During an interview on 1/12/23, at 9:48 a.m. RN-B stated R28 needed reorientation to the day of the week, time of day or where he was. Staff usually waited to give R28 lorazepam until the evening or night shift so R28 would get some sleep. R28 would often get up at night and eat snacks, but his blood sugar would be elevated in the morning. R28 could be restless and hard to redirect. R28 did wander but never entered other residents' rooms or attempted to hurt anyone. He would just have a lost look on his face. During an interview on 1/12/23, at 1:29 p.m. RN-A stated neither R28's EMAR, nor progress notes identified why PRN medications were given nor did they identify what non-pharmacological interventions were attempted prior to the administration. During an interview on 1/12/23, at 4:55 p.m. DON stated staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R28. R20's significant change MDS dated [DATE], identified R20 had no cognitive impairment and had diagnoses that included disorientation, major depression disorder, and amnesia. R20's Psychotropic Drug Use CAA dated 12/26/22, identified R20 was prescribed Melatonin 5 mg for insomnia. R20 reported sleeping very little during the night, documentation showed between 5-8 hours each night. R20 napped frequently throughout the day. R20 was prescribed duloxetine 20mg for depression. R20 reported feeling down/depressed and had chronic pain. R20 was very angry, swung out at staff, and refused staff to care for him. The CAA did not address R20's prescribed lorazepam 1 mg by mouth three times a day PRN. R20's care plan dated 12/28/22, identified R20 utilized antidepressant medication. R20's target behaviors were refusal of care, hitting, yelling, swearing. Staff were directed to administer mediations per orders, monitor and document behaviors, complete assessments, make referrals as needed, meet with R20/family to address concerns, and offer activity. The care plan did not identify R20 was prescribed lorazepam PRN. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20's physician orders dated 12/2/22, included an order for lorazepam 1 mg by mouth two times per day PRN due to disorientation, pain/anxiety from 12/2/22 to 3/20/23. R20's December 2022 , EMAR identified the following: - On 12/3/22, at 7:57 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/3/22, at 8:56 p.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/4/22, at 9:19 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/4/22, at 10:59 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/4/22 at 10:59 p.m. identified R20 had received hydrocodone acetaminophen 5/325 mg at 8:00 a.m. and 8:00 p.m. for moderate pain in his left hip and lower extremities. R20 also received lorazepam PRN morning and evening for anxiety. This was effective in providing restful periods for R20. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/5/22, at 9:30 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/6/22, at 4:29 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/7/22, at 7:28 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/7/2022, at 10:10 p.m. identified R20 was alert and oriented. R20's physician orders were updated with scheduled twice daily hydrocodone acetaminophen 10/325 mg for moderate pain in his left hip and lower extremity. Lorazepam 1 mg twice daily for anxiety. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/10/22, at 5:33 p.m. R20 received 1 mg of lorazepam. R20's nursing progress note dated 12/10/22, at 7:59 p.m. identified R20 was alert and oriented. Lorazepam 1 mg PRN for anxiety. However, the nursing progress note did not identify R20's exhibited behaviors nor the non-pharmacological interventions attempted prior to the administration. - On 12/21/22, at 7:41 a.m. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 12/24/22, at 7:24 a.m. R20 received 1 mg of lorazepam. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. - On 12/29/22, 11:17 a.m. R20 received 1 mg of lorazepam. R20 received 1 mg of lorazepam. R20's medical record did not identify why the medication was administered nor what non-pharmacological interventions were attempted prior to the administration. During an observation on 1/10/23, at 1:46 p.m. R20 was lying in bed with blankets covering to his neck. R20's eyes were closed and R20 was resting peacefully. During an observation on 1/12/23, at 8:00 a.m. NA-H entered R20's room and greeted R20. NA-H then asked R20 if he was ready to get up for the day. While NA-H began prepping for morning cares, she began speaking with R20 about his family, where they live and how the roads were that day. R20 stated it was hard for his kids to come, especially in winter when roads could be bad. NA-H then proceeded to assist R20 to dress for the day. NA-H gave verbal cues that allowed R20 to make choices, such as: can I help you roll to the other side? - At 8:08 a.m. R20 asked NA-H to just let him stay in bed because he was having pain. R20 stated sometimes you just need to lay still for a bit. NA-H assisted R20 to lie on his left side and covered him with a blanket. NA-H opened R20's window blinds, telling R20 he could watch the deer outside. NA-H ensured R20 had his call light and R20 told NA-H thank you. During an interview on 1/12/23, at 8:14 a.m. NA-H stated R20 could become very angry. R20's triggers included loud noises, tv, radio, and large groups of people talking. If people were talking in low voices around him, R20 would think they were talking about him. R20 would become angry if staff did not tell him what they were doing or not giving him options. NA-H then stated staff really needed to make it R20's idea to do something. Also, R20 liked to get dressed early and go back to bed to lie down, or he wouldn't cooperate with morning cares. When R20 did become angry, staff would just walk away and try again later. During an interview on 1/12/23, at 9:53 a.m. RN-B stated R20 was monitored for behaviors and had orders for lorazepam 1 mg twice daily PRN, but RN-B had never witnessed R20 receive lorazepam. During an interview on 1/12/23, at 1:42 p.m. RN-A stated neither R20's EMAR, nor progress notes, identified why PRN medications were given nor did they identify what non-pharmacological interventions had been attempted prior to the administration. During an interview on 1/12/23, at 4:55 p.m. DON stated staff were expected to follow facility policy regarding documentation of non-pharmacological interventions attempted, what was effective or not and to determine patterns of use. The DON stated this information was needed to provide the IDT with the appropriate information to determine if the medication was an appropriate choice for R20. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Psychotropic Medications policy dated 10/1/15, identified the purpose was to ensure the therapeutic use of and to minimize the risks associated with psychotropic medications. The facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. Efforts to reduce dosage or discontinue of psychopharmacological medications would be ongoing, as appropriate, for the clinical situation. New orders for PRN psychotropic medications would be time limited and only for specific clearly documented circumstances. The policy also identified physicians and other providers (nursing practitioners and physician assistants) would order psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation, and monitoring. The policy directed nursing to: 1. Monitor psychotropic drug use daily, noting any adverse effects such as increased somnolence or functional decline. 2. Monitor for the presence of target behaviors on a daily basis, charting by exception (i.e., charting only when the behaviors are present). 3. Review the use of the medications with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and/or the presence of any adverse effects of the medication use. 4. Complete assessments on any resident on an antipsychotic medication, at least every 6 months, and changes would be reported to the physician. 5. Include specific target behaviors on the care plan.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 42075 Based on observation, interview and document review, the facility failed to ensure dietary staff had the appropriate competencies for obtaining dishwasher temperatures, to prevent potential cross-contamination which may result in foodborne illness. This had the potential to affect all 54 residents residing in the facility and staff who consumed food from the kitchen. Findings include: During the kitchen tour on 1/11/23, at 5:07 p.m. the dietary manager (DM) stated the dishwasher was recently serviced as the dishes were not drying fast enough. The DM stated the final rinse needed to reach 180 degrees Fahrenheit (F) or higher and the dishwasher was not reaching that temperature (temp). There was a note attached to the dishwasher directing staff to check the temp after breakfast, after lunch and after dinner, however a temp log was not near the dishwasher. The DM stated she didn't know where the log was. During a joint interview with DM and the administrator on 1/11/23, at 5:45 p.m. the DM stated she had been working with the staff to check the temps three times daily, however staff were not completing the task due to staffing and competency issues. During interview on 1/12/23, at 7:07 a.m. CK-B stated all the dietary staff washed dishes. CK-B pointed to two gauges on the front of the machine and stated they were the only temps he would look at and would mark the temps on the paper log that was usually located next to the dishwasher, however he didn't know the purpose for logging the temps. CK-B pointed to the gauges towards the back and stated he did not know what the gauges were or what they were used for. CK-B was not aware of what the temp ranges should be, how often the temps should be checked or how to ensure the dishes were sanitized, however, CK-B stated he would tell the DM if there was a problem. CK-B stated he did not check the dishwasher temp and if the dishes looked clean and were hot, then they were clean. During interview on 1/12/23, at 7:11 a.m. dietary aide (DA)-E stated everyone was responsible for checking and marking the dishwasher temperatures, however, DA-E stated she was not familiar with the gauges on the dishwasher. If the dishes looked clean and were hot, then they were clean but did not know if the dishes were sanitized. During follow up joint interview on 1/12/23, at 8:39 a.m. the DM stated staff should be checking and documenting the dishwasher temps on a log, but staff were not doing it. The administrator stated the staff did not have specific training related to the dishwasher including temperature expectations, frequency of temping, nor how to monitor the temp. During interview on 1/12/23, at 12:10 p.m. DA-F stated he would wash dirty dishes in the dishwasher but never checked the dishwasher temps, did not know how to check the temps, and was never instructed to do so. DA-F made sure the dishes were sanitized by making sure the detergent was full. The Dietary Aide Meeting minutes dated 11/26/21 indicated recording dish machine temps was discussed. (continued on next page)

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Thief River Care Center	2001 Eastwood Drive Thief River Falls, MN 56701

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dietary Aide Job Description dated 10/14/22, described the primary purpose of the job included performing dishwashing duties. Dietary staff training related to dishwasher temp monitoring was requested but was not provided.

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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. 42075 Based on observation, interview and document review, the facility failed to ensure dietary staff were monitoring the dishwasher temperatures in 1 of 1 kitchen to prevent potential cross-contamination which may result in foodborne illness. This had potential to affect 54 residents residing in the facility and consumed food from the kitchen. Findings include: During the kitchen tour on 1/11/23, at 5:07 p.m. the dietary manager (DM) stated the dishwasher was recently serviced as the dishes were not drying fast enough. The final rinse needed to reach 180 degrees Fahrenheit (F) or higher and the dishwasher was not reaching that temperature. There was a note on the dishwasher directing staff to check the temperature after breakfast, after lunch and after dinner, however there was no temperature log near the dishwasher. The DM stated she didn't know where the log was. The DM stated if there were any problems with the equipment, she would tell the maintenance manager. Further, she was unable to find the test strips to check the dishwasher temperature. During observation on 1/11/23, at 5:07 p.m. after surveyor prompting, the DM ran a dish tray through the dishwasher and stated the rinse temperature was 180 F. During a joint interview with the DM and administrator on 1/11/23, at 5:45 p.m. the DM stated she did not have the dishwasher temperature logs and did not know when the last time the temperature were obtained. The DM was working with the staff to check the temperature three times daily, but the staff were not compliant with checking the temperature. If there was a concern, then staff were to fill out a form which then went to the maintenance manager. During interview on 1/11/23, at 6:02 p.m. the administrator stated the dishwasher booster was changed and tested good on 11/9/22, and was rechecked and working on 11/11/22. During interview on 1/12/23, at 7:07 a.m. CK-B stated all the dietary staff washed dishes. CK-B pointed to two gauges on the front of the machine and stated they were the only temperature he would look at and would mark the temperature on the paper log that was usually located next to the dishwasher, however he didn't know the purpose for logging the temperature. CK-B pointed to the gauges towards the back and stated he did not know what the gauges were or what they were used for. CK-B was not aware of what the temperature ranges should be, how often the temperature should be checked or how to ensure the dishes were sanitized, however, CK-B stated he would tell the DM if there was a problem. CK-B stated he did not check the dishwasher temperature and if the dishes looked clean and were hot, then they were clean. During interview on 1/12/23, at 7:11 a.m. dietary aide (DA)-E stated everyone was responsible for checking and marking the dishwasher temperature, however, DA-E stated she didn't monitor any of the temperature and was not familiar with the gauges on the dishwasher. DA-E stated she did not know how to determine if the dishes were clean, and further stated if the dishes looked clean and were hot then they were clean but did not know if the dishes were sanitized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview 1/12/23, at 7:35 a.m. after surveyor prompting, cook (CK)-B sent a tray through the dishwasher. CK-B did not attempt to check the rinse cycle temperature until prompted and then read the temperature from the two gauges on the front of the machine labeled wash tank and rinse tank. CK-B did not attempt to read the gauge in the back. After prompting, CK-B stated the gauge was hard to read. With further prompting, CK-B stated the gauge read 180 F. CK-B stated he didn't know what the gauges were for and had not been trained on how or why to read them. CK-B did not log the temperature anywhere. Another joint interview with the administrator and the DM was conducted on 1/12/23, at 8:39 a.m. The DM stated staff should be checking and documenting the dishwasher temperature on a log, but staff were not doing it. During interview on 1/12/23, at 12:10 p.m. DA-F stated he would wash dirty dishes in the dishwasher but never checked the dishwasher temperature, did not know how to check the temperatures, and was never instructed to do so. DA-F made sure the dishes were sanitized by making sure the detergent was full. Although, the dishwasher temperatures were within range on survey, the facility failed to ensure staff were following the facility process to check the dishwasher temperatures to ensure the dishwasher was running in a manner to sanitize the dishes. The Cleaning Dishes/Dish Machine policy dated 4/20/22, directed all flatware, dishware, serving dishes and cookware were to be cleaned, rinsed, and sanitized after each use. The dish machines were to be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Staff were directed to follow the procedures for washing dishes including temperature verified and logged for each shift.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40948 Based on interview and document review, the facility failed to ensure its quality assessment and assurance (QAA)/Quality Assurance Process Improvement (QAPI) committee was effective in identifying and implementing appropriate action plans to correct quality deficiencies identified during the survey. The facility was aware of or should have been aware of as it was previously identified over previous surveys. This deficient practice had the potential to affect all 54 residents currently residing in the facility. Findings include: The Certification and Survey Provider Enhanced Reports (CASPER)-3 (assessment data is converted to quality measures (QM) to evaluate nursing home's performance) dated 1/4/23, identified the following prior deficiencies by month and year: - F880, Infection Control was cited on 8/18 at a scope and severity of a D (isolated); 6/19 at a scope and severity at a D and on 8/21 at a scope and severity of a F (widespread) - F881, Antibiotic Stewardship Program was cited on 8/21, at a scope and severity of a F - F886, COVID-19 Testing-Residents and Staff was cited on 8/21, at a scope and severity of a F See also F880, Infection Prevention and Control: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initiate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	See also F881, Antibiotic Stewardship: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R 23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the potential to affect all 54 residents who resided in the facility. See also F886, COVID- 19 Testing- Residents and Staff: Based on observation, interview and record review, the facility failed to ensure all staff were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing protocols. This system wide breakdown resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. See F888: COVID-19 Vaccination of Facility Staff: Based on interview and document review, the facility failed to ensure 13 of 72 staff members (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. On 1/11/23, at 1:30 p.m. the administrator stated she was aware the employee vaccination logs and data were not up to date and felt registered nurse (RN)-D struggled with utilizing the computer to organize and track the needed information. QAPI Committee Agenda/Minutes were requested since the last standard survey exited on 8/19/22. Notes were received for the following quarterly meetings and identified the following: - 1/26/22, failed to identify concerns related to infection control which were cited on the previous three annual surveys. It also, failed to address identified concerns from the last survey related to antibiotic stewardship and COVID-19 testing of residents and staff from the last standard survey exited 12/2/21. - 4/20/22, during the quarter from 1/1/22, through 3/31/22, there were 4 respiratory infections, 9 urinary tract infections (bladder infection) (UTI), 10 skin/wound infections, 30 gastrointestinal (stomach and intestines) (GI) infections (24 of which were in February 2022), and 4 other infections. The facility had COVID-19 in January 2022, and norovirus in February 2022. A root cause analysis (RCA) was done for the January 2022, COVID-19 outbreak and identified a staff member who normally worked on Evergreen Unit had family on the Blueberry Unit who tested positive for COVID-19. The identified 18 residents and 19 staff were positive for COVID-19. There was no other follow up from the COVID-19 outbreak. There were no comments or concerns brought up related to norovirus. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 7/27/22, during the quarter from 4/1/22, through 6/30/22, there were 9 respiratory infections, 14 UTIs, 2 skin/wound infections, 6 GI infections, and 4 other infections. There was no follow-up identified on meeting minutes regarding resident illnesses for the quarter. Staff Infection Surveillance Log from April 2022 identified 10 staff were ill of which 4 had diarrhea/vomiting (norovirus was questioned but lacked follow up), 3 complaints of headache, 2 with sore throats, and 1 with general not feeling well. Staff Infection Surveillance Log from May 2022 identified 3 staff were ill of which 1 was fever, 1 was GI, and 1 was sent home not feeling well. The May illnesses lacked follow up. The Staff Infection Surveillance Log from June 2022 identified 4 illnesses of which 3 were GI and 1 sore throat. 1 of the GI illness identified COVID exposure and follow up PCR and antigen were negative. No other follow up was done on other illnesses. - 11/16/22, during the quarter from 7/1/22, through 9/30/22, there were 7 respiratory infections, 11 UTIs, 3 skin/wound infections, 2 GI infections, and 7 other infections. Follow-up was done on UTIs regarding treatments prior to receiving culture results and contacting provider to inform treatment was not needed, but noted the treatment continued. An improvement project was started regarding antibiotic usage in UTIs. No follow-up was identified for the other infections and did not address cause or spread of UTIs. The resident infections grid for previous quarters were unreliable. The infection grid did not identify the 30 GI illnesses from 1/31/22, through 3/31/22, and only identified 6 of 14 UTIs identified from 4/122, through 6/30/22. The provided QAPI Committee Agenda/Minutes did not identify a plan to ensure infections were investigated, tracked, trended, and analyzed appropriately, ensure appropriate antibiotic use; ensure staff had the necessary vaccination or exceptions and collected the necessary data to report accurately to Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN); when the facility staff had known there were issues with the infection control program. During an interview on 1/12/23, at 7:15 p.m. the administrator stated when the QAA/QAPI committee picked a quality measure (QM) QM to work on for improvement they would review previous years surveys, CASPER-3, and corporate QM measures. When a high-risk area was discovered, the committee would work on an improvement project to improve quality of life for the residents. The administrator identified infection control was a high-risk area and there have been continued concerns with it over the past couple of years. An improvement project was not started because of frequent changes of leadership in the building. Because infection control was a high-risk area, an improvement measure should have been started for the benefit of the residents. The facility's QAPI policy dated 4/6/15 identified the facility would monitor and drawn data from previous surveys to conduct Performance Improvement Projects (PIPs) to improve care or services in areas that have been identified as a concern. These projects would concentrate on a particular problem in one area of the care center or care center wide.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. The IJ began on 12/20/22, when NA-D returned to work following COVID-19 symptoms on 12/19/22 and subsequently became positive on 12/21/22. Following the positive COVID-19 test result, the facility failed to conduct contact tracing or initate facility wide testing for COVID-19. The facility failed to isolate and implement transmission based precautions for R108, R29 and R41 when they displayed signs and symptoms of COVID-19. In addition, after the facility placed residents in isolation, staff were observed to not use the appropriate PPE. The administrator and DON were notified of the IJ on 1/11/23, at 2:00 p.m. The IJ was removed on 1/12/23, at 3:00 p.m. when the facility implemented actions to reduce/prevent the spread of illness, including COVID-19. However, noncompliance remained at the lower scope and severity, F, widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ. Findings include: The Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 23, 2022, identified anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for COVID-19 as soon as possible. Mild illness is defined as any various signs and symptoms of COVID-19 such as fever, cough, sore throat, malaise, headache, muscle pain, without shortness of breath, dyspnea or abnormal chest imaging. Moderate illness is defined as evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen of <94% on room air. CDC further indicated HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e. g., cough, shortness of breath) have improved. Further, patients with symptoms of COVID-19 (even before results or diagnostic testing) should be placed in Transmission-Based Precautions. The decision to discontinue empiric transmission based precautions by excluding the diagnosis of a current COVID-19 infection for a patient with symptoms can be made based upon having negative results from at least one viral test. If using an antigen test, a negative result should be confirmed by either a negative molecular test or a second negative antigen test taken 48 hours after the first negative test. Patients with suspected or confirmed COVID-19 should be placed in a single person room and the door should be kept closed, if safe to do so. Healthcare workers who enter the patients rooms should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). The CDC Symptoms of COVID-19, updated October 26, 2022, identified people with COVID-19 have had a wide range of symptoms reported-ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Possible symptoms include: fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Employee Illness Tracking The facility employee infection control logs for the month of December 2022, identified the following: Respiratory Illness - On 11/24/22, dietary aide (DA)-A tested positive for RSV. DA-A was not tested for COVID-19 illness. DA-A returned to work on 11/28/22. -On 12/4/22, licensed practical nurse (LPN)-A reported aching, sore throat, and headache. LPN-A was not tested for COVID-19 illness. LPN-A returned to work on 12/5/22. LPN-A was not tested for COVID-19 illness. LPN-A worked 12/5/22, 12/6/22 and 12/7/22. On 12/8/22, LPN-A tested positive for influenza B and was still not tested to rule out COVID-19. An analysis of potential contacts who may have been exposed or resolution of symptoms was not documented. -On 12/6/22, DA-D reported increase respiratory symptoms. DA-D was not tested for COVID-19 illness. DA-D returned to work on 12/21/22. -On 12/7/22, AA-C reported symptoms of aching and cough. AA-C was not tested for COVID-19 illness. AA-C returned to work on 12/12/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-On 12/19/22, NA-D reported respiratory symptoms. NA-D was not tested for COVID-19 illness. NA-D returned to work on 12/20/22. On 12/21/22, NA-D reported illness and tested positive for COVID-19. Contact tracing and testing for COVID-19 to evaluate staff and residents potential exposure and limit the spread of the illness within the facility was not initiated, despite NA-D having worked providing direct care to residents the day prior to her positive test result. -On 12/24/22, LPN-B reported illness of headache and aching while working her shift. LPN-B tested positive for COVID-19 on 12/27/22. LPN-B returned to work on 12/29/22. Contact tracing and testing for COVID-19 to evaluate staff and residents potential exposure and limit the spread of the illness within the facility was not initiated, despite LPN-B having worked providing direct care to residents the day she began exhibiting symptoms of illness. Gastrointestinal Illness (GI) -On 12/8/22, cook (CK)-A reported diarrhea illness and went home. CK-A was not tested for COVID-19 illness. CK-A returned to work on 12/9/22. -On 12/8/22, activity director (AD)-A reported nausea and went home. AD-A was not tested for COVID-19 illness. AD-A returned to work on 12/9/22. -On 12/8/22, dietary aide (DA)-B reported nausea, vomiting and diarrhea and went home. DA-B was not tested for COVID-19 illness. DA-B returned to work on 12/9/22 -On 12/9/22, the director of nursing (DON) reported diarrhea and headache. The DON was not tested for COVID-19 illness. The DON returned to work on 12/12/22. -On 12/9/22, DA-C reported GI symptoms. DA-C was not tested for COVID-19 illness. DA-C returned to work on 12/19/22. -On 12/9/22, assistant dietary manager (ADM)-A reported GI symptoms. ADM-A was not tested for COVID-19 illness. -On 12/12/22, DA-B reported GI symptoms. DA-B was not tested for COVID-19 illness. DA-B returned to work on 12/13/22. -On 12/14/22, registered nurse (RN)-D reported body aches, nausea and vomiting. RN-D did not test for COVID-19 illness. RN-D returned to work on 12/16/22 -On 12/21/22, DA-D reported GI symptoms. DA-D was not tested for COVID-19 illness. DA-D returned to work on 12/30/22 -On 12/27/22, nursing assistant (NA)-C reported vomiting and diarrhea. NA-C was not tested for COVID-19 illness. NA-C returned to work on 12/29/22 -On 12/28/22, NA-A reported nausea and dizziness. NA-A was not tested for COVID-19 illness. NA-A returned to work on 1/9/23. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-On 12/29/22, NA-B reported nausea, vomiting and diarrhea. NA-B was not tested for COVID-19 illness. NA-B returned to work on 12/31/22. There was no evidence assessments were conducted to determine if employee illness could potentially be COVID-19 symptoms and require testing prior to return to work or if there were potential resident and staff exposures and a need to conduct contact or outbreak testing. The infection control logs lacked evidence the facility conducted a comprehensive analysis of the collected outcome surveillance data to determine if any of the infections identified were potentially related or corresponded with resident illness for the same month period. There was no evidence the facility had investigated the infections identified for potential causes and/or subsequent actions to reduce the risk of recurrence. When interviewed on 1/10/23, at 2:15 p.m. LPN-A stated if an employee came to her with complaints of feeling sick she would ask them about their symptoms. If it was just sniffles or a little under the weather, she would not send them home. If they were really sick and they had coverage, she would send them home. During interview on 1/10/23 at 2:35 p.m. NA-C stated she would not come to work if she felt sick. If NA-C was already working and started to feel sick, she would try to get someone to come in and replace her but if could not find anyone, she couldn't just go home. It depended on what her symptoms were and which of the nurses was working. If she was throwing up she would probably go home, but if was just feeling run down she would have to work out her shift. When interviewed on 1/10/23, at 3:40 p.m. NA-D stated she was ill with COVID in December of 2022, and tested positive for COVID-19 on 12/21/22. The symptoms NA-D experienced during that illness were GI upset of nausea, vomiting and diarrhea. During interview on 1/11/23, at 10:30 a.m. LPN-B stated she was sick the day she worked on 12/24/22. LPN-B called the administrator that evening to let her know and did not work on 12/25/22 or 12/26/22. LPN-B tested positive on 12/27/22, as she knew she would as a family member in her home was ill with COVID-19 the week before. LPN-B returned to work on 12/29/22, when she was no longer feeling ill and it was five days since her symptoms first appeared. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During interview on 1/10/23, at 10:20 a.m. RN-D, who was the infection preventionist, stated she saw the employees when they returned to work after having called in and none appeared ill. RN-D did not test the employees on their return to work. RN-D had known LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/23; however, continued to work her entire shift. LPN-B did test positive on 12/27/22. The facility had not initiated any testing of potentially exposed residents or staff, as RN-D felt the doctors in the area believed people tested for COVID too often. RN-D was aware of the facility's policies for staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) should not report to work until testing could be completed as well as contact tracing for potential exposures; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D stated she visualized all the staff members LPN-B worked with when LPN-B was presenting with symptoms at work. The unidentified staff did not display any symptoms of illness, so RN-D did not feel any COVID-19 testing was necessary, despite COVID-19 having asymptomatic transmission. RN-D saw DA-A on her return to work on 11/28/22, after testing positive for RSV on 11/24/22, and DA-A had no obvious symptoms of illness, and there were no other cases of RSV in the facility. The employees who reported symptoms of GI illness during the month of December were not tested for COVID-19 as their symptoms did not act like a COVID-19 illness. It depended on staff symptoms if they would need to test before returning to work after an illness. An interview was conducted with the DON and administrator on 11/10/22, at 3:30 p.m. The administrator stated if staff or residents displayed illness that could indicate a COVID-19 infection, the ill resident or staff were to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If the results were negative and the resident or staff was asymptomatic isolation was lifted. For contact tracing, the facility did outbreak testing with COVID-19 antigen tests. The facility had not completed an assessment to see if outbreak testing would be needed when LPN-B had tested positive as her positive test was more than 48 hours since she had last worked, despite having displayed symptoms of COVID-19 while at work on 12/24/22. The facility allowed staff to return to work in five to ten days of a positive COVID test, five days if emergency staffing, if they had improved symptoms and were fever free. They allowed LPN-B to return to work on 12/29/22, because they had used onset of symptoms 12/24/22, for the start of her illness. RESIDENT OBSERVATIONS: During observation of R41 on 1/11/23, at 8:40 a.m. there was a sign on R41's door which directed staff/visitors to stop at nurses station prior to going into the room. An isolation cart was outside of the room. During observation of R41 on 1/11/23, at 8:51 a.m. R41's door was wide open and R41 was not in the room. During observation of R41 on 1/11/23, at 8:56 a.m. R41 was in the dining room and seated at a table in the far corner of the room approximately 10-12 feet (ft) from other residents. Nursing assistant (NA)-C was wearing a face mask and was seated next to R41 to assist R41 with eating. During observation of R41 on 1/11/23, at 8:58 a.m. activity aide (AA)-C wheeled R41 out of the dining room and into the hallway near the waterfall. R41 was not wearing a face mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During observation on 1/11/23, at 9:06 a.m. R41 was seated in her wheelchair, was not wearing a face mask and was seated next to two unidentified residents in the hallway near the waterfall. During observation of R41 on 1/11/23, at 9:06 a.m. R41 was observed unmasked and seated in her wheelchair in the activity area. R41 stated she didn't feel well. R41 coughed several times. Licensed practical nurse (LPN)-C stated R41 could eat in the dining room as long as the resident wore a face mask and sat at the table in the far corner. LPN-C needed to give R41 a breathing treatment and started to wheel R41 out of the activity area. While LPN-C was wheeling R41 down the hallway, LPN-C was interrupted and left R41 in the hallway. R41 was still unmasked. During observation of R41 on 1/11/23, at 9:17 a.m. LPN-C returned to R41 and started wheeling R41 towards her room. LPN-C stated R41 should be wearing a face mask since she was in the hallway. During observation on 1/11/23, at 9:21 a.m. LPN-C was standing next to R41, nurse prepped nebulizer equipment near R41 and then exited residents room. LPN-C did not put on personal protective equipment (PPE) prior to entering R41's room, and did not perform hand hygiene prior to entering or upon exiting the room. LPN-C re-entered R41's room wearing a face mask and carried gloves balled up in her left hand. LPN-C did not put on PPE or use hand sanitizer prior to entered R41's room. With bare hands, LPN-C prepped R41's nebulizer medication (inhaled medication used to reduce inflammation in the lungs or to open airways to improve breathing ability), and placed the face mask over R41's face, secured the elastic straps around R41's head and turned the machine on. LPN-C proceeded to clean and walk around the area near R41 while the nebulizer machine was bubbling and running. LPN-C maintained a distance between 2 feet and 8 feet from R41 during the entire time. During observation at 9:28 a.m. NA-F entered R41's room, talked with LPN-C and then exited the room. Upon entering R41's room NA-F did not use hand sanitizer or put PPE on prior to entering room, use hand sanitizer upon exiting the room or to change face mask after exiting the room. During observation at 9:30 a.m. LPN-C continued to walk around R41's room. LPN-C leaned over R41 and stand face-to-face with R41 while R41's nebulizer was still running. LPN-C was wearing a face mask . LPN-C then removed R41's nebulizer mask, walked behind resident and turned nebulizer machine off. With bare hands, LPN-C carried the nebulizer mask into the bathroom. LPN-C exited the bathroom and walked to R41's side. LPN-C arranged R41's oxygen tubing, placed the nasal cannula on the resident's face and listened to her chest with a stethoscope. LPN-C was within one to two feet of R41 the entire time. Then LPN-C walked into the bathroom, washed hands, removed the face mask, exited R41's room and put on a clean face mask. LPN-C was in R41's room for a total of 8 minutes while in close proximity of R41 and only wearing a face mask. During interview on 1/11/23, at 9:28 a.m. NA-F stated despite there being a sign on the door and a cart outside R41's room she completely forgot to put on PPE prior to entering R41's room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During interview on 1/11/23, at 9:35 a.m. LPN-C stated R41 had a cough and tested negative for COVID-19 on 1/10/23. LPN-C stated R41 was on contact and droplet precautions due to R41's cough and R41 should wear a face mask when out of the room. Staff were supposed to wear on a gown, gloves and face mask when entering R41's room and the sign on the door identified that information. LPN-C did not wear a gown and gloves upon entering R41's room but should have. COVID-19 testing recommendations were to test on day 1, day 3 and day 5 before residents were considered negative. Yesterday was R41's first test. LPN-C stated she did not think R41 would be considered free from COVID-19 after one negative test. When interviewed on 1/11/23, at 9:57 a.m. NA-G stated when she came to work that morning R41 had transmission based precautions (TBP) cart with PPE and a sign on the door directing staff to wear a gown, gloves, eye goggles and face mask when entering the room. Wearing PPE was used to help reduce the risk of spreading infections to other staff and residents. NA-G was initially told R41 had to stay in her room but then later was told the resident could go to the dining room for breakfast as long as she sat at the table furthest in the corner and away from other people. When NA-G wheeled R41 through the dining room R41 did not wear a face mask. During interview on 1/12/23, at 3:48 p.m. the director of nursing (DON) stated when a resident was on TBP the staff were expected to wear a gown, gloves, mask, and depending on the precaution would also expect staff to wear eye goggles, face shield or N95 mask. The staff would also be expected to use hand sanitizer prior to and upon exiting the residents room. That was the policy and staff knew and were expected to follow the policy. When interviewed on 1/11/23, at 10:34 a.m. LPN-B stated R50 started to complain of a sore throat and headache that morning. R50's first COVID-19 test that morning was negative; however, R50 was placed on isolation until confirmatory COVID-19 testing could be completed and her symptoms evaluated. During observation of R50 on 1/11/23, at 10:50 a.m. housekeeper (HK)-A was cleaning R50's room while wearing a surgical face mask and gloves. R50's room had an isolation cart outside of her door and the door way to her room was clearly marked with a sign that indicated anyone who entered needed to observe transmission based precautions and put on a disposable gown, gloves, eye protection and face mask before entering the room. R50 was lying on her bed reading a magazine. The DON approached the room and asked HK-A to leave the room to talk with her. HK-A was instructed on contact precautions. HK-A removed and discarded her gloves in the garbage; however, continued to wear the same surgical mask. HK-A stated they were not told residents were placed in transmission based precautions. HK-A did not see the signs indicating the TBP on R50's door, as R50's door was open when she approached it. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During observation odf R50 on 1/11/23, at 10:53 a.m. HK-B entered R50's room to deliver laundry. R50 was lying on her bed reading a magazine. HK-B wore a surgical face mask under her chin, that did not cover her mouth or nose. HK-B did not put on a gown, gloves or eye protection, and entered the room with clean laundry. HK-B delivered the resident's laundry, putting the clean clothes in the residents closet and exited the room; however, did not perform hand hygiene. HK-B stated the transmission based precaution sign hanging on R50's door and the isolation cart outside her door was set up just for visitors, if they were staying in the room for a long time. If the resident was being quarantined for COVID infection there would have been a large COVID sign on her door and in that case, she would not have entered the resident's room and just hung the clean laundry outside her door for nursing staff to put away. HK-B knew her mask was to cover her nose and mouth. It kept sliding down and so she adjusted it back in place. Resident Illness Tracking Resident illness tracking logs for the month of November 2022, identified the following: Respiratory illness -On 11/4/22, R15 developed symptoms of lethargy, decrease oxygen saturation, cough and increase confusion. R15 received two antibiotics for treatment of pneumonia; however, sensitivities were not identified and COVID-19 testing was not conducted. -On 11/19/22, R34 developed symptoms of nasal drainage, cough, loss of taste and smell. R34 tested positive for COVID-19 on 11/22/22 and placed in isolation. -On 11/28/22, R38 was identified as positive for COVID-19 and placed in isolation. Urinary Tract Infections (UTI) -On 11/21/22, R3 developed a UTI. R3 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 11/28/22, R38 developed a UTI. R38 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. Resident illness tracking logs for the month of December 2022, identified the following: Urinary Tract Infections (UTI) The December 2022 Infection Surveillance Log (ISL) identified : -On 11/30/22, R23 developed a UTI -On 11/24/22, R3 developed a UTI. R3 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/2/22, R35 developed a UTI. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-On 12/6/22, R23 developed a UTI. R23 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/8/22, R33 developed a UTI. R38 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified. -On 12/8/22, R41 developed a UTI. R41 received antibiotic treatment; however, sensitivities to see if the organism was sensitive to the antibiotic ordered, were not identified -On 12/27/22, R23 developed a UTI. R23 received two different antibiotics for treatment; however, sensitivities to see if the organism was sensitive to the antibiotics ordered, were not identified The summary of December 2022 infection control log identified eight resident UTI's, 7 consisted of bacterial infections and 1 was contaminated but treated anyway. The infection control logs lacked evidence the facility conducted a comprehensive analysis of the collected outcome surveillance data to determine if any of the infections identified were potentially related or corresponded with staff illness for the same month period to initiate appropriate corrective action. There was no evidence the facility investigated the infections identified for potential causes and/or subsequent actions to reduce the risk of reoccurrence. The following resident medical records in conjunction with the facility infection control logs identified the following: - Progress note (PN) dated 12/16/22, identified R108 developed decrease lung sounds and oxygen saturations of 70 to 80% with oxygen in place. R108 required hospitalization and returned with diagnosis of pneumonia with unknown origin. R108 was not identified on resident illness logs for surveillance when he presented with initial illness, or throughout his illness. R108 was not evaluated or tested for COVID-19 during the initial course of illness and was not isolated from other residents until COVID-19 testing could be completed to rule out the infectious illness. -PN dated 1/9/23, identified R29 developed symptoms of nausea and vomiting. A rapid COVID-19 test was performed and was negative. R29 was not listed on the resident illness tracking log for surveillance, nor placed on isolation pending a confirmatory test. -PN dated 1/4/23, identified R41 developed low grade temperature of 99. 5, oxygen saturation of 93% with supplemental oxygen at 2L/min, and complaints of not feeling well. A rapid COVID-19 test was performed and was negative. However, R41 was not listed on the resident illness tracking log. R41 remained symptomatic with cough and general malaise, no further COVID-19 test were performed and R41 was not placed into transmission based precautions as recommended by the Centers for Disease Control (CDC) until facility was notified of surveyor concerns on 1/11/23. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During interview on 1/10/23, at 10:20 a.m. RN-D stated the nursing staff were supposed to fill out a sick log form when residents had symptoms of illness and she would update her surveillance logs from those forms weekly. RN-D was notified R41 was tested for COVID-19 on 1/4/23, and was negative. R41 had nasal drainage and a cough when she had assisted her in the dining room on 1/6/23. RN-D then notified the charge nurse after wheeling R41 out of the dining room. Testing was usually done on day one, day three and day five for symptomatic staff and residents because of the potential incubation period of the illness. RN-D usually did the COVID-19 testing for residents but did not fill out the sheets for R41's follow up tests, so the required follow up testing was not completed. RN-D was not sure why R108 was not on the resident infection December 2022 logs, as R108 should have been, especially because of his emergency room visit and diagnosis of pneumonia. RN-D indicated it was important to be sure to include all ill resident and employees on the surveillance logs so you could track where they were, how the illness was going and if it was spreading. During interview on 1/10/23, at 4:00 p.m. registered nurse (RN)-A stated if a resident showed signs of COVID-19, they would isolate the resident and test with a rapid antigen test. If still showing symptoms they would retest the resident. They always notified RN-D when they tested a resident for COVID-19. R41 displayed a cough and low grade fever. R41 was tested on [DATE] and was negative for COVID-19. R41 still exhibited symptoms of cough and her oxygen saturation was 95% at rest with supplemental oxygen. R41's cough was loose and in her chest, not in her lungs. RN-A had not personally done a repeat COVID test and would have to check with the nurses working on the floor if another test was needed. No second confirmatory testing was completed after the initial test was done on 1/4/23, despite her continued symptoms. R41 had not been isolated, although continued to exhibit symptoms of cough and shortness of breath. When interviewed on 1/11/23, at 8:30 a.m. RN-D stated some of the resident UTI infections should not have had an antibiotic ordered because no specific bacteria was cultured. RN-D looked for patterns and trends with the resident infections but could only find incontinence of urine and resisting staff assist with peri care after an incontinent episode as a common factor. There did not seem to be a common bacteria with the infections or in the same areas of the facility or she would have suspected staff as the source. RN-D did not document sensitivities to cultures or follow up to make sure the antibiotic ordered was effective against the identified organism. Some times the facility would get sensitivity results on cultures and sometimes they would not. In some instances the lab would not even do a sensitivity on a culture. RN-D stated she watched some staff complete peri care to ensure proper technique; however, had not documented audits formally. She had tried to start audit forms but staff had become angry with the audits and so they were not completed. RN-D did not identify if any concerns or training with peri care had been completed while performing audits. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the potential to affect all 54 residents who resided in the facility. Findings include: The facility form, Infection Surveillance Log from November through December 2022, tracked actual infections and antibiotic use. The form was organized with twelve columns which collected the following data: resident name, room number, physician, signs and symptoms, infection site, identified pathogen and date of test, risk factors/pertinent remarks/admit to hospital, date/type of antibiotic treatment, preventative measures/precautions/isolation, follow up/antibiotic effective/interventions effective/date resolved. The December 2022, Infection Surveillance Log and corresponding analysis identified eleven antibiotics were prescribed. Nine infections on the surveillance log did not identify culture and sensitivity results were identified to track. The analysis identified eight resident urinary tract infections (UTI)s in the month of December, six of which received antibiotic treatment. One resident infection was treated with more than one antibiotic at the same time for the same infection; however, it did not identify a rationale for the treatment of two antibiotics for the same infection. Further, the analysis identified antibiotic treatment for R33 with a potential urinary infection that produced mixed flora and was not positive for infection. R33 was prescribed Cipro (antibiotic), there was no evidence the antibiotic was reviewed and discontinued. There was no evidence any of the antibiotics were reviewed for appropriate use, nor were any culture sensitivities identified to demonstrate the organism was susceptible to the prescribed antibiotic. There was no evidence of any established criteria (i.e. McGeer, Loeb's) being used to determine the presence of infection before the antibiotics were initiated for resident UTI symptoms. On the back of the December 2022, surveillance log was a handwritten note, which registered nurse (RN)-D, who was also the infection control (IP) nurse, indicated was her written summary of the facility's December resident infections. The note identified there were eight UTI's, seven with bacterial infection and one that had a contaminant but was treated anyway. The report identified each resident along with their symptoms and prescribed antibiotic; however, lacked any information if a sensitivity was done and if the organism was susceptible to the prescribed antibiotic. There was no evidence of any established criteria being used or interventions implemented prior to the start of treatment, nor the date the symptoms resolved. R23's undated Resident Face Sheet, identified an admitted [DATE]. Diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, polyp of corpus uteri, and urge incontinence. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R23's nurse progress notes identified the following: -12/6/22, a verbal order was received to start Cipro (an antibiotic) 500 milligrams (mg) by mouth (po) two times per day (BID) for seven days. The culture showed Klebsiella pneumoniae infection and identified the organism as an abnormal result. The medical record lacked sensitivity for the organism being treated. -12/21/22, new orders received to start Augmentin (an antibiotic) 875-125 mg BID for seven days for urinary tract infection (UTI). -12/27/22, orders received to stop amoxicillin (an antibiotic) and start Doxycycline 100 mg BID until gone. The medical record lacked evidence of a culture or sensitivity to identify if the antibiotic ordered would be effective to treat the infection. R23's progress notes were reviewed 12/1/22 through 12/31/22, lacked any documentation of assessments, symptoms, or complaints of urinary tract infections. The medical record failed to identify if any non-pharmacological interventions were attempted, such as increase fluids. Laboratory documentation identified a urinalysis and culture was completed on 12/20/22. A sensitivity was recorded and did indicate the organism was susceptible to the current antibiotic treatment. The medical record lacked urinalysis, cultures or sensitivities for the treated UTI infections on 12/6/22 and 12/27/22. R33's undated Resident Face Sheet, identified an admitted [DATE]. Diagnoses included hydronephrosis, hematuria, cystitis, abnormal uterine and vaginal bleeding and stress urinary incontinence. R33's Outpatient Medication Orders, dated 12/5/22, indicated Cipro (an antibiotic) 500 milligrams (mg) two times per day. R33's Family Medicine Clinic Note dated 12/5/22, identified R33 had been seen in the emergency department on 12/4/22, and was started on an antibiotic for an urinary tract infection (UTI). R33's medical record was reviewed and lacked evidence of a urinalysis, culture or sensitivity results (a laboratory test to identify infective germs and which antibiotics were effective for treatment), however, the December Resident Infection Surveillance Log identified R33 had symptoms of lethargy, confusion and behaviors and received Cipro antibiotic treatment two times per day (BID) for seven days for a UTI. The organism was identified as mixed microflora. (indicated at least 2 organisms present and does not meet the criteria for a positive urine culture. Urine cultures that contain more than one organism are usually considered a contaminated specimen.) R33's Medication Administration Record dated December 2022, identified R33 received Cipro 500 mg BID from 12/8/22 through 12/15/22. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R33's progress notes and physician communication notes were reviewed 12/8/22 through 1/10/23, and lacked evidence the physician was notified of the culture results and inappropriate antibiotic treatment. Further, the progress notes lacked documentation of assessments, symptoms, or complaints of urinary tract infection and failed to identify non-pharmacological interventions attempted, such as increase in fluids. On 1/12/22, at 2:00 p.m. RN-D, the IP, stated if an antibiotic was ordered and it was identified the infection was not appropriate to treat with an antibiotic, the resident usually had already completed the treatment by the time the facility received the culture results. The area physicians did not usually wait for the culture results before treating. RN-D looked at resident culture and sensitivities, and at times looked them up in the resident clinic notes. The physicians were the problem, as they did not wait for the results before ordering antibiotics. Sometimes the lab would send the culture and sensitivities to the facility following urinalysis and sometimes they did not. Sometimes the lab would not even do a sensitivity on the cultures. RN-D tried to get the nurses to try to increase fluids and other interventions for three days prior to calling to obtain a urinalysis and was trying to get the nurses to use the SBAR (situation, background, assessment and recommendation format to facilitate prompt and appropriate communication) forms for notifying the physicians of possible resident infections, or Loeb's or the McGeer criteria, but it was only as good as what the nurses were putting in the medical record for her to review. RN-D checked the report log daily to see if any residents had started an antibiotic treatment and frequently the culture and sensitivity would not be back. RN-D was unsure what could be done, and felt maybe the facility should hold the antibiotic until the culture and sensitivity was received. That way RN-D would be able to pull it all together in a SBAR form to fax to the physician. RN-D did not have any documentation culture or sensitivities were received or reviewed by the facility for resident infections that were treated with antibiotics and did not have documentation of physician notifications. During interview on 1/12/23, at 5:30 p.m. the director of nursing (DON) stated RN-D, the IP should be documenting sensitivities and compare and analyze resident antibiotic use. RN-D should notify the physician if an antibiotic was felt to be inappropriate. The facility should be using an antibiotic use criteria such as McGeer to determine the need for treatment. She planned to revamp the whole infection control program. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy Antibiotic Stewardship Program dated 7/1/19, indicated the care center would establish and antibiotic stewardship team that would be accountable for antibiotic stewardship activities. The team would implement antibiotic use protocol and criteria, review infections and monitor antibiotic use patterns, review reports on number of antibiotics prescribed and the number of residents treated each month, quarter, and year. Review reports on the number of residents on antibiotics that did not meet criteria for active infection, and review trends of antibiotic use, overuse and trends of resistance. Direct care nurse, charge nurse or IP nurse would communicate with the prescribing physician if an antibiotic was ordered outside of criteria. The pharmacy consultant would review antibiotic usage data each month and make recommendations as needed. The medical director would review antibiotic use and resistance data at Quality Assurance Performance Improvement (QAPI) meetings or as needed. The facility would use McGeer's, Loeb's, or The National Healthcare and Safety Network (NHSN) criteria for assessing resident for infections. The facility would assess appropriate diagnostic testing such as cultures for various infections and evaluate the appropriateness of antibiotic therapy per laboratory results. The direct care nurse, charge nurse and/or IP nurse would screen antibiotic orders for appropriate agent selection and would communicate with the prescriber and make recommendations if indicated. The direct care nurse and prescriber would conduct an antibiotic review process after an antibiotic was started for all antibiotics prescribed. When culture results were received the nurse would contact the prescriber to review the results to ensure follow up on appropriate antibiotic therapy. The IP nurse would be responsible for ensuring the facility infection and multi-drug resistant surveillance was being done by the nursing staff. The IP nurse would be responsible to interpret data and do action responses as needed. The IP nurse would review if appropriate tests/cultures were obtained for the antibiotic order.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility infection preventionist (IP) failed to adequately assesses, develop, implement, monitor, and manage the infection prevention and control program. This had the potential to affect all 54 residents residing in the facility including staff and visitors. Findings include See also F880, Infection Prevention and Control: Based on observation, interview and document review the facility failed to ensure 5 of 5 employees, (licensed practical nurse (LPN)-A, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D and LPN-B) were appropriately cleared to return to work following reports of potential symptoms of COVID-19; failed to initiate contact tracing or facility wide testing for COVID-19 following potential exposure from a staff who tested positive for COVID-19; failed to ensure 3 of 53 residents (R108, R29, R41) were isolated while presenting with symptoms of COVID-19; and failed to utilize appropriate protective equipment for 2 of 3 residents (R41, R50) when they were placed in isolation. In addition, the facility failed to ensure twelve employees (cook (CK)-A, activity director (AD)-A, DA-B, the director of nursing (DON), DA-C, assistant dietary manager (ADM)-A, DA-B, registered nurse (RN)-D, DA-D, NA-C, NA-A,NA-B) who were out ill with potentially communicable illness' were cleared to return to work: failed to to track resident symptoms of infection and implement an ongoing analysis of collected data to ensure patterns and trends were identified and acted upon to reduce the risk of disease spread within the facility as recommended by the Centers for Disease Control (CDC) guidance to prevent/or minimize the transmission of COVID-19. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility to vulnerable residents and the staff of the facility and resulted in an immediate jeopardy (IJ) which placed all 54 residents at a high likelihood to for serious illness and/or death by contracting a communicable disease, including but not limited to COVID-19. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 1/10/23, at 10:20 a.m. RN-D, who was the IP, stated she saw the employees when they returned to work after having called in and none appeared ill. RN-D did not test the employees on their return to work. RN-D had known LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/23; however, continued to work her entire shift. LPN-B did test positive on 12/27/22. The facility had not initiated any testing of potentially exposed residents or staff, as RN-D felt the doctors in the area believed people tested for COVID too often. RN-D was aware of the facility's policies for staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) should not report to work until testing could be completed as well as contact tracing for potential exposures; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D stated she visualized all the staff members LPN-B worked with when LPN-B was presenting with symptoms at work. The unidentified staff did not display any symptoms of illness, so RN-D did not feel any COVID-19 testing was necessary, despite COVID-19 having asymptomatic transmission. RN-D saw DA-A on her return to work on 11/28/22, after testing positive for RSV on 11/24/22, and DA-A had no obvious symptoms of illness, and there were no other cases of RSV in the facility. The employees who reported symptoms of GI illness during the month of December were not tested for COVID-19 as their symptoms did not act like a COVID-19 illness. It depended on staff symptoms if they would need to test before returning to work after an illness. See also F881, Antibiotic Stewardship: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included implementation of protocols and a system to monitor antibiotic use to ensure appropriate antibiotics were utilized. In addition, the facility failed to ensure cultures were obtained for antibiotic use for 2 of 2 residents (R 23, R33) who were prescribed antibiotics for urinary tract infections (UTI). This deficient practice had the potential to affect all 54 residents who resided in the facility. When interviewed on 1/11/23, at 8:30 a.m. RN-D, who was the IP stated some of the resident UTI infections should not have had an antibiotic ordered because no specific bacteria was cultured. RN-D looked for patterns and trends with the resident infections but could only find incontinence of urine and resisting staff assist with peri care after an incontinent episode as a common factor. There did not seem to be a common bacteria with the infections or in the same areas of the facility or she would have suspected staff as the source. RN-D did not document sensitivities to cultures or follow up to make sure the antibiotic ordered was effective against the identified organism. Some times the facility would get sensitivity results on cultures and sometimes they would not. In some instances the lab would not even do a sensitivity on a culture. RN-D stated she watched some staff complete peri care to ensure proper technique; however, had not documented audits formally. She had tried to start audit forms but staff had become angry with the audits and so they were not completed. RN-D did not identify if any concerns or training with peri care had been completed while performing audits. During interview on 1/12/23, at 5:30 p.m. the director of nursing (DON) stated RN-D, the IP should be documenting sensitivities and compare and analyze resident antibiotic use. RN-D should notify the physician if an antibiotic was felt to be inappropriate. The facility should be using an antibiotic use criteria such as McGeer to determine the need for treatment. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	See also F886, COVID- 19 Testing- Residents and Staff: Based on observation, interview and record review, the facility failed to ensure all staff were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing protocols. This system wide breakdown resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. During interview on 1/10/22, at 10:15 a.m. RN-D, who was the IP, stated the facility conducted outbreak testing 11/23/22 through 12/5/22, after two residents tested positive for COVID-19 in the facility. Staff were notified of the facility test dates and were expected to test prior to working. RN-D went on the nursing floor and reminded staff who had not tested to do so, but they refused to test. The facility policy to send the staff home if they refused to test was not enforced because the facility would not have enough staff to care for their residents. Some staff who did not test during the outbreak testing were still permitted to work. RN-D stated she notified the administrator of staff non-compliance with testing; however, felt she would not have the back up to enforce staff to not work if do not test. See F888: COVID-19 Vaccination of Facility Staff: Based on interview and document review, the facility failed to ensure 13 of 72 staff members (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. A joint interview with the administrator and RN-D was conducted on 1/11/23, at 1:30 p.m. The administrator stated DHR-A was to add the names of the new hires with a sheet regarding their vaccination status and put these on a vaccination log list. The facility struggled to keep the list up to date. RN-D identified when she got the sheets from DHR-A she looked in MIIC to verify the employee's vaccination status and had even tried to get the information from the local clinic's electronic health record, but at times had difficulty finding the information. The administrator stated she was monitoring the new hires to be sure they completed exemption forms if they were not up to date with their COVID-19 vaccinations. The administrator stated she was aware the employee vaccination logs and the NHSN data was not up to date due to the difficulty keeping the employee logs up to date and current. The administrator felt RN-D struggled with utilizing the computer to organize and track the needed information. During interview on 1/12/23, at 5:30 p.m. DON stated she planned to revamp the whole infection control program. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility Infection Prevention and Control Officer 5/8/17, identified St. [NAME] Health Services (SFHS) will designate one or more individuals as the Infection Prevention and Control Officer (IPCO) who will be responsible for the care center ' s Infection Prevention and Control Program (IPCP). The care center IPCO will have completed specialized training in infection prevention and control and professional training in nursing, medical technology, microbiology, epidemiology or related field. The IPCO will have the following organizational responsibilities: a. Coordinate the development and monitoring of the facility ' s established Infection Prevention and Control policies and practices, b. Establish Infection Prevention and Control procedures for surveillance, identification, investigation, control, and prevention of infections and communicable diseases, for all persons providing services in the facility, c. Identify and implement basic infection control measures (e.g. hand hygiene and standard precautions), transmission-based precautions for identified potentially communicable infections, and isolation procedures as appropriate, d. Implement Antibiotic Stewardship program that includes antibiotic use protocols and a system to monitor ABI use and resistance data, e. Implement outbreak control and preparedness planning procedures, f. Report required diseases to public health authorities, g. Maintain an Infection Surveillance program with Infection Control Log of incidents for both residents and staff, with documentation of analysis of tracking and trending and measures taken according to findings, h. Promote Infection prevention, and responsibility of care during Care Transitions, i. Serve as a member of and bring reports on the IPCP to the facility ' s QAPI Committee. The IPCO will have the following resident care responsibilities: a. Maintain a resident health program that includes Tb screening, Influenza and Pneumovac immunizations, and tracking of infections. b. Ensure resident care equipment is cleaned and disinfected according to Centers for Disease Control and Prevention (CDC) and manufacturer guidelines. c. Monitor resident infection control care practices. The IPCO will have the following personnel responsibilities: a. Ensure implementation of the employee health program that includes: (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	i. Employee TB program, ii. Employee immunization program, iii. Employee infectious illness guidelines, iv. Employee exposure plan. b. Provide required health care staff orientation and annual in-service training on infection control, including bloodborne pathogens and use of personal protective equipment (PPE), c. Provide educational materials for residents, families and providers d. Ensure linen handling procedures comply with infection control practices.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and record review, the facility failed to ensure all staff were tested for COVID-19 during outbreak testing; and failed to test and/or implement confirmatory testing for symptomatic residents and staff, licensed practical nurse (LPN)-A, LPN-B, dietary aide (DA)-D, activity aide (AA)-C, nursing assistant (NA)-D, R108, R29 and R41, who were not tested or had an initial negative rapid antigen testing for COVID-19, per the Centers for Disease Control (CDC) guidance on testing protocols. This system wide breakdown resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death to all 54 residents residing in the facility, along with staff and visitors. The IJ began on 11/23/22, when the facility identified an outbreak of COVID-19 in November and failed to ensure all staff were tested according to CDC outbreak testing requirements. The facility failed to provide evidence 34 staff who worked during outbreak were tested . In addition, the facility failed to initially test or provide a confirmatory test for residents and/or staff who exhibited or reported symptoms of COVID-19 and were tested with antigen tests. The administrator and the director of nursing (DON) were notified of the IJ on 1/10/23, at 2:00 p.m. The immediate jeopardy was removed on 1/11/23, at 3:00 p.m. when the facility implemented interventions to ensure all staff would be tested according to CDC guidelines; however, noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Diseases 2019 (COVID-19) Pandemic updated 9/23/22, indicated for nursing homes, a single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts could not be identified or managed with contact tracing or if contact tracing failed to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. The CDC guidance Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 (COVID-19) Infection or Exposure to SARS-CoV-2 updated 9/23/22 indicated when testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. HCP who are not symptomatic could return to work after results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	STAFF OUTBREAK TESTING: The facility's undated staff line testing forms identified outbreak testing began on 11/23/22, and the facility was testing three times weekly through 12/5/22. The staff line testing form and corresponding working schedules for November 23, 2022 through 12/9/22, identified the following: - On 11/23/22, the facility began their first week of outbreak testing for all staff and residents in the facility following two residents who tested positive for COVID-19. The facility scheduled the first week of testing for staff on 11/23/22, 11/25/22, and 11/28/22. Of the 76 staff listed on the testing logs, 21 staff tested negative on 11/23/22, two staff were not eligible to be tested and the remaining 53 staff did not have test results recorded. On 11/25/22, 10 staff tested negative for COVID-19, two staff were ineligible for testing and 64 staff did not have test results recorded. On 11/28/22, 18 staff tested negative for COVID-19, two staff were ineligible to test and 56 staff did not have test results recorded. - On 11/29/22, the facility began their second week of outbreak testing for COVID-19. The facility scheduled the second week of testing staff on 11/29/22, 12/1/22, and 12/5/22. On 11/29/22, of the 82 staff listed on the testing logs, 14 staff tested negative on 11/29/22, two were ineligible to test, and 64 staff did not have test results recorded. On 12/1/22, 22 staff tested negative, two were ineligible to test and 58 staff did not have test results recorded. On 12/5/22, 25 staff tested negative for COVID-19, two staff were ineligible to test and 55 staff did not have test results recorded. The facility time sheets during the entire outbreak period identified 34 of the facility staff worked in the facility during the outbreak period 11/23/22, through 12/5/22, without having completed any of the required outbreak testing. During interview on 1/10/22, at 10:15 a.m. registered nurse (RN)-D, who was also the infection prevention (IP) nurse, stated the facility conducted outbreak testing 11/23/22 through 12/5/22, after two residents tested positive for COVID-19 in the facility. Staff were notified of the facility test dates and were expected to test prior to working. RN-D went on the nursing floor and reminded staff who had not tested to do so, but they refused to test. The facility policy to send the staff home if they refused to test was not enforced because the facility would not have enough staff to care for their residents. Some staff who did not test during the outbreak testing were still permitted to work. RN-D stated she notified the administrator of staff non-compliance with testing; however, felt she would not have the back up to enforce staff to not work if do not test. - LPN-B had a family member who was ill with COVID-19 living in her home and reported not feeling well on 12/24/22; however, continued to work her entire shift and tested positive on 12/27/22. The facility did not initiate any testing of potentially exposed residents or staff, as RN-D thought the doctors in the area felt people tested for COVID to often. RN-D was aware of the facility's policy's regarding COVID-19 testing; however, the policies were written by the corporate office and did not necessarily reflect current practice. RN-D had observed the staff LPN-B worked with and they did not display any symptoms of illness, and didn't feel testing them was necessary. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When interviewed on 1/10/22, at 3:30 p.m. the administrator stated when outbreak testing, the facility would conduct antigen testing three times a week for two weeks. If any COVID positive tests were obtained the start cycle of testing would start over, until no new positive tests were obtained. The facility would stop testing and consider the outbreak resolved when no new positive tests were documented for two weeks. The administrator was not sure how the facility determined the outbreak had resolved when all the employees had not tested as required. All staff were notified by mass text to comply with outbreak testing and assumed they were compliant. If staff did not work on the scheduled test dates, they could test prior to their next scheduled shift. The administrator was not aware any staff were refusing to test. The facility expected all staff to test prior to working with residents when in outbreak status. The administrator did not think this was enforced but it was the expectation. If staff displayed illness that could indicate a COVID-19 infection, the ill staff was to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If results of the testing was negative and the staff was asymptomatic, isolation was lifted. The facility had not initiated outbreak testing when LPN-B had tested positive as her positive test was more than 48 hours since she had last worked, despite having displayed symptoms of COVID-19 while at work on 12/24/22. During interview on 1/11/23, at 8:51 a.m. LPN-C stated outbreak testing was done two times per week. LPN-C may have forgotten to get tested during the outbreak as required. No one ever stated a test was needed to be done before the start of the shift. Sometimes RN-D would remind staff to come and test but LPN-C was already working on the floor by then. If LPN-C remembered to test she did so. LPN-C was not aware of any consequences if staff did not test as required. When interviewed on 1/11/23, at 9:15 a.m. NA-G stated facility outbreak testing was done sometimes two times per week and sometimes three times per week. NA-G tested when she was told to test. NA-G did not think the last round of facility testing was for everyone to test, just some of the staff, as not all of the staff were exposed to the COVID positive resident. On 1/11/23, at 10:30 a.m. LPN-B stated the staff did have to test for COVID-19 during the outbreak starting 11/23/22. The testing was done one or two times per week or if you lived a distance from the facility, staff just had to test prior to start of their shift. When interviewed on 1/11/23, at 10:50 a.m. NA-H stated facility outbreak testing was conducted two times per week. NA-H did not come in for the testing but did a rapid antigen test prior to starting her shift. The nurse on the duty did the test and gave the results to RN-D. RN-D did not always document all the staff COVID antigen tests, but NA-H knew she tested when required. During interview on 1/11/23, at 9:55 a.m. the administrator stated she was not aware so many of the facility staff had not tested during the outbreak testing that was conducted 11/23/22 through 12/5/22, and thought the facility compliance had improved. The administrator did not know why the untested staff were allowed to work and felt the facility needed to do a better job with their COVID-19 testing. The expectation was a list would be made of all the staff who had not tested and a plan to see who had not been tested and how it would get done prior to their next scheduled shifts. TESTING WITH SYMPTOMS: Staff: (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility staff infection control logs for the month of December 2022, identified the following: -On 12/4/22, licensed practical nurse (LPN)-A reported aching, sore throat, and headache. LPN-A was not tested for COVID-19 illness. LPN-A returned to work on 12/5/22. LPN-A worked 12/5/22, 12/6/22 and 12/7/22. On 12/8/22, LPN-A tested positive for influenza B. LPN-A was not tested for COVID-19. LPN-A returned to work on 12/10/22. -On 12/6/22, DA-D reported increase respiratory symptoms. DA-D returned to work on 12/21/22. A COVID-19 test was not documented prior to return to work. -On 12/7/22, AA-C reported symptoms of aching and cough. AA-C was not tested for COVID-19. AA-C returned to work on 12/12/22. -On 12/19/22, NA-D reported respiratory symptoms. NA-D was not tested for COVID-19. NA-D returned to work on 12/20/22. On 12/21/22, NA-D reported illness and tested positive for COVID-19. -On 12/24/22, LPN-B reported illness of headache and aching while working her shift. LPN-B tested positive for COVID-19 on 12/27/22. LPN-B returned to work on 12/29/22. There was no evidence an assessment was conducted to determine potential resident and staff exposures or if there were a need to conduct contact or outbreak testing based on the positive staff results. Residents: -Progress note (PN) on 12/16/22, identified R108 developed decrease lung sounds and oxygen saturations of 70 to 80% with oxygen in place. R108 required hospitalization and returned with a diagnosis of pneumonia with unknown origin. R108 was not evaluated or tested for COVID-19 during the initial course of illness to rule out COVID-19. -PN on 1/9/23, identified R29 developed symptoms of nausea and vomiting. A rapid antigen COVID-19 test was performed and was negative. The medical record lacked documentation of a secondary test performed to confirm the negative finding. -PN on 1/4/23, identified R41 developed a low grade temperature of 99. 5 F, oxygen saturation of 93% with supplemental oxygen at 2L/min, and had complaints of not feeling well. A rapid antigen COVID-19 test was performed and was negative. On 1/10/23, R41 was observed symptomatic with cough and general malaise and out with other residents; however, no further COVID-19 tests had been conducted. During interview on 1/10/22, at 10:15 a.m. registered nurse RN-D, the IP nurse, was notified R41 was tested for COVID-19 on 1/4/23, and was negative. RN-D was not sure why further follow up testing for COVID-19 was not done for R41. RN-D assisted R41 in the dining room on 1/6/23, and observed R41 with nasal drainage and was coughing, so she wheeled her out of the dining room and notified the charge nurse. Testing was usually done on day one, day three and day five for symptomatic staff and residents because of the potential incubation period of the illness. RN-D usually did the COVID testing for residents but had not filled out the sheets for R41's follow up tests .The sheets were completed so the required follow up testing can be completed. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When interviewed on 1/10/22, at 3:30 p.m. the administrator stated if residents displayed illness that could indicate a COVID-19 infection, the ill resident was to isolate and COVID-19 testing would be done on day one, day three and day five of symptom onset. If results of the testing was negative and the resident was asymptomatic isolation was lifted. During interview on 1/10/23, at 4:00 p.m. registered nurse (RN)-A stated if a resident showed signs of COVID-19, they would isolate the resident and test with a rapid antigen test. If still showing symptoms they would retest the resident. They always notified RN-D when they tested a resident for COVID-19. R41 displayed a cough and low grade fever. R41 was tested on [DATE], and was negative for COVID-19. R41 still exhibited symptoms of cough and her oxygen saturation was 95% at rest with supplemental oxygen, but the cough was loose and in the chest, not in the lungs. RN-A had not personally done a repeat COVID test and would have to check with the nurses working on the floor if another test was needed. No second confirmatory testing was completed after the initial test was done on 1/4/23, despite R41's continued symptoms. The facility's Coronavirus Prevention, Screening and Identification policy dated 10/9/22, indicated If a resident exhibited any symptoms of respiratory infection, or other COVID-19 related symptoms the resident's provider would be notified immediately. Quarantine interventions and testing would be initiated. If initial test was negative, the resident would be encouraged to use mask and social distance. Staff who had signs and symptoms of COVID-19 like illness (based on screening) and/or a temperature (100 degrees or higher) would not report to work until testing can be completed. Staff who had mild to moderate illness who were not moderately to severely Immunocompromised, could return to work if at least 7 days if a negative antigen or reverse transcription polymerase chain reaction (PCR) was obtained within 48 hours prior to returning to work or 10 days have passed since symptoms had first appeared, and at least 24 hours had passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) had improved. Staff who were asymptomatic throughout their infection and were not moderately to severely Immunocompromised could return to work if at least 7 days if a negative antigen or PCR was obtained within 48 hours prior to returning to work or after 10 days if testing was not performed. Staff who had a high risk exposure would have three viral tests for SARS-CoV-2 infection. testing would occur (as able) on day one (where day of exposure is day 0), day three, and day five. Care center would keep a list of any staff unprotected exposure to COVID-19. The list would include all staff that interacted with the positive person from two days before symptoms started. For potential staff exposure, the facility would complete Assessment for Health Care Workers (HCW) Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota. Identify the risk level using assessment. Contact tracing may indicate low risk when there was no direct exposure to a COVID-19 infected person. Contact risk was identified as close (within 6 feet for 15 minutes or more, or within same living space) contact of person(s) with COVID-19 within 48 hours. Communicate the risk level to the staff with work-related recommendations. Recommendations would be followed for staff who had high-risk workplace exposure to COVID-19 and staff with household or intimate contacts who had confirmed or suspected COVID-19. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's policy COVID-19 Testing, dated 9/29/22, indicated COVID-19 testing strategies would be implemented to assist with identification and mitigation of spread of COVID-19 illness. The care center would test residents and staff based on parameters defined by the Center for Medicare and Medicaid Services (CMS), the Minnesota Department of Health (MDH) and the CDC. Symptomatic residents or staff would be tested . If newly identified COVID-19 positive staff or resident were identified all staff and residents would be tested , regardless of vaccination status. Any care center staff who refused to test would not be allowed to work within the care center. An employee must be tested prior to returning to work. Positive results from antigen tests are highly accurate, but there would be a chance of false negatives. A negative rapid antigen test may need to be confirmed using a RT-PCR test, especially if the result of the antigen test was inconsistent with the clinical symptoms. Individuals who have signs and symptoms must be tested on days one, three and five for COVID-19. If positive results the employee must be removed from the care center and may remain out for up to ten days from the beginning of symptoms. Residents with signs and symptoms must be tested and if positive test, quarantine for ten days. All residents and staff with exposure should be tested immediately and all staff and residents that tested negative should be retested every five to seven days until testing identified no new cases of COVID-19 infection among staff or residents. Care centers will complete testing according to MDH, CDC and CMS guidelines. For symptomatic residents and staff, the date and time of identification of symptoms, when testing was conducted and the results and the actions the care center took based on the results would be documented. The facility would document the actions taken for residents and staff who refuse testing. The IJ which began on 11/23/22, was removed on 1/11/23, at 3:00 p.m. when it could be verified through interview and document review the facility implemented housewide COVID-19 testing in accordance with CDC guidance, including performing confirmatory testing on symptomatic antigen negative residents and staff. Education was provided to all employees on current and updated COVID-19 protocols for testing.

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 41575 Based on interview and document review, the facility failed to ensure 13 of 72 staff members (registered nurse (RN)-E, RN-F, licensed practical nurse (LPN)-E, dietary aide (DA)-C, DA-G. activity aide (AA)-D, director of human resources (DHR)-A, nursing assistant (NA)-B, NA-D, NA-J, NA-K, NA-L , NA-M) were vaccinated with a complete primary series of COVID-19 vaccine and/or had an approved or pending exemption on record. In addition, the facility failed to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff and report accurate COVID-19 vaccination status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This resulted in a vaccination rate of 81.94% which was greater than 10% from the data the facility had submitted to the National Healthcare Safety Network (NHSN) and had potential to affect all 54 residents in the facility. Findings include: During the recertification survey, from 1/9/23 to 1/12/23, evidence of staff vaccinations was requested. An untitled Staff COVID Vaccine Status listing dated 9/18/22, provided by registered nurse (RN)-D, the infection preventionist (IP), demonstrated all staff member's vaccination status with completed primary series date(s), and any provided booster doses of COVID-19 vaccines. Exempt staff members were identified with an E by their name. This listing identified a total of 72 staff members and four contracted staff members. Thirteen staff members, RN-E, RN-F, LPN-E, DA-C, DA-G. AA-D, DHR-A, NA-B, NA-D, NA-J, NA-K, NA-L and NA-M were not listed on the staff vaccination log at all. Further, the thirteen staff members were not included with the staff who had filed and approved exemptions. The vaccination data reported to NHSN for the week ending 12/18/22, indicated the facility reported staff completed vaccination rate as 70%, which reflected greater than 10% difference from the facility's actual staff vaccination rate of 81.94%. During interview on 1/10/23, at 11:45 a.m. RN-D, the infection control nurse (IP) stated she was not sure what the vaccination or exemption status was for DA-G and NA-M, as they were hired in September 2022, and she had not gotten the information from them. RN-D stated she should have known their status and would check the Minnesota Immunization Information Connection (MIIC) to get that information. On 1/10/23, at 4:00 p.m. RN-D provided seven employee MIIC reports. The reports included vaccination status for DA-G. and NA-M, both of whom were not up to date with the COVID-19 vaccinations. RN-D did not answer when asked if she had informed consent from the employees to access their MIIC report data and was unable to provide a release of information from the employees. (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	A joint interview with the administrator and RN-D was conducted on 1/11/23, at 1:30 p.m. The administrator stated DHR-A was to add the names of the new hires with a sheet regarding their vaccination status and put these on a vaccination log list. The facility struggled to keep the list up to date. RN-D identified when she got the sheets from DHR-A she looked in MIIC to verify the employee's vaccination status and even tried to get the private employee information from the local clinics electronic health record but at times had difficulty finding the information. The administrator stated she was monitoring the new hires to be sure they completed exemption forms if they were not up to date with their COVID-19 vaccinations. The administrator stated she was aware the employee vaccination logs and the NHSN data was not up to date due to the difficulty keeping the employee logs up to date and current. The administrator felt RN-D struggled with utilizing the computer to organize and track the needed information. The facility's undated Mandatory COVID Immunization policy indicated the policy required employees to receive the COVID-19 vaccine or obtain a documented exemption as a condition of employment as mandated by federal regulations. All employees must provide written documentation to Human Resources demonstrating they had been fully vaccinated or obtained a religious or medical exemption as an accommodation. Initial failure of any employee to receive a COVID-19 vaccination or submit a Request for Exemption form by the deadline would result in the employee being placed on unpaid suspension for up to 14 days so that the employee could come into compliance.