STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. Building B. Wing	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows on University	1315 S University Dr Fargo, ND 58103

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 28611 Based on review of Medicare Part A letters/notices and staff interview, the facility failed to ensure the resident/their representative completed the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) for 1 of 2 supplemental residents (Resident #35) discharged from Medicare Part A who remained in the facility. Failure to ensure the completion of the SNFABN limited the resident/representative's ability to exercise their rights in regard to Medicare Part A services. Findings include: Review of Medicare Part A beneficiary notices identified Resident #35 discharged from Medicare Part A on 01/21/22. The SNFABN, signed by the resident's legal representative, failed to identify if they chose to continue or discontinue skilled services or request a demand bill. During an interview on the morning of 04/20/22, a social services staff member (#5) confirmed the resident's representative failed to choose an option on the SNFABN and stated staff should have ensured they completed the form.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19410 Based on observation, information from the complainant, review of facility policy, and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment for 4 of 21 sampled residents (#22, #41, #46, and #71) and 8 supplemental residents (#4, #7, #8, #16, #33, #38, #39, and #61). Failure to clean personal fans, maintain and clean environmental surfaces (walls, doors, outlets, hand-rails, toilet seats) does not provide a comfortable/homelike environment and has the potential to place resident's at risk for injury or illness. Findings include: Information received by the department from an anonymous complainant identified concerns with cleanliness and upkeep of the environment of the facility. Review of the facility policy titled Cleaning and Disinfection of Environmental Surfaces occurred on 04/21/22. This policy, dated June 2021, stated, Policy Statement: Environmental surfaces will be cleaned and disinfected . Policy Interpretation and Implementation . 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. Observation on 04/18/21 at 5:30 p.m. showed Resident #16 sitting up in bed and wearing oxygen per nasal cannula. The resident stated she was in the hospital for pneumonia and just returned to the facility that afternoon. Observation showed a small fan (with visible dust on the outside grate covering the fan blade) on the window ledge by the resident's bed, blowing air directly toward the resident. Observation also showed a larger fan on the floor in the room with visible dust on the grate. Observation on 04/19/21 at 8:00 a.m. showed the same small fan, not in use, on Resident #16's window ledge next to the bed with a thick accumulation of dust on the fan blade and on the grate covering the fan. The thick dust hung in clumps on some areas of the blade. Review of Resident #16's medical record occurred on the morning of 04/19/21. Diagnoses included pneumonia and shortness of breath. Resident #16's current care plan stated, Potential for altered respiratory function r/t [related to] diagnosis of Pneumonia. O2 [oxygen] as ordered. Potential for impaired gas exchange r/t CHF [congestive heart failure], COPD [chronic obstructive pulmonary disease] . General observations of the environment on all days of survey showed the following: Resident #8's room - Wallpaper torn at left side of bed near the head of the bed. Resident #38's room - Walls scuffed/scraped.Resident #16's room - Electrical outlet cover broken by the air conditioner. Missing end caps on the handrails on both sides of the hall outside of rooms [ROOM NUMBERS]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7's room - Wallpaper torn and scuffed; hallway wall just outside of room with dried liquid spill. Resident #33's room - Large area of torn wallpaper above the head of the bed.Resident #22's room - Liquid spill stains on the outside of bathroom door. Side of bedside table with a dried-on red/orange colored stain; floor dark in color around the edges and with visible dirt/debris.Resident #61's room - Wallpaper scuffed, hole in electrical outlet cover for air conditioner. Resident #46's room - Toilet seat removed from toilet revealing two sharp edges where the toilet seat used to be. Floor shows visible dirt around the edges and dark dirt-like stains on the floor. Locked door in hallway across from room [ROOM NUMBER] - large area of black scuff marks.Resident #39's room - Wallpaper scraped away from wall in multiple areas to the right of the bathroom, air conditioner facing broken.Resident #71's room - Wallpaper peeling from wall above left side of window and around air conditioner. Wallpaper scraped away from wall in multiple areas to the left of sink area. Built in dresser drawers with multiple broken areas with sharp edges and large areas of cork visible. Resident #4's room - Wallpaper peeling from wall under the air conditioner. Resident #41's room - Fan blade and grates with accumulation of dust. During an interview on 04/21/22 at 12:20 p.m., two administrative staff members (#1 and #3) confirmed peeling wallpaper on some walls. During an interview on 04/21/22 at 12:25 p.m., a maintenance staff member (#4) stated staff periodically check fans for cleaning as needed, but confirmed it was not on a scheduled basis. 44566

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40489 Based on review of facility policy, review of the facility's investigation report, and staff and resident interviews, the facility failed to provide an environment free of verbal abuse for 1 of 1 resident (Resident #11) with an allegation of mistreatment by staff. Failure to ensure residents are free from verbal abuse, which includes disparaging and derogatory terms, and the disregard for resident personal possessions and privacy resulted in psychosocial harm. Findings include: Review of the facility policy titled Abuse Prevention Program occurred on 04/21/22. This undated policy stated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse . During an interview on 04/18/22 at 2:45 p.m., when asked about abuse and neglect, Resident #11 reported an incident that occurred with a registered nurse (RN) (#14) a week ago Saturday. Resident #11 stated the nurse brought his medications into his room along with several other medication cups containing pills and an insulin pen. The resident asked the nurse who the other medication and insulin were for, and the nurse said they were for other residents and then left the resident's room. Resident #11 stated after about ten minutes the nurse returned to his room, looked on top and inside the drawer of the resident's nightstand, and then left the room. After another 5-10 minutes the nurse returned to the resident's room and accused the resident of hiding the other resident's medications and insulin pen. Resident #11 stated the nurse opened his nightstand drawer and started going through the resident's wallet. The resident stated he told the nurse he did not have permission to be going through his personal belongings. The resident said the nurse stated, You're an [expletive] idiot and I'm on a drug seize and no one can tell me to get out of this room. The resident stated the nurse continued searching his room, looking in the resident's closet and other drawers. The resident told the nurse to leave and stop looking through his personal belongings and that he did not have the medications or insulin pen. Resident #11 said the nurse (#14) stated, Where did you put them? You are an [expletive] loser. The resident stated a certified nurse aide (CNA) (#15) entered the resident's room and attempted to get the nurse out of his room and the nurse kept saying, I'm on a drug seize and I'm not leaving this room. The resident reported after a short time the nurse and CNA left his room. The resident stated later he put his call light on to ask when he would get his lunch tray and the nurse (#14) answered his call light. When the resident asked the nurse his question the nurse stated, By the looks of you, you don't need any [expletive] food. The resident stated he spoke with the head nurse and the administrator on the following Monday regarding the situation. Information from the facility's investigative report, dated 04/15/22, identified the following: * During the administrative nurse's phone interview on 04/12/22 with the RN (#14) Employee was very aggressive with communication, raised voiced . continued to be aggressive with communication . During the interview the nurse (#14) acknowledged he did pre-dish 4 resident medications and carried them into other residents rooms and misplaced these. The nurse acknowledged he made an error yet continued to place the entire blame on the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/20/22 at 10:38 a.m., an administrative nurse (#1) stated she was first notified of the situation on Monday 04/11/22 when Resident #11 requested to speak with her and the administrator. The administrative nurse stated she immediately started an investigation and notified the North Dakota Department of Health (NDDOH). The administrative nurse confirmed the incident happened on Saturday 04/09/22 and the RN (#14) worked in the facility the next day 04/10/22. The administrative nurse confirmed she terminated the RN's (#14) employment on 4/12/22 when she conducted a phone interview with the RN. During an interview on 04/20/22 at 11:00 a.m., the administrative nurse (#1) verified she had not educated all staff on abuse prevention stating, Starting 04/11/22, I just grabbed whoever I could and spoke to them about abuse. Review of a facility in-service attendance form showed the administrative nurse (#1) had provided education titled Mandatory Reporting/Handling Concerning Situation to eight staff members on 04/11/22 - 04/15/22. During an interview on 04/20/22 at 6:32 p.m., a CNA (#15) stated she became aware of the incident described above when she answered the phone at the facility on 04/09/22 and the caller, Resident (#11) demanding to get the administrator's phone number. The CNA stated she went to the resident's room and heard the nurse (#14) screaming and yelling at the resident that he was not leaving his room and was on a drug seize. I attempted to get him to leave the resident's room and apologized to the resident, other residents and visitors in the facility that had witnessed or overheard the incident. The CNA stated, (RN's name) was out of his mind accusing the resident of hiding the other medications. The CNA stated she had heard the nurse (#14) on the phone reporting the incident to the on call manager, so she felt the incident was already reported. When asked who the CNA would report potential abuse to she stated, The admission's lady is who we are to report it to. The CNA verified she had received abuse training but could not recall when the date of the last training. During an interview on 04/21/22 at 8:13 a.m., an administrative nurse (#1) stated the missing medications and insulin were found in another resident's room. During an interview on 04/21/22 at 8:33 a.m., an administrative nurse (#1) verified the nurse (#14) had received abuse education upon hire 02/17/21 and had not received any further education on abuse. During an interview on 04/22/22 at 10:38 a.m., an administrative nurse (#1) stated it is inappropriate and unacceptable for staff to use disparaging and derogatory terms to the residents. The facility failed to protect the resident from abuse and the staff failed to immediately report the abuse to the administrative staff.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44566 Based on record review, review of the facility policy, and resident and staff interview, the facility failed to develop a comprehensive care plan for 1 of 21 sampled residents (Resident #34) with care plans. Failure to develop a comprehensive care plan that includes the services to be provided to the resident may negatively impact the resident's quality of care. Findings Include: Review of the facility policy titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol occurred on 04/21/22. This policy, dated Qtr (quarter) 3, 2021, stated, . When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and complications . Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified severe weight loss. The care plan failed to address weight loss management. The record identified the following weights obtained from admission on 11/24/21 through 03/09/22: * 11/24/21 116 lbs. (pounds) * 11/29/21 116 lbs. * 12/06/21 116 lbs. * 12/09/21 114 lbs. * 01/10/22 110 lbs. * 01/28/22 94 lbs. (14.5% decrease in 30 days represents a severe weight loss) * 02/15/22 90 lbs. (22.4% decrease in 180 days represents a severe weight loss) * 03/01/22 94 lbs. * 03/02/22 93.6 lbs. * 03/04/22 93 lbs. * 03/07/22 91.2 lbs. * 03/09/22 91.4 lbs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/20/22 at 2:30 p.m., a supervisory nurse (#8) stated, The dietician determines recommendations and works with nursing for care plan interventions and goals. During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) confirmed staff failed to care plan goals and interventions for Resident #34's weight loss management.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28611 1. Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to administer medications according to professional standards of practice for 1 of 1 sampled resident (Resident #63) who received a medication without a current order and 1 supplemental resident (Resident #52). Failure to follow physician's orders when administering medications may lead to adverse reactions. Findings include: Review of the facility policy titled Administering Medications occurred on 04/20/22. This undated policy stated, . 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. 3. Medications must be administered in accordance with the orders, including any required time frame. Review of the facility policy titled Medication and Treatment Orders occurred on 04/20/22. This undated policy stated, . Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. All drug and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order . Review of the facility policy titled Administering Topical Medications occurred on 04/21/22. This undated policy stated, . 1. Verify that there is a physician's medication order for this procedure. - During an interview on the afternoon of 04/19/22, Resident #52 expressed concern that he did not always get his medications as prescribed. Review of Resident #52's medical record occurred on April 19-20, 2022. The medication administration records (MARs) identified: *Calcium Acetate Capsule 667 MG [milligrams] Give 2 capsule by mouth with meals for Hyperphosphatemia [high phosphorus levels in the blood], ESRD [end stage renal dialysis], HTN [hypertension] **OK TO HOLD if pt [patient] does not eat a meal or if pt is out of the facility** -Start Date- 09/29/2021 . *Labetalol HCl [high blood pressure medication] Tablet, Give 150 mg by mouth in the morning every Tue [Tuesday], Thu [Thursday], Sat [Saturday] for Hypertension, -Start Date- 08/07/2021 . -D/C [discontinue] Date- 01/19/2022 . *On 01/20/22, a nurse added the following entry to the MAR without obtaining a physician's order: Labetalol HCl Tablet, Give 150 mg by mouth in the morning every Tue, Thu, Sat for Hypertension **GIVE ONLY IF REFUSES DIALYSIS. HE DOES NOT WANT BEFORE DIALYSIS -Start Date- 01/20/2022 . Resident #52's medical record lacked evidence of a physician's order dated 01/20/22 to hold labetalol on dialysis days and only give if Resident #52 refused dialysis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52's meal intake records and MAR for December 18, 2021 through April 18, 2022 identified 10 occasions when Resident #52 ate a meal, but staff did not administer (i.e., held) the calcium acetate. During an interview on the afternoon of 04/20/22, a supervisory nurse (#1) stated staff should not hold medications if Resident #52 has eaten and identified that staff updated the physician's order for labetalol without getting a verbal order from the provider. 40489 Observation on 04/19/22 at 11:38 a.m. showed a certified nurse aide (CNA) (#13) removed a tube of flucinonide cream from a drawer in the Resident #63's room and applied the flucinonide cream to the resident's left abdomen/groin area. The drawer also contained a tube of hydrocortisone cream with a prescription label. - Review of Resident #63's medical record occurred on all days of survey. Review of medication orders showed the flucinonide cream prescribed on 04/04/22 and discontinued on 04/14/22, and hydrocortisone cream prescribed on 04/04/22 and discontinued on 04/06/22. During an interview on 04/21/22 at 10:09 a.m., a nurse manager (#1) verified the doctor discontinued the ointments, staff should not keep them in the resident's room, and agreed the CNA should not apply the ointment. 44566 2. Based on record review, review of facility policy, and staff interview, the facility failed to ensure staff followed standards of practice for 1 of 5 sampled residents (Resident #71) selected for unnecessary medication review. Failure to notify the physician of abnormal blood glucose levels may result in untreated hypoglycemia (low blood glucose level) or hyperglycemia (high blood glucose level). Review of the facility policy titled Change in a Resident's Condition or Status occurred on 04/21/22. This policy, dated Qtr [quarter] 3, 2018, stated, . The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): specific instruction to notify the physician of changes in the residence condition . Review of Resident #71's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The quarterly Minimum Data Set (MDS), dated [DATE], identified the resident required insulin injections for all seven days of the assessment period. The care plan stated, Observe for high blood sugar symptoms . Observe for low blood sugar symptoms . Report abnormal results per Physician parameters/guideline . The physician's orders identified, . Accuchecks [blood glucose checks] QID [four times a day] - Call PCP [primary care provider] if < [less than] 100 [milligram per deciliter (mg/dl)] or > [greater than] 400 [mg/dl] . before meals and at bedtime for blood sugars . Review of Resident #71's blood glucose levels for February and March 2022, showed facility staff failed to notify the physician of blood glucose results less than 100 mg/dl or greater than 400 mg/dl on 12 occasions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/21/22 at 9:45 a.m., the nurse (#16) stated, The nurses document physician notification in the nurses progress notes and verified the documentation lacked provider notification required for Resident #71's blood glucose results. During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) confirmed their expectation is to notify the physician of blood glucose results per physician's order.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40489 Based on observation, facility policy, record review, and staff interview, the facility failed to ensure appropriate care and services for 1 of 2 sampled residents (Resident #63) with a foley catheter. Failure to ensure timely and consistent emptying of a foley catheter may result in back flow of urine causing unnecessary pain and complications for the resident. Findings include: Review of the facility's policy titled Emptying a Urinary Drainage Bag occurred on 04/21/22. This undated policy stated, . The purpose of this procedure are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder . Review of Resident #63's medical record occurred on all days of survey. Current physician orders included, Catheter care per facility protocol: Empty the bag when 2/3 full or when impeded flow. Two times a day. Observations on 04/19/22 showed the following: * 8:53 a.m., Resident #63 in his room in the bed with his call light on. * 8:55 a.m., an unidentified staff member looked into the resident's room asking him what she could help him with. Resident #63 stated, Can you get a nurse in here right away I think my catheter is kinked again. * 8:56 a.m., the unidentified staff member informed a nurse (#11) who was at the nurse's station. The nurse stated she would tell the resident's nurse. * 8:57 a.m., Resident #63 yelling out for a nurse stating, Having problems with catheter backing up again, someone hurry up. * 9:14 a.m., a nurse (#2) was in the hallway and noticed Resident #63's call light was on and entered the resident's room and asked how he could help the resident. The resident stated, I think my catheter was kinked. I had a few really sharp pains. * 9:16 a.m., the nurse (#2) ensured the resident's foley catheter wasn't kinked and emptied the resident's bag, stating, This is really full. Apparently it has not been emptied for a while. There was 1400 ml's [milliliters] in it [bag]. During an interview on 04/21/21 at 10:18 a.m., a nurse manager (#1) verified she expected the facility staff to follow physician orders and facility policy regarding emptying the residents foley catheter.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40489 Based on observation, record review, review of professional reference, and staff and resident interviews, the facility failed to provide the necessary treatment/services to prevent the occurrence and promote the healing of pressure ulcers for 1 of 4 sampled residents (Resident #63) identified with pressure ulcers. Failure to consistently use interventions and follow physician orders to prevent and heal the resident's pressure ulcers may result in deterioration of the ulcers and result in further skin breakdown and/or ulcers. Findings include: [NAME], [NAME], and Frandsen's Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice, 11th ed., Pearson Education, Inc., Massachusetts, page 64, stated, . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. During an interview on 04/19/22 at 9:33 a.m., Resident #63 stated, Yesterday I was up in my wheelchair for four hours and I'm only supposed to be in the chair for two hours because of the sores on my butt. Review of Resident #63's medical record occurred on all days of survey and included the following pressure ulcers: * Left heel- stage II * Left ankle- stage II * Right buttock- stage II * Left buttock- stage II A current physician order, dated 04/14/22, stated, . May be up in chair for 60 minutes at a time, then rest for 2 hours in supine (lying horizontally with the face and torso facing up), then may get back up in chair. two times a day. Observation on 04/20/22 at 11:48 a.m., showed Resident #63 in his wheelchair. At 3:05 p.m., observation showed a certified nurse aide (CNA) (#6) covered Resident #63 up in the bed. During an interview on 04/20/22 at 3:05 p.m., the CNA (#6) stated Resident #63 had been in the wheelchair since 11:00 a.m. Observation showed the CNA (#6) had just transferred the resident to bed at 3:05 p.m., (four hours later). During an interview on 04/20/22 at 3:09 p.m., Resident #63 stated he had put his call light on for the staff to assist him back into the bed. (continued on next page)

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	355024	A. Building B. Wing	04/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows on University	1315 S University Dr Fargo, ND 58103

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/21/22 at 10:26 a.m., an administrative nurse (#1) confirmed the facility failed to consistently follow interventions that would prevent worsening of Resident #63's pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44566 Based on information received from the complainant, observation, facility policy, record review, and staff, resident, and family interview, the facility failed to provide the necessary assistance to prevent a fall for 1 of 1 sampled resident (Resident #71) who slid out of his powered wheelchair while transported in the facility van. Failure of the facility to ensure staff properly secured Resident #71 in his wheelchair, in the van, immediately called for assistance, and transferred resident using the van's restraint system, resulted in the resident experiencing a fall with possible injury. Findings include: The complainant alleged the facility failed to properly transport a resident in the facility van. Review of the facility policy titled Transportation Services occurred on 04/21/22. This policy, dated December 2020, stated, . Drivers shall be trained on safe transportation of residents routinely with periodic re-training and return demonstration. Drivers will have access to two-way communication at all times . Resident care needs will be considered when arranging transport so that needs will be appropriately met during travel to and from the facility . Observation on all days of survey showed Resident #71 with the safety belt secured while in his powered wheelchair. Review of Resident #71's medical record occurred on all days of survey. Diagnoses included right above the knee amputation, pain in right hip, muscle weakness, and difficulty walking. The care plan stated, . I like to wear my safety belt at times when in electric [powered] wheelchair . The progress notes identified the following: * 03/16/22 at 4:26 p.m., . On return slid down in W/C [wheelchair] in van and drive [sic] [#9] helped him back into or up in w/c. resident said that he is sore and tired. requested a pain pill and given. * 03/17/22 at 5:25 p.m., . fall-witnessed . Resident was sent Via [by] ambulance to ED [emergency department] to be evaluated per family request. Resident was [NAME] [sic] in to be evaluated by ED. Came back around 2100 [9:00 p.m.] . No new orders [sic] or treatments- no injuries identified in ED. Review of Grievance/Concern form, dated 03/29/22, stated, . Driver [#9] reported resident slid out of chair in van. Chair was restrained in as was shoulder restraint latched. [Resident #71] refuses to use chair seat belt. This has not happened before but he began to slide so driver stopped lowered him to floor positioned him and drove van two blocks to facility for help. The incident report, dated 03/24/22, stated, . Root Cause - Resident avoids use of the chair seat belt . Intervention: Driver retraining on restraint system and van use and properly restraining wheelchairs, notification of facility . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated staff education form stated, Communicating repositioning concerns during transports -Transport drivers have been educated to alert nursing/therapy to assess resident if noticing any problems with positioning. Transport drivers will always stop and contact the facility for additional support if there is a safety concern while transporting. The Driver (#9) completed the Wheelchair Transportation Safety Checklist on 04/08/22. During an interview on 04/21/22 at 11:10 a.m., a driver (#9) described the transport from the clinic appointment and stated, Resident #71 got himself onto the van in his [powered] wheelchair. The driver secured the four wheelchair restraints, the van lap restraint, and shoulder restraint. The driver said as she drove the van the resident told her he was sliding, she asked him to push his butt back in the chair, as she continued to drive, he answered, I can't. The resident was unable to reposition in his chair and yelled I'm slipping. As the driver approached a stop light, she looked in the rearview mirror and saw the resident sliding towards the bottom of the wheelchair with his arms up in the air and the shoulder restraint in his armpit area and the van lap belt up to his chest. The driver pulled the van over, lowered the resident to the floor, and positioned him against the inside wall of the van, unable to use restraint system. The driver called for assistance while driving the van the remainder of the way to the facility. After arriving at the facility, two additional staff boarded the van, and all three staff manually lifted the resident onto his wheelchair. The driver confirmed she failed to ensure the resident's wheelchair safety belt was secured because he usually refuses it. During an interview on 04/18/22 at 2:32 p.m., Resident #71 denied that he refused his safety belt on the date of the incident and stated, I usually wear it [safety belt]. A family member D, stated, sometimes they [staff] don't even use it [safety belt]. During an interview on 04/21/22 at 12:48 p.m., two administrative staff (#1 and #3) confirmed the van driver transported Resident #71 without his wheelchair safety belt and the van's restraint system secured, and staff failed to stop and call for assistance with a safety concern while transporting.

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F 0692 Level of Harm - 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** 44566 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/25/21 Based on review of facility policy, record review, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 1 of 1 sampled resident (Resident #34) with severe weight loss. Failure to adequately monitor and evaluate weights, implement recommended dietician recommendations, assess the effectiveness of current interventions, re-evaluate the need for updated or additional interventions, and physician notification of weight loss resulted in continued, severe weight loss. Findings include: Review of the facility policy titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol occurred on 04/21/22. This policy, dated Qtr [quarter] 3, 2021, stated, . The physician and staff will monitor nutritional status, an individual's response to interventions . When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and complications . Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified severe weight loss. Review of Resident #34's physician's orders identified, . Regular diet . Med Plus 2.0 [nutritional supplement] two times a day . Weight 3x [times] / [per] week - Monday/Wednesday/Friday every day shift . The record identified the following weights obtained from admission on 11/24/21 to 03/09/22: * 11/24/21 116 lbs. (pounds) * 11/29/21 116 lbs. * 12/06/21 116 lbs. * 12/09/21 114 lbs. * 01/10/22 110 lbs. * 01/28/22 94 lbs. (14.5% decrease in 30 days represents a severe weight loss) * 02/15/22 90 lbs. (22.4% decrease in 180 days represents a severe weight loss) * 03/01/22 94 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	* 03/02/22 93.6 lbs. * 03/04/22 93 lbs. * 03/07/22 91.2 lbs. * 03/09/22 91.4 lbs. The facility failed to weigh Resident #34 as ordered on six occasions 12/13/21, 12/20/21, 12/27/21, 12/31/21, 02/25/22, and 02/28/22. Review of Resident #34's nursing progress note, dated 02/17/22, stated, Orders placed for Med Pass [nutritional supplement] BID [twice a day]. Pt. [patient's] son, [name], notified of weight loss and supplement added. Will monitor weight closely at this time. Review of Resident #34's dietician's notes showed the following: * 02/17/21 Nutritional review given underweight status and weight loss. PO [by mouth] intakes variable. Overall suboptimal intakes. Will add MedPass BID given high kcal [kilocalorie] content. * 02/25/21 Nutritional review given weight loss. Resident very underweight. Current BMI [body mass index] of 15.9 [percent]. Med Pass not accepted well. Does like Liquacel [protein supplement], would recommend 1 ounce daily. Would also trial Magic Cup [nutritional supplement] for more caloric supplement. Will continue to monitor. If intakes remain poor and weight not increasing would recommend enteral nutrition if appropriate. The facility failed to implement the dietician's recommendations of Liquacel, Magic Cup, or enteral nutrition. Resident #34's physician progress note, dated 03/10/22, identified a weight of 91.2 lbs., but failed to evaluate the resident's response to interventions and failed to address the 24.8 pound severe weight loss. During an interview on 04/20/22 at 2:30 p.m., a supervisory nurse (#8) confirmed the dietician and nursing staff failed to obtain an order for, and implement recommended nutritional supplements, failed to monitor Resident #34's severe weight loss, complete weights as ordered, and were unable to locate a physician's note that addressed the weight loss. During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) confirmed the physician and staff failed to adequately monitor Resident #34's nutritional status and severe weight loss. Failure to consistently obtain weights as ordered, monitor and notify physician and dietician of weight loss identified, ensure implementation of nutritional recommendations, evaluate interventions for effectiveness, and promptly communicate weight changes to the physician and nursing staff resulted in Resident #34's continued, severe weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 19410 THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 02/25/21 and 03/25/21. Based on observation, record review, information from the complainant, review of facility policy and procedure, family and staff interviews, the facility failed to provide respiratory care consistent with professional standards of practice for 3 of 10 sampled residents (Residents #10, #55, and #63) receiving respiratory care. Failure to administer nebulizer medications and clean nebulizer equipment according to policy and professional standards (Residents #10 and #55), failure to replace broken respiratory equipment promptly (Resident #55), and failure to obtain a physician's order for oxygen administration (Resident #63) may result in complications and compromise of residents' respiratory status. Findings include: NEBULIZER TREATMENTS Information received by the department from an anonymous complainant identified concerns with nebulizer treatments not being administered properly. Review of the facility policy, Administering Medications through a Small Volume (Handheld) Nebulizer occurred on 04/20/22. This policy, dated 2021, stated, Purpose: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Steps in the Procedure: . 6. Obtain baseline pulse, respiratory rate and lung sounds. 7. Wash and dry hands. 8. Draw up the medication to be nebulized. 9. Dispense medication into nebulizer cup. 13. Turn on the nebulizer and check the outflow port for visible mist. 14. Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask). 15. Instruct the resident to take a deep breath, pause briefly and then exhale normally. 16. Encourage the resident to repeat the above breathing pattern until the medication is completely nebulized or until the designated time of treatment has been reached. 17. Remain with the resident for the treatment. 18. Approximately five minutes after treatment begins (or sooner if clinical judgement indicated) obtain the resident's pulse. 19. Monitor for medication side effects, including rapid pulse, restlessness and nervousness throughout the treatment. 20. Stop the treatment and notify the physician if the pulse increases 20 percent above baseline or if the resident complains of nausea or vomits. 21. Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. 22. Encourage the resident to cough and expectorate as needed. 23. Administer therapy until medication is gone. 24. When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup. 25. Wash and dry hands. 26. Obtain post-treatment pulse, respiratory rate and lung sounds. 27. Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. Wash pieces with warm, soapy water: b. Rinse with hot water: c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; d. Rinse all pieces with sterile water (NOT tap, bottle or distilled); and e. Allow to air dry on a paper towel. 28. Wash and dry hands. 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included shortness of breath and chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/19/22 at 8:50 a.m. showed a licensed nurse (#10) administered Resident #10's nebulizer medication. The nurse failed to assess lung sounds and obtain a baseline pulse and respiratory rate prior to starting the treatment, failed to check pulse rate during the treatment, and failed to obtain pulse, respiratory rate and assess lungs post treatment. The nurse failed to clean the nebulizer equipment, and re-apply Resident #10's nasal cannula and resume oxygen. During an interview on 04/21/22 at 12:48 p.m., two administrative staff (#1 and #3) confirmed staff failed to follow the facility's policy when administering nebulizer treatments. - Review of Resident #55's medical record occurred on all days of survey. Diagnoses included COPD, respiratory disorders, and sleep related hypoventilation (reduced amount of oxygen entering the lungs). Observation on 04/19/22 at 4:11 p.m. showed a licensed nurse (#12) administered two separate nebulizer treatments to Resident #55. The nurse failed to assess lung sounds and obtain a baseline pulse and respiratory rate prior to each treatment, failed to check pulse rate during the treatments, and failed to obtain pulse, respiratory rate and assess lungs post treatments. After treatments, the nurse rinsed the mask and the nebulizer cup with tap water, cleaned the mask and cup with soap, rinsed the mask and cup with tap water and placed the pieces on a paper towel to dry. The nurse failed to soak all pieces in a bowl with isopropyl alcohol for five minutes and rinse with sterile water. During an interview on 04/21/22 at 12:20 p.m., two administrative staff (#1 and #3) confirmed staff failed to follow the facility's policy regarding nebulizer treatments. CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY Review of the facility policy, CPAP/BiPAP [Bilevel Positive Airway Pressure] Support occurred on 04/20/22. This policy, dated 2021, stated, Purpose: 1. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2. To improve arterial oxygenation . in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. 3. To promote resident comfort and safety . Steps in the Procedure: . 10. Holding the mask to the resident's face, turn on the machine and allow him/her to become acclimated to the pressure. 11. Once the resident is acclimated, secure mask to his/her face. a. The mask should fit firmly but does not need to be airtight . During an interview with family member (E) and a social service staff member (#5) on 04/19/22 at 4:30 p.m., the family member stated a nurse informed her of the resident's cracked CPAP eight days ago. At 5:02 p.m., an administrative nurse (#1) entered the room to check the CPAP mask. Observation showed a crack in the seal of the mask. The family member (E) stated she has never seen staff cleaning the CPAP and has at times seen parts of it on the floor. The administrative nurse (#1) stated he/she would make sure the mask is replaced. Review of Resident #55's nursing progress note, dated 04/15/22, stated CPAP on as ordered but noted to have a tear on the mask, leaks at times . morning nurse to call [health care accessories business] for possible replacement. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/20/22 at 2:25 p.m. showed a nurse (#16) came into Resident #55's room to apply the CPAP. The nurse (#16) placed the mask on the resident and stated the air is leaking out and it does not have a good seal and left the room to check on getting a new mask. Review of Resident #55's treatment administration records showed staff utilized the mask with the cracked seal for CPAP therapy each night from 04/15/22 until 04/20/22. During an interview on 04/20/22 at 4:00 p.m., an administrative nurse (#1) stated the CPAP masks have been ordered and will arrive later that day. 40489 OXYGEN Review of the facility policy titled Oxygen Administration occurred on 04/21/22. This undated policy stated, . Verify that there is a physician's order for this procedure . Observation on all days of survey showed Resident #63 had oxygen on at 2 liters per nasal cannula (L/NC). Review of Resident #63's medical record occurred on all days of survey. Diagnoses included acute respiratory failure with hypoxia. A physician's history and physical (H&P), dated 04/11/22, included the following admitting diagnoses: community acquired pneumonia, large left side pleural effusion, congestive heart failure, and history of paroxysmal atrial fibrillation. The medical record lacked an order to administer oxygen and monitoring of the resident's respiratory/oxygen status. During an interview on 04/19/22 at 9:47 a.m., Resident #63 stated he used oxygen at all times since returning from the hospital last week. During an interview on 04/20/22 at 2:00 p.m., a licensed nurse (#2) stated, He [Resident #63] uses oxygen continuously. During an interview on 04/21/22 at 10:21 a.m., an administrative nurse (#1) verified staff did not have an order for administering oxygen for Resident #63 and failed to document the resident's respiratory/oxygen status. The administrative nurse (#1) agreed failure to have a physician's order for oxygen and monitor the resident's respiratory status while on oxygen may complicate the resident's respiratory status. 44566

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44566 Based on facility policy, record review, and staff interview, the facility failed to ensure a physician response to changes in resident's weight/condition for 1 of 1 sampled resident (Resident #34) with severe weight loss. Failure to ensure the physician responded in a timely manner may result in a delay of treatment and resulted in further weight loss for Resident #34. Findings include: Review of the facility policy titled Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol occurred on 04/21/22. This policy, dated Qtr (quarter) 3, 2021, stated, . The physician and staff will monitor nutritional status, an individual's response to interventions . When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses, goals, wishes, prognosis, and complications . Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS), dated [DATE], identified severe weight loss. The care plan failed to address weight loss. The record identified the following weights completed from admission on 11/24/21 to 03/09/22: * 11/24/21 116 lbs. (pounds) * 11/29/21 116 lbs. * 12/06/21 116 lbs. * 12/09/21 114 lbs. * 01/10/22 110 lbs. * 01/28/22 94 lbs. (14.5% decrease in 30 days represents a severe weight loss) * 02/15/22 90 lbs. (22.4% decrease in 180 days represents a severe weight loss) * 03/01/22 94 lbs. * 03/02/22 93.6 lbs. * 03/04/22 93 lbs. * 03/07/22 91.2 lbs. * 03/09/22 91.4 lbs. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34's physician progress note, dated 03/10/22, identified a weight of 91.2 lbs., but failed to evaluate the resident's response to the MedPass (liquid supplement) recommended by the dietician on 02/17/22 or address the 24.6 pound severe weight loss. During an interview on 04/20/22 at 2:30 p.m., a licensed nurse (#8) confirmed Resident #34's physician note failed to address the severe weight loss. During an interview on 04/21/22 at 12:48 p.m., the administrative staff (#1 and #3) agreed the physician failed to address Resident #34's severe weight loss.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 28611 Based on observation, review of employee files, facility policy, and staff interview, the facility failed to ensure nursing staff with appropriate competencies and skill sets to care for the needs of residents for 1 of 1 nursing staff observed using the suction machine (Staff A) and 1 of 3 certified nursing assistant (CNA) personnel files reviewed (Staff B). Failure to ensure nursing staff are knowledgeable regarding the use of suction machines and CNAs complete annual competencies may result in inadequately trained staff and poor resident care. Findings include: Review of the facility policy titled Job Descriptions and Performance Evaluations occurred on 04/20/22. This policy, revised August 2021, stated, . The primary purpose of our facility's job descriptions and performance evaluations is to provide uniform guidelines for the implementation of our job requirements and the evaluation of the standards of job performance. - CNA (Staff B's) personnel file identified a hire date of 07/09/19. The facility completed the most recent performance evaluation on 06/01/20 (22 months prior). During an interview on the morning of 04/20/22, a supervisory nurse (#1) stated the facility should complete CNA performance evaluations annually. - Observation of the suction machine on 04/20/22 at 2:09 p.m. showed a staff nurse (Staff A) attempted to demonstrate the use of the suction machine. The staff member located tubing in the drawer of the cart, and stated she needed an adaptor to be able to connect the tubing. When asked where she would find an adaptor, the staff nurse stated she was unsure and would find out. At 2:45 p.m., the staff nurse returned and identified the adaptor as part of the tubing. The nurse then demonstrated the use of the suction machine. During an interview on the afternoon of 04/20/22, a supervisory nurse (#1) stated nursing staff should know how to use the suction machine in case of emergencies.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40489 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/25/21 Based on observation, record review, review of facility policy, and staff and resident interviews, the facility failed to obtain routine, regularly scheduled medication for 1 of 21 sampled residents (Resident #63). Failure to ensure each resident receives routine, regularly scheduled pain medications has the potential for unnecessary pain and other adverse effects. Findings include: Review of the facility policy titled Administering Medications occurred on 04/21/22. This undated policy stated, . Medications shall be administered in a safe and timely manner, and as prescribed. During observation of morning cares on 04/19/22 at 11:38 a.m., Resident #63 requested the staff apply the pressure relieving boot to his left foot due to increased pain from the ulcer to his left heel. During an interview on 04/20/22 at 2:00 p.m., Resident #63 stated, I didn't get much sleep last night because my left heel was hurting so bad, and they said they were out of my Tramadol. Review of Resident #63's medical record occurred on all days of survey and included diagnoses of pressure ulcers to right and left buttocks, left heel and left ankle, neuropathy (bone pain), and osteomyelitis (bone infection). Resident #63's current physician orders included: Tramadol 50 milligrams [mg]. Give one tablet by mouth three times a day for pain. Resident #63's current care plan stated, . I need pain management and monitoring related to: pressure wounds . Pain medication scheduled routinely. The electronic medication administration record (EMAR) for Resident #63 identified the following: * 04/19/22 at 8:00 a.m., Tramadol not administered. scheduled Tramadol Tablet 50 mg. Give one tablet by mouth three times a day for pain. Hold per MD [medical doctor] orders. * 04/19/22 at 12:00 p.m., Tramadol not administered. scheduled Tramadol Tablet 50 mg. Give one tablet by mouth three times a day for pain. Resident out of facility. (Resident #63 was out of facility at emergency room at this time). * 04/19/22 at 8:00 p.m., Tramadol not administered. Tramadol Tablet 50 mg. Give one tablet by mouth three times a day for pain. Hold per MD orders. Nursing progress notes included the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 4/20/22 at 9:20 p.m., . [Dr. name] oncall (sic) attending was unable to give one time order for Tramadol tonight. One time hold order Tramadol tonight obtained by [Dr. name]. Resident is made aware. Resident #63's controlled substance record showed no Tramadol 50 mg tablets available on 04/18/22 at 8:15 p.m. The controlled substance record on 04/20/22 showed twelve Tramadol 50 mg tablets available. During an interview on 04/20/22 at 2:25 p.m., a nurse (#12) verified he had received twelve Tramadol from the pharmacy this morning for Resident #63. When asked the process when a scheduled medication is not available the nurse stated, We have the nexys system [automated medication dispensing system] but I don't believe I have access to that system and even if I did the pharmacist needs to do something in it so I could get the medication out, but I'm not sure how that all works. During an interview on 04/20/22 at 2:35 p.m., a unit manager (#8) stated, I don't think I have access to the nexys system, and I'm not even sure how it works. I think staff use their fingerprint to get into it. During an interview on 04/20/22 at 2:40 p.m., a unit manager (#17) stated, I did receive a call from the nurse (#19) last evening telling me there was no Tramadol for [Resident #63's name], and I asked her if there was any Tramadol in the nexys system and the nurse (#19) stated there was no Tramadol in the nexys system. So I told the nurse (#19)to call the physician and get a one time hold order for the resident's Tramadol. For whatever reason the day nurse didn't order a refill. During the interview both unit managers (#8 and #17) verified the nexys system contained Tramadol 50 mg during this time period. During an interview on 04/22/22 at 10:15 a.m., an administrative nurse (#1) verified facility nursing staff failed to refill Resident #63's Tramadol and incorrectly obtained a hold order instead of refilling Resident #63's Tramadol.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28611 Based on observation, facility policy review, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 1 medication cart (North Hall). Failure to lock the medication cart at all times when unattended may result in unauthorized access to medications. Findings include: Review of the facility policy titled Storage of Medications occurred on 04/20/22. This policy, revised April 2021, stated, . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Observation on 04/20/22 from 11:12 a.m. until 11:22 a.m. showed an unlocked medication cart located in the North Hall. Multiple staff members and residents walked by unlocked and unattended medication cart. During an interview on the afternoon of 04/20/22, a supervisory nurse (#1) stated staff should lock the medication cart when it is unattended.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 28611 Based on review of facility menus, facility policy review, and staff interview, the facility failed to ensure the nutritional adequacy of menus on 4 of 4 days of survey (April 18-21, 2022). Failure to ensure the dietician reviews menus, include portion sizes, and include menus for altered or therapeutic diets may result in residents experiencing nutritional deficiencies and weight loss. Findings include:Review of the facility policy titled Menus occurred on 04/20/22. The policy, revised October 2021, stated, . The Dietician reviews and approves all menus . Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal . The facility provided a copy of the daily menu for the week of survey. The menu lacked portion sizes, menus for therapeutic and altered diets, and review by a dietician. During an interview on the afternoon of 04/19/22, a dietary cook (#18) identified she developed the menus and confirmed they lacked review by a dietician.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19410 Based on observation, record review, and staff interview, the facility failed to accommodate resident/resident representative's preferences for food during 2 of 3 meals observed (evening meal on 04/18/22 and noon meal on 04/19/22). Failure to follow the resident/resident representative's preferences for less carbohydrates and less high calorie foods has the potential to result in weight gain. Findings include: During interviews on 04/19/22 at 3:45 p.m. and on 04/20/22 at 2:30 p.m., family member (E) expressed concern the resident's weight has slowly increased and she has talked with staff/dietary/administration many times about the resident's diet. The family member stated the resident gets too many carbohydrates and sweets and wants the resident to have lower calorie food items for dessert and less carbohydrates. The family member (E) stated she has discussed this with staff, but they continue to give high calorie desserts. Observation of the evening meal on 04/18/22 showed the resident ate 100% of the following meal: broccoli cheese soup, egg salad (without bread), mashed potatoes with gravy, and vanilla pudding with chocolate sauce. Observation of the lunch meal on 04/19/22 showed the resident ate 100% of the following meal: mashed potatoes, pasta, mixed vegetables (carrots, green beans, zucchini), and a pureed cake dessert (menu: peanut butter cake and chocolate frosting). Review of Resident #55's medical record occurred on all days of survey. The record identified the resident's family member as her decision maker. Resident #55's quarterly Minimum Data Set, dated dated [DATE], identified the resident with mild cognitive impairment. The resident currently receives a regular diet (minced and moist in texture). Review of the resident's tray card from the kitchen identified the following preferences: Double vegetable, Half Carb [carbohydrates], Regular Protein. Review of Resident #55's current care plan identified the following: I am at moderate nutrition risk r/t [related to] . dysphagia, high BMI [body mass index] for age, weight fluctuations . nutrition/weights/diet order as needed. Honor food preferences as requested . Adjusted nutritional estimates per BMI > 30 . Offer snacks throughout the day and encourage low calorie snacks . I have cognitive loss as evidenced by memory deficits related to Dementia dx [diagnoses] secondary to MS [multiple sclerosis], dx of cognitive dysfunction. Provide reminders to support memory. Review of dietary notes identified the following: 3/25/2022 Nutrition/Weight . [name of Resident #55's family member] spoke to me about . menu. explained that if she would like [Resident #55] to be on a specific diet, she would have to have a conversation with her primary doctor. I stated that we do offer choice when we can to upkeep quality of life. I again told her to follow up with her doctor and that we will follow his/her direction. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/23/2021 Nutrition/Weight . Met with [Resident #55's family member] about diet recommendations from the doctor. More plant based-diet . (no complex starches like rice, pasta, breads, etc.) More vegetables at least two at lunch and dinner and fresh fruit, (no cake or cookies) Updated tray card. [Resident #55's family member] . wanted [resident] to have more fresh fruit and vegetables and I explained that we recommend she doesn't because of the mechanical soft diet recommended by therapy and that she could aspirate on the foods. Recommended some other fruits, some cooked and some fresh along with cooked vegetables. The dietary notes from 06/23/21 identified recommendations for no cake or cookies, however the kitchen tray card did not reflect this recommendation. Observation of the meal served to Resident #55 on 04/19/22 showed two servings of carbohydrates (potatoes and pasta) and a dessert. The facility failed to follow the resident/resident representative's wishes regarding food preferences.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 19410 Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, and staff interview, the facility failed to maintain a Quality Assessment and Assurance (QAA) process, which identified and addressed quality issues; and failed to develop and implement appropriate plans of action to correct deficient practice and ensure compliance with federal requirements. These failures have the potential to result in adverse outcomes for all the residents. Findings include: Review of the North Dakota Department of Health, Division of Health Facilities provider files identified the facility failed to maintain compliance in the following areas cited during the 04/21/22 standard recertification survey. The facility had repeat deficiencies cited from the recertfication survey on 02/25/21 and the federal survey on 03/25/21. F692 Nutrition/Hydration Status Maintenance (cited 02/25/21) F695 Respiratory/Tracheostomy Care (cited 02/25/21 and 03/25/21) F755 Pharmacy Services/Procedures (cited 02/25/21 and 03/25/21) F880 Infection Prevention & Control (cited 02/25/21 and 03/25/21) The facility failed to develop and implement appropriate plans of action to correct the repeat deficient practices listed above. Failure of the facility to effectively utilize QAA resulted in continued noncompliance at F692, F695, F755, and F880.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40489 THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 02/25/21 and 03/25/21. Based on observation, review of facility policy, record review and staff interview, the facility failed to ensure staff followed appropriate infection control practices for 1 of 4 sampled resident (Resident #63) observed with pressure ulcers. Failure to follow appropriate infection control practices for pressure ulcer care may result in an infection or worsening of the affected area and cause delay in healing. Finding include: Review of the facility policy titled Wound Care occurred on 04/21/22. This undated policy, stated, Steps in the Procedure 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's overbed table. Place all items to be used during procedure on the clean field. 14. Be certain all clean items are on the clean field. Review of Resident #63's medical record occurred on all days of survey and included the following pressure ulcers: * Left heel- stage II * Left ankle- stage II * Right buttock- stage II * Left buttock- stage II Observation on 04/19/22 at 11:53 a.m., showed Resident #63 lying in bed on his left side. A licensed nurse (#2) gathered supplies to complete dressing changes to the resident's pressure ulcers on his buttocks and placed the supplies on the resident's bed sheets. The nurse donned gloves, poured sterile water on the old dressings, removed the old dressings and doffed his gloves. The nurse donned new gloves and applied more sterile water cleansing the resident's buttocks ulcers. The nurse opened the bottle of prescribed wound cleanser, poured the wound cleanser into the cap of the bottle, which he had placed on the resident's bed sheet, handed the scissors and gauze to the certified nurse aide (CNA) (#13) who cut the gauze for the nurse and placed the scissors and remaining roll of gauze back on the bed sheets. The nurse soaked the gauze in the cap of the wound cleanser, opened a package of sterile q-tips removed one, placed the open package of q-tips back on the resident's bed sheets and packed the wound. The nurse picked up the rolled gauze and scissors from the bed sheets and handed them to the CNA (#13) who cut the gauze for the nurse. The nurse failed to provide a clean field while completing the resident's wound care, and failed to sanitize or wash his hands in between doffing and donning gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/21/22 at 10:15 a.m., an administrative nurse (#1) stated she expected staff to use a clean field for dressing changes and to sanitize hands in between doffing and donning gloves.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure staff are vaccinated for COVID-19 28611 Based on record review, facility policy review, and staff interview, the facility failed to ensure an appropriate exemption from COVID-19 vaccination for 1 of 2 unvaccinated staff members (Staff C). Failure to ensure an appropriate exemption allowed staff to work while unvaccinated which placed residents and staff at risk for COVID-19 infection. Findings include: Review of the facility policy titled Federal Vaccination Mandate Policy for Healthcare Facilities occurred on 04/20/22. This undated policy stated, . Medical Exemption: To be eligible for a Qualified Medical Reasons exemption the Eligible Person must provide to their employer a written statement that meets the following requirements: A letter or form signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccine requirements for staff based on the recognized clinical contraindications. Review of Staff C's COVID-19 vaccination exemption occurred on 04/20/22. The exemption lacked a statement from a licensed practitioner, specific contraindicated vaccines, and recognized clinical reasons for a vaccine exemption. During an interview on 04/20/22 at 12:02 p.m., an infection control nurse (#7) identified Staff C last worked on 04/12/22 and agreed the exemption the facility has on file is not acceptable.