STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245618	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walker Methodist Westwood Ridge II	61 Thompson Avenue West West Saint Paul, MN 55118

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident choices for bathing preferences were assessed and honored for 1 of 1 residents (R5) reviewed for choices. Findings include: R5's admission Minimum Data Set (MDS), dated [DATE], indicated R5 had intact cognition with no hallucinations or delusions. On 1/21/25 at 8:57 a.m., R5 indicated he has only been out of bed one time since admission to the facility. R5 indicated he was transferred out of bed with assist of 2 staff and walker and back to bed with a Hoyer lift (mechanical lift/device that lifts patients from one place to another who cannot bear weight on their lower extremities). R5 indicated he was currently receiving hospice services. R5 indicated staff come in and wash me up and rotate me but has not had a shower since admission which he prefers. R5's care plan, printed 1/23/25, identified the following: -BATHING/SHOWERING: The resident requires assistance from 1 staff with bathing. -TRANSFER: The resident is totally dependent on staff for transferring. -PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene and oral care. -The resident is WEIGHT-BEARING. -AMBULATION: The resident does not ambulate. R5's care plan lacked evidence of R5's preference to have a shower versus a bed bath. R5's care sheet, printed 1/21/25, lacked evidence of preference of bathing preferences: showers vs baths. R5's [NAME], printed 1/21/25, identified the following: -Bladder/Bowel: Encourage resident to sit on toilet to evacuate bowels if possible. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Toileting: Ensure resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote east of evacuation where possible. -BATHING/SHOWERING: The resident requires assistance from 1 staff with bathing. -TRANSFER: The resident is totally dependent on staff for transferring. -PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene and oral care. R5's [NAME] lacked evidence of R5's preference to have a shower versus a bed bath. R5's progress notes, dated 12/31/25 to 1/23/25, were reviewed. R5's progress notes lacked evidence of an assessment or conversation of R5's choice for bathing preference. R5's Nursing Assessment Admission/Readmission, dated 12/31/25 was reviewed and identified the following: -Bathing Preference/Day/Shift marked ADL-Bathing Monday and Thursday PM R5's Nursing Assessment lacked evidence of assessment of R5 being offered a choice between a bed bath and shower. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and [NAME]'s to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 requires staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week. NA-C verified they have not assisted R5 with a shower, adding hospice has been doing his bed baths, and verified showering was a responsibility of nursing assistants. NA-C was unable to indicate whether R5 preferred a bed bath or a shower. NA-C stated the care plan indicates that R5 needs assist of 1 staff. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D indicated they have not transferred R5 for a while and were unable to give a time frame of the last time they assisted. NA-D indicated they think he is a Hoyer. NA-D indicated they are not sure when hospice comes to see R5 and stated, there is a schedule for hospice I think. NA-D indicated they have not assisted R5 with a shower. During a follow up interview on 1/22/25 at 2:50 p.m., R5 verified they prefer a shower. R5 stated he has not been offered a shower since admission. R5 added he doesn't know if there was a shower in the bathroom as he has not been in the bathroom in his room before. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated this would be added to the care plan. RN-B stated (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that if a resident has a preference to have a bed bath versus a shower, that would have been assessed and added to the care plan for continuity of care. RN-B verified R5 was on hospice. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care sheets, care plans, [NAME] to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. NA-B stated if it was resident's preference to have a bed bath versus a shower, that would be on the care plan and stated, an aid cannot decide this. NA-B stated an aide's job is to help the resident, wash the resident if needed, change the resident, you make beds, give them the call lights. NA-B stated residents' preferences would be on their care plan such as if they prefer to stay in bed or if they want a bed bath or a shower. On 1/23/25 at 10:08 a.m., licenses practical nurse coordinator (LPN)-C indicated residents should be given choices regarding their cares and their preferences are put on their care plans. LPN-C reviewed R5's assessments and care plan. LPN-C verified R5's electronic medical record (EMR) lacked evidence R5 was provided choices regarding showers versus baths. Furthermore, LPN-C verified R5's care plan indicates R5 was able to bear weight and dependent on staff for transferring. LPN-C verified R5 was not assessed by physical therapy or occupational therapy as [R5] is on hospice. LPN-C stated it is important that residents have choices as, it is their right to make choices .we are taking care of them .we want to meet their needs and provide the best care we want to accommodate that to the best of our ability. On 1/23/25 at 12:15 p.m., director of nursing (DON) verified a resident should be assessed for preferences and the preferences would be on a resident's care plan. DON verified if a resident has a preference to have a shower or a bed bath, that would be on a care plan as that would have been assessed. A facility policy on resident choices was requested and not received.

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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. Based on interview and document review, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN; CMS-10055) and/or Notice of Medicare Non-Coverage (NOMNOC; CMS-10123) upon the termination of Medicare A coverage for 3 of 4 residents (R26, R187, and R188) reviewed. Findings include: R26's Census Record, printed 1/23/25, identified on 1/15/25, R26's payor source changed. The record further indicated R26 remained in the facility. R26's Centers for Medicare and Medicaid Services (CMS)-10123 signed as received on 1/10/25, identified a last covered day (LCD) of 1/14/25, when R26's Medicare coverage would end. R26's Centers for Medicare and Medicaid Services (CMS)-R-131 signed as received on 1/21/25 which was 6 days after private pay costs started and after survey entrance. R187's Census Record, printed 1/23/25, identified on 10/15/24, R187's payor source changed. The record further indicated R187's billing stopped on 10/16/24. R187's Centers for Medicare and Medicaid Services (CMS)-10123 signed as received on 10/11/25, identified a last covered day (LCD) of 10/14/24, when R187's Medicare coverage would end. R187's medical record was reviewed and lacked any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. R188's Census Record, printed 1/23/25, identified on 8/5/24, R188's payor source changed. The record further indicated R188's billing stopped on 8/7/24. R188's medical record was reviewed and lacked any evidence a SNFABN or NOMNOC had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. On 1/23/25 at 11:27 a.m., administrator verified R26 had received a NOMNOC but did not receive a SNFABN until after payor source had started and after survey entrance. Administrator verified R187 received a NOMNOC but did not receive a SNFABN and should have. Furthermore, administrator verified R188 did not receive a SNFABN or NOMNOC and should have. Administrator stated retraining has been provided regarding notices as it was discovered that some things weren't getting done. Administrator stated they are currently reviewing NOMNOC's and SNFABN's to ensure accuracy. A facility policy titled Beneficiary Notices, revised 1/2025, indicated the facility will inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview and document review the facility failed to ensure private and confidential resident information was secure and not visible to residents and visitors when multiple care sheets were left out in public view. This had the ability to affect eleven residents on the 400 hallway including R4. Findings include: During observation on 1/21/25 at 12:17 p.m., a medication cart down the 400 hallway was left unattended with a care sheet out in public view which identified five patient rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. Multiple residents were seen wandering by the unattended medication cart with resident private information in sight. During an interview on 1/21/25 at 12:27 p.m., registered nurse (RN)-D stated he was working from the medication cart that day and due to the private resident information on the care sheets, they should be tucked away under the computer or behind the nursing desk so it was not out and visible to residents or visitors. During observation on 1/21/25 at 9:48 a.m., a clip board was observed sitting on the edge of the unit desk with a care sheet cart 1out in public view which identified five resident rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. Multiple residents and family members were seen wandering by the unattended clip board with resident private information in sight. At 9:53 a.m., registered nurse (RN)-E was observed to pick up the clip board that contained the care sheet. On 1/23/25 at 8:22 a.m., it was observed medication cart 3 was left unattended in the hallway outside a room with the computer screen open with R4's medication orders on the screen along with a care sheet out in public view. The care sheet labeled cart 3 identified six resident rooms which included the residents full name, diagnoses, special programs such as hospice, how alert and oriented they were, transfer and ambulation status, bowel and bladder continence, diet, precautions, skin conditions, and notes such as oxygen use, and devices used, new orders, etc. There was no nurse in the area. At 8:25 a.m., licensed practical nurse (LPN)-A came out of a resident room stating, Oh my, did I leave that open? when asked about the computer screen. LPN-A verified the screen was left open and unattended with resident information viewable and verified they were working on medication cart 3. LPN-A grabbed the care sheet when asked to verify what the sheet was titled and placed it in their pocket stating, it is always in my pocket. LPN-A verified the sheet had resident information on it. On 1/23/25 at 10:30 a.m., licensed practical nurse coordinator (LPN)-C stated it is important to keep resident information private. LPN-C stated the expectation was that resident information is not to be left out in public view and any papers are to be flipped over and computer screens should be locked when not in use. A facility policy titled Notice of Privacy Practices, revised 1/2025, indicated we are required by law to maintain the privacy and security of your protected health information.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide a copy of the resident's base line care plan for 1 of 2 resident (R26) reviewed for baseline care plans. Findings include: R26's admission Minimal Data Set (MDS), dated [DATE], indicated R26 was admitted to the care facility on 12/10/24 and was cognitively intact. R4's Care Conference Summary, dated 12/22/24, contained a section for comment that stated, copies of care plan given/sent. In the text box was typed N/A [not applicable]. During an interview on 1/22/25 at 1:51 p.m., R26 stated she had attended a care conference since she arrived at the care facility but had not received a copy of her care plan, stating I would like to see it and have a copy if possible. During an interview on 1/22/25 at 12;10 p.m., social services (SW)-A stated there process was to start the baseline care plan the day a resident was admitted but they did not provide a copy of the care plan to residents or their representatives until they discharged . During an interview on 1/22/25 at 11:00 a.m., the nurse coordinator (NC) and director of nursing (DON) confirmed their process was to give resident a copy of their care plan on discharge along with a recapitulation of stay. A facility policy titled Care Plans, revised 1/2025, indicated the facility will provide the resident and their representative, if applicable, with a written summary of the baseline care plan by completion of the comprehensive care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand.

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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** Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate care was provided for 1 of 5 residents (R29) reviewed for comprehensive care plan. Findings include: R5's admission Minimum Data Set (MDS), dated [DATE], indicated R5 was admitted on [DATE], had intact cognition and required maximum assistance for oral hygiene, toileting, dressing lower part of body, footwear, personal hygiene, bed mobility, and transfers. R5 required touching assistance for upper body dressing. Noted for tub/shower transfer, not applicable. R5's MDS indicated no behaviors were present, and no rejection of care exhibited. Section H: Bladder and Bowel indicating R5's always continent of bowel. Section V: Care Area Assessment (CAA) summary, the following care areas were triggered and marked as addressed in care plan: communication; ADL function/rehabilitation potential; urinary incontinence and indwelling catheter; falls; nutritional status; dental care; pressure ulcer and psychotropic drug use. R5's diagnosis report, printed 1/23/25, included the following diagnoses: acute kidney failure (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few day), retention of urine (condition where the bladder doesn't empty completely), diabetes (condition that affects your blood sugar levels), anemia (body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Atrial fibrillation (an irregular and often rapid heart rhythm that can lead to stroke and heart failure), congestive heart failure (heart not pumping pump properly), hypertension (high blood pressure), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should). R5's Order Summary Report, dated 1/22/25, indicated the following orders: - hospice referral on 12/31/24. -Apixaban (used to prevent stroke and blood clots) 5 milligrams (mg) tablet; give 2.5 mg by mouth two times a day for CVA [cerebral vascular accident], stroke started 12/31/24 -Gabapentin (anti-convulsant medication which can be used to treat nerve pain) 300 mg capsule; give 1 capsule by mouth one time a day for neuropathic pain [order entered twice for two different times during the day] started 12/31/24 -Gabapentin 300 mg capsule; give 2 capsules by mouth at bedtime for neuropathic pain started 12/31/24 -haloperidol (antipsychotic medication) tablet 1 mg; give 1 tablet by mouth every 4 hours as needed for nausea/vomiting (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hydromorphone (opioid pain medication) HCL 2 mg tablet; give 1 mg by mouth every 4 hours as needed for pain, dyspnea (shortness of breath) started 12/31/24 -mirtazapine 15 mg tablet; give 0.5 tablet by mouth at bedtime for MDD (major depressive disorder) started 12/31/24 R5's care plan, printed 1/23/25, identified the following: -Resident has potential/actual risk of abuse from (self/others) to admission with no goal or interventions listed. -The resident has an ADL self-care performance deficit with no goal listed the following interventions: -Mobility/Safety/Medical Devices: (Examples: TLSE, Splint, Brace, Walker, Wheelchair, Oxygen, Wound Vac, etc). -Bed Mobility: The resident is totally dependent on staff for repositioning and turning in bed (SPECIFY FREQ) and as necessary. -The resident has constipation r/t [related to] with a goal and interventions. - The resident is on anticoagulant therapy r/t with a goal and interventions. -The resident is on pain medication therapy r/t with a goal and interventions. -The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure ulcer development r/t with a no goal listed with three interventions. -The resident has potential/actual impairment to skin integrity of (SPECIFY location) r/t with no goal listed with three interventions. R5's care plan lacked evidence of the following areas being identified in the care plan after identified being in the CAA: communication, urinary incontinence and indwelling catheter, falls, psychotropic drug use. R5's care plan lacked evidence of R5's cognitive abilities, behavioral symptoms, resident specifics regarding mobility/safety/medical devices (what medical devices R5 utilizes), resident specific how frequent resident should be repositioned and turned in bed, resident specific pressure ulcer concerns, resident specific skin integrity concerns, specifics relating to pain/anticoagulant/constipation. Furthermore, the care plan lacked any coordination with hospice or discharge plan. Additionally, R5's care plan lacked a goal for focus areas for: -Resident has potential/actual risk of abuse from (self/others) to admission -The resident has an ADL self-care performance deficit -The resident has limited physical mobility (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident has (SPECIFY) pressure ulcer (SPECIFY LOCATION) or potential for pressure ulcer development r/t -The resident has potential/actual impairment to skin integrity of (SPECIFY location) r/t In addition, R5's care plan lacked any interventions for the focus area of -Resident has potential/actual risk of abuse from (self/others) to admission Additionally, R5's care plan lacked evidence of R5's preference of a shower versus a bed. R 5' s' care plan lacked evidence of R5's specific needs to transfer (assist of 2 staff, or Hoyer lift). Additionally, R5's care plan lacked evidence of R5's preference to use the bathroom vs incontinent pad and need for Foley catheter. R5's care plan lacked evidence of R5's preferences for therapeutic activities. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and [NAME]'s to find the information needed to care for residents. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week, adding we go in and reposition him. NA-C stated R5's incontinent pad is check and changed when R5's repositioned, verifying R5 has not been offered a bed pan, use of the bathroom or toilet. NA-C was unable to indicate whether a bed bath was NA-C preference versus a shower. NA-C verified R5 had a catheter upon admission to the facility. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D verified they do not offer R5 a bed pan, or toilet as R5 was to be repositioned and changed. NA-D indicated they have not transferred R5 for a while and were unable to give a time frame of the last time they assisted. NA-D indicated they think he is a Hoyer. NA-D indicated they are not unsure when hospice comes to see R5 and stated, there is a schedule for hospice I think. NA-D verified nursing assistants use [NAME] and care sheets to know resident needs. During a follow up interview on 1/22/25 at 2:50 p.m., R5 stated he prefers a shower vs a bed bath. Furthermore, R5 stated he prefers to use bathroom vs an incontinent pad. R5 verified he has a Foley catheter. R5 stated his spouse (who resides in a separate part of facility) visits daily, enjoys listening to music and likes to watch TV. R5 stated he enjoys watching football. R5 stated he doesn't know if he is going to discharge from facility but would like to stay with his spouse but doesn't know if that is possible. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated preferences would be added to the care plan. RN-B stated that if a resident has a preference to have a bed bath vs a shower, that would have been assessed and added to the care plan for continuity of care. RN-B verified R5's current plan as of 1/22/25 and lacked items listed above. On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care plans, care sheets, and [NAME]'s to help determine resident needs. NA-B stated residents' preferences would be on their care plan such as if a resident preferred a bed bath vs a shower. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 10:08 a.m., licenses practical nurse (LPN)-C nurse coordinator indicated a comprehensive care plan should include all activities of daily (ADL) needs (transferring, dressing, ambulating, etc.), any wounds or potential skin issues, antibiotics and dependent on the resident. LPN-C indicated the entire team, including social services adds to the care plan. LPN-C verified hospice information included hospice contact information, hospice goals should be on the comprehensive care plan. LPN-C verified resident preferences should be on the comprehensive care plan such as if a resident prefers a bed bath vs a shower or if a resident prefers to stay in bed vs getting out of bed. LPN-C verified the comprehensive care plan needs to be specific to each resident and all areas need to be completed to be resident specific. LPN-C verified R5's care plan lacks hospice information, preferences with shower vs bed bath, responsibility of R5's showers. LPN-C verified R5's care plan was not comprehensive or resident specific. On 1/23/25 at 12:15 p.m., director of nursing (DON) stated a comprehensive care plan needs to be completed by day 21 after admission. DON verified the comprehensive care plan needs to be resident specific and would include treatments, preferences, hospice information, diagnosis and other pertinent information. DON stated the comprehensive care plan needs to be resident focused. A facility policy titled Care plans, dated 1/2025, indicated the comprehensive care plan must describe the following: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . Furthermore, the comprehensive care plan must reflect interventions, the specific care and services that will be implemented, to enable each resident to meet his/her objectives.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care conferences were conducted upon admission for 1 of 2 residents (R5) reviewed for care conferences. Findings include: R5's admission Minimum Data Set (MDS), dated [DATE], indicated R5 had intact cognition with no hallucinations or delusions with an admission date of 12/31/24. Diagnoses included: heart failure, hypertension (high blood pressure), diabetes (condition that affects your blood sugar levels), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damages and can't filter blood as well as they should). R5's progress notes, dated 12/31/24 to 1/23/25, were reviewed. Progress notes lacked evidence of R5 having a care conference since admission on [DATE]. Furthermore, lacked documentation of planning a care conference. R5's assessment tab in the electronic medical record (EMR), dated 12/31/24 to 1/23/25, were reviewed for care conference note. Assessment for care conference lacked evidence of R5 having a care conference since admission on [DATE]. On 1/21/25 at 8:57 a.m., R5 was observed lying in bed. R5 indicated he had not had a care conference since admission. R5 indicated there has not been a meeting of any kind to talk about a plan going forward. R5 stated his apartment had been given up and spouse was moved out of their joint apartment. R5 stated he isn't sure if the plan is for him to stay where he is at now or go somewhere else as no one has talked to him about the plan. R5 stated he is not doing any therapy. On 1/23/25 at 10:08 a.m., licensed practical nurse coordinator (LPN)-C indicated care conferences are typically completed within about a week or so after admission to the facility. LPN-C stated care conferences are held after therapy and nursing can assess residents. LPN-C stated therapy (physical, occupational and speech), nurse coordinator, social worker, family, and resident are all invited to care conferences. LPN-C stated the social worker sets up care conferences and puts in the notes afterwards. LPN-C verified she did not see a care conference in the EMR but wanted to verify with the social worker if a care conference was completed. LPN-C verified R5 admitted on [DATE] (23 days prior). On 1/23/25 at 10:47 a.m., social worker (SW)-A stated the expectation was to have a care conference about a week after admission after therapy and nursing can assess a resident. When asked about R5, SW-A stated, we have not had one for him as he came in on private pay on hospice his plan is to stay here private pay on hospice. SW-A indicated there was not a plan in place for a care conference for R5. SW-A stated there was no policy that a care conference had to be completed in a certain time frame. On 1/23/25 at 12:14 p.m., director of nursing (DON) stated care conferences are scheduled typically (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the first week or two. DON stated care conferences are done after a resident has been assessed by therapies and nursing. DON stated, I would have to double check to see if there is requirement for when they have to be completed by. DON did not follow with a requirement. A policy on care conference timing was requested and not received.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure effective collaboration between the facility and a contracted hospice organization that affected 1 of 1 residents (R5) reviewed for hospice services. Findings include: R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact with no hallucinations or delusions and required maximum assistance for oral hygiene, toileting, dressing lower part of body, footwear, personal hygiene, bed mobility, and transfers. R5's diagnosis report, printed 1/23/25, included the following diagnoses: acute kidney failure (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few day), retention of urine (condition where the bladder doesn't empty completely), anemia (body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), Atrial fibrillation (an irregular and often rapid heart rhythm that can lead to stroke and heart failure), congestive heart failure (heart not pumping pump properly), hypertension (high blood pressure), diabetes (condition that affects your blood sugar levels), depression, obstructive sleep apnea (sleep disorder characterized by episodes of a complete or partial collapse of the airway with an associated decrease in oxygen saturation or arousal from sleep), ischemic cardiomyopathy (a condition of weakened heart muscles due to heart attack or coronary heart disease), and chronic kidney disease (a condition in which the kidneys are damaged and can't filter blood as well as they should). R5's hospice chart lacked a calendar of planned hospice visits. Furthermore, the hospice chart lacked a copy of the hospice care plan. There was a section for hospice staff to use for collaboration of care of between the hospice staff and facility staff. This section lacked any coordination from the hospice nursing assistants. R5's care plan, printed 1/23/25, lacked evidence of hospice provider, services provided, contact information, frequency of visits or disciplines visiting R5. R5's Order Summary Report, printed 1/22/25, identified referral: hospice on 12/31/24. R5's Order Summary Report lacked evidence of hospice provider name, contact information, services provided, frequency of visits or disciplines visiting R5. R5's Medication Administration Record (MAR/TAR), dated 1/22/25, for January included the following orders: -Hospice Charting. Document any changes in condition in a progress note every day shift on even days for Charting started 1/02/25 -Hospice Charting. Document any changes in condition in a progress note every evening shift on odd days for Charting started 12/31/24 R5's MAR/TAR lacked evidence of hospice provider, contact information, frequency of visits, disciplines visiting or services provided to R5. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's progress notes, dated 12/31/24 to 1/21/25, were reviewed and identified the following: -1/13/25: RN called hospice regarding R5's urine. -1/8/25: Foley is patent, maceration in groin hospice informed. -1/3/245: R5 followed by [identified company] hospice for EOL [end of lift] services. -12/31/24: [R5] being admitted to [identified company] hospice. R5's progress notes lacked evidence of frequency of hospice visits, planned hospice visits, services hospice providing or disciplines providing services to R5 from hospice. R5's [NAME], printed 1/21/25, lacked evidence R5 was receiving hospice services. R5's care sheet, printed 1/21/25, identified R5 shower/bath days were Tuesday and Saturday AM. Care sheet indicates R5 receives hospice services with provider listed. R5's care sheet lacked evidence indicating hospice was responsible for R5's showers. During an interview on 1/21/25 at 8:57 a.m., R5 stated he currently receives hospice services. R5 stated he was not sure when hospice was scheduled to come as they just show up. R5 stated he has gotten music therapy and massage therapy through hospice. R5 verified he has been getting bed baths by hospice and no showers or bathing by facility staff. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and [NAME]'s to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated, hospice has been doing his bed baths. NA-C verified they have not been completing R5's showers. On 1/22/25 at 11:31 a.m., NA-D verified they are familiar with R5. NA-D indicated they are not sure when hospice comes to see R5 and stated, there is a schedule for hospice I think. NA-D stated they are not sure the services the additional hospice provides for R5, adding there was a hospice book. On 1/22/25 at 11:42 a.m., registered nurse (RN)-C verified they are not sure when R5's hospice nurse comes to the facility. RN-C verified they are familiar with R5. RN-C verified they think it varies when the hospice staff comes to the facility to see R5. RN-C stated she was not sure the last time the hospice nurse seen R5 or the next scheduled visit with R5 was and added, I can call her with any changes which is what I do. RN-C stated, the hospice nursing assistant came today and last Wednesday. RN-C reviewed R5's hospice binder and verified the following information: identification of R5's hospice provider, RN care manager, social worker; a section with hospice provider address and phone number; list of standing house orders protocol; and an area for hospice staff to write notes after their visit with R5. RN-C verified the hospice binder, which was used for coordination of care, lacked a calendar of when hospice staff was coming and any notes from nursing assistant. The notes left (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the hospice nurse lacked evidence of when the next visit was scheduled for. Furthermore, the hospice binder lacked a copy of the hospice plan of care. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B reviewed and verified R5's care plan lacked information regarding hospice provider. Furthermore, lacked hospice provider name, contact information, services provided, frequency of visits or disciplines visiting R5. On 1/22/25 at 2:56 p.m., NA-B verified they are trained to follow the care sheets, care plans, and [NAME] to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. On 1/23/25 at 10:08 a.m., licenses practical nurse coordinator (LPN)-C verified coordination between facility and hospice needs to be occurring. LPN-C verified the care plan needs to be specific to each resident. LPN-C verified R5's care plan lacks hospice information. LPN-C stated the facility should have the hospice care plan which she thinks would be kept in the hospice binder. LPN-C verified R5's hospice binder lacked a calendar or any notification/plan on hospice visits, did not have any notes entered by nursing assistants on what care was provided during visits or a hospice care plan. LPN-C verified the binder should include this information. On 1/23/25 at 12:18 p.m., director of nursing (DON) stated it is expected that the facility and hospice are coordinating care. DON verified resident's hospice information is kept in the hospice binder and should include hospice care, communication of scheduled visits, POLST and a log for hospice staff to write in after visits. DON verified the facility, and hospice should be sharing the responsibility of showering residents. DON reviewed R5's shower log and verified based on the documentation, I would be unable to determine if R5 is getting a shower and would have to follow up with the nursing assistants. DON stated coordinating care was important to ensure we are providing the best care. A facility policy on coordination with providers was requested and not received.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to comprehensively reassess and demonstrate adequate justification for the continued use of an indwelling catheter for 1 of 2 residents (R4) reviewed who used a catheter. Further, the facility failed to develop a comprehensive plan of care to monitor and assess residents with indwelling catheters for 1 of 2 residents (R4) reviewed who used a catheter. The facility further failed to ensure a resident who was continent of bowel received services to maintain bowel continence for 1 of 2 residents (R5) reviewed for bowel and bladder. Findings include: R4's admission Minimum Data Set (MDS), dated [DATE], indicated R4 was admitted to the care facility on 12/4/24, had severe cognitive impairment and was dependent on staff for bathing, toileting, and dressing. The MDS further indicated R4 had a Foley catheter on place. R4's Urology Consult Note, dated 12/27/24, indicated R4 had an indwelling Foley catheter placed by urology that day as R4 relied on daily intermittent catheterization (a process where the catheter is removed after each use vs an indwelling catheter which remains in place) managed by R4's wife who had difficulty performing catheterization while R4 was in the hospital. The Urology note indicated to maintain Foley catheter at discharge, until patient is back to baseline or in 7-14 days. We can help arrange follow up to remove this otherwise okay for wife to deflate balloon and resume cathing 2-3 times daily after discharge. R4's Hospital Discharge note, dated 1/3/25, indicated unable to straight cath on 12/27/24. Urology placed a Foley 12/27/24. Plan to discontinue Foley and resume intermittent straight cath with wife to manage at TCU [transitional care unit] per discussion with wife and TCU facility. R4's Physician Progress note, dated 1/6/25, indicated R4 had a comorbidity of urine retention due to Parkinson's Disease. The note further indicated early discontinuation of Foley if present to help prevent CAUTI [catheter associated urinary tract infection] and initiation of intermittent straight catheterizations recommended. Initiate timed voids and bladder training as indicated. R4's Physician Progress note, dated 1/20/25, indicated the same catheter recommendations from the note dated 1/6/25. R4's Physician Orders, dated 1/20/25, indicated an order for Ciprofloxacin (an antibiotic) 500 mg twice a day for 7 days for a urinary tract infection. During an interview on 1/22/25 at 11:00, the nurse coordinator (NC) stated she believed that R4's spouse had wanted the catheter to stay in place as she had been running the show. The NC was unsure what the ongoing plan was for R4's catheter. During an interview on 1/22/25 at 12:44 p.m., R4's nurse practitioner (NP) stated that R4's Foley catheter was placed due to R4's spouse having a hard time with the intermittent straight catheterization for R4 and had requested a Foley catheter. During an interview on 1/23/25 at 11:35 a.m., the director of nursing (DON) and NC stated if there (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were no specific orders for a Foley catheter, the facility had standing orders to remove the Foley catheter and attempt a void trial (a procedure that assess a person's ability to urinate normally without a catheter.) During an interview on 1/23/25 at 1:09 p.m., R4's physician stated R4's spouse had been managing R4's intermittent straight catheterizations but that the care facility staff would be able to manage the catheterizations if necessary. The physician stated R4 would be moving to the assisted living next week and would probably end up needing a long term cath[eter] with monthly changes. A facility policy titled Catheter, revised 1/2025, indicated Vivie will ensure that a resident who admits to a Skilled Nursing Facility (SNF) without an indwelling catheter will not be catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; or that a resident who enters the facility with an indwelling urinary catheter or subsequently receives one, is assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization is necessary. R5 R5's admission Minimum Data Set (MDS), dated [DATE], identified R5 was cognitively intact and required substantial/maximal staff assistance with toileting care. Further, the MDS outlined R5 as being always incontinent of bowel, however, a toileting program to manage the resident's bowel continence was marked no with a check mark. During interview on 1/21/25 at 8:57 a.m., R5 was observed lying in bed. R5 stated he would like to use the toilet instead of going in his incontinent pad for bowel movements. R5 stated he has a Foley catheter (a flexible tube that drains urine from the bladder into a bag). R5 stated staff does not offer to bring him to the bathroom and added, they tell me they will just clean me up. R5 stated, it is so unnatural to just go and get cleaned up. R5 stated his preference is to use the bathroom/toilet. R5's care plan, printed 1/23/25, identified the following: -TOILET USE: The resident is totally dependent on staff for toilet use. -TRANSFER: The resident is totally dependent on staff for transferring. -The resident is WEIGHT-BEARING. -Encourage the resident to sit on the toilet to evacuate bowels if possible. -Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote east of evacuation where possible. R5's progress notes, dated 12/31/24 to 1/23/25, were reviewed and lacked evidence of a toileting program attempted. Furthermore, the progress notes lacked evidence of offering R5 the use of a toilet or a bed pan [a device used as a receptacle for the urine and/or feces of a person who is confined to a bed]. R5's Order Summary Report, printed 1/22/25, lacked evidence of toileting program. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Kardex, printed 1/21/25, indicated the following: -Bladder/Bowel: Encourage resident to sit on toilet to evacuate bowels if possible. -Toileting: Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote ease of evacuation where possible. -Mobility: The resident is WEIGHT-BEARING. -Transferring: TRANSFER: The resident is totally dependent on staff for transferring. -Toileting: TOILET USE: The resident is totally dependent on staff for toilet use. R5's care sheet, printed 1/21/25, indicated R5 continent of bowel and bladder. Furthermore, indicated on EBP [enhanced barrier precautions] for Foley. R5's Nursing Assessment - Admission/Readmission, dated 12/31/24, indicated the following: R5 was occasionally incontinent of bowel. On 1/21/25 at 12:15 p.m., nursing assistant (NA)-A indicated nursing assistants and nurses use care sheets and Kardex's to find the information needed to care for residents. NA-A indicated if they had any questions about resident cares/needs, they would ask the nurse. NA-A verified there was important information on the care sheets such as residents name, bath days, how they transfer, if they are continent or incontinent of bowel and bladder and other health information. On 1/21/25 at 2:58 p.m., NA-C verified they are familiar with R5. NA-C verified that R5 needs staff assist with ADLs and is dependent on staff. NA-C stated R5 has not been out of bed for at least the last week, adding we go in and reposition him. NA-C stated R5's incontinent pad is check and changed when R5 is repositioned, verifying R5 has not been offered a bed pan or use of the bathroom or toilet. On 1/22/25 at 11:31 a.m., NA- D verified they are familiar with R5. NA-D verified R5 does not use the toilet or bed pan. NA-D verified they have not offered R5 a bed pan or toilet as R5 was to be repositioned and changed. NA-D indicated they have not transferred R5 for a while and were unable to give a time frame of the last time they assisted him transferring out of bed. During a follow up interview on 1/22/25 at 2:50 p.m., R5 stated again staff had not offered to bring him to the bathroom which is what he prefers. R5 stated he has not been in the bathroom in his room. R5 stated he knows when he must have a bowel movement and when he tells staff they tell him they will clean him up after he goes. R5 stated he has not been offered any other options beside getting cleaned up after having a bowel movement. On 1/22/25 at 3:11 p.m., registered nurse (RN)-B stated that when a resident admits a resident should be asked about their preferences. RN-B stated this would be added to the care plan. RN-B stated a resident would be offered the bathroom but if they couldn't use the bathroom, it would be expected the resident was offered a bed pan. RN-B verified R5's care plan did not have a preference to not use the bathroom, bedside commode or bed pan. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 2:56 p.m. NA-B verified they are trained to follow the care sheets, care plans, and Kardex to help determine resident needs. NA-B stated if they had questions about resident needs, they would ask the nurse. NA-B stated residents' preferences would be on their care plan. On 1/23/25 at 10:28 a.m., licenses practical nurse coordinator (LPN)-C verified R5's admission nursing assessment indicates R5 was continent of bowels with occasional incontinence. Furthermore, LPN-C verified R5's care plan indicates R5 was able to bear weight and dependent on staff for toileting needs. LPN-C stated the expectation would be staff would be assisting with toileting as R5's not independent. On 1/23/25 at 12:15 p.m., director of nursing (DON) verified resident preferences and needs should be on resident's care plan. DON stated it is important so we can provide the best care. On 1/23/25 at 1:21 p.m., RN-F verified they are familiar with R5. RN-F verified R5 has not been transferred out of bed in at least the last couple of weeks to use the bathroom. RN-F stated they were unsure if they were transferred out of bed prior to that. A facility policy titled Incontinence, revised 1/2025, indicated the following: When deemed appropriate, Vivie staff will implement interventions that may promote achieving the highest practicable level of functioning, may prevent the development of incontinence, or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address factors that are potentially modifiable, such as: a. Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc. b. Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet); c. Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion); d. Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and e. Implementing a fluid and/or bowel management program to meet the assessed needs. f. Bladder Rehabilitation/Bladder retraining g. Pelvic floor muscle rehabilitation h. Prompted voiding i. Habit training/scheduled voiding

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and document review, the facility failed to ensure a resident that was prescribed psychotropic medications was monitored for side effects, for 1 of 2 residents (R283) reviewed for unnecessary medications. Findings include: R283's admission Minimum Assessment Data (MDS) dated [DATE], indicated R283 had moderate cognitive impairment and no mood or behavior concerns. R283's MDS indicated diagnoses of pneumonia, heart failure, and malnutrition. R283's clinical diagnosis report indicated the following diagnoses: acute respiratory failure, severe protein calorie malnutrition, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (lung disease that blocks the airflow and makes it difficult to breathe), abscess of lung with pneumonia and acute systolic congestive heart failure. R283's clinical orders report included the following orders: 1/6/25- trazadone (antidepressant also used to treat insomnia) HCL oral tablet 50 milligrams (mg), give 0.25 tablet orally at bedtime for insomnia. 1/7/25- buspirone HCL oral tablet 5 mg, give 0.5 tablet orally once a day for repeated episodes of anxiety. R283's January Medication Administration Record (MAR) printed on 1/23/25, indicated an order dated 1/8/23 started on the evening shift to monitor psychotropic side effects to medications every shift until the night shift of 1/14/25. During interview on 1/23/25 at 9:18 a.m., licensed practical nurse (LPN)-A stated she monitored for side effects every time she administered psychotropic medications. LPN-A added to her knowledge we are supposed to monitor our residents as long as they take a psychotropic medication. During interview on 01/23/25 at 11:12 a.m., care coordinator licensed practical nurse (LPN)-C indicated side effects to psychotropic medications were monitored for as long as a resident received one of those medications. The residents were monitored continuously, every shift without an end date. During interview on 01/23/25 at 12:56 p.m., director of nursing (DON) stated the documentation of side effects was done every shift for psychotropic medications, and a progress note is created if side effects are identified. A facility Policy concerning Monitoring Psychotropic side effects was requested but not received.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure proper personal protective equipment (PPE) use for 1 of 3 residents (R4) on enhanced barrier precautions (EBP) reviewed for proper PPE use during survey. In addition, the facility failed to ensure a comprehensive Infection Prevention and Control Program (IPCP) was maintained to include an ongoing analysis of collected data to help identify and reduce the risk of infection spread and outbreak. This had potential to affect all 30 residents, staff, and visitors. Findings include: R4's admission Minimum Data Set (MDS), dated [DATE], indicated R4 was dependent on facility staff for bathing, toileting and dressing and had a Foley catheter in place. During observation on 1/22/25 at 9:05 a.m., nursing assistant (NA)-E and NA-F entered R4's room. A sign was posted on R4's door indicating R4 was on enhanced barrier precautions (EBP) indicating staff must wear gown and gloves when providing high contact resident care activities including bathing, dressing, transferring and brief changes. NA-E and NA-F did not don appropriate PPE when they failed to wear a gown while providing high contact activities. NA-E and NA-F donned gloves and provided R4 with a partial bed bath, brief change and peri care, transferred him to his recliner chair via a mechanical lift. R4 was observed to have a Foley catheter in place with a drainage bag hanging on the side of the bed. NA-F emptied the urine in R4's drainage bag into a graduated cylinder. During all cares, neither NA-E nor NA-F were observed to wear a gown. During an interview on 1/22/25 at 1:43 p.m., R4's family member (FM)-A stated she did not see staff wearing gowns very often, stating therapy staff were often wearing gowns but otherwise she did not see staff wear gowns. During an interview on 1/22/25 at 1:47 p.m., NA-F stated R4 was on EBP because he had a Foley catheter and that she was aware she should have had a gown on when providing cares but forgot. During an interview on 1/22/25 at 11:00 a.m., the nurse coordinator (NC) and director of nursing (DON) stated that all staff should be wearing gloves and gowns when providing care in residents' rooms on EBP, stating it was important to prevent the spread of infection. SURVEILLANCE The facility' infection control program, including surveillance and analysis data, was requested. The following was provided: a white three ring binder titled Infection Prevention Resource Manual. The binder lacked any specific data related to the facility. Furthermore, the binder lacked any surveillance data or analysis data of the facility. During an interview on 1/22/25 at 1:46 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified there was no current surveillance of infections, resident symptoms or tracking of antibiotic use. DON stated she was unable to provide any current type of surveillance or data analysis. DON stated there are currently no audits being completed of staff adherence/proper use of PPE or handwashing. DON stated the facility was currently not tracking resident antibiotic use to ensure (continued on next page)

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	245618	A. Building B. Wing	01/23/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	proper use and follow up, tracking of prophylactic antibiotics to ensure proper use and follow up and she was unaware if any antibiotic time-outs were occurring. During a follow up interview on 1/23/25 at 8:49 a.m., DON verified there are currently no antibiotic time-outs occurring at the facility. A facility policy titled Infection Control Surveillance, revised 1/2025, indicated The Infection Preventionist (IP) or Director of Nursing (DON) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions.

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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. Based on interview and document review, the facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor appropriateness of antibiotic use to prevent antibiotic resistance and help prevent the spread of infectious diseases. This had the potential to affect all 30 residents residing in the facility. Findings include: During an interview on 1/22/25 at 1:46 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified the facility was currently not tracking resident antibiotic use to ensure proper use and follow up. DON verified there are currently no tracking of prophylactic antibiotics to ensure proper use and follow up. DON stated she was unaware if any antibiotic time-outs were occurring. During a follow up interview on 1/23/25 at 8:49 a.m., DON verified there are currently no antibiotic time-outs occurring at the facility. A facility policy titled Antibiotic Stewardship, revised 1/2025, indicated the Antibiotic Stewardship program included the following: - A designated Registered Nurse (RN) as the Infection Preventionist (IP) responsible for assessing, developing, implementing, monitoring, and managing the IPCP, and is - The IP will be certified in Infection Prevention and Control. - A system to monitor antibiotic use (i.e., antibiotic use reports, antibiotic resistance reports, response to antibiotics and lab results when available to determine if the antibiotic is still indicated or requires adjustments). Furthermore, the policy identified: resident antibiotic regimens will be documented on an antibiotic surveillance tracking form. The information gathered will include: 1) Resident name and medical record number; 2) Unit and room number; 3) Date symptoms appeared; 4) Name of antibiotic; 5) Start date of antibiotic; 6) Pathogen identified; 7) Site of infection; 8) Date of culture; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9) Stop date; and 10) Total days of therapy.

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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. Based on interview and document review, the facility failed to ensure the acting infection preventionist had completed specialized training in infection prevention and control. This had the potential to affect all 30 residents residing in the facility. Findings include: On 1/22/25 at 1:26 p.m., director of nursing (DON) stated she was currently the acting facility infection preventionist and was responsible for overseeing the infection control program. DON verified that she had not completed specialized training for infection prevention and control. DON verified they were not currently enrolled in any specialized training at this time nor had any specialized infection control education scheduled. DON verified no other staff in the facility had specialized training in infection prevention and control. A facility policy titled Infection Preventionist, revised 1/2025, indicated the following: The IP will be a Registered Nurse or have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; will be qualified by education, training, experience or certification; Work at least part-time at the facility; and have completed specialized training in infection prevention and control. Continuing Education: The designated IP will maintain current knowledge in infectious disease and epidemiology by: o Attending programs and courses provided by infection control organizations o Accessing to published guidelines for best practice for infection prevention o Accessing current federal, state, local regulations related to infection control requirements.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 5 of the 6 residents (R5, R9, R26, R28, and R133) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). In addition, the facility failed to ensure 1 of the 5 residents (R26) was offered and/or provided the influenza vaccination as recommended by the CDC. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated October 2024, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult who had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer, after 5 years, the Pneumococcal 20-valent Conjugate Vaccine (PCV20) or Pneumococcal 21-valent Conjugate Vaccine (PCV21) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. This also identified an adult over [AGE] years old, who received one dose of PPSV23 at any age should be offered either option A (PCV20 or PCV21) or option B (PCV15) after one year. According to 2024-2025 CDC Flu Vaccination Recommendations Adopted article, dated 8/29/2024, the Advisory Committee on Immunization Practices (ACIP) recommended an annual influenza (flu) vaccine for everyone 6 months or older in the United States. R5's face sheet, printed 1/23/25, indicated R5 was [AGE] years old. The immunization record, dated 1/23/25, indicated R5 received a PPSV23 and PCV13 on 10/18/02 followed by the PPSV on 6/22/11. R5's electronic medical record (EMR) and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R5 was offered or received PCV20 or PCV21 or education was provided. R9's face sheet, printed 1/23/25, indicated R9 was [AGE] years old. The immunization record, dated 1/23/25, indicated R9 received PPSV23 on 3/24/03. R9's EMR and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R9 was offered or received PCV20, PCV21, or PCV15 or education was provided. R26's face sheet, printed 1/23/25, indicated R26 was [AGE] years old. The immunization record, dated 1/23/25, indicated R26 did not have any pneumococcal immunizations on file. Furthermore, R26's immunization lacked evidence for influenza immunization. R26's EMR and paper chart lacked evidence of R26 being offered or received any pneumococcal doses or education. Furthermore, the records lacked evidence of R26 being provided education, offered, or receiving an annual influenza immunization. R28's face sheet, printed 1/23/25, indicated R28 was [AGE] years old. The immunization record, dated 1/23/25, indicated R28 received PPSV23 on 9/23/2008 followed by a PPSV23 on 9/2/14 followed by a PCV13 on 9/4/15. R28's EMR and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R28 was offered or received PCV20 or PCV21education was (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided. R133's face sheet, printed 1/23/25, indicated R133 was [AGE] years old. The immunization record, dated 1/23/25, indicated R133 received PPSV23 on 1/1/2008 followed by a PCV13 on 7/26/16 followed by a PPSV23 on 9/24/19. R133's EMR and paper chart lacked evidence of shared clinical decision making occurring with the physician for PCV20 or PCV21 as it was more than 5 years after the previous pneumococcal dose. The records lacked evidence that R133 was offered or received PCV20 or PCV21education was provided. On 1/22/25 at 10:13 a.m., licensed practical nurse (LPN)-A stated nursing offers immunizations upon admission. LPN-A stated if a resident declines an immunization, it would be documented in a progress note and if a resident accepts a immunization than we would work on getting a physician order and then it would show up on the medication administration record (MAR). On 1/22/25 at 1:46 p.m., director of nursing (DON) verified she was the acting infection preventionist (IP). DON indicated during the admission process; a Minnesota Immunization Information Connection (MIIC) report is pulled which will show which immunizations a resident previously had. DON verified pneumococcal, COVID and influenza immunizations are offered as part of the admission process. DON stated the documentation of residents being offered/educated about immunizations would be found in either progress notes or the residents' hard chart. During a follow up interview on 1/23/25 at 2:04 p.m., DON verified the following: -R5's EMR and hard chart lacked evidence of R5 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. -R9's EMR and hard chart lacked evidence of R9 being offered, receiving, or provided education on PCV20, PCV21 or PCV15 until after survey entrance and would be eligible for an updated pneumococcal dose. -R26's EMR and hard chart lacked evidence of R26 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. DON verified R26 would be eligible for an influenza vaccine. DON verified EMR and [NAME] chart lacked evidence of R26 being offered, receiving, or being provided an influenza vaccine. -R28's EMR and hard chart lacked evidence of R28 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. -R133's EMR and hard chart lacked evidence of R133 being offered, receiving, or provided education on PCV20 or PCV21 until after survey entrance and would be eligible for an updated pneumococcal dose. DON verified using the current CDC October 2024 pneumococcal recommendations. A facility policy titled Pneumococcal Vaccines, revised 1/2025, indicates that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. A facility policy titled Influenza Prevention and Outbreak Management, revised 1/2025, indicated the facility will offer vaccination to residents upon admission.