



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 15, 2025

Administrator
Havenwood Care Center
1633 Delton Avenue Nw
Bemidji, MN 56601

RE: CCN: 245397
Cycle Start Date: February 12, 2025

Dear Administrator:

On April 7, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 25, 2025

Administrator
Havenwood Care Center
1633 Delton Avenue NW
Bemidji, MN 56601

RE: CCN: 245397
Cycle Start Date: February 12, 2025

Dear Administrator:

On February 12, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Havenwood Care Center

February 25, 2025

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The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor

Bemidji District Office

Health Regulation Division

Minnesota Department of Health

705 5th Street NW, Suite A

Bemidji, Minnesota 56601-2933

Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE NW BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 2/10/25 through 2/12/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 2/10/25 through 2/12/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no deficiencies cited: H53977061C (MN00110476). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584			3/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2025

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.

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F 584 SS=D	Continued From page 1 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and			F 584			

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F 584	Continued From page 2 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure flooring was maintained in a safe manner for 1 of 1 resident (R49) reviewed for environment. Findings include: R49's quarterly Minimum Data Set (MDS) dated 11/13/24, identified moderate cognitive impairment and had non-Alzheimer's dementia. During observation on 2/11/25 at 8:42 a.m., the floor in R49's room had a black substance built up on the seams between the flooring tiles in the room which covered approximately 50 percent of the floor. When walking on the black substance between the seams would stick to your shoes. During an interview on 2/12/25 at 11:44 a.m., housekeepers (HSK)-A and HSK-B stated R49's room was cleaned about three days a week and included sweeping and mopping the floor. They stated the stuff coming up between the tiles was sticky and not sure if it was cleanable. HSK-A and HSK-B stated sometimes they can get a little bit of it to come off, but within a couple of days more sticky stuff would come up through the seams. During an interview on 2/12/25 at 11:58 a.m., the maintenance director (M)-A stated he was aware of the substance coming between the seams in R49's room and sated it was probably the glue from the tiles. M-A stated the resident resident's floor was replaced in the past year, and after the			F 584	Failure to provide a safe and homelike environment has the potential to affect the comfort and dignity for all residents living in the facility. On 2/28/25, a contractor was to the facility and assessed the flooring in room 71. A quote was received from the contractor and approved on 3/3/25. Materials for replacement of the floor tiles were ordered on 3/3/25 with a delivery date pending. Upon receipt of the materials, the contractor will complete floor renovation. On 3/5/25, an audit of all resident room floors was completed and identified 5 additional rooms needing tile repair or replacement. These additional repairs will be completed by facility staff by 3/14/25. Education is being provided to staff at an all staff meeting to be held between the dates of 3/17/25-3/21/25. This education will cover the proper channels for maintenance requests and expectations for reporting items that are in need of repair. The facility administrator additionally will educate the maintenance director on monthly floor auditing expectations and timely review of audits with the administrator each month. Audits of facility flooring condition began		

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F 584	Continued From page 3 resident moved into the room is when the glue started to come out. About mid-summer R49 was moved out of his room and the floor was scraped and rewaxed. Within a week more of the glue was coming out from between the seams. M-A stated the floor needed to be replaced in the room, but the resident would need to be moved out of the room before they could do it; however, there was not a current plan in place to replace the flooring. During an interview on 2/12/25 at 12:40 p.m., licensed practical nurse (LPN)-A, the infection preventionist, stated she was aware of the substance on R49's floor and stated it was sticky and tacky to touch and the floor could not be cleaned thoroughly because of the substance being sticky. Further, the floor in R49's room would need to be replaced. During an interview on 2/12/25 at 1:20 p.m., the administrator stated it was unacceptable for R49 to be in the room with a floor in that condition and it needed to be replaced. A policy for maintenance of flooring was requested, but not received.	F 584	on 3/5/25 and will be completed each month on an ongoing basis for timely identification of repair needs. Results of monthly audits will be discussed with the facility administrator for determination of repair needs and timelines. Results of audits will be discussed monthly at QAPI meetings.		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code a significant weight loss on the Minimum Data Set (MDS) for 1	F 641	Failure to complete MDS assessments accurately has the potential to affect care planning efforts and interventions to		3/31/25

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F 641	Continued From page 4 of 3 residents (R30) reviewed for nutrition Findings include: R30's quarterly MDS dated 1/22/25, identified R30 had a severe cognitive impairment and diagnoses t included diabetes, hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), chronic kidney disease, dysphasia (difficulty swallowing food or liquids) and aphasia (a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain). R30's weight was 153 pounds (lbs.) and R30 had no loss of 5% or more in the last month or loss of 10% or more in last 6 months. R30's medical records identified the following weights: - 7/14/24 172.5 lbs. - 1/3/25 153.3 lbs. Which is a 11.13 percent decrease in weight in 180 days. R30's Mini Nutrition Assessment dated 1/22/25, identified the registered dietician would continue R30's current plan of care and monitor weights monthly. Intake would be assessed regularly to ensure that nutrient needs were being met. Laboratory values would be reviewed for trends, and interventions would be adjusted as necessary. R30 would not trigger for any significant weight changes as evidenced by a 5% change in 30 days or 10% change in 180 days. The RD would continue to monitor weights monthly and reassess quarterly or as needed if significant changes in weight, intake, or health status occurred.	F 641	prevent weight loss for all residents. On 3/6/25, the MDS for R30 was modified to reflect weight loss in 180 days. On 3/06/25 an audit was initiated of all MDS assessments in the past quarter to ensure proper coding of weight fluctuations. This was completed by running weight variance reports and comparing coding vs weight changes of 5% in 30 days and 10% in 180 days based on ARD of the MDS. Discrepancies will be evaluated for modification of MDS. This process will be completed by March 15th, 2025. In an effort to minimize the risk for error in calculating weight changes over 30 and 180 days, the dietician will adjust report parameters for the weight variance report to include 180 days from the most recent weight vs 180 days from the date the report is run. This data will be input on the quarterly observation that is completed by the dietician. MDS nurses will continue to code MDS assessments according to observation data during the look back period. Education will be provided to all staff at an all staff meeting to be held between the dates of 3/17/25 and 3/21/25. Education will include rationale for MDS coding accuracy along with the importance of accurate and timely weights by direct care staff. Audits for compliance will begin on 3/10/25 and will be competed by reviewing		

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F 641	Continued From page 5 During an interview with the RD-A and dietary manager (DM)-A on 2/11/25 at 1:10 p.m., the RD stated she just did the quarterly assessment on R30 and R30 was not a significant weight loss. Upon review of R30's weights, the RD stated her initial report did not identify R30's 180-day weight "for some reason it did not pull that". R30 should have been triggered on the MDS as a significant weight loss. During an interview on 2/12/25 at 9:33 a.m., registered nurse (RN)-D stated her role was the facility's MDS coordinator. The RD completed the nutrition assessment, and that information was pulled into section K of the MDS. RN-D stated R30's quarterly MDS dated 1/22/25 was coded incorrectly. Coding of the MDS was important because it affected reimbursement, quality reports, and R30 could have had further weight loss because the appropriate interventions were not put into place. During an interview on 2/12/25 at 12:21 p.m., the director of nursing (DON) stated R30 should have been recognized as a significant weight loss in 6 months. During an interview on 2/12/25 at 1:05 p.m., the administrator stated assessments were expected to be completed accurately to ensure accurate care planning and interventions were implemented to either stabilize weight and/or to prevent further weight loss. The facility policy Resident Assessment Minimum Data Set (MDS revised 1/2025, identified assessments will be completed by staff qualified and knowledgeable to assess a specific care	F 641	all OBRA MDS assessments completed each week through April 6th to ensure compliance and accurate coding followed by 3 OBRA MDS assessments each week through the end of April. Audit data will be reviewed in QAPI in April for ongoing auditing needs.		

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F 641	Continued From page 6	F 641			
F 655 SS=D	area. Assessments would be coded accurately to correctly assess medical, functional, and psychosocial problems and strengths to develop person-centered care plans and interventions to maintain and improve status. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655			3/31/25

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F 655	Continued From page 7 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a baseline care plan to ensure immediate resident needs were identified and addressed for 1 of 4 residents (R211) whom were newly admitted. Findings include: R211's Discharge Summary dated 1/24/25, identified R211 was hospitalized for acute blood loss anemia and acute knee pain due to gout. R211's bleeding resolved and was restarted on anticoagulant medications as well as gout medications to treat his left knee pain. R211's progress note dated 1/24/25, identified R21 arrived at the facility to be admitted. R21 had a foley catheter in place, which would remain until his urology appointment in March. R21 had experienced a lot of falls at home prior to admission and would need assist of one and walker with ambulation. On 2/11/25, at 8:14 a.m. R211 was observed sitting in a recliner watching television in his	F 655	On 2/14/25, R211's baseline care plan was completed and placed into the medical record. Master care plan was additionally initiated on 1/24/25 following completion of admission MDS assessment. All admissions in the past 90 days were audited for the presence of baseline care plan in the medical record with no others being identified as missing. The baseline care plan will continue to be completed on day of admission and scanned into the medical record by the end of the next business day. The facility policy for baseline care plan was reviewed and no changes were made. Education on regulatory requirements and facility policy for baseline care planning will be completed at an all staff meeting to be held between the dates of 3/17/25-3/21/25. This education will include expectations of baseline care plan		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245397	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE NW BEMIDJI, MN 56601		
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F 655	Continued From page 8 room. The door to the room was open and R211's foley catheter bag was visible attached to the side of his recliner. R211's medical record lacked evidence a baseline care plan had been developed to ensure staff were knowledgeable in R211's care needs despite R211 having an indwelling foley catheter, need for enhanced barrier precautions, and need for assistance with activities of daily living (ADLs) and mobility. When interviewed on 2/12/25, at 12:43 p.m. the director of nursing (DON) stated they were unable to locate a baseline care plan for R211. It was the facility's practice to have a baseline care plan completed for all residents within 48 hours of their admission. A baseline care plan was important as it identified a resident's care needs and how to care for each resident. The facility's undated Baseline Care Plan policy, identified the facility would develop a baseline care plan within 48 hours of admission. The care plan would include at minimum initial goals, physician orders, dietary orders, therapy services, social services, PASARR recommendations, instructions to provide effective and person centered care, address resident health and safety concerns to prevent decline or injury and identify needs for supervision, behavioral interventions and assistance with ADL's.	F 655	content including addition of enhanced barrier precautions and timing of completion. Audits will be completed within 48 hours following each admission for 60 days beginning on 3/17/25. The DON or designee will ensure the baseline care plan has been completed and is scanned into the medical record. Follow up with admitting nurse for reeducation will be completed by the DON or designee for any missing records identified upon identification during audit. Results of audits will be discussed at each QAPI meeting through the auditing window for determination of ongoing auditing needs.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656			3/31/25

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F 656	Continued From page 9 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged	F 656			

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F 656	Continued From page 10 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed identify enhanced barrier precautions (EBP) interventions for 1 of 1 resident (R18) reviewed with a surgical wound. Findings include: R18's admission minimum data set (MDS) dated 1/30/25, identified R18 was admitted on 1/24/25, was cognitively intact and was receiving surgical wound care. R18's orders report dated 1/24/25, identified staff were to monitor R18's dressing placement and for signs and symptoms of infection such as increased redness, warmth, swelling, drainage, or generalized fever over 101. Staff were to notify the charge nurse so they could notify the provider. R18's care plan revised 2/12/25, identified R18 recently had a hip replacement and required staff to complete dressing changes and monitor and report any signs or symptoms of infection. The plan further identified R18 required assist of one staff for transfers, toileting and dressing. However, the plan failed to address R18's need for EBP. During observation on 2/10/25 at 7:06 p.m., there was no personal protection equipment (PPE) cart near or inside R18's room. Further, there was no sign directing staff to wear PPE during dressing changes or cares.			F 656	Failure to develop comprehensive care plans places residents at risk for unmet care needs. R18's comprehensive care plan was initially developed on 2/12/25. EBP was initiated for residents the week of 2/10/25. R18's surgical wounds healed on 2/25/25 and EBP were discontinued on that date. An audit of all residents' medical records will be completed to ensure residents meeting criteria for EBP have them in place and have this listed on the care plan by 3/7/25 with a focus being put on wounds, indwelling devices and MDRO's. The current facility policy for EBP includes when EBP is indicated and was not revised. Education will be provided to all staff regarding enhanced barrier precautions. This education will be completed between the dates of 3/17/25-3/21/25 and will include explanation of EBP, criteria for implementation along with expectations for this being noted on the baseline and master care plans along with the care sheets carried by staff. Each day in morning meeting, a review of residents who require EBP, have wounds, indwelling devices and/or MDRO's will be conducted to ensure proper care		

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F 656	Continued From page 11 On 2/12/25 at 7:33 a.m., RN-C was observed in R18's room and changing R18's dressing. Observation of the dressing identified a dark red spot, approximately 1-inch in diameter in the middle area of the outside of the dressing. While wearing gloves, RN-C removed R18's dressing and stated there was an area on the distal end of the incision that appeared to be a fluid filled bubble/blister. RN-C stated the skin around the distal end appeared to be darker red although was not warm to touch. RN-C cleansed and reapplied a dressing to the wound. RN-C stated the wound looked worse than the other day and thought it may be starting to get infected. RN-C did not apply or wear a gown during the dressing change. On 2/12/25 at 12:32 p.m., RN-C stated upon R18's admission she was told by the infection preventionist, staff did not need to wear PPE while providing wound care. RN-C stated she worked with multiple residents during the day and had the potential to carry bacteria on her clothing. RN-C stated wearing PPE would help prevent the spread of bacteria to/from herself and the resident. RN-C stated she had not worn PPE including a gown when she cared for the wound or changed R18's dressing. The Care Plan policy reviewed 4/2015, identified a care plan started on the day of admission, was reviewed every 90 days and would be updated as needed. The care plan included what kind of services were needed, who provided the services and how the care plan would help the resident reach their goals of care.	F 656	planning, ongoing need, and implementation/discontinuation of enhanced barrier precautions. Audits will be conducted by the DON or designee each weekday following IDT for a period of 4 weeks beginning on 3/17/25. The audit will consist of ensuring proper care planning and implementation and discontinuation for EBP upon identification of need.		
F 657	Care Plan Timing and Revision	F 657			3/31/25

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F 657	Continued From page 12 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise and update a comprehensive care plan for 1 of 3 residents (R10) reviewed for weight loss. Findings include: R10's quarterly minimum data set (MDS) dated			F 657	Failure to implement interventions to manage weight loss has the potential to affect all residents struggling with maintaining nutrition and weight. The care plan for R10 was updated 3/3/25 to include recommendations of offering alternatives including high calorie		

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F 657	Continued From page 13 12/25/24, identified R10 was cognitively intact and required set-up assistance for eating, and had a weight loss that was not a physician-prescribed weight-loss regimen. R10's progress notes, identified the following: - 10/16/24, registered dietician (RD)-A identified R10 weighed 115 lbs. and had been drinking a nutritional supplement daily. RD-A's recommendations included staff to offer and provide high calorie, high protein shakes. - 11/5/24 RD-A identified R10's weight had been stable for one week and recommendations included high caloric foods per patient request and continue to follow up and monitor weights. - 11/12/24 RD-A identified staff were to provide alternate meals upon request, offer high calorie/high protein shakes, food items to help promote weight gain, and to monitor intake and weights weekly. R10's care plan dated 4/3/24, identified R10 had a potential for alteration in nutrition. Interventions included staff to offer a regular diet, thin liquids and assist with meal set up. Further interventions included weights as ordered, offer food alternatives as needed, and offer snacks two times per day. The plan failed to identify individualized interventions for weekly weights, weekly intake documentation and options for high calorie, high protein foods to help promote weight gain as recommended by the RD. On 2/11/25 at 12:42 p.m., RD-A stated in R10 weighed 125 lbs. on August 9, 2024 and had lost by November 18, 2024 10 weighed 110 lbs., a weight loss of 15 lbs. in 3 months. RD-A stated a significant change assessment was completed on 10/16/24. RD-A had talked with R10 about a plan	F 657	shakes/food items to promote weight gain. The RD was trained to update care plans within the medical record following MDS assessment periods and as needed on 3/4/25. An audit of all residents who have triggered for weight loss on MDS assessments in previous quarter will be reviewed for care plan interventions matching dietician recommendation by 3/15/25. Residents identified as having interventions recommended by the dietician without proper follow through for care planning will have edits made to care plan. Audits for compliance will be completed by reviewing the care plan for all residents who trigger weight loss on scheduled MDS's each week for 4 weeks beginning on 3/10/25 to ensure the care plan matches the dietician recommendations documented in the look back period. Discrepancies noted during the audit will be addressed with the dietician upon identification and care plans will be updated to reflect current and accurate information. Results of audits will be brought to QAPI for discussion and review of ongoing auditing needs.		

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F 657	Continued From page 14 to increase her weight and recommendations included higher calorie/higher protein shakes and continue with the nutritional supplement. RD-A stated in December 2024, documentation of weekly meal intakes and weights were recommended. R10's care plan failed to identify the recommendations. During an interview on 2/12/25 at 1:05 p.m., the administrator stated staff were expected to complete accurate assessments to aid in care planning and implementing interventions to either stabilize weight or to prevent loss. The Care Plan policy reviewed 4/2015, identified a care plan started on the day of admission, was reviewed every 90 days and would be updated as needed. The care plan included what kind of services were needed, who provided the services and how the care plan would help the resident reach their goals of care.	F 657			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a bed was kept in the low position to prevent falls for 1 of 2 residents (R40) reviewed for falls.	F 689	Failure to ensure low beds are in a safe position before leaving the resident has the potential to affect residents with low beds as fall interventions.		3/31/25

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F 689	Continued From page 15 Findings include: R40's Falls Risk Assessment dated 12/9/24, identified R40 was at high risk for falls. R40's quarterly Minimum Data Set (MDS) dated 12/11/24, identified R40 had moderate cognitive impairment and a diagnosis of unspecified convulsions. R40 required substantial/maximal assistance to roll left and right. R40's care plan revised 12/19/24, identified R40 had decreased physical mobility with potential for falls related to lower extremity weakness, impaired mobility related to general muscle weakness and poor coordination manifested by inability to transfer, wheel self, turn and reposition self, sit up, lie down or get feet and legs into bed independently. R40 was unable to ambulate. The care plan directed to follow fall interventions as listed in nursing orders. R40's nursing order dated 2/6/25, identified R40's fall interventions included a contour mattress with cutout, low bed, mats at bedside and anti-tip bars to wheelchair. During an observation on 2/11/25 a 9:04 a.m., registered nurse (RN)-B and nursing assistant (NA)-A transferred R40 into bed using a full body mechanical lift. The bed was approximately 3.5 feet (ft) high. NA-A pulled R40's privacy closed and began assisting R40's roommate on the other side. RN-B pulled the full body mechanical lift from the room. However, R40's bed was left in an elevated position and was not in the view of staff. - At 9:14 a.m., NA-B stepped into the room and	F 689	On 2/11/25 following receiving cares, the bed was placed in low position. On 3/6/25, an audit was completed to identify all residents who require low beds. All staff will be educated on the proper use of low beds, expectations for supervision when bed is not in low position during staff meetings to be held between the dates of 3/17/25 - 3/21/25. Audits will be conducted via direct observation of transfers and cares to ensure proper use and lowering of beds when leaving resident unattended. This will begin on 3/22/25 and will be completed by the DON or designee at a rate of 3 observations per day across all shifts for 2 weeks, followed by 10/week for 2 weeks. Results of audits will be brought to QAPI in May 2025 for review of results and determination of ongoing auditing needs.		

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F 689	Continued From page 16 asked NA-A if she needed help. NA-B stated NA-A could provide incontinence care to R40. NA-B looked into R40's dresser drawer for supplies and stated she needed to leave the room to find more. However, R40's bed remained in an elevated position and was not in view of staff. - At 9:19 a.m., NA-B returned to the room and provided incontinence care to R40. R40's bed was lowered to the floor and R40 was given her call light. During an interview on 2/11/25 at 9:29 a.m., NA-B stated R40 was "kind of" high risk for falls. R40 rolled out of bed and staff thought it was because R40 had a seizure. NA-B stated she had never seen R40 roll ever but R40 should not have been left unattended in an elevated bed because she could have another seizure. During an interview on 2/12/25 at 8:44 a.m., RN-C stated R40 was a fall risk due to a history of seizures. R40 was care planned for a low bed and floor mats to prevent falls and/or injury. R40 should not have been left unattended in an elevated bed. During an interview on 2/12/25 at 12:17 p.m., the director of nursing (DON) stated R40 should not have been left unattended in an elevated bed for safety to prevent falls. During an interview on 2/12/25 at 1:01 p.m., the administrator stated staff were expected to follow care planned intervention for safety. The facility policy Fall Prevention revised 3/2022, identified the facility would identify residents who were at high risk for falls and develop individual	F 689			

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F 689	Continued From page 17	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to prevent weight loss for 1 of 3 residents (R30); and failed to implement assess nutrition interventions to prevent further weight loss for 1 of 3 residents (R10) reviewed for nutrition. Findings include:	F 692			3/31/25
			On 3/3/25 R30 and R10 were set up on the eTAR with weekly weights. Care plans for both residents were also updated to include recommendations from the RD to meet nutritional needs. An audit of RD recommendations from the past quarter was completed and compared to care planned interventions. Interventions identified as missing will be		

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F 692	Continued From page 18 R30: R30's quarterly MDS dated 1/22/25, identified R30 had severe cognitive impairment and diagnoses included diabetes, hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), chronic kidney disease, dysphasia (difficulty swallowing food or liquids) and aphasia (a comprehension and communication (reading, speaking, or writing) disorder resulting from damage or injury to the specific area in the brain). R30's weight was 153 pounds (lbs) and R30 had no loss of 5% or more in the last month or loss of 10% or more in last 6 months. R30's Mini Nutrition Assessment dated 1/22/25, identified the registered dietician would continue R30's current plan of care and monitor weights monthly. Intake would be assessed regularly to ensure that nutrient needs were being met. Laboratory values would be reviewed for trends, and interventions would be adjusted as necessary. R30 would not trigger for any significant weight changes as evidenced by a 5% change in 30 days or 10% change in 180 days. The RD would continue to monitor weights monthly and reassess quarterly or as needed if significant changes in weight, intake, or health status occurred. R30's care plan revised 2/7/25, identified R30 had a potential for alteration in nutrition related to diabetes, hemiplegia of right side, heart disease and depression. The care plan directed to provide a regular diet, set up tray, open and pour liquids, butter bread, cut meat and arrange food then R40 was independent in eating. Weigh as ordered. Offer alternates as needed. Offer snacks two			F 692	added to the care plan by 3/15/25. Additionally, a list of always available high calorie, nutrient dense foods was developed and reviewed by the dietitian and dietary manager on 3/6/25. Beginning on 3/24/25 all residents care planned to have high calorie /nutrient dense foods will have items on the "always available" menu offered a high calorie/nutrient dense item at each meal to increased caloric and nutritional intake. Beginning on 3/24/25, dietary aides will be responsible for meal intakes in the dining room and Nursing staff will be responsible for documenting meal intakes from room trays. This will be designated on assignment sheets in both nursing and dietary departments. Weights will continue to be obtained at least monthly for all residents unless otherwise specified by the dietician. Medical records will maintain and print monthly weight list the first of each month. Data will be reviewed and compared to the previous months' weights prior to entry. Re-weights will be obtained for weights more than 5# off from last weight at the direction of medical records. Weights will be entered into the medical record by the medical records staff upon reconciliation. Dietician will continue to run monthly weight variance report to assess for concerns between assessment periods. Staff will be educated that concerns with weight or intakes will be communicated to the dietician via written message upon identification. This will also be documented in the medical record.		

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F 692	Continued From page 19 times a day. R30's weights identified the following: - 7/14/24 172.5 lbs - 7/21/24 157.6 lbs - 7/28/24 154.7 lbs - 7/30/24 170.6 lbs - 8/9/24 171 lbs - 8/16/24 171 lbs - 8/23/24 167.2 lbs - 8/30/24 164 lbs - 8/30/24 207 lbs - 9/6/24 164.4 lbs - 9/13/24 162.8 lbs - 9/20/24 162 lbs - 9/27/24 165 lbs - 10/11/24 164 lbs - 10/18/24 165 lbs - 10/25/24 164.6 lbs - 11/1/24 164 lbs - 11/15/24 162.2 lbs - 11/22/24 160 lbs - 12/6/24 158 lbs - 12/13/24 156.7 lbs - 12/20/24 156 lbs - 1/3/25 153.3 lbs - 2/7/25 146.8 lbs This identified R30's weight loss was 25.7 lbs or 14.89 percent (%) in 6 months. R30's Nutrition Assessment dated 1/23/25, failed to identify weight Loss of 5% or more in the last month or loss of 10% or more in last 6 months. R30's meal intakes identified the following: - 7/14/24 dinner 76-100% - 7/15/24 breakfast 26-50% and dinner 26-50% - 7/16/24 breakfast 51-75% and 26-50%; dinner 1-25%			F 692	All dietary and nursing staff will be educated between the dates of 3/17/25 and 3/21/25 on updated menu items to promote nutritional intake. The facility policy for intakes has been updated to include guidelines for documenting meal intakes in percentages of food served that is consumed. Additionally, dietary and nursing staff responsible for documenting intakes will be competency checked by the dietary manager or designee by 3/30/25. Audits of meals will be completed to assess for compliance with nutritional recommendations. All residents identified as requiring this intervention will be observed during meals daily for 14 days beginning on 3/24/25 to ensure they are being offered items off the hc/ndf menu. Followed by 4x/week for 2 weeks followed by 2x/week for 2 weeks. Results of initial audits will be reviewed in QAPI in May for ongoing auditing needs. Audits of meal intake documentation will be completed following each meal will begin on 3/24/25 for 14 day, followed by 6 meals/week for 2 weeks, followed by 3 meals a week for 2 weeks. Results of initial audits will be reviewed in QAPI in May for ongoing auditing needs. Noncompliance with intake documentation will be addressed in the moment to ensure compliance and changed systems. Audits of weight completion will be completed monthly by the DON or designee for 3 months.		

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F 692	Continued From page 20 - 7/17/24 breakfast 1-25%, dinner 1-25% - 7/20/24 breakfast 1-25%, dinner 1-25% - 7/21/24 breakfast none, dinner 1-25% - 7/23/24 breakfast 26-50% - 7/24/24 breakfast 26-50%, dinner 76-100% - 7/25/24 breakfast 26-50%, dinner 1-25% - 7/26/24 breakfast 51-75%, dinner 1-25% - 7/27/24 breakfast 51-75% - 7/29/24 breakfast 51-75%, dinner 1-25% - 7/30/24 breakfast 51-75%, dinner 1-25% - 8/2/24 breakfast 51-75%, lunch 1-25%, dinner 76-100% - 8/8/24 dinner 76-100% - 8/9/24 breakfast 1-25%, lunch 51-75% and dinner 1-25% - 8/13/24 lunch 1-25%, dinner 26-50% - 8/14/24 breakfast 51-75%, lunch 1-25%, dinner 1-25% - 8/19/24 dinner none - 8/20/24 dinner 51-75% - 8/21/24 breakfast 1-25% - 8/22/24 lunch none - 8/23/24 breakfast 26-50%, lunch 1-25% - 8/24/24 breakfast 26-50%, lunch 1-25% - 8/28/24 breakfast 26-50% - 8/31/24 dinner 1-25%- - 9/1/24 breakfast 1-25%, lunch 26-50% - 9/3/24 dinner 1-25% - 9/3/24 dinner 1-25% - 9/5/24 breakfast 76-100% - 9/8/24 breakfast 1-25% - 9/13/24 breakfast 1-25%, lunch 76-100% - 9/18/24 dinner 26-50% - 9/23/24 dinner 51-75% - 9/26/24 dinner 76-100% - 9/27/24 breakfast 1-25% - 9/29/24 dinner 51-75% - 10/1/24 dinner 76-100% - 10/6/24 breakfast 51-75%	F 692			

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F 692	Continued From page 21 - 10/10/24 breakfast 51-75% - 10/17/24 lunch 51-75% -10/18/24 dinner 26-50% - 10/20/24 dinner 26-50% - 10/25/24 dinner 26-50% - 10/30/24 breakfast 26-50%, lunch 76-100% -11/2/24 breakfast 1-25% - 11/9/24 breakfast 26-50%, lunch 26-50% - 11/10/24 breakfast 76-100% - 11/18/24 breakfast 1-25%, lunch 51-75% - 11/19/24 lunch 26-50% - 11/21/24 dinner 51-75% - 11/22/24 dinner 26-50% - 11/26/24 breakfast 51-75%, lunch 76-100% - 11/27/24 breakfast 76-100% - 11/29/24 breakfast 1-25% - 11/30/24 breakfast 26-50% - 12/1/24 breakfast 51-75%, lunch 51-75% - 12/4/24 lunch 76-100% - 12/9/24 breakfast 76-100%, lunch 76-100% - 12/10/24 breakfast 26-50% - 12/11/24 breakfast 1-25%, dinner 1-25% - 12/12/24 breakfast 76-100%, lunch 1-25%, dinner 51-75% - 12/13/24 breakfast 51-75%, lunch 76-100% - 12/14/24 breakfast 76-100%, lunch 26-50% - 12/15/24 breakfast 51-75%, lunch 1-25% - 12/16/24 breakfast 26-50%, lunch 26-50%, dinner 51-75% - 12/17/24 breakfast 51-75%, lunch 51-75% - 12/18/24 breakfast 51-75%, lunch 51-75% - 12/19/24 lunch 51-75% - 12/20/24 breakfast 1-25%, lunch 1-25% - 12/23/24 breakfast 51-75%, lunch 26-50% - 12/24/24 breakfast 51-75% - 12/25/24 breakfast 51-75%, lunch 26-50% - 12/26/24 dinner 76-100% - 12/27/24 breakfast 51-75%, lunch 26-50% - 12/28/24 lunch 1-25%, dinner 26-50%	F 692			

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F 692	Continued From page 22 - 12/29/24 breakfast 76-100%, lunch 51-75% - 12/30/24 breakfast 26-50%, lunch 1-25% - 12/31/24 breakfast 51-75% - 1/2/25 breakfast 51-75%, lunch 26-50% - 1/3/25 breakfast 51-75%lunch 26-50% - 1/4/25 dinner 1-25% - 1/5/25 lunch 51-75% - 1/6/25 breakfast 1-25% - 1/10/25 lunch 76-100% - 1/11/25 breakfast 26-50% - 1/14/25 dinner 76-100% - 1/15/25 breakfast 1-25% - 1/17/25 breakfast 1-25%, lunch 26-50% - 1/18/25 breakfast 51-75%, lunch 26-50% - 1/21/25 breakfast 51-75%, lunch 76-100% - 1/24/25 breakfast 51-75%, lunch 51-75% - 1/26/25 breakfast not taken - 1/27/25 breakfast 1-25% - 1/29/25 breakfast none, dinner 51-75% - 1/30/25 breakfast 26+-50%, - 1/31/25 breakfast none, lunch 1-25% - 2/1/25 breakfast 1-25% - 2/2/25 breakfast 1-25% - 2/725 breakfast none, lunch 26-50% - 2/10/25 breakfast 51-75%, lunch 1-25%, dinner 51-75% - 2/11/25 breakfast 76-100%, lunch 26-50% - 2/12/25 breakfast 1-25% During an observation on 2/10/25 at 11:59 a.m., R30 was assisted in her wheelchair to the dining room to wait for her lunch meal. R30 was given a cup of tea, a glass of milk and a glass of water. - At 12:41 p.m., R30 was served her lunch meal of chicken ala king over a buttered biscuit, parsley carrots and fruit salad. R30 had tea, water and milk to drink. - At 12:47 p.m., trained medication aide (TMA)-A asked R30 if she was going to eat. R30 shook	F 692			

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F 692	Continued From page 23 her head no and TMA-A stated "ok" and walked away. - At 12:49 pm., nursing assistant (NA)-C asked R30 if she would at least eat her dessert. R30 nodded her head yes and NA-C brought R30 a cup of fruit salad. R30 ate the fruit salad but no other part of her meal. During an observation on 2/10/25 at 6:10 p.m., R30 was sitting in her wheelchair at the dining room table but R30 was asleep. R30 dinner meal of fried potatoes, hamburger steak and peas with carrots was in front of R30. R30 had eaten the peas with carrots but other part of her meal. NA-D approached R30 and asked if she was done eating. R30 nodded yes and NA-D assisted R30 from the dining room. NA-D did not encourage R30 to eat more or offered to assist R30. During an observation on 2/11/25 at 12:22 p.m., R30 was sitting in her wheelchair at the dining room table. R30 had her lunch meal of shepherd's pie, peas and pudding in front of R30. R30 had eaten a few bites of her meal. No staff offered to assist R30 or encouraged R30 to eat more. During an interview with the registered dietician (RD)-A and dietary manager (DM)-A on 2/11/25 at 1:10 p.m., RD-A stated she was unable to speak with R30 for R30's quarterly assessment so RD-A spoke with staff about R30. R30 had difficulty with self-feeding and the nursing assistants explained they didn't always help R30, but they were always watching R30 from a distance. If R30 had difficulty with a meal, the nursing assistant would approach R30 and offer assistance. Limited self-feeding happened so staff needed to be there			F 692			

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F 692	Continued From page 24 proactively. RD-A stated when she pulled the report for R30's weights, it did not show R30 had a significant weight loss. RD-A stated weight entries were not documented consistently, and this played a factor as well. Inconsistency was also identified with meal intakes. For example, if a resident did not want breakfast but requested a banana, staff should not document the resident ate 100% of their meal. RD-A stated the weekly weights and meal intakes were so important because the assessment would not be accurate due to either a lack of information or inaccurate information. RD-A stated she has explained this to nursing through email and during R30's care conference. "If I see something I let them know, but if they do it or not is out of my control." RD-A stated she relied on nursing staff to also identify weight loss or gain when entering weight into the medical record and to obtain a re-weigh. RD-A stated finger foods were also recommended for R30, and shepherd's pie would be harder for R30 to eat independently. Staff wanted to encourage the nursing assistants to monitor meals and make sure every resident received foods that would allow the most independence. Residents could not or would not always verbalize the need for help. RD-A stated she did bring R30 to the quality assurance and performance improvement (QAPI) meeting because R30's weights were constantly fluctuating, however, RD-A stated she did not recognize R30 had had a significant weight loss. During an interview on 2/12/25 at 8:47 a.m., RN-C stated the facility changed the process of weights from weekly to monthly at the beginning of the year. Some residents were weekly depending on need, and some were daily. Nursing and dietary monitored residents' weights	F 692			

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F 692	Continued From page 25 to ensure no resident had either lost or gained too much weight in a period. The nursing assistants collected the meal percentages. They wrote the percentages on a sheet and then the nurse entered it into the computer. RN-C stated she knew R30 lost about 30 lbs since her admission and staff did try to assist R30 but R30 was just a picky eater and would only eat what R30 wanted to eat. RN-C stated the percentage of the meal eaten reflected what was gone from the resident's plate. For example, if the resident only wanted a banana that was 100% of the meal. During an interview on 2/12/25 at 9:33 a.m., RN-D stated R30 did have a significant weight loss that should have been recognized, and interventions care planned to either stabilized R30's weight or to prevent further weight loss. During an interview with the director of nursing (DON) and RN-A on 2/12/25 at 12:21 p.m., the DON stated, staff should have recognized R30's significant weight loss and implemented interventions to either promote the stabilization of R30's weight or to prevent further loss. R10: R10's quarterly MDS dated 12/25/24, identified R10 was cognitively intact, required set-up assistance for eating, and had a weight loss that was not a physician-prescribed weight-loss regimen. R10's mini nutritional assessment dated 12/25/24, identified a nutritional risk score of 6.0 and identified R10 as malnourished. Risk factors included weight loss of 3.2 and 6.6 lbs. during the last 3 months, no change in food intake, was bed or chair bound, had suffered psychological stress	F 692			

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F 692	Continued From page 26 or acute distress in the past months, and had a BMI less than 19. R10's weights identified the following: - 1/6/25 108 lbs. - 12/30/24 107 lbs. - 12/23/24 107 lbs. - 12/2/24 110 lbs. - 11/25/24 110 lbs. - 11/18/24 110 lbs. - 11/11/24 112 lbs. - 11/4/24 112 lbs. - 10/21/24 109 lbs. - 10/14/25 115 lbs. - 10/12/24 115 lbs. - 10/11/24 114 lbs. - 10/10/24 115 lbs. - 9/30/24 114 lbs. - 9/23/24 112 lbs. - 9/20/24 111 lbs. - 9/19/24 114 lbs. - 9/2/24 114 lbs. - 8/30/24 116 lbs. - 8/29/24 117 lbs. - 8/28/24 118 lbs. - 8/27/24 119 lbs. - 8/26/24 117 lbs. - 8/25/24 118 lbs. - 8/23/24 118 lbs. - 8/21/24 119 lbs. - 8/20/24 120 lbs. - 8/19/24 121 lbs. - 8/16/24 122 lbs. - 8/15/24 123 lbs. - 8/9/24 125 lbs. - 8/8/24 126 lbs. - 8/4/24 123 lbs. R10's Nutrition MDS Assessment dated 12/26/24,	F 692			

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F 692	Continued From page 27 identified R10 weighed 107 lbs. and had a weight loss of 5% or more in the past month, or a loss of 10% or more in the last 6 months and was not a physician-prescribed weight-loss regimen. R10's progress notes, identified the following: - On 10/16/24, registered dietician (RD)-A identified R10 weighed 115 lbs. and had been drinking a nutritional supplement daily. RD-A's recommendations included staff to offer and provide high calorie, high protein shakes. - On 11/5/24 RD-A identified R10's weight had been stable for one week and recommendations included high caloric foods per patient request and continue to follow up and monitor weights. - On 11/12/24 RD-A identified staff were to provide alternate meals upon request, offer high calorie/high protein shakes, food items to help promote weight gain, and to monitor intake and weights weekly. R10's care plan dated 4/3/24, identified R10 had a potential for alteration in nutrition. Interventions included staff to offer a regular diet, thin liquids and assist with meal set up. Further interventions included weighs as ordered, offer food alternatives as needed, and offer snacks two times per day. The plan failed to identify individualized interventions for weekly weights, weekly intake documentation and options for high calorie, high protein foods to help promote weight gain as recommended by the RD. On 2/12/25 at 9:29 a.m., R10 was seated at a dining room table and had the morning meal in front of her that included two slices of toast and a glass of juice. At 10:01 a.m., R10 was observed leaving the dining room. R10 had eaten 3/4th of the toast and drank the juice.			F 692			

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F 692	Continued From page 28 On 2/12/25 9:25 a.m., licensed practical nurse (LPN)-C stated she would document morning meal intake for the residents that ate in the dining room. LPN-C stated she knew what the residents normally ate for their morning meal and would mark the intakes accordingly. LPN-C stated R10 usually had two slices of dry toast and juice every morning and would mark 100% intake when R10 ate all her meal. On 2/11/25 at 12:42 p.m., RD-A stated in R10 weighed 125 lbs. on August 9, 2024 and had lost by November 18, 2024 10 weighed 110 lbs., a weight loss of 15 lbs. in 3 months. RD-A stated a significant change assessment was completed on 10/16/24. RD-A had talked with R10 about a plan to increase her weight and recommendations included higher calorie/higher protein shakes and continue with the nutritional supplement. RD-A stated in December 2024, documentation of weekly meal intakes and weights were recommended. R10's care plan failed to identify the recommendations. On 2/12/25 at 9:58 a.m., nursing assistant (NA)-I stated the nurses would let NAs know when a resident needed to be weighed. The NA's told the nurses the weight and the nurses would document in the chart. On 2/12/25 at 11:50 a.m., LPN-B stated weights used to be done on bath days but that had recently changed and was uncertain why. LPN-B stated when a resident needed to be weighed, she would let the NAs know, they would weigh the resident and report the weight back to the nurse. If there was a 5 lb. weight difference from the previous weight LPN-B stated she would re-weigh	F 692			

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F 692	Continued From page 29 the resident herself and would contact the provider if needed. On 2/12/25 at 12:05 p.m., LPN-A residents used to be weighed on bath days but that had recently changed. LPN-A stated she was uncertain why it had changed. LPN-A stated the nurse that received the weight would document in the resident's chart and follow up as needed. LPN-A stated the RD would follow the resident's weight whenever there was a weight loss. The RD would recommend interventions including nutritional supplement, high protein/high calorie shakes and/or supplements ans sometimes snacks between meals. The RD would communicate the recommendations to the unit manager. The unit manager would add the recommendations to the care plan and notify staff. LPN-A was uncertain if any of these interventions were recommended for R10. Further, LPN-A stated R10's weight should have been monitored weekly. During an interview with the DON and RN-A on 2/12/25 at 12:21 p.m., the DON stated staff were expected to collect weights per facility policy, and to document meal intakes accurately. During an interview on 2/12/25 at 1:05 p.m., the administrator stated staff were expected to collect weights according to facility policy, accurately document meal intakes and to complete accurate assessments to aid in care planning and implementing interventions to either stabilize weight or to prevent loss. The Interventions for Unintended Weight Loss policy dated 2019, identified unintended weight loss or gradual weight loss would be identified and monitored so that appropriate and			F 692			

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F 692	Continued From page 30 individualized interventions could be implemented. The facility policy Weighing a Resident revised 1/20/25, identified all residents would be weighed on admission and at least monthly while they are in the nursing home. Monthly weights will be done the first seven days of each month. A. Tell the resident what you are going to do. B. Take the resident to the scale or bring Medi-lift to resident's room. C. Check to be sure the scale is balanced. (Allow the scale time to balance - wait until the scale reads "0") If using the Media-lift scale, balance the scale to zero with sling prior to getting resident into sling. D. Ask the resident to step on the scale. Read the weight indicated on the screen of the scale. If you use Medi-lift scale, press the weight button after resident is in sling. E. Record the weight in the designated spot. NOTE: 1. If it is necessary to weigh a resident with braces, an artificial limb, or clothing, a note should be made on the record that the brace or clothing is included in the weight. 2. A resident may be weighed in a WC or on a platform balance scale. In this case, weigh the chair first and write down the weight. Then weigh the resident in the chair. Write this down. Take the weight of the resident and the chair and subtract the weight of the chair to get the weight of the resident. 3. When weighing a resident in a WC it is important that the WC is wheeled forward enough so that the platform is off the floor. 4. If the resident has oxygen or anti-rollback on their W/C it should be noted as well. 5. If a resident's weight needs to be monitored	F 692			

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F 692	Continued From page 31 more closely, they will be set up as indicated. Such as weekly weights for weight loss or daily weights for fluid status monitoring. The facility policy Interventions for Unintended Weight Loss dated 2019, identified unintended weight loss or gradual weight loss will be identified and monitored so that appropriate and individualized intervention can be implemented. Patients/residents will be weighed upon admission or readmission, weekly for the first 4 weeks after admission, and at least monthly thereafter to help identify and document weight trends. Weekly weights may be ordered due to a significant change in condition, if food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. Factors that may impact weight and the significance of apparent weight changes include: a. Usual weight through adult life b. Current medical condition c. Therapeutic diet d. Calorie restricted diet or calorie-enhanced diet e. Recent changes in food or fluid intake f. Edema g. Dehydration Staff will follow a consistent approach to weighing and use an appropriately calibrated and functioning scale (e.g., wheelchair scale or bed scale). Since weight varies throughout the day, a consistent process and technique (e.g., weighing the patient/resident wearing a similar type of clothing, at approximately the same time of the day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy) can help make weight comparisons more reliable.	F 692			

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F 692	Continued From page 32 The facility policy Method To Determine Percent of Meal Eaten reviewed 4/2015, identified the following: 1. Count the number of nutritious items served at the meal. Do not count: desserts (unless fruits), coffee, tea, Jello, Jello salad, broth, donut, sweet roll, cake, and pie. 2. Figure the amount of food consumed of each item that counts from above: None eaten = 0 points ¼ eaten = .25 points ½ eaten = .5 points ¾ eaten = .75 points All eaten = 1 point 3. Total the number of points eaten. 4. Divide the number of points eaten by the number of points served and multiple by 100 to obtain the percentage of the meal eaten.	F 692			
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 711			3/31/25

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F 711	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a complete medical record was maintained to include the physician reviewed orders, treatments and care plans during routine visits for 1 of 2 residents (R7) reviewed during medication administration. Findings include: R7's undated Resident Face Sheet identified admission date 6/13/24. Diagnoses included epilepsy, diabetes, pain, autistic disorder, fibromyalgia and chronic kidney disease. R7's Physician Order Report dated 10/7/24 to 1/7/25, lacked complete orders. The signed physician order report identified 12 ordered medications on page one and two of the documents. Of the 12 orders, only nine were legible as the document had faded and incomplete printed areas over the pages. R7's activities of daily living (ADL) order with start date 8/15/20, appeared to order a non-pharmaceutical intervention for pain, however, was illegible as the scanning was faded and incomplete in areas. Pages three and four of the order report were not available. When interviewed on 2/12/25, at 11:52 a.m. the medical records staff member (MR)-F stated she was unable to locate the full four-page Physician Order Report dated 10/7/24 through 1/7/25. MR-F usually checked the documents after she scanned them into the resident's medical records to ensure the document was legible. MR-F stated she must have missed checking R7's physician report and she was unsure why only two pages of	F 711	Failure to ensure complete medical records. On 3/5/25, an updated physician order form with physician signature was obtained by the PCP and scanned into the medical record. An audit of all residents most recent physician orders was reviewed to ensure completion and legibility. Any residents identified to have incomplete or eligible documentation will have new orders printed, signed, and scanned by 3/15/25. The facility policy for physician orders was reviewed and updated to include verbiage for complete and legible orders being placed into the medical records. Audits for complete and legible order sheets will be completed each week for 6 weeks beginning on 3/17/25 and will consist of reviewing the visits from the week prior for legible and complete physician order forms being present in the chart. This audit will be completed by the corporate RN or designee. Incomplete records will be noted and medical records will facilitate re-scanning or assisting with obtaining new signed orders by the PCP within 24 hours of identification of missing documentation. Results of audits will be reviewed at QAPI to determine ongoing auditing needs.		

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F 711	Continued From page 34 the four-page document was scanned. It should have been the full four pages as there were more orders on the missing pages. During interview on 2/12/25, at 12:00 p.m. the director of nursing (DON) confirmed they were unable to locate the complete four-page Physician Order Report for R7's medical record. The facility policy Doctors Review and Renewal Policy revised 4/2015, identified the physician's progress notes would be stamped each visit, and the physician would sign that the plan of care was reviewed, including resident care plan, medications, treatments and all other orders.	F 711			
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.	F 712			3/31/25

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F 712	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure long term residents received routine physician visits every 60 days as required for 2 of 2 residents (R7, R39) reviewed during medication administration. Findings include: R7: R7's quarterly Minimum Data Set (MDS) dated 1/1/25, identified R7 had intact cognition. Diagnoses included epilepsy, diabetes, pain, autistic disorder, polyneuropathy, fibromyalgia, conduct disorder, and chronic kidney disease. R7's medical record identified R7 had physician visits for his primary care on 7/26/24 and 1/8/25. R7's medical record lacked documentation of routine 60 day visits for 165 days, from 7/26/24 to 1/8/25. During interview on 2/12/25, at 11:52 a.m. the medical record staff (MR)-F stated she was only able to find documentation of physician visits July 25, 2024 and January 8, 2024. It appeared a visit had been scheduled in September and November 2024, however the visits were not completed or billed. MR-F thought they must have been canceled for some reason. A joint interview was conducted with consultant registered nurse (RN)-A and the director of nursing (DON), 2/12/25, at 12:00 p.m. RN-A stated R7's primary physician stopped rounding at the facility and had also canceled R7's medical appointments the facility had scheduled. R7 had	F 712	Failure to ensure physician visits on a routine basis of every 60 days places residents at risk for unmet needs. On 1/8/25 R7 was seen by a new PCP to be compliant with physician visit expectations. R39 was seen on 1/15/25 by PCP to be compliant with physician visit expectations. An audit completed on 3/5/25 was completed to review all residents physician visit schedules to ensure all resident have been seen in the past 60 days. A spreadsheet has been developed for medical records to accurately track physician visits for all residents. The sheet has date last seen and when next visit is due. This spreadsheet will be utilized and updated weekly by medical records to track and schedule visits to ensure ongoing compliance with physician visit schedules. This spreadsheet will also be updated when visits are rescheduled d/t vacations or other absences of the PCP. All staff will be educated on the process for reviewing 60 day visit schedules and importance of regulatory compliance at the all staff meeting between the dates of 3/17/25-3/21/25. Audits of physician schedules and upcoming visits will be conducted by the medical records staff the first week of each month to determine physician visit		

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F 712	Continued From page 36 agreed to change to a different primary physician and then was seen by that physician in January, so the facility hoped to continue regularly scheduled visits from that point on. RN-A stated R7 had not been seen for recertification visits every 60 days and it was the facility's usual practice to have established residents seen every 60 days to be re-certified as required. R39: R39's quarterly MDS dated 11/21/24, identified R39 had a severe cognitive impairment and included a diagnosis of dementia. R39 exhibited no hallucinations, delusions or behaviors during the assessment period. R39's medical record identified R39 was evaluated by a medical provider on 6/25/24, 8/21/24, 11/5/24 and 1/15/25. During an interview on 2/12/25 at 12:00 p.m., MR-F stated she was responsible for the facility's medical records. MR-F stated she was responsible to figure out when a resident was last seen then schedule a follow up visit every 60 days with the resident's provider. There was a 10-day grace period as well, but the resident must be seen by day 70. R39 was seen on 8/21/24 but not again until 11/5/24 which was 76 days. MR-F stated she did not start her role until January 2025 and could not say why R39 was not seen timely. After 11/5/24, R39 was seen again on 1/15/25 which was 71 days. MR-F stated R39 was scheduled on 1/8/25 but for some reason that was cancelled. MR-F stated she was new to her role at that time and must have mistakenly			F 712	timing has been calculated correctly. This will be competed by comparing the prior months visit dates to their next scheduled visit to ensure on an every 60 day schedule. Results of audits will be shared with assistant administrator each month for 3 months beginning April 2025 to ensure compliance and systems management. Results will be reviewed at QAPI for ongoing auditing needs.		

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F 712	Continued From page 37 counted days when the appointment was rescheduled for 1/15/25. "It just slipped through my fingers." During an interview on 2/12/25 at 12:31 p.m., the DON stated the facility needed to ensure timely physician visits occurred to ensure appropriate resident care was provided. During an interview on 2/12/25 at 1:14 p.m., the administrator stated staff were expected to ensure timely physician visits occurred. The facility policy Doctors Review and Renewal Policy revised 4/2015, identified the following: A. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The physician's progress notes should be stamped each visit and the physician sign that he has reviewed the plan of care including resident care plan, meds, treatments, and all other orders. B. A physician visit will be considered timely if it occurs not later than 10 days after the date the visit was required. C. If any resident is receiving physical therapy, they must be seen by their physician every 30 days and orders reviewed. D. If a resident is on Medicare they must be seen by their physician every 30 days and orders reviewed. E. Medications, orders and plan of care must be RENEWED by the physician at least every 90 days. The computer sheet will be generated at these times and the physician will review, sign, and date to renew the orders. F. On new admits and hospital returns all MD orders are to be computer generated the first time			F 712			

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F 712	Continued From page 38	F 712			
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and implement interventions for identified behaviors for 1 of 3 residents (R17) reviewed for dementia care. Findings include: R39's quarterly Minimum Data Set (MDS) dated 11/21/24, identified R39 had a severe cognitive impairment, R39 used antipsychotic medication daily and exhibited no hallucinations, delusions or behaviors during the assessment period and had a diagnosis of dementia. R39's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 8/21/24, identifield R38 was unable to complete BIMS interview. R39 was at risk for alteration in thought process with potential for anxiety, falls, and decreased mobility related to cognitive decline secondary to unspecified dementia.Would proceed to anticipate R39 needs and intervene when making poor decisions. R39's care plan revised 11/26/24, identified R39 had alteration in thought process with potential for	F 744	R39's care plan was updated on 3/6/25 to include resident specific behaviors and behavioral interventions that are effective for her current behaviors. This was also added to the care sheet the staff carry with them. Additionally, a referral for psychiatry services was offered to resident/family on 3/5/25 by PCP. On 3/12/25, a comprehensive review was documented in the medical record for R39. This included a chart and behavioral history review along with review of interventions and effectiveness and medication review. An audit will be completed to identify other residents with dementia and behaviors by 3/15/25. The identified residents will have comprehensive care plan reviews and updates to include current and historical behaviors and personalized interventions to manage behaviors. This information will also be included on the care sheets staff carry with them and the review will be documented in the medical record by 3/30/25.		3/31/25

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F 744	Continued From page 39 anxiety related dementia and nursing home placement manifested by impaired cognition. Staff were directed to reorient and validate as needed. Staff would anticipate and meet needs, provide cues and supervision when making poor decisions, and intervene as needed. R39 was not to leave facility unattended. Explain all procedures before doing them. Approach in an unhurried calm manner. Offer information regarding schedules, routines, locations, and services as R39 and family need. Encourage family and or friends to visit or maintain usual contact. R39's nursing progress notes identified the following: - 1/21/25 at 3:06 a.m., R39 had been yelling out all night. When asked if R39 needed anything R39 stated "get out of my room you b**ch." R39 continued to yell "you b**ch" over and over for about half an hour after this nurse left the room. When the aide went in to try calm R39, R39 yelled at her to get out as well. R39 was unable to be consoled and continued to yell in her room despite every effort to give her what she could need. - 1/21/25 at 11:39 a.m., R39 slapped a staff member across the face with cares. R39 had been yelling at staff constantly - 1/22/25 at 2:23 a.m., R39 was awake most of the night yelling out. When staff entered the room, R39 told her to "get out of my room!" R39 had had her as needed (PRN) Zyprexa (an antipsychotic medication) earlier in the day and was not available to give again. This behavior continued throughout the night until around 3:00 a.m. - 1/22/25 at 1:51 p.m., R39 got up for breakfast without complaint. R39 then stayed up in her	F 744	Between the dates of 3/17/25 -3/21/25, all staff will be educated on dementia, behaviors and behavior management along with where to locate resident specific interventions. Audits will be conducted via staff interviews to ensure knowledge regarding resident behaviors. This will include questions regarding resident specific behaviors and interventions and actions to take if behaviors are new. This will begin on 3/24/25 and will be completed at a rate of 28 a week across all shifts for 2 weeks followed by 14/week for 2 weeks across all shifts, followed by 7/week for 2 weeks. Results of audits will be reviewed at QAPI in May 2025 for determination of ongoing auditing or education needs.		

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F 744	Continued From page 40 wheelchair and wheeled herself around with some talking to herself. Between 11:00 a.m. to 12:00 p.m., R39 was yelling to herself in her room "I want to lay down but no one to help me. Help." R39 was not using the call light at this time. The nursing assistant (NA) asked to bring R39 to lunch and R39 said no. Writer asked R39 again about 15 minutes later and R39 still did not want to come to lunch. R39 was assisted to lie down, and staff saved her lunch meal for when R39 was hungry. - 1/23/25 at 2:25 a.m., R39 was awake yelling out again tonight. Attempted to talk with R39 and asked if R39 was hungry, R39 stated that she was and that she would like some toast. This nurse made R39 some toast and gave R39 some apple juice. R39 continued to yell, appearing to be talking to "people" in the room trying to get them to try the toast as it was the best thing R39 had tasted in years. R39 was upset that they wouldn't try the toast. (There was no one in the room with her) After R39 finished her toast and juice R39 continued to yell out. PRN Zyprexa was given. Will continue to monitor. - 1/23/25 at 4:54 a.m., R39 finally settled and fell asleep around 4:00 a.m. - 1/28/25 at 2:59 a.m., R39 slept fairly well. R39 did holler out a few times during the night and was talking loudly. R39 had a shower last night on the evening shift and was very upset. - 1/30/25 at 2:43 p.m., R39 did not need her PRN Zyprexa this shift. R39 got up for both meals. R39 was yelling for help in room between breakfast and lunch, writer helped R39 change sweaters, that was what R39 was asking for help with. R39 then went to music at activities for a short time. R39 yelled out loud to herself minimally this shift. - 2/2/25 at 2:31 a.m., R39 refused her bedtime medication. PRN Zyprexa given. R39 too half the	F 744			

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F 744	Continued From page 41 medication and refused to finish. R39 kicked and pinched staff. - 2/4/25 at 2:39 a.m., R39 was very agitated and hollering out. Talking about going to school and R39 would be late if she did not get to the bus. Unable to redirect R39. PRN Zyprexa given for agitation. - 2/4/25 at 5:08 a.m., R39 sleeping. Was no longer hollering out or agitated about 30 minutes after PRN Zyprexa was given. - 2/6/25 at 4:54 a.m., R39 slept well all night. Continued to holler at staff when they come in to give medication or reposition/change her, but as soon as staff left, R39 was calm and quiet again. - 2/8/25 at 3:10 a.m., R39 was yelling out all shift. PRN Zyprexa was attempted to be administered but R39 refused to take. - 2/11/25 at 5:29 a.m., R39 slept well throughout the night. R39 started hollering nonstop at around 5:00 a.m. this morning. Unable to redirect. R39 was given PRN Zyprexa. R39's medical record lacked any assessment into R39's distress and behaviors and implementation of specific interventions. R39's Physician orders identified the following: - 12/18/24, identified Zyprexa (olanzapine) (an antipsychotic medication) 5 milligram (mg) tablet. Give 1 tablet by mouth once a day in the morning. - 1/21/25, Zyprexa 2.5 mg tablets. Give 2.5 mg by mouth once a day as needed. Used for behaviors. Add note when given. Okay to stand until next face to face visit. - 1/21/25, Zyprexa 2.5 mg tablets. Give 2.5 mg by mouth once a day as needed. Used for behaviors. Add note when given. Okay to stand	F 744			

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F 744	Continued From page 42 until next face to face visit. Saff were to monitor behavior and document every shift. R39 needed her PRN Zyprexa put a note In for the doctor. If R39 was lethargic, notify the charge nurse. - 1/28/25, Zyprexa 5 mg tablet. Give 1.5 tablet by mouth once a day in the evening. R39's electronic medication administration record (EMAR) dated January 2025, identified R39 received Zyprexa 2. 5mg PRN on the following days; - On 1/23/25 at 2:36 a.m. for "other" - On 1/25/25 at 4:13 p.m. for "behavior issues" "yelling at table" R39's EMAR dated February 2025, identified R39 received Zyprexa 2.5 mg PRN on the following days: - On 2/1/25 at 11:37 p.m. for "behavior issue" "refused all bedtime (HS) meds" - On 2/4/25 at 2:38 a.m. for "other" "agitation" - On 2/11/25 at 5:40 a.m. for "other" "agitation at 5 am". There was no evidence of non pharmacological interventions attempted prior to the administration of Zyprexa and what the result was of the medication. During a continuous observation on 2/10/25 at 6:15 p.m., R39 was sitting in her room in her wheelchair next to her bed with an overbed table against the wall in front of her. R39 had her hairbrush in her hands and was pulling on the bristles. R39 repeatedly stated "I don't care. breakfast, whatever." R39 was wearing a dark blue cardigan sweater over a gown, black slippers and a blanket across her lap.	F 744			

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F 744	Continued From page 43 - At 6:19 p.m., R39 loudly sang "I don't know what that is" and "oh my bra they took it off because I don't need one." R39 could be clearly heard five rooms away. - At 6:40 p.m., R39 turned her wheelchair to face her bed. R39 repeatedly stated "I want my bed", "I don't know", "are you helpless?", "yes, yes, I am", "I don't want the chair over there I want it over here where I can sit on it", "I don't know who put it over there", "I don't know what's going on. I have nothing on my feet besides my shoes. I have socks but I don't know how to put them on" and "you should, yes, you should". - At 6:42 p.m., "well I just don't" "I have socks right here and I just don't know how to put them on", "didn't you ever dress yourself?", "I don't know", "do you know nothing?" - At 6:44 p.m., "help me get my socks on", "are you helpless?", "yes, I am". R39 began weeping. "Oh, I don't like it either. I don't like being helpless." - At 6:50 p.m., R39 continued hollering. Trained medication aide (TMA)-B pushed the medication cart up against the wall outside R39's door but did not redirect R39. R39 loudly sang "ooohhhhhhhh, I don't know what to doooooooo. Cooome and help meeeeeeeeeeeee". "Take my shoes off." TMA-B was directly outside R39's room and did not respond. "Oh, are you that helpless!?! "Yes, I am." "Didn't you ever dress yourself?" "No, my mother dressed me." - At 6:52 p.m., TMA-B administered R39 her bedtime medication. However, TMA-B did not offer R39 toileting, repositioning or to lie down. TMA-B exited the room and R39 began hollering again. - At 6:56 p.m., "What do I got to do now? Go to bed in your clothes. What do you know? Nothing!" - At 6:56 p.m., R39 was crying. "I don't know how	F 744			

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F 744	Continued From page 44 to do things." "Who put you to bed last night?" "Nobody. I didn't go to bed." "Are you helpless?" "Yes, I am. My mother never showed me how." "You poor child." - At 7:04 p.m., the social worker (SS)-A approached R39 and stated "Hi, did you have any chocolate today?" SS-A continued to reminisce with R39 about family. SS-A offered R39 a drink of water and R39 took a drink. SS-A asked R39 if she wanted to lie down and R39 stated yes. SS-A turned on R39's call light, reassured R39 someone would assist her to bed and left the room. - At 7:09 p.m., R39 began hollering. "How did I get so helpless?" "Have you always been so helpless?" "I guess so. My mother did everything." - At 7:11 p.m., "just climb into bed." "I'll fall on my face in between." No, you won't." "How do you know that?" "You're not that bad." - At 7:14 p.m., NA-E entered R39's room and asked R39 if she needed something because R39's call light was on. "I don't know." NA-E turned off R39's call light and told R39 if she remembered what she needed to press her call light. NA-E left the room. R39 immediately started hollering. "Oh, my legs hurt. I just want to go to bed." - At 7:23 p.m., NA-F entered R39's and assisted R39 to bed. R39 was quiet after lying down. During an interview on 2/10/25 at 7:33 p.m., NA-F stated R39 hollered "a lot". R39 was impatient and would holler out when R39 wanted something. NA-F stated she was too busy, and this was the first chance she had to assist R39 to bed. R39 did not get along with a lot of people and NA-F was responsible to put her to bed that shift. R39 would "swat" you. R39 didn't mean it	F 744			

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F 744	Continued From page 45 but would hit. NA-F stated once R39 laid down R39 would be quiet the rest of the night. During an interview on 2/10/25 at 7:38 p.m., TMA-B stated R39 hollered "like that every day." R39 hallucinated all day long and R39 believed she was sitting with people and talking to them. R39 sang "I don't know" all day long. Staff tried to talk to her and bring her to activities or to watch tv but R39 didn't like that stuff. R39 liked to stay in bed but staff had to get her up for meals. TMA-B During an interview on 2/11/25 at 10:16 a.m., NA-G stated R39 yelled "a lot". Staff could ask R39 what she wanted and sometimes R39 would say and other times R39 wouldn't. During an interview on 2/11/25 at 4:14 p.m., TMA-B stated R39 did have a PRN dose of Zyprexa that could be used once a day for R39's behaviors. Before giving, TMA-B had to talk to the charge nurse who assessed R39. The charge nurse could give the PRN dose of Zyprexa but most of the time the charge nurse told the TMA to do it. TMA-B stated there were no non-pharmacological interventions to try first. Staff just needed to tell the charge nurse what was going on so the charge nurse could assess the behavior. During an interview on 2/11/25 at 4:16 p.m., RN-E stated, for behaviors, she would assess the situation and try to diffuse the R39's agitation. If that didn't work, RN-E would check to see the last time the PRN Zyprexa was used and would administer the medication. RN-E redirect like conversation, find something common, calm, reminiscing, RN-E did not know R39 well and would have to ask the staff who would know R39	F 744			

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F 744	Continued From page 46 better what interventions worked best. RN-E stated R39's care plan really didn't direct specific interventions about R39's behaviors. As an employee, RN-E stated she expected the care plan be more resident centered and have triggers and interventions identified to either prevent behaviors or to calm R39 so R39 would not need that PRN medication. During an interview on 2/12/25 at 7:13 a.m., NA-H stated R39's behaviors had no rhyme or reason that NA-H could think of. If R39's son came to visit, R39 would be calm but then got worked up again when he left. You can try every intervention you can think of and then if you try too long, R39 would become combative. R39 had a stuffed puppy that she liked and would help R39 stay calm. Also, if a man came into the dining room, R39 would scream at him to leave. During an observation in the dining room on 2/12/25 at 7:27 a.m., R39 was reading aloud from the conversational starter on her table. A male resident from another unit came into the dining room to talk to another female resident and R39 yelled " you get out of here!" The male resident did not respond but left the dining room shortly after. During an interview on 2/12/25 at 8:55 a.m., RN-C stated there was no rhyme or reason to R39's behaviors. RN-C stated there were no unique resident-centered interventions care planned R39's behaviors and staff should attempt non-pharmacological interventions before giving an antipsychotic medication. Staff were also expected to document all behaviors and attempts at redirection for monitoring.	F 744			

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F 744	Continued From page 47 During an interview on 2/12/25 at 12:31 p.m., the director of nursing (DON) stated staff were expected to find something for R39 to do, go on walks, out of her room, get her up or lie her down. The behaviors often occurred in the dining room prior to meals and R39 was in the dining room way before the meal started. Staff should offer a snack, a drink. The DON stated R39's care plan should have interventions that are individualized to R39's behaviors so staff could identify triggers and have resources to try to prevent R39's behaviors or to calm R39. During an interview on 2/12/25 at 1:14 p.m., the administrator stated the care plan should show specific resident centered care plan to promote non-pharmacological interventions to prevent behaviors. Staff were expected to follow the care plans.	F 744			
F 755 SS=D	A facility policy regarding dementia care was requested but not received. Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755			3/31/25

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F 755	Continued From page 48 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as needed medication from facility standing orders were transcribed and administered appropriately to reduce the risk of complications for 1 of 1 resident (R56) reviewed for loose stools. Findings include: R56's admission Minimum Data Set (MDS) dated 1/14/25, identified R56 had mild cognitive impairment and was continent of both bowel and bladder with no constipation present. A diagnosis of diarrhea was included. R56's Medication Administration Record (MAR) dated 2/1/25 to 2/10/25, identified loperamide (an antidiarrheal) OTC (over the counter) medication was added on 2/5/25. Instructions were for			F 755	On 2/10/25 the loperamide was discontinued from the residents' order list On 3/6/25 an audit of all residents loperamide orders was completed to ensure PRN loperamide was not entered as scheduled instead of PRN. 10 Residents were identified as having PRN loperamide and one resident had scheduled loperamide by the PCP. On 3/6/25, the policy for standing orders was reviewed with no changes being made. All nursing staff will be educated on the facility policy for standing orders. This will include instruction to nursing staff regarding entering standing orders from the order sets to ensure proper transcription.		

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F 755	Continued From page 49 loperamide 2 milligrams (mg) to be administered four times per day for diarrhea. Special instructions instructed to give 2 mg of the medication after each loose stool, not to exceed 8 mg in a 24-hour period. The medication was scheduled to be given every day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. Staff initialed the medication administration as administered as follows: - 2/5/24 at 12:00 p.m. the 4:00 p.m. and 8:00 p.m. scheduled doses were documented as resident refused. - 2/6/25, the medication was administered at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. - 2/7/25, the medication was administered at 8:00 a.m. The 12:00 p.m., 4:00 p.m., and 8:00 p.m. scheduled doses were documented as resident refused. - 2/8/25, the medication was administered at 9:00 p.m. The 8:00 a.m., 12:00 p.m., and 4:00 p.m., scheduled doses were documented as resident refused. - 2/9/25, the medication was administered at 8:00 a.m., and 12:00 p.m. with the 4:00 p.m. and 8:00 p.m. scheduled doses refused. A notation was made in the MAR, R56 had stated she should not be taking loperamide four times per day and did not want it. - 2/10/25, the medication was refused at 8:00 a.m., 12:00 p.m., and 4:00 p.m. The medication was discontinued after 4:00 p.m. R56's bowel monitoring record identified R56 had four bowel movements on 2/5/25, a medium bowel movement on 2/6/25, and two medium bowel movements on 2/9/25. When interviewed on 2/10/25, at 5:57 p.m. R56 stated she had loose stools on 2/5/25, then her	F 755	Audits will be conducted by reviewing message board in EMR for new standing orders entered beginning on 3/17/25. All standing orders entered will be reviewed to ensure PRN status. Audits will be conducted by the DON or designee daily every morning for 14 days followed by 3x/week for 2 weeks. Results of audits will be reviewed at QAPI for ongoing auditing needs.		

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F 755	Continued From page 50 stools were fairly normal. R56 stated she only took the loperamide two times after the first loose stool on 2/5/25 and that did the trick. The nurses mentioned something about taking it four times per day and R56 told the nurse there was no way she was taking it that often. R56 told the nurses she should not be taking loperamide like that and should only take it when it was needed after a loose stool. R56 indicated she never took any more of the loperamide after the two initial doses on 2/5/25 and refused it after that. During interview on 2/11/25, at 4:47 p.m. licensed practical nurse (LPN)-B stated the loperamide order was transcribed from the facility standing orders and should not have scheduled times for administration. The medication was to be given for a loose stool and so should have been transcribed on to the MAR as a one-time order from standing orders. Then if needed to be given again, would need to be re-entered onto the MAR again and each time it was needed. R56 did not have a physician order for as needed (PRN) loperamide and so when taking it from the facility's standing orders would be a one-time only medication administration. When interviewed on 2/11/25, at 5:05 p.m., the director of nursing (DON) stated she had spoken with R56 who denied having loose stools and so the DON questioned why R56 was still receiving scheduled loperamide. The DON contacted R56's primary provider and had the medication discontinued. The DON stated if the loperamide order was transcribed from the facility's standing orders, the medication should not have been scheduled with administration times. The medication should have been identified as PRN on the resident's MAR. The medication was	F 755			

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F 755	Continued From page 51 transcribed to the MAR incorrectly and therefore, lead to medication errors as well. Medication errors occurred each time the medication had been given on the scheduled times. If R56 had been experiencing loose stools for that amount of time, the provider should have been notified. It was the facility's policy to notify the provider if a resident was having four or more loose stools in a 24-hour period. When interviewed on 2/12/25, at 9:30 p.m., LPN-D stated on 2/5/25, she had entered the loperamide order on R56's MAR from the facility's standing orders in order to administer R56 the medication for complaints of loose stools. LPN-D indicated the medication should have been identified as PRN and not scheduled four times per day. LPN-D thought she must not have pressed the PRN button and so the medication had not been recorded on R56's MAR correctly. The facility's policy Medication Discrepancies revised 4/2015, identified a goal to ensure safe administration of all medications to residents. Medication discrepancies included medications given at the wrong time, a PRN medication given sooner than the physician's stated order, or an order transcribed incorrectly,	F 755			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756			3/31/25

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F 756	Continued From page 52 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 1 of 5 residents (R51) reviewed for unnecessary medication use.	F 756			
			On 3/6/25, the missing pharmacy reviews were reviewed by the PCP. The PCP did not agree with the recommendation and no changes were made to the residents orders All pharmacy reviews for this resident have been addressed as of 3/6/25.		

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F 756	Continued From page 53 Findings include: R5's quarterly Minimum Data Set (MDS) dated 11/7/24, identified R5 had intact cognition. Diagnoses included paroxysmal atrial fibrillation, heart disease, and secondary hypertension. R5's Physician Order Report signed 10/9/24, identified R5's current medication regimen with their corresponding start dates and included the following: Eliquis (an anticoagulant) 2.5 milligrams (mg) two times per day, aspirin (reduces the formation of blood clots) 81 mg every day, and Diltiazem (to prevent chest pain) 120 mg every day. R5's Consultant Pharmacist's Medication Review dated August 2024, identified R5's medication regimen had been reviewed by the consulting pharmacist (CP) and listed an irregularity regarding the medication Diltiazem. The CP comment included concomitant use of Diltiazem with oral anticoagulants such as Eliquis was associated with higher bleeding risk. A suggested course of action was listed to consider reassessing risks vs. benefits of using Diltiazem. There was no recorded response from the physician on either accepting the recommendation or rejecting it despite the follow up implementation time frame for the physician to address ASAP (as soon as possible) but no later than 30 days. R5's Consultant Pharmacist's Medication Review dated October 2024, identified R5's medication regimen had been reviewed by the consulting pharmacist (CP) and listed an irregularity regarding the medication Diltiazem. The CP comment included concomitant use of Diltiazem	F 756	An audit of all pharmacy recommendations received January 2025 through current were audit to ensure signature and placement in the medical record. Any missing reviews will be obtained by 3/15/25. Education will be conducted between the dates 3/17/25-3/21/25. Education will be include explanation of benefit of pharmacy reviews and process for obtaining signatures, processing pharmacy review orders, and scanning into medical records. The Director of Nursing has developed a tracking system to ensure return of pharmacy reviews after being sent out which includes printing the resident level list which identifies if discrepancies were found during that months review. As reviews are returned, the printed list will be updated to indicate the review was returned. The DON or designee will process any reviews that have new orders upon receipt and place in the location for scanning into the medical record. Each month, an overview of the pharmacy review recommendations will be provided to the medical director via email by the DON. Audits of pharmacy reviews for the prior month will be completed each month by the 15th by the corporate nurse for 3 months. This will be completed by comparing the resident level listing with pharmacy review records found in the		

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F 756	Continued From page 54 with oral anticoagulants such as Eliquis was associated with higher bleeding risk. An additional comment was added the CP had not found a response to his August recommendation and so was renewing the recommendation again. A suggested course of action was listed to consider reassessing risks vs. benefits of using Diltiazem. There was no recorded response from the physician on either accepting the recommendation or rejecting it despite the follow up implementation time frame for the physician to address ASAP (as soon as possible) but no later than 30 days. R5's medical record lacked evidence the consulting pharmacist's recommendation on R5's Diltiazem dose irregularity had been forwarded, reviewed and/or acted upon by the physician despite the recommendation being made both in August and October and R5 continued to receive the medication which had been identified as a potential for increased risk of bleeding, with need for close monitoring for signs of bleeding. When interviewed on 2/12/25, at 12:00 p.m. the director of nursing (DON) stated she was unable to find the provider's response to the CP's recommendations. The DON was responsible to ensure the physician reviewed the recommendations. When pharmacy recommendations were received, she sorted them into physician rounding and fax for non-rounding physicians. Sometimes the physician would take the CP recommendation forms back to the clinic for further review and did not always return them. The DON was working on a new process to ensure recommendations were being followed up on. The expectation was to have the physician address all pharmacy	F 756	residents medical records. After 3 months, results of initial audits will be reported to QAPI for determination of ongoing auditing needs.		

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F 756	Continued From page 55 recommendations within 14 days. The facility policy Pharmacy Service Medication Regimen Review dated 10/2022, identified the consultant pharmacist would review the medication regimen of each resident at least monthly to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The pharmacist would provide a written report to the DIN within 3 business days of completing the monthly review. Copies of the report would be provided to the DON, the patient's attending physician and the facility's medical director. Recommendations would be acted upon and documented by the facility staff and/or the prescriber. The physician would accept and act upon suggestions or reject and provide an explanation for disagreeing.	F 756			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758			3/31/25

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F 758	Continued From page 56 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a face-to-face provider evaluation for continued use of a as needed (PRN) psychotropic medication for 1 of 2 residents (R39) reviewed for mood/behavior. Findings include:	F 758	On 3/4/2025, the PRN Zyprexa for R39 was discontinued. An audit was completed on 3/6/25 to identify all PRN psychotropic medications. All PRN psychotropic medications greater than 14 days old have been reviewed with		

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F 758	Continued From page 57 R39's quarterly Minimum Data Set (MDS) dated 11/21/24, identified R39 had severe cognitive impairment. R39 used antipsychotic medication daily and exhibited no hallucinations, delusions or behaviors during the assessment period. R39 had a diagnosis of dementia. R39's Physician order dated 1/21/25, identified Zyprexa (olanzapine) (an antipsychotic medication) 2.5 milligram (mg) tablets. Give 2.5 mg by mouth once a day as needed. Used for behaviors. Add note when given. Okay to stand until next face to face visit. R39's electronic medication administration record (EMAR) dated January 2025, identified R39 received Zyprexa 2. 5mg PRN on the following days; - On 1/23/25 at 2:36 a.m. for "other" - On 1/25/25 at 4:13 p.m. for "behavior issues" "yelling at table" R39's EMAR dated February 2025, identified R39 received Zyprexa 2.5 mg PRN on the following days: - On 2/1/25 at 11:37 p.m. for "behavior issue" "refused all bedtime (HS) meds" - On 2/4/25 at 2:38 a.m. for "other" "agitation" - On 2/11/25 at 5:40 a.m. for "other" "agitation at 5 am". R39's medical record 1/22/25 through 2/12/25, failed to identify R39's physician failed to document the rationale and duration of need for PRN antipsychotic medication. During an interview on 2/11/25 at 5:05 p.m., the director of nursing (DON) stated PRN			F 758	providers for discontinuation or scheduling. The facility policy for psychotropic medication use has been reviewed on 3/11/25 with updates made to explicitly note that PRN antipsychotics are not permitted for greater than 14 days. Education will be provided to all staff to include expectations for order entry of psychotropic medications with stop dates no greater than 14 days from the start of the order. Providers involved in the care of R39 were also educated on expectations for 14 day stop dates and face-to-face reviews within 14 days of any PRN psychotropic medications, including antipsychotics. Upon receiving an order for any PRN psychotropic medications, target behaviors and interventions will be listed in the order and PRN given only for only specific and clearly documented circumstances. An audit of PRN psychotropic medication orders will be completed weekly for a duration of 6 weeks beginning on 3/10/25 to ensure compliance by the DON or designee. Orders identified as being entered with no stop date or target behaviors/interventions will be reviewed by the DON with the entering nurse for correction and scheduling appropriate face to face follow up. Results of audits will be reviewed at QAPI for ongoing auditing needs.		

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F 758	Continued From page 58 antipsychotic medications should be re-evaluated by the physician every 14 days with a documented rationale and duration for use. During an interview on 2/12/25 at 1:14 p.m., the administrator stated staff were expected to ensure PRN antipsychotic medication rationale and duration for use was clearly documented to ensure appropriate use. The facility's Psychotropic Medication Monitoring Policy and Procedure reviewed 6/2023, identified orders for PRN psychotropic medications would be given only for specific, clearly documented circumstances. PRN psychotropic medications require a face-to-face assessment by the prescribing provider 14 days after initiating of the new medication. Specific target behaviors and interventions will be listed for PRN psychotropic medications.	F 758			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880			3/31/25

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F 880	Continued From page 59 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the			F 880			

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F 880	Continued From page 60 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBP) for 1 of 1 resident (R211) reviewed for catheter care; and 1 of 1 resident (R18) reviewed with a surgical wound. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring,	F 880	Failure to properly implement proper infection prevention and control procedures has the potential to impact all residents who reside in the facility. R18 wound that required EBP has since healed. On 2/10/25, EBP were put into place for R211. A chart audit was conducted by the DON that included review of all current residents with impaired skin integrity and indwelling devices to ensure EBP is in place both in practice and on the care plan. This was completed on 3/6/25 and indicated that 1 additional resident required EBP for openings in the skin present or indwelling devices. The current facility policy for EBP includes when EBP is indicated and was not revised. Staff education for expectations of initiation of EBP for wounds and indwelling devices and wearing gowns and gloves when EBP is warranted was completed at an all staff meeting held between the		

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F 880	Continued From page 61 changing linens or briefs, and wound care. R211: R211's admission Minimum Data Set (MDS) dated 1/30/25, identified R211 was cognitively intact. R211 required maximum assistance with dressing and transfers and moderate assistance with toileting. R211 had an indwelling foley catheter with a diagnosis of retention of urine. R211's care plan with revision date 2/12/25, identified enhanced barrier precautions were needed due to the indwelling foley catheter. On 2/10/25 at 6:15 p.m., R18's room was observed and there was no personal protective equipment (PPE) cart in or near R18's room. Further, there was no sign posted outside R18's room identifying R18 was on EBP. On 2/10/25, at 6:45 p.m. R211 was observed seated in a recliner in reclined position in his room. Nursing assistant (NA)-J entered the room and assisted R211 to stand and ambulate to the side of his bed. NA-J with gloved hands transferred, removed clothing, assisted to wash up and position R211's catheter leg bag on to the bed. At no time did NA-J wear a gown. On 2/10/25, at 7:37 p.m. registered nurse (RN)-F entered R211's room. RN-F stated the facility did not allow residents to sleep at night with leg bags as the urine would not drain properly. RN-F changed R211's beg bag to a leg bag maintaining proper hand hygiene ; however, RN-F failed to wear a gown for EBP requirements. When interviewed on 2/10/25, at 7:45 p.m. RN-F	F 880	dates of 3/17/25-3/21/25. Beginning on 3/22/25 the DON or designee will audit high risk contact activities with staff 10 times a week for 2 weeks followed by 5 times a week for 4 weeks. Audit will occur across all shifts. If at such time staff observation results in inadequate EBP practice, DON or designee will provide real time feedback and education to specific staff member. Results of all EBP and laundry procedure audits will be reported to the QAPI on an ongoing basis until such time is determined to be in substantial compliance.		

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F 880	Continued From page 62 stated it was not the facility's practice to initiate EBP with standard catheter care. EBP would only be initiated if the resident had some type of infection. The facility initiated EBP with all residents with wounds or supra pubic catheter care, but not for standard catheter care, or colostomies. If staff were required to do EBP with resident care, there would be signage on the resident's door to indicate that and R211 did not have any signage in his room. On 2/11/25, at 2:55 p.m. NA-J assisted R211 with toileting cares. Although NA-J used proper hand hygiene with glove use, NA-J failed to wear a gown when assisting R211 with toileting cares. When interviewed on 2/11/25, at 3:00 p.m. NA-J stated she had not worn EBP when she had assisted R211 to the bathroom. Staff only had to wear EBP when working with R211's catheter or when providing peri care. NA-J assisted R211 to the bathroom but had not grabbed a washcloth and washed him up, so had not really provided peri care. NA-J had wiped R211's peri area with toilet paper to clean after his bowel movement when she assisted him off the toilet. That may have constituted peri care, and she should have been wearing a gown while assisting him with toileting. During interview on 2/12/25, at 8:56 a.m. infection preventionist licensed practical nurse (LPN)-A stated EBP was required for all residents with wounds, gastrostomy tubes, and foley catheters. The residents did not have signage on their doors to identify if EBP was required. Staff knew which residents required EBP as it was identified on the resident's care sheet and was also passed along during shift report. Staff were required to wear	F 880			

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F 880	Continued From page 63 gown and gloves for EBP whenever working with a resident's foley catheter and should have been wearing EBP when changing a foley catheter leg bag to a collection bed bag. During interview on 2/12/25, at 12:00 p.m. the director of nursing (DON) stated it was the facility's expectation for staff to use EBP for foley catheter care as well as peri care with all residents with wounds or invasive medical devices. Staff were trained on EBP during their orientation on hire and at all staff meetings. Residents who required EBP during care were identified on staff care sheets and a gown was required for all close contact personal care. R18: R18's admission MDS dated 1/30/25, identified R18 was admitted on 1/24/25, was cognitively intact and was receiving surgical wound care. R18's care plan revised 2/12/25, identified R18 recently had a hip replacement and required staff to complete dressing changes and monitor and report any signs or symptoms of infection. The plan further identified R18 required assist of 1 staff for transfers, toileting and dressing. However, the plan failed to address R18's need for contact and/or EBP. R18's orders report dated 1/24/25, identified the following: - Right hip: monitor dressing placement and monitor for any signs and symptoms of infection such as increased redness, warmth, swelling, drainage, or generalized fever over 101. Notify charge nurse if noted so that provider can be notified.	F 880			

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F 880	Continued From page 64 During observation on 2/10/25 at 7:06 p.m., there was no PPE cart near or inside R18's room. Further, there was no sign directing staff to wear PPE during dressing changes or cares R18's orders report dated 1/24/25, identified staff were to monitor R18's dressing placement and for signs and symptoms of infection such as increased redness, warmth, swelling, drainage, or generalized fever over 101. Staff were to notify the charge nurse so they could notify the provider. R18's care plan revised 2/12/25, identified R18 recently had a hip replacement and required staff to complete dressing changes and monitor and report any signs or symptoms of infection. The plan further identified R18 required assist of one staff for transfers, toileting and dressing. However, the plan failed to address R18's need for EBP. During observation on 2/10/25 at 7:06 p.m., there was no personal protection equipment (PPE) cart near or inside R18's room. Further, there was no sign directing staff to wear PPE during dressing changes or cares. On 2/11/25 at 10:10 a.m., registered nurse (RN)-C was in R18's room and assisted R18 to lay down in bed. Wearing gloves, RN-C assessed the area around R18's surgical dressing by touching and stated the dressing was intact with no drainage outside of the dressing. The skin around the dressing was a little warm to touch. RN-C failed to wear a gown while assessing R18's surgical wound.	F 880			

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F 880	Continued From page 65 On 2/12/25 at 7:33 a.m., RN-C was observed in R18's room and changing R18's dressing. Observation of the dressing identified a dark red spot, approximately 1-inch in diameter in the middle area of the outside of the dressing. While wearing gloves, RN-C removed R18's dressing and stated there was an area on the distal end of the incision that appeared to be a fluid filled bubble/blister. RN-C stated the skin around the distal end appeared to be darker red although was not warm to touch. RN-C cleansed and reapplied a dressing to the wound. RN-C stated the wound looked worse than the other day and thought it may be starting to get infected. RN-C did not apply or wear a gown during the dressing change. On 2/12/25 at 12:15 p.m., licensed practical nurse (LPN)-A stated staff were to wear PPE during direct patient care for residents that had catheters, tubes and open wounds that required a dressing change, including surgical wounds. LPN-A stated R18 should have been placed in EBP because the wound was open and draining. Further, LPN-A stated all staff should wear a gown and gloves when providing direct patient care or working with or changing a wound dressing. On 2/12/25 at 12:32 p.m., RN-C stated upon R18's admission she was told by the infection preventionist, staff did not need to wear PPE while providing wound care. RN-C stated she worked with multiple residents during the day and had the potential to carry bacteria on her clothing. RN-C stated wearing PPE would help prevent the spread of bacteria to/from herself and the resident. RN-C stated she had not worn PPE	F 880			

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F 880	Continued From page 66 including a gown when she cared for the wound or changed R18's dressing. The facility Enhanced Barrier Precautions policy dated 11/2024, identified EBP expanded the use of PPE and referred to the use of gown and gloves during high-contact resident care activities that provided opportunities for transfer of multidrug-resistant organisms (MDRO)'s to staff hands and clothing. MDRO's may be indirectly transferred from resident to resident during high contact care activities. Residents with wounds and indwelling medical devices are at an especially high risk of both acquisition of and colonization with MDRO's. The policy further identified EBP would be implemented for residents with wounds and/or indwelling medical devices during high-contact resident care activities regardless of MDRO infection or colonization. High risk care activities included device care or use, and wound care.	F 880			
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to have a system in place to ensure water temperatures were maintained a comfortable temperature for 2 of 13 residents (R22 ,R45) who resided on Maple Lane unit reviewed for complaints of cold-water temperatures. This had the potential to affect all 13 residents residing who resided on Maple Lane unit.	F 921	On 2/10/25, daily water temperature audits were initiated to be completed by the Maintenance Director and reported daily at morning meeting. This included testing water temps and documenting findings. On 2/19/25, prior maintenance personnel, also came to assess plumbing maps to assist in identifying issues. Water		3/31/25

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F 921	Continued From page 67 Findings include: R22's annual Minimum Data Set (MDS) dated 11/13/24, identified R22 had severe cognitive impairment and was dependent on staff for bathing, dressing and grooming. R45's quarterly MDS dated 1/29/25, identified R45 had moderate cognitive impairment and was independent with dressing and grooming and required supervision with bathing. During interview on 2/10/25, at 1:45 p.m. family member (FM)-H stated R22 did not have hot water in his room. Staff had to take R22 to another wing in the facility for his showers as there wasn't any hot water on the wing R22 resided. FM-H felt it was terrible the residents had to wash up in cold water and were carted down two halls half naked for their showers. During interview on 2/10/25, at 6:23 p.m. R45 stated the water never got hot in their sink. It was always lukewarm at best. They washed up the best they could and had to take their showers on the other wing. On 2/11/25, at 8:14 a.m. licensed practical nurse (LPN)-B was observed running water at the end of the resident hallway in the facility's sunshine conference room. LPN-B stated running the water in the sink helped to get hot water going to the resident rooms in the wing. At 9:15 a.m. the continuously running water in the sink remained a cool tepid temperature to the touch. During interview on 2/11/25, at 3:48 p.m. maintenance director (M)-A stated the facility	F 921	temps have continued to fluctuate, and alternative bathing means have continued to be utilized at tub rooms on different units. Various valves in the system are also being assessed by plumbing contractors and are being replaced as recommended. On 3/3/25, three hydronic pumps were installed. Quote was received on 3/5/25 for replacement of check valve Residents have continued to get showers and bathing despite temperature fluctuations in alternate locations. Education is being provided to staff at an all staff meeting to be held between the dates of 3/17/25-3/21/25. This education will cover the proper channels for maintenance requests and expectations for reporting items that are in need of repair including water temperatures that are not meeting expectations of residents and staff. The facility administrator additionally will educate the maintenance director on water temping expectations and timely review with the facility administrator for determination of further actions upon identification of out of range water temperature. Daily water temperature checks will continue to be done until temps reach the desired range for 5 consecutive days on the unit that is affected. Following that temps will continue to be checked at least weekly or 4 weeks following temps reaching desired range. Water temps will continue to be checked monthly on a		

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F 921	Continued From page 68 installed a new hot water heater in November 2024 alongside the exiting water heaters, and he thought that had corrected the problem until now. M-A had only just learned of the lack of hot water on the Maple Lane unit the day prior and had called a local heating and plumbing to come out, however, they would not be able to come until the following week. M-A had done a few water temperatures that day and had ranged 93 to 98 degrees, so the temperatures were a little under what they should be. M-A stated hot water temperatures should be at maximum temperature of 115 degrees. M-A did not have a consistent process for monitoring the water temperatures. On 2/11/25, at 5:09 p.m. LPN-B stated she reported the cold-water issues to maintenance a few times over the past couple of months. Staff filled out their requests to maintenance in the maintenance logbook on each wing. The maintenance staff would pick up the forms and she did not know what happened to them after that. There were no copies made of the requests. The current maintenance book for the wing was reviewed and had several blank maintenance requests forms, however, no current requests were documented. The maintenance book failed to identify staff requests for hot water on Maple Lane. On 2/12/25, at 8:32 a.m. M-A was observed testing the water temperature at the end of resident's hall Maple Lane. The hot water had been running five minutes prior to test. The temperature of the running hot water at the sink registered 89.7 degrees. M-A stated he only did hot water tests when he had complaints about the hot water, and he had only gotten complaints two days prior. M-A stated he thought the aides had	F 921	regular PM maintenance schedule. Results of audits will be reviewed at QAPI for ongoing auditing needs.		

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F 921	Continued From page 69 been bringing residents from Maple Lane to another resident wing to take their showers as the showers on Maple Lane did not work. Hot water issues had been coming up from time to time. MD-A thought the old plumbing was causing the issues and so the facility kept getting sporadic cold water that showed up for a day or so. During interview on 2/12/25, at 12:00 p.m. the director of nursing (DON) stated the facility had ongoing hot water issues on the south wing and were doing their best to correct the problem. DON thought it was something to do with the piping and would possibly requiring tearing into some walls to fix the plumbing. A joint interview was conducted with administrator, owner and registered nurse (RN)-A on 2/12/25 at 1:56 p.m., the administrator stated there were ongoing concerns with the water temperature that were discussed during the quality assurance and performance improvement (QAPI) meeting. A new water heater had been installed but that had not resolved the issue. They called in the previous facility director who had also given them some direction on what to try to resolve the issue. Also, the administrator had started a new process for maintenance requests because it had become apparent staff were making verbal requests that could not be verified. A binder was placed on each unit for maintenance requests. That way, the administrator was able to audit those requests and ensure they were followed up on. A policy on water temperature management was not received.			F 921			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/11/2025. At the time of this survey, Havenwood Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2025

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Havenwood Care Center was built in 4 stages. The 1968 original building is 1- story, without a basement and was determined to be Type II (111) construction. In 1971 an addition to the south of the original building was built, is 1-story with a partial basement and was determined to be of a Type II (222) construction. The 1974 addition was built to the south of the 1971 addition, is 1-story without a basement and was determined to be of Type II (111) construction. In 1992 additions were built to the west of the 1968 building and east of	K 000			

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K 000	Continued From page 2 the 1971 building. They are separated with 2-hour fire barriers and determined to be Type II(111) construction. The facility has a capacity of 70 beds and had a census of 63 at the time of the survey.			K 000			
K 163 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain non-combustible ceiling in accordance with the NFPA Life Safety Code 101 2012 edition section 19.1.6.3 subsection 1 and 3. This deficient practice could have an isolated impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm,it was revealed by observation that the following storage room are missing ceiling tiles and / or			K 163	Ceiling tiles in C-21 and C-12 were replaced on 2/11/25. The Maintenance Director or designee will complete audits to ensure ceiling tiles are in place and in repair on a weekly basis x 4 weeks, bi-weekly x 4 weeks, then monthly thereafter. Results to be reviewed at QAPI.		3/31/25

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K 163	Continued From page 3 had tiles in disrepair: 1) C-21 Janitor Closet - missing ceiling tile 2) C-12 Soiled Utility Room - missing tile An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.	K 163			
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1) On 02/11/2025, between 08:00am and	K 223	The Maintenance Director installed self-closing hinges in the closet on 02/18/2025. All storage room doors were audited on 3/4/25 to ensure they were self-closing. The Maintenance Director or designee will audit storage room doors on a monthly basis thereafter to ensure they self-close x 3 months. Results will be reviewed at QAPI.	3/31/25	

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K 223	Continued From page 4 12:00pm, it was revealed by observation that the old maintenance Director Office has been converted into a storage room. This storage room door required to have self-closing device.	K 223			
K 226 SS=F	An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery. Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 19.1.1.4.1.1, 19.1.1.4.1.2, 19.1.1.4.1.3, 19.2.2.2.7, Chapter 7, section 7.2.1.4.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1) On 02/11/2025, between 08:00am and 12:00pm, it was revealed by observation that the exit door at the end of Maple Lane Wing (Door 16) did not open 30psi of force and was unable to be continued in operation with a maximum force	K 226	On 02/12/2025, the Maintenance Director and Maintenance Worker inspected Door 16 on Maple Lane and deterimed that the weather stripping was causing excess resistance when opening the door. The weather stripping was replaced and the door is able to easily be opened. On 2/11/25, the Maintenance Director placed signs on Door 14 indicating that the left door must be opened first when exiting that door. The Maintenance Director or designee will audit all exit doors weekly x 2 weeks then monthly x 2 months to ensure they are	3/31/25	

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K 226	Continued From page 5 of 15psi. When tested the emergency exit was catching on baseplate /sill plate area. 2) On 02/11/2025, between 08:00am and 12:00pm, it was revealed by observation that the exit door outside of Activities (Door 14), the emergency exit requires special knowledge to operate. Facility must indicate proper operation by placard or signage. An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.	K 226	able to be opened easily and no special directions are needed to exit, or the door is marked accordingly. Results will be reviewed at QAPI.		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: 1) On 02/11/2025, between 08:00am and 12:00pm, it was revealed by document review that the facility failed to conduct emergency lighting testing for the month of April. 2) On 02/11/2025, between 08:00am and 12:00pm, it was revealed by document review	K 291	The Maintenance Director or designee will complete monthly checks of the emergency lighting system on all emergency lights. Any repairs will be documented. The Administrator or designee will audit the completion of the testing on a monthly basis x 3 months, then quarterly thereafter x 2 quarters. Results will be reviewed at QAPI.	3/31/25	

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K 291	Continued From page 6 that the facility failed to document repairs of failed battery test conducted on Staff Break-room Emergency Light.	K 291			
K 321 SS=D	An interview with the Director or Environmental Serviced verified this deficient finding at the time of discovery. Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321			3/31/25

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K 321	Continued From page 7 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm, it was revealed by observation that the Boiler Room door near the kitchen stairs did not close and / or latch. An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.	K 321	On 2/18/25, the Maintenance Director adjusted the closing speed on the door so the door closes and latches when let go. The fire doors around the boiler room will be checked to ensure they close and latch weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 2 months. Audits will be completed by the Maintenance Director or Designee.		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324			3/31/25

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K 324	Continued From page 8 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 02/11/2025, between 08:00am and 12:00pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.			K 324	The kitchen hood ventilation and fire suppression system is expected to be tested/inspected semi-annually. The missing inspection report was found on 2/12/25. The kitchen hood was inspected again by Glacier on 2/18/2025. The Administrator or designee will audit the inspections in September 2025 to ensure the next semi-annual inspection is completed.		

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K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm, it was revealed by observation that storage	K 353	On 2/11/25, the boxes obstructing the sprinkler head were removed from within 18" of the sprinkler head. On 3/6/25, a mark was made on the freezer wall and ceiling to indicate items should be piled in that area. Audits to ensure the sprinkler head is free of obstruction will be completed by the Administrator or designee 2x/week x 3 weeks, 1x/week x 2 weeks, then bi-weekly x 1 month. Results will be reviewed at QAPI.	3/31/25	

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K 353	Continued From page 10 materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the kitchen freezer.			K 353			
K 372 SS=F	An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm,			K 372	On 2/12/25, the Maintenance Director caulked the penetration in the smoke compartment wall with fire caulking. The Maintenance Director or designee will check the fire walls for penetrations monthly x 2 months and if no other infractions are discovered, audits will end. Results will be reviewed at QAPI		3/31/25

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K 372	Continued From page 11 it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to Maple Line Wing.	K 372			
K 712 SS=F	An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm, it was revealed by a review of available documentation that the first shift / third quarter	K 712	Fire drills will be conducted on each shift on a quarterly basis by the Maintenance Director or designee. The Administrator or designee will audit fire drills by the end of each quarter x 2 quarters to ensure they are being completed on all shifts at a variety of times. Results will be reviewed at QAPI.	3/31/25	

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K 712	Continued From page 12 fire drill was not completed.	K 712			
K 761 SS=F	An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery. Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm, it was revealed by review of available	K 761	On 3/6/25, the Maintenance Director inspected all fire doors using the required 13-point inspection. The Maintenance Director or designee will use the 13-point inspection form on annual inspection of fire doors moving forward. The Administrator or designee will audit the inspection form annually to ensure it was completed.	3/31/25	

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NAME OF PROVIDER OR SUPPLIER HAVENWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1633 DELTON AVENUE NW BEMIDJI, MN 56601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 761	Continued From page 13 documentation that the required annual door inspection documentation was not available at the time of the survey. Facility has not been applying a 13 point inspection form during Annual Door Inspections.	K 761			
K 920 SS=E	An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery. Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920			3/31/25

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K 920	Continued From page 14 Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/11/2025, between 08:00am and 12:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Power-strip in Social services office 2) Power-strip in Main office area An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.	K 920	On 2/11/25, the appliance plugged into the power strip in the Social Services office was plugged directly into the wall. On 2/20/2025, the appliance plugged into the power strip in the Social Services office was plugged directly into the wall. On 3/6/25, all offices were audited to ensure appliances were not plugged into power strips, multi-plug adapters, and/or extension cords. Audits will be completed bi-weekly by the Maintenance Director or designee x 1 month, and monthly x 2 months to ensure appliances are not plugged into power strips. Staff will be educated at staff meetings the week of 3/17/25. Results of audits will be reviewed at QAPI.		