



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2025

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: December 5, 2024

Dear Administrator:

On March 4, 2025, we notified you a remedy was imposed. On March 12, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 4, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 5, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 4, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 4, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 17, 2024

Administrator
Neilson Place
1000 Anne Street Northwest
Bemidji, MN 56601

RE: CCN: 245039
Cycle Start Date: December 5, 2024

Dear Administrator:

On December 5, 2024, 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.

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 March 5, 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 June 5, 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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2024
NAME OF PROVIDER OR SUPPLIER NEILSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST 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
F 000	INITIAL COMMENTS On 12/3/24 through 12/5/24, a standard recertification survey was conducted at your facility. Complaint investigations were 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 complaints were reviewed with NO deficiencies cited: H50397907C (MN106328) H50391745C (MN107153) H50391744C (MN106170) H50391743C (MN107058) H50391746C (MN099178) H50391747C (MN100546) 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677			1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/27/2024

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 677	Continued From page 1 Based on observation, interview, and document review, the facility failed to provide routine oral care and shaving assistance to 1 of 5 residents (R23) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/5/24, identified R23 was cognitively intact, had a diagnosis that included hemiplegia (one side paralysis or weakness) due to a history of a stroke. R23 had an indwelling catheter and a feeding tube. R23 was dependent on staff for all care activities. R23's care plan revised 12/3/24, identified R23 had a self-care deficit due to left sided hemiparesis related to a history of stroke. Staff were directed to provide assist of one for grooming. The care plan did not direct shaving on certain days or how often and when oral cares would be completed. During an observation on 12/3/24 at 4:31 p.m., R23 was lying in bed with his head of bed elevated 45 degrees. R23 had a sheet covering R23 to his waist and R23 was not wearing a shirt. R23 was unshaven with approximately a ¼ inch of beard growth. During an observation on 12/5/24 at 9:46 a.m., nursing assistant (NA)-A and NA-B entered R23's room. After putting on a gown and gloves NA-A and NA-B provided morning care assistance to R23. - At 10:08 a.m., NA-A and NA-B removed their gowns and gloves to exit R23's room, however, R23 was not offered shaving assistance or oral	F 677	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R23 was assisted with shaving and oral care. Nurse manager provided education to NA-A and NA-B. Care plan has been updated to reflect shaving and oral ADL care. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents requiring assistance with ADLs in the facility have the potential to be affected by the deficient practice. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, DON/designee will educate staff on components of ADL cares		

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F 677	Continued From page 2 cares. NA-B stated R23 was always shaved on his bath day and sometimes R23 would shave on his own, but shaving should have been offered. NA-A stated they do oral cares for R23 throughout the day because R23 had a feeding tube, but oral cares should have been offered. During an interview on 12/5/24 at 11:23 a.m., registered nurse (RN)-A stated all residents should be offered shaving and oral care assistance during cares. During an interview on 12/5/24 at 2:33 p.m., the director of nursing stated shaving and oral cares should have been offered during cares. During an interview on 12/5/24 at 4:59 p.m., the administrator stated shaving and oral cares should be offered during cares per policy. The facility policy Activities of Daily Living revised 12/4/23, identified the facility would ensure any resident who was unable to carry out activities of daily living would receive necessary services to maintain good nutrition, grooming and personal and oral hygiene.	F 677	including the Activities of Daily Living R/S, LTC policy. All nursing staff will be educated during all staff meetings, education will be completed by January 10th. DON/designee will update care plans to include ADL cares for all residents by January 10th, 2024. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, the DON/designee will audit ADL cares for 8 residents weekly, for 6 weeks to ensure compliance. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5.What is the date of completion? January 17th, 2025		
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	F 692			1/17/25

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F 692	Continued From page 3 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 interview and document review the facility failed to comprehensively assess and develop interventions to reduce or prevent continued weight loss for 1 of 1 resident (R30) reviewed for nutrition. We should also righ notification to he Dr at F580... jsut need peices of it the record showing weight losss and interviews they should notify dr. Findings include: R30's quarterly Minimum Data Set (MDS) dated 9/13/24, identified R30 had severe cognitive impairment and required moderate to maximum assist with all activities of daily living (ADLs). R30's weight was 114 pounds, Diagnoses included Alzheimer's and congestive heart failure. R30's MDS IDT Assessment dated 9/13/24, identified R30 had no difficulty with chewing or swallowing and required one person assist to eat at times. R30's height, weight, weight loss or gain and appetite was not completed on the assessment form.			F 692	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. A nutrition review/note was completed on 12/5/24 to assess the current nutrition status of resident R30. A care conference is scheduled for 1/3/25 and RD will review weights, intakes and appetite at that time. A quarterly assessment was completed on 12/9/2024. The monthly weight report has been reviewed. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified. All residents have the potential to be affected by this deficient practice. The facility has employed a full time registered and licensed dietitian who will complete a nutrition visit upon admission to identify food preferences and areas of potential nutrition concern. The RD/designee will also complete an initial assessment to determine areas of nutritional concern and		

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F 692	Continued From page 4 R30's care plan dated 12/2/24, identified R30 had a potential for weight loss. R30 was to receive a regular diet and offer point of service choice of foods. R30 was weighed weekly with the following weights documented: - 6/7/24 123 lbs. - 7/12/24=117 lbs. (a 4.88% wt loss in one month) - 8/16/24=112 lbs. - 9/20/24=110 lbs. (a 13% wt loss in three months) -10/18/24=107 lbs. -11/15/24=106 lbs. R30's medical record lacked evidence her ongoing weight loss was assessed and evaluated. There was no evidence dietary assessments were completed at admission, quarterly or with a identified decrease in weight. On 12/04/24, at 12:10 PM R30 was seated in dining room eating her lunch. R30 had eaten all her desert of cake and was trying to eat some of the lunch meal provided. R30 attempted to use her fork and poke two slices of bread and bring it to her mouth to eat. The bread was too heavy for the fork and kept dropping onto R30's lap. After several attempts, R30 picked the bread up with her hands and took two bites. Staff were in the dining room; however, did not offer R30 assistance to eat. When interviewed on 12/4/24, at 11:20 a.m. trained medical assistant (TMA)-A stated staff could not do much to get R30 to eat. It just depended on what kind of day R30 was having. Some days she would not eat a thing and other			F 692	to provide nutrition recommendations. RD/designee will complete other assessments as assigned by MDS to identify areas of nutrition concern and provide nutrition recommendations. A facility weight report will be reviewed at a minimum of monthly to help identify any residents who may be losing weight. Residents who identify as having a significant weight loss per MDS standards will be added to the Nutrition at Risk list (NAR) and be reviewed by facility RD/designee monthly until it is deemed, they are considered nutritionally stable. RD completed an audit on 12/5 to determine residents in need of a nutrition assessment and a monthly weight report was completed 12/23 to identify anyone needing to be monitored via NAR. An assessment will be completed by the end of this month for those identified as high risk. All new admissions are being reviewed. 3. What measures will be put in place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic change is sustained, the RD will create a high-risk list that will include residents who have had a significant weight loss. This list will require a monthly tracking by RD to assure residents weight status have been reviewed at a minimum of monthly. Nursing will conduct weekly weights on all residents (unless otherwise indicated). If weight is +/- 5 lbs., a re-weight will be obtained to determine accuracy. If weight is still +/- 5 lbs. after the reweight, nursing		

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F 692	Continued From page 5 days she would. During interview on 12/4/24, at 5:50 p.m. registered nurse (RN)-D stated they had a dietician on staff that the facility shared with other facilities. The dietician did a lot of her documentation on paper and not sure where any of it was. The facility just hired a new dietician in the past three or four weeks and the new dietician was reviewing all the resident charts to see where all the residents were at. RN-D stated the nursing assistants obtained resident weights weekly on their bath days. They were supposed to notify the nurse when a weight loss was noted; however, the aides did not get a good look at all the resident weights and so would not necessarily know when a weight loss occurred week to week. The nurses inputted the weights on the resident's medication administration record (MAR) and when they brought up the MAR to enter the weight, the residents previous wt was listed. The nurses were also able to click on the history and review more weights for a quick look back. RN-D was not sure why the weight los was not noted by the nurses when they entered them on the MAR weekly. The nurses should have noted the significant weight discrepancies and requested the nursing assistants to reweigh the patient. If determined accurate, the nurses should have reported to the unit manager and/or dietary. On review now, RN-D did see R30 had lost weight. During interview on 12/5/24, at 11:22 a.m. the dietician stated she monitored resident weights on a monthly basis. R30's quarterly assessment identified a 7.5% weight loss, which would have put her on high risk. When the dietician identified a high-risk resident, she monitored them at least monthly and documented a progress note for	F 692	will notify the provider and the RD. RD/designee will educate nursing staff on this process by January 10th. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, the RD conducted an audit on 12/5 and will assure all resident have an up to date nutrition assessment (within the past 3 months). Moving forward, nutrition assessments will be completed by the ARD as identified by the MDS nurse. The RD will audit 8 residents weekly for the next 6 weeks to ensure assessments are completed and weights, reweights are obtained and provider and RD notified as appropriate. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. What is the date of completion? The RD will ensure all assessments are up to date and those identified with a significant weight loss will be on the RD Nutrition at Risk list by January 17, 2025.		

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F 692	Continued From page 6 resident. Dietary assessments were required on admission and with quarterly MDS assessments. The dietician did not see a dietary assessment had been completed at all for R30, so she assessed R30 today and documented a progress note. The progress note dated 11/5/24, identified a review of R30's weights and intakes, with possible consideration of initiating a nutritional supplement. When interviewed on 12/5/24, at 11:50 a.m. RN-C stated the floor nurses were supposed to be evaluating resident weights when they entered them in to the resident's MAR. RN-C was surprised dietary assessments were not completed as one should have been done when R30 was admitted. The previous dietician was keeping an eye on resident weights and RN-C would collaborate with the dietician and discuss new interventions as well as notifying the residents primary care provider. RN-C would have also expected a dietary assessment to have been completed during R30's quarterly review in September. The previous dietician would discuss weight loss with residents or residents that should be monitored but the previous dietician did not always document her findings in the resident's charts. During interview on 12/5/24, at 4:13 p.m. RN-D stated she generally notified the physician as soon as she noticed a resident's weight was going down. The weight loss did not even have to be significant, as she just wanted to give the provider a heads up, even if it was just noticing their food intake had declined. When interviewed on 12/5/24, at 4:27 p.m. the director of nursing (DON) stated she would have			F 692			

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F 692	Continued From page 7 expected nurses to evaluate a resident's weight weekly and notify the provider for resident weight loss or gains. R30's weight loss should have been addressed during her quarterly reassessment. The facility expected residents to have dietary assessments to be completed on admission and with quarterly reassessments at the minimum. During interview with the administrator and administrator designee on 12/5/24, at 4:50 p.m. the administrator stated he would expect dietary assessments to be completed on admission and with all reassessments. The facility expected nurses to monitor resident weights and report any concerns to dietary. The facility policy Weight and Height dated 10/15/24, identified the purpose was to ensure the resident maintained acceptable parameters of nutritional status regarding weight. Based on comprehensive assessment the facility would ensure that a resident would maintain appeasable parameters of nutritional status such as body weight, unless their clinical condition demonstrated it was not possible. The licensed nurse would notify the director of food and nutrition (DFN) within 24 hours regarding any significant weight change. A significant weight change was defined as five percent in 30 days, 7.5% in 90 days and 10% in 180 days. The licensed nurse should immediately notify the medical provider of any significant weight change.	F 692			
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility	F 732		1/17/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2024
NAME OF PROVIDER OR SUPPLIER NEILSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601		
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F 732	Continued From page 8 must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was consistently posted on a	F 732			
			1. What corrective action will be accomplished for those residents found to have been affected by the deficient		

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F 732	Continued From page 9 daily basis. This had potential to affect all 72 residents, staff, and visitors who could wish to review this information. Findings include: On 12/3/24, at 6:45 a.m. adjacent to the front doors was a wall-mounted, particle board which had a paper document hung with a thumbtack titled Daily Staffing for Tuesday November 26, 2024 and identified a census of 70. The document listed staff scheduled hours per shift for each nursing job class. However, the posting was dated 11/26/24, seven days prior. When interviewed on 12/5/24, at 2:40 p.m. medical records (MR)-I stated she was responsible for the daily staffing posting. MR-I thought she had posted for the holiday weekend but must not have done so. MR-I was working on system to ensure she did not forget to post staffing daily. It was important to have the posting updated every day so staff, family and state knew how many residents were in the building and that the facility was sufficiently staffed. On 12/5/24, at 4:27 p.m. the director of nursing stated the facility expected the daily staff posting to be posted consistently every day. A joint interview with the administrator and administrator designee was conducted on 12/5/24, at 4:49 p.m. The administrator stated the staff posting was expected to be posted and updated daily. It was important as a way to communicate with family, visitors, and residents for staff ratio and census. A policy regarding the nurse staff posting was			F 732	practice? All residents had the potential to be affected by this deficient practice. Nursing staffing information will be posted daily. Administrator/designee, educated Nursing Scheduler on the Nursing Staff Daily Posting Requirements policy-LTC, on 12/12/2024. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents current and future have the potential to be affected by the deficient practice. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, nursing staffing information to be posted daily and when changes are made to the schedule. These will be posted in public facing area, accessible to the public, residents, and staff by the Nursing Scheduler, with Administrative Assistant as a backup. Scheduler will retain records in a binder for 18 months. Administrator/designee will provide education regarding Nursing staffing posting requirements including Nursing Staff Daily Posting Requirements Policy-LTC, at all staff meetings, education will be completed by January 10th. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained the Administrator/designee will audit twice		

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F 732	Continued From page 10 requested but not received.	F 732	weekly for 6 weeks that Nursing staffing is posted. Education on Nursing Staff Daily Posting Requirements. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits.		
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. §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	F 756	5. What is the date of completion? January 17th, 2025		1/17/25

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F 756	Continued From page 11 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 the consulting pharmacist (CP) identified the need for a gradual dose reduction (GDR) or medical justification of use for 1 of 5 residents (R3) reviewed for unnecessary medication. Findings include: R3's significant change Minimum Data Set (MDS) dated 10/16/24, identified R3 had severe cognitive impairment and R3 received antipsychotic medication daily. The MDS identified GDR was not attempted and there was no documentation that a GDR was contraindicated from R3's physician. Diagnoses included Alzheimer's, bipolar disorder, drug induced subacute dyskinesia (define), heart disease, and kidney failure. R3's most recent Physician Order Report dated 12/5/24, identified R3's current physician ordered medications. These included olanzapine five milligrams (mg) at bedtime for bipolar disorder with start date 3/31/22.			F 756	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The identified resident (R3) had an immediate pharmacist review of their olanzapine medication with recommendations made to the physician regarding need for GDR or documented medical justification for continued use. Resident #3 GDR was completed. Olanzapine decreased from 5mg to 2.5mg on 12/11/2024. Care plan was updated. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents receiving psychotropic medications were audited by DON on 12/10/2024 identifying residents requiring GDR evaluation or medical justification. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, the DON/designee will provide in-service education to licensed nursing		

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F 756	Continued From page 12 R3's most recent Physician Progress note dated 10/25/24, identified R3 received olanzapine 5 mg daily for a diagnosis of bipolar. All medications were reviewed; however, the olanzapine was not identified to have medical justification of continued use by the physician. R3's Pharmacy Monthly Reviews were reviewed from 12/2023 to 11/2024, with no irregularities identified. R3's medical record was reviewed and lacked evidence a GDR had been attempted or identified a medical justification for continued use and R3 was at the lowest effective does within the past calendar year of R3's received olanzapine. During interview on 12/5/24, at 3:37 p.m. registered nurse (RN)-D stated there had been no pharmacy recommendation for a gradual dose reduction on R3's olanzapine. During telephone interview on 12/5/24, at 4:00 p.m. the consultant pharmacist (CP) stated he conducted monthly medication reviews for the residents. He should have asked the physician to review R3's dose of olanzapine to ensure minimal effective dosing. The pharmacy was trying to be more assertive with their recommendations to physicians and so he should have recommended to consider a GDR on R3's medication. When interviewed on 12/5/24, at 4:35 p.m. the director of nursing (DON) stated she would have expected the provider to have been notified of the need for GDR consideration of R3's olanzapine. A GDR for psychotropic medications was expected to be addressed annually.	F 756	staff on requirements for GDR and medical justification documentation and Pharmaceutical Services LTC Policy. DON/designee will review pharmacy GDR recommendations monthly to ensure timely follow-up. All nursing staff will be educated during all staff meetings, education will be completed by January 10th. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, DON/designee will audit 100% of pharmacy recommendations monthly for 4 months. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. Additional education/interventions will be implemented based on audit findings. 5. What is the date of completion? January 17, 2025		

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F 756	Continued From page 13 A joint interview with the administrator and administrator designee on 12/5/24, at 4:50 p.m. The administrator stated he would have expected CP to have reviewed and requested a GDR on R3's medication olanzapine. It was important to review for a GDR to make sure the resident was receiving the lowest optimal dose. The facility policy Psychotropic Medications dated 12/6/23, identified a gradual dose reduction was the step wise tapering of a medication to determine whether symptoms, conditions, or risks could be managed by a lower dose or whether the medication could be discontinued. Based on comprehensive assessment of the resident, the facility must ensure residents who use psychotropic drugs receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue those drugs.	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	F 758			1/17/25

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F 758	Continued From page 14 psychotropic drugs are not given these drugs 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 observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted and/or medical justification was provided to support ongoing use of an antipsychotic medication for 1 of 5 residents (R3) reviewed for unnecessary medication use.			F 758	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 GDR was completed. Olanzapine decreased from 5mg to 2.5mg on 12/11/2024. Care plan		

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F 758	Continued From page 15 Findings include: R3's significant change Minimum Data Set (MDS) dated 10/16/24, identified R3 had severe cognitive impairment and R3 received antipsychotic medication daily. A gradual dose reduction was not attempted and there was no documentation that a GDR was contraindicated from R3's physician. R3 was dependent with most activities of daily living (ADLs) and maximum assist with mobility. Diagnoses included Alzheimer's, bipolar disorder, drug induced subacute dyskinesia (a movement disorder associated with long term exposure to certain medications) , heart disease and kidney failure. R3's care plan dated 12/2/24, identified a potential problem related to psychotropic medication use with a goal for medication effectiveness with minimal side effects and long-term goal for reduction in targeted behaviors. The care plan listed interventions to help R3 meet this goal which included to administer medication as ordered, to monitor for side effects as well as adverse behaviors and periodic pharmacist review. R3's most recent Physician Order Report dated 12/5/24, identified R3's current physician ordered medications. These included olanzapine five milligrams (mg) at bedtime for bipolar disorder started 3/31/22. R3's Physician Progress note dated 10/25/24, identified R3 received olanzapine 5 mg daily for a diagnosis of Bipolar. All medications were reviewed; however the continued daily use of	F 758	was updated. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified. Specifically, all residents receiving psychotropic medications have the potential to be affected by this deficient practice. These residents were audited on 12/10/2024 by the DON and Consultant Pharmacist to ensure gradual dose reductions have been attempted per the regulations. Physicians have been notified and documentation for reduction placed in the chart. 3. What measures will be put in place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, nursing staff will be educated by DON/designee on the Psychotropic Medication Policy and the requirements for gradual dose reduction, to notify the Manager of the unit with new psychotropic medication orders and on medication monitoring requirements, documentation expectations, communication process for recommendations and follow-up procedures for identified concerns. All nursing staff will be educated during all staff meetings, education will be completed by January 10th. DON/designee monitors for GDRs monthly and nursing completes quarterly assessments with MDS cycle. 4. How will the corrective action be		

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F 758	Continued From page 16 olanzapine was not discussed. R3's Pharmacy Monthly Reviews were reviewed from 12/2023 to 11/2024, with no irregularities identified. R3's medical record was reviewed and lacked evidence a GDR was attempted within the past calendar year R3 received olanzapine. Further, the medical record lacked evidence the ongoing use of olanzapine had been addressed by the medical provider to provide adequate medical justification. During observation on 12/03/24 at 4:46 p.m. R3 was seated in dining room at a table with another resident, eating supper. R3 was fully dressed and groomed and was eating her meal independently. No visible medication side effects were noted and R3 appeared comfortable. During interview on 12/5/24, at 3:37 p.m. registered nurse (RN)-D stated there had been no pharmacy recommendation for a gradual dose reduction on R3's olanzapine. Nursing had not requested a GDR either. It would be expected to ask R3's physician to review her psychotropic medication and consider a dose reduction. RN-D stated RN-C completed the resident psychotropic medication program and would be the one to follow when GDR's were required. During telephone interview on 12/5/24, at 4:00 p.m. the consultant pharmacist (CP) stated he conducted monthly medication reviews for the residents. He should have asked the physician to review R3's dose of olanzapine to ensure minimal effective dosing. The pharmacy was trying to be more assertive with their recommendations to	F 758	monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, the DON/designee will conduct weekly audits of 8 residents medication regimens for 6 weeks to ensure any necessary GDRs are completed timely. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. What is the date of completion? January 17, 2025		

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F 758	Continued From page 17 physicians and so he should have recommended to consider a GDR on R3's medication. During interview on 12/5/24, at 4:30 p.m. RN-C stated she was responsible to review residents' psychotropic medication use. RN-C usually relied on pharmacist recommendations to prompt her to ask the provider to consider a GDR for residents. Because the pharmacist had not made the recommendation to consider a GDR for R3, RN-C had not reviewed R3's psychotropic medication use with the provider and/or requested he consider a GDR for R3's olanzapine. RN-C did not have a process to track when resident's were due for consideration of a GDR and just relied on her chart review during her quarterly assessments to monitor for this. When interviewed on 12/5/24, at 4:35 p.m. the director of nursing (DON) stated she would have expected the provider to have been notified of the need for GDR consideration of R3's olanzapine. A GDR for psychotropic medications was expected to be addressed annually. A joint interview with the administrator and administrator designee was conducted on on 12/5/24, at 4:50 p.m. the administrator stated he would have expected nursing and/or the CP to have reviewed and requested a GDR on R3's medication olanzapine. It was important to review for a GDR to make sure the resident was receiving the lowest optimal dose. The facility policy Psychotropic Medications dated 12/6/23, identified a gradual dose reduction was the step wise tapering of a medication to determine whether symptoms, conditions, or risks could be managed by a lower dose or whether			F 758			

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F 758	Continued From page 18	F 758			
F 759 SS=D	the medication could be discontinued. Based on comprehensive assessment of the resident, the facility must ensure residents who use psychotropic drugs receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue those drugs. Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders and/or manufacturer guidelines for 2 of 6 residents (R23, R54) observed to receive medication during the survey. This resulted in a facility medication administration error rate of 6.9 percent (%). Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/5/24, identified R23 was cognitively intact and included a had diagnosis of hemiplegia (one side paralysis or weakness) due to a history of a stroke. R23 exhibited pain and received scheduled and as needed pain medications. R23's Physician Order Report dated 12/8/23 identified R23 received Voltaren Arthritis Pain (diclofenac sodium) (an anti-inflammatory topical	F 759			1/17/25
			1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? For R23 and R54: " DON Reviewed R23 & R54 med orders 12/6/2024. " DON completed med pass observations for the two nurses (RN-B & RN-E) involved in errors on 12/11/2024 and 12/17/2024. " Laminated Voltaren gel dosing cards were made available to all med carts. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents receiving medications have the potential to be impacted by this deficient practice. 3. What measures will be put into place,		

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F 759	Continued From page 19 pain medication) gel 1%. Apply 4 gram (g) to affected area 4 times a day for back pain. During an observation on 12/4/24 at 6:52 p.m., registered nurse (RN)-B took R23's tube of Voltaren gel and apply approximately 1 inch to RN-B's gloved hand and then applied it to R23's left thigh/knee where R23 was complaining of discomfort. - At 7:11 p.m., RN-B stated R23's dose of Voltaren gel was "3 mg", but RN-B had "no idea" how to know the correct dose had been dispensed. RN-B then stated there was a dosing chart in the box. However, R23's Voltaren gel had been removed from the box and the box and/or dosing chart was no longer available. RN-B stated Voltaren gel could be hard on a person's kidneys if they were given too much. During an interview on 12/5/24 at 2:49 p.m., the director of nursing (DON) stated staff were expected to measure Voltaren gel per the manufacturer's instructions and apply the correct dosage because it's different dosages for different concerns. The Voltaren Gel Manufacturer's Instructions for Use dated 2023, instructed to use the provided dosing card to apply the following amounts: - Upper body areas (hand, wrist, elbow): 2.25 inches - Lower body areas (foot, ankle, knee): 4.5 inches			F 759	or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained All licensed nurses will receive education from DON/designee on proper medication administration procedures including the Policy, Medication Administration-Including Scheduling and Medication Aids. All nursing staff will be educated during all staff meetings, education will be completed by January 10th. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, the DON/designee will conduct weekly medication pass observations on 8 residents for 6 weeks. Audits will include error rate calculations. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. What is the date of completion? January 17, 2024		

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F 759	Continued From page 21 When interviewed on 12/5/24 at 9:05 a.m. RN-E stated it was important to check medication labels and cross check the labels with the resident's MAR. This was done to ensure to administer the correct ordered dose. RN-E stated she had not crossed checked the bottle of D3 with R54's MAR and that was something she should have done. When interviewed on 12/5/24, at 4:24 p.m. the DON stated she would expect nurses to check prescription bottle labels and compare the bottle with the resident's MAR and to administer medications as ordered. A oint interview with the administrator and administrator designee on 12/5/24, at 4:49 p.m. The administrator stated he would expect nurses to go through the rights of medication administrations and administer all medications accordingly and as ordered. The facility policy Medication Administration dated 5/21/24, identified all medications were administered to residents according to the six rights: right medication, right dose, right resident, right route, right time and right documentation. Before medication administration staff were to perform three checks. Read the label on medication container and compare with the resident's MAR when removing the medication from the supply drawer, when placing the medication in the resident's medication cup and just before administering the medication. The facility policy Medication: Administration Including Scheduling and Medication Aides revised 5/21/24, directed staff to follow the "Six Rights": right medication, right dose, right			F 759			

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F 759	Continued From page 22	F 759			
F 803 SS=D	resident, right route, right time and right documentation. However, the policy failed to identify how staff were to administer a topical medication per manufacturer's instructions Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the correct diet texture was served to 1 of 5 residents (R38)	F 803			1/17/25
			1. What corrective action will be accomplished for those residents found to have been affected by the deficient		

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F 803	Continued From page 23 reviewed for pressure ulcers; and failed to accommodate dietary preferences of 1 of 1 resident (R58) reviewed for food choices. Findings include: R38 R38's quarterly MDS dated 9/24/24, identified R38 had severe cognitive impairment and a diagnosis of Alzheimer's disease. R38 was dependent on staff for all care activities. R38's care plan revised 12/26/23, identified R23 required a mechanically altered diet related to chewing and swallowing abilities. Staff were directed to encourage oral intake of food and fluids. R38's dietary order dated 8/23/24, identified R38 required a minced and moist texture (a minced and moist diet consists of soft and moist foods that are easy to chew and swallow. The food was minced or mashed before serving, with no big lumps, and requires little or no biting. Lumps should be no more than 4 millimeter (mm) in size for adults. Foods in this diet should be easy to form into a ball and must not contain any hard lumps) with thin liquids without a straw. R38's In-Patient Speech Therapy Clinical Swallow Evaluation Initial Evaluation dated 7/22/24, identified R23's food recommendations were a level 6 Soft & Bite Sized (NDD3) (This diet consists of many ordinary foods that are soft and easy to chew. Foods can be eaten with a fork or spoon. Foods are soft and fork-tender; they are moist, but there is no separate thin liquid present. Solid food pieces are 8mm or smaller for children	F 803	practice? Regarding Resident R38 minced and moist diet, staff member was educated regarding use of food processor and adding sauce/liquid. Resident R58 with a vegetarian diet, dietary staff were shown where vegetarian options were. Education provided during all staff dietary meeting on 12/19/2024. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be impacted by this deficient practice. Dietary staff have been educated on accommodating diet orders, preferences, and religious and cultural needs. Dietary staff were trained on 12-19-2024 by Dietary Manager/designee. Mandatory IDDSI training is scheduled for January 6th. Vegetarian options have been added to the always available menu. New dietary staff will receive IDDSI training from the Dietary Manager/designee upon hire. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? When did this occur and who completed it? To ensure systemic changes are sustained, dietary staff were trained on 12-19-2024 by Dietary Manager/designee on their responsibilities in serving residents, accommodating diet orders, preferences, and addressing religious, cultural, and ethnic needs. The training		

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F 803	Continued From page 24 or 15mm (about 1-2 inch) for adults) diet and thin liquids. Guidelines: alternate one bite solid with one sip liquid; assist with feeding; R23 was to sit fully upright for all oral intakes; reduce environmental distractions during oral intake; and provide frequent, thorough oral cares (slow rate, small bites/sips). During a meal service observation on 12/4/24 at 11:26 a.m., dietary aide (DA)-A placed pork on a plate and diced the pork with a fork and spoon. No sauce was added to the pork. DA-A then placed steamed broccoli and hot potato salad on R38's plate and served the meal to R38. R38's pork with stringy, with pieces approximately larger than 1 inch and the broccoli nor hot potato salad were minced. - At 12:13 p.m., DA-A provided a printed stack of dietary orders and stated staff went by those to determine what residents needed for meals. For example, some residents needed minced and moist. DA-A stated minced and moist meant staff "chop" it up and put either a sauce or a gravy on it. DA-A did not put a sauce or a gravy on R38's pork, but stated DA-A was dependent on the kitchen for what was available, and the kitchen did not send a sauce or gravy for this meal. Nursing assistant (NA)-A was observed to assist R38 with his meal. R38 did cough while eating but had no signs or symptoms of choking. R38's medical record did not identify R38 had any choking episodes in the past. During an interview with the facilities manager (F)-A and DA-B on 12/5/24 at 10:22 a.m., DA-B stated preparation of the minced and moist diets would require the use of a food processor and some type of liquid to make the food moist. The			F 803	covered diet spreadsheet books, alternate menus, and the International Dysphagia Diet Standardized Initiative (IDDSI). Reference books are available in each kitchen. A hands-on IDDSI training session with speech therapy is scheduled for January 6th, 2025. The dietary orientation includes IDDSI training, with hands-on sessions for all new staff conducted by the Dietary Manager/designee. An annual in-service with speech therapy will also be implemented to demonstrate the IDDSI process. 4. How will the corrective action be monitored to ensure the deficient practice in being corrected and will not recur? To ensure Dietary Manager/designee will audit 8 residents weekly for 6 weeks to ensure residents receive proper diet. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. Completion Date January 17th, 2025.		

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F 803	Continued From page 25 kitchenettes had chicken or beef stock and homemakers would use that. During an interview on 12/5/24 at 11:09 a.m., the registered dietitian (RD) stated a minced and moist diet was a dysphagia (difficulty swallowing) diet, a step before a pureed diet. R38's food should have been pulse in the food processor and a liquid added to it, hence the moist. Not doing this could potentially increase the risk of a choking incident and/or aspiration. The RD stated R38's meal should have been prepped in the kitchenette and presented to R38 as prescribed. During an interview on 12/5/24 at 11:32 a.m., registered nurse (RN)-A stated she expected staff to be aware of resident dietary orders and to send the meal back if incorrect to prevent a risk for choking or aspiration. During an interview on 12/5/24 at 2:48 p.m., the director of nursing (DON) stated she expected nursing staff to report an incorrect meal type to dietary staff and request the correct meal. Additionally, the DON stated dietary staff had a list of prescribed resident diets and the DON expected dietary staff to follow that list during meal service to prevent the risk for choking or aspiration. R58 R58's admission Minimum Data Set (MDS) dated 10/31/24, identified R58 had a severe cognitive impairment and had diagnoses that included Type 2 diabetes. R58's care plan dated 11/18/24, identified R58 was at nutrition risk related to use of multiple			F 803			

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F 803	Continued From page 26 medications, R58 was an ovo pescetarian (a dietary practice in which seafood and eggs were consumed in an otherwise vegetarian diet), and R58's weight was below his ideal body weight. Interventions included: 1. Regular diet per order - ovo pescatarian (will eat eggs, dairy and fish) 2. Monitor weight, labs, and intakes 3. Encourage fluids 4. Meals to the area dining room per his preference 5. Assist with meal set up as needed 6. Request addition of a dietary supplement to help meet his protein needs related to R58 did not eat meat 7. R58 liked cottage cheese, yogurt, peanut butter, eggs, chocolate or white milk, all vegetables, and all fruits 8. RD to make changes to his nutrition plan as needed. Additionally, R58's care plan identified R58 was hearing impaired. Staff were directed to speak slowly, clearly, explain and allow participation in all tasks and procedures. R58's physician order dated 10/25/24, directed to provide a regular vegetarian diet. Special instructions: R58 liked eggs and hashbrowns, wheat toast, fruits and vegetables and fish. R58's physician order dated 11/21/24, directed to provide 8 ounces (oz) of a dietary supplement around 3:00 pm. to help meet R58's protein needs. R58's nutrition note dated 11/27/24, identified R58 remained on a regular diet and was noted to be a vegetarian. Family member (FM)-A felt R58's appetite/intakes had decreased lately.	F 803			

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F 803	Continued From page 27 R58's current weight was 149.1 pounds (lbs) on 11/26/24 and was stable in comparison to his admission weight. Order for a dietary supplement was received and was being provided. 100% intakes noted the past 3 days. FM-A voiced concern that R58 was not receiving adequate protein. FM-A was aware of options that could be offered with meals that R58 liked in place of the meat options but also knew R58 would not request any additional items. Discussed option of FM-A filling out a menu for R58 that would include foods of preference and FM-A agreed with this plan. Informed neighborhood foodservice staff of this request and they indicated they would post the menu on the unit to assure everyone was aware of R58's preferences. Would continue to monitor weight, labs, and intakes. Follow for changes. R58's Woodsedge Senior Living Menus undated, identified the following meal selections for R58: - 12/4/24 lunch: seasoned broccoli, wheat roll and cheese with banana cream pie. - 12/4/24 supper: garden rice seasoned zucchini, wheat bread, mandarin oranges, and cottage cheese with peaches. During an interview on 12/3/24 at 8:30 a.m., FM-A stated R58 was a vegetarian and that must be something new for the facility. FM-A had provided a list of food that R58 like to eat, but R58 did not always received those types of food. For example, when the facility had a chicken sandwich and carrots, the dietary staff removed the meat and gave R58 a bun and carrots. Dietary staff did not know what to provide. "This must all be new for them." During a meal service observation on 12/4/24 at	F 803			

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F 803	Continued From page 28 11:26 a.m., DA-A asked R58 what he wanted to eat. R58 stared at DA-A and did not respond. - At 11:51 a.m., DA-A placed a scoop of hot potato salad and a scoop of broccoli onto a plate with a glass of milk and served the meal to R58. During an interview on 12/4/24 at 12:13 p.m., DA-A stated he always used a black scoop for all side dishes. "You just look at the portion size and know how much to give." DA-A pulled out a stack of printed resident dietary orders and stated it showed what each resident needed. However, DA-A did not look at the list while serving. DA-A stated, for R58, staff gave him vegetables. If R58 did not want the vegetables, DA-A could call the kitchen and ask what was available for R58. However, R58 had not eaten his meal and DA-A did not attempt to provide another meal for R58. DA-A then stated staff never gave R58 "protein, only vegetables." During an observation on 12/4/24 at 4:06 p.m., R58 was sitting in his wheelchair at the dining room table with FM-A. R58 was served a grilled cheese sandwich with a peeled mandarin orange. During an interview on 12/4/24 at 6:43 p.m., DA-C stated R58 was a vegetarian and did not want to eat meat. However, staff needed to give R58 something more filling than just vegetables. FM-A was good about telling staff what to give R58. Usually, DA-C made a grilled cheese sandwich and there was always some fruit available. Also, R58 like to eat dessert or some bread. "Something that I know will fill R58 up for the night." During an interview on 12/5/24 at 11:13 a.m., the RD stated the facility had brought in the	F 803			

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F 803	Continued From page 29 assistance of FM-A regarding R58's meal choices. FM-A made a menu selection for R58 that was posted in the kitchen. R58 liked grilled cheese sandwiches, cottage cheese, yogurt, eggs, and fish. FM-A brought nuts and those types of things for R58 as well. The RD stated staff should follow R58's food choices and ensure R58 received adequate nutrition. During an interview on 12/5/24 at 2:40 p.m., the DON stated staff were expected to provide all residents with their dietary needs as ordered. During an interview on 12/5/24 at 4:59 p.m., the administrator stated the dietary staff were expected to follow dietary menus and choices selected to allow resident rights and to prevent choking and/or aspiration. The facility policy Diet Orders revised 9/11/24, identified the facility would provide food and nutrition to encourage adequate nutrition intake for residents by promoting a liberalized diet approach while maintaining compliance with physician-ordered diets and accepted standards of menu planning. Procedure: 1. A list of diets an menu extensions available in the location is maintained with food and nutrition services and given to the nursing department. The list of diets available may vary from location to location based on community standards and practices. 2. The location's approved diet manual and the Society Menu Program Standards can be used as a guide in developing the list of diets available in the location. The list reflects liberalization of diets as recommended in current practice. Rehabilitation/skilled care ocations and assisted	F 803			

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F 803	Continued From page 30 living locations that use the Society Menu Program can generate a custom diet spreadsheet. Diets and Nutritional Supplements is used for maintaining the list of diets at rehabilitation/skilled care locations. 4. Employees ensure that residents receive the most liberal approach their condition can tolerate. Assess the risk/benefit of the liberalized approach. Stricter diets should only be considered based on resident outcome goals. a. Stricter diets are not shown to improve outcomes in long term care. b. Stricter diets may be required for some residents in the post-acute care setting (e.g., congestive heart failure, insulin-dependent diabetes). 5. There should not be "diet as tolerated" or "thickened liquids as tolerated" orders. 6. All orders for thickened liquids should identify texture: 1 Slightly Thick 2 Mildly Thick 3 Moderately Thick 4 Extremely Thick 7. Physician's orders must include the name of the diet, including any therapeutic restrictions and texture alterations. a. Revised diet orders are complete and include any previous diet orders that are to remain. 8. When a physician requests a diet order that is required for the plan of care but is not on the list of diets, location employees contact the dietitian for assistance with determining the course of action. a. The dietitian writes the initial menu extension or approves such menu extension. The dietitian evaluates the menu extension using the menu planning guides in the approved diet manual or another reputable source.			F 803			

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NAME OF PROVIDER OR SUPPLIER NEILSON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601			
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F 803	Continued From page 31 9. If an individualized meal pan developed for any resident is in conflict with the current diet order, the director of food and nutrition services (DFN) requests a change in the diet order before implementing the meal plan. If an individualized meal plan is within the parameters for the physician ordered diet, no action is required prior to implementation. 10. When a new diet order is received or an existing order is changed, food and nutrition services is notified, a. Rehabilitation/skilled care: The Diet Notification Form is completed and given to the food and nutrition department and other departments as needed. Any diets not listed can be written under "Other" using the appropriate terminology from the approved diet manual. Any orders for enteral (tube) feeding, medical nutritional supplements and any special requests are also communicated on the form. 11. All pertinent records including diet lists, care plans, medication sheets, charts and diet tray cards must be updated with the revised diet order. 12. A roster/list of physician-ordered diets is maintained in the food and nutrition department. The diet list report from Society-approved software is acceptable for this purpose. 13. On a monthly basis, the diet roster should be compared to the physician's orders, diet tray cards and menu extensions to monitor compliance with the physician's diet order. If a discrepancy is found, correct it and check the care plan for accuracy. Update and/or correct the care plan as needed. 14. The DFN, dietitian or dietetic technician (NDTR) provides in-service education to employees on the diets ordered in the location as needed.			F 803			

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F 812 F 812 SS=F	Continued From page 32 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary conditions of kitchen equipment and ensure hairnets were worn when preparing resident meals, to prevent the spread of food born illness. This had the potential to affect 69 out of 69 residents that received food out of the kitchen or kitchenette. Findings include: Mixer: During an initial tour of the main kitchen on 12/3/24 at 7:02 a.m., a large industrial mixer was	F 812 F 812			1/17/25

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F 812	Continued From page 33 on the counter. The underside of the mixer head, which sat over the mixing bowl, was coated in a tan colored food debris on the underside. There was a white dust covering the mixing bowl arms. During an observation of the large industrial mixer on 12/5/24 at 11:20 a.m., the underside of the mixer head continued to be coated with a tan colored food debris. DA-B stated, "that's bad, really bad" and equipment should be thoroughly cleaned after every use to prevent contamination of food. During an interview on 12/5/24 at 4:59 p.m., the administrator stated staff were expected to clean kitchen equipment after every use to prevent contamination of food and to prevent foodborne illness. Ice and Water Dispenser: During an observation on 12/4/24 at 11:26 a.m., the Huckleberry units kitchenette's ice and water dispenser was dribbling water. Inside the clear acrylic spout was a black colored tar-like substance stuck to the ridges and corners. DA-A stated he did not how often the ice and water dispenser were cleaned because it was done by the maintenance department. DA-A stated he had no idea how long the black colored substance was in the spout and stated he was only responsible for cleaning the drip tray. During an interview with the facilities manager (F)-A and DA-B on 12/5/24 at 10:20 a.m., F-A stated the ice and water dispensers were cleaned by a contracted service quarterly; however, the front of the machine, including the spout was cleaned by dietary staff. The spout was	F 812	recur? To ensure systemic changes are sustained, a meeting was held for all dietary staff on 12-19-2024. Dietary Manager educated staff regarding kitchen cleanliness and sanitation, proper procedures on cleaning mixers, ice and water dispensers and documenting the process to ensure it is completed. Employee Hygiene and Dress Code policy was reviewed, including hairnet usage. 4. How will the corrective action be monitored to ensure the deficient practice in being corrected and will not recur? To ensure compliance is maintained, Dietary manager/designee to round on daily documentation and cleanliness. Audits will be completed on water dispensers, hair net usage and kitchen cleanliness. Audits will be completed for 6 weeks to ensure compliance.. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. Completion Date 01/17/2025		

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F 812	Continued From page 34 removable and should be cleaned at least every couple of days. DA-B stated she was unaware the spout was removable and stated dietary staff would need education how to clean the ice and water dispenser. During an interview on 12/5/24 at 4:59 p.m., the administrator stated she expected a policy/procedure directing cleaning of the ice and water dispenser and staff education so that everyone was aware to complete the task to prevent transmission of foodborne illness. The facility policy Sanitation for Hosp and NH Kitchens revised 1/30/24, identified the facility would ensure a sanitary environment for storage of food in the floor kitchens by Weekly; an assigned NFS employee will clear all kitchenettes including a weekly sanitation checklist of the following: - Removing any outdated foods and ensuring all foods are labeled and dated. - Cleaning and sanitizing refrigerators, including freezer compartment. - Cleaning and sanitizing microwave. - Straightening and sanitizing cupboards, drawers, and counter tops. - Restocking assigned items. - Coffee / hot water machine is cleaned per vendor recommendation. - Food belonging to a specific patient or resident will meet the same requirements as listed above. However, the policy failed to identify the cleaning procedure of the mixer and/or the ice and water dispenser. Hairnets During the initial tour of the main kitchen on	F 812			

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F 812	Continued From page 35 12/3/24 at 7:02 a.m., dietary aide (DA)-D was wearing a baseball cap with her long hair not fully contained under the cap and was not wearing a hairnet. DA-D was preparing bacon and potatoes. DA-D went into the bathroom and put her hair in a bun and covered with a hairnet and stated, "every morning I put my hair up in a bun and the one time I don't of course state shows up." DA-D proceeded to pack up the bacon and potatoes to take the units for breakfast service. During an interview with the facilities manager (F)-A and DA-B on 12/5/24 at 10:22 a.m., DA-B stated staff were expected to wear a hairnet when preparing food to prevent foodborne illness. On 12/4/24, at 4:03 p.m. a brief tour of the kitchenette located on Elderberry Neighborhood was conducted. Dietary aide (DA)-E was preparing the area to begin supper service and had placed the supper food in the unit's steam tables. DA-E had short black hair and was not wearing a hair net to cover his hair. DA-E immediately took a hairnet from the container at the kitchenette entrance and put it on. DA-E stated he usually wore a hairnet and had just forgotten. The facility policy Employee Hygiene and Dress revised 6/12/24, identified hairnets or hair restraints and beard nets or beard restraints are used when cooking, preparing, assembling food or ingredients. This includes dish rooms and			F 812			

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F 812	Continued From page 36 storage areas. Hair is to be covered completely.			F 812			
F 880 SS=F	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, 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			F 880			1/17/25

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F 880	Continued From page 37 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 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	F 880	. What corrective action will be		

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F 880	Continued From page 38 review, the facility failed to develop and implement an infection control surveillance plan for identifying, tracking, monitoring for 2 of 2 residents (R277, R278) who had diarrhea; and failed to ensure all resident potential infection symptoms were tracked along with providing a monthly written analysis of infections; and failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 residents (R10, R2) with wound care and indwelling medical devices; and failed to ensure staff utilized masks in the appropriate manner on 1 of 3 units affected by COVID-19 in an effort to reduce the potential spread of illness. This had the potential to affect 71 residents residing in the facility. Findings include: SURVEILANCE/ ANALYSIS: R277's admission Minimum Data Set (MDS) dated 11/28/24, identified no cognitive impairment. R277's diagnosis included UTI. R277's progress note dated 11/22/24, identified was having loose stools. During an interview on 12/5/24 at 4:46 p.m., registered nurse (RN)-B stated R277 had been having loose stools since the weekend and just received an order for loperamide (a medication used to treat various forms of diarrhea). The consistency of a bowel movement should be documented by either the nursing assistant or the nurse. It was not a required thing but should have been documented. Information regarding loose stools should have been reported to the day nurse. Then the day nurse would have reported them to the infection control nurse.			F 880	accomplished for those residents found to have been affected by the deficient practice? Resident R277 – placed on GI contact precautions, tested for c-diff, and started on antibiotics. Resident R278 – diarrhea resolved as of 12/6/2024 – no further testing ordered by provider, discharged home Residents R10 and R2 – Nurse Manager on affected unit immediately educated NA-A and NA-C on proper PPE usage for EBP residents. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents in the facility have the potential to be affected by the deficient practice. DON/designee audited all residents for diarrhea on 12/6/2024. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? • Infectious disease symptom tracker initiated in each neighborhood that includes daily symptom tracking as well as prompts to isolate and initiate precautions as appropriate, document, and report to provider and infection prevention nurse. • Infection Prevention nurse/designee will review and analyze tracker daily to ensure all symptoms were documented, reported, and acted upon appropriately and timely. • Infection Prevention nurse to track all symptoms to identify possible communicable diseases or infections. All findings will be reported to QAPI along		

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F 880	Continued From page 39 R278's admission MDS dated 11/27/24, identified no cognitive impairment. R278 was continent of bowel and bladder. R278's diagnoses identified sepsis (severe infection in the body), UTI, and respiratory failure. R278's progress notes and bowel documentation lacked any identification of the consistency of bowel movements During an interview on 12/5/24 at 4:50 p.m., licensed practical nurse (LPN)-B (the infection preventionist) stated R278 was seen by a provider in the facility and ordered a lab test for C. Diff. due to R278 having loose stools. She was surprised because she was unaware of R278 had loose stools and was not documented. Further, LPN-B was not aware R277 was having loose stools the past few days. Both residents resided on the same unit. The facility provided monthly infection control (line list) the form identified the unit, resident name, type of infection, date of onset, testing performed and results, antibiotic or antimicrobial used, length of therapy, if criteria was met and time out was performed, and if it was facility acquired or community acquired. - The monthly infection control log (line list) for September 2024, identified six residents with pneumonia, four residents with a urinary tract infection (UTI), two residents with a tooth infection, two residents with a skin infection, one resident with a blood infection, one resident with a lower respiratory infection, one resident received a prophylactic antibiotic, three residents from previous month and carried forward but did	F 880	with a monthly analysis of confirmed infections. - The DON/designee will educate all staff regarding Enhanced Barrier Precautions, our Standard and Transmission Based Precautions Policy, source-control masking based on our COVID-19 outbreak management policies and procedures, and our Infection Control Surveillance plan and policies and new infectious disease symptom tracker. All staff will be educated during all staff meetings, and education will be completed by January 10th. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? - To ensure compliance is maintained, Infection Prevention nurse or designee will audit symptom monitoring, reporting, and tracking by reviewing neighborhood symptom trackers daily and by interviewing 8 staff weekly for 6 weeks for potential resident symptoms to ensure they were acted on appropriately. - To ensure compliance is maintained, the Infection Prevention nurse or designee will audit staff usage of EBP PPE usage on 8 staff weekly for 6 weeks. - To ensure compliance is maintained, Infection Prevention nurse or designee with audit correct mask usage for 8 staff weekly for 6 weeks. - Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits.		

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F 880	Continued From page 40 not identify reason for antibiotic. All the residents were treated with an antibiotic. It identified eight residents with COVID and one was treated with an antimicrobial. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility failed provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection related to the COVID, pneumonia, or UTIs. The monthly infection control log (line list) for October 2024, identified eight residents with a UTI, three with osteomyelitis (a serious infection in the bone), two with pneumonia, one resident with clostridioides difficile (C. Diff) (a bacteria that causes diarrhea and colitis (an inflammation of the colon) and can be life-threatening), one resident with a lower respiratory infection. All the residents were treated with an antibiotic. It identified one resident with COVID and was treated with an antimicrobial. There were no listed infections or resident infection symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility failed to provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection related to UTIs, or osteomyelitis. The monthly infection control log (line list) for November 2024, identified nine residents with a UTI, two with a skin infection, two with a COPD exacerbation, one with pneumonia, 4 on prophylaxis. All the residents were treated with an antibiotic. It identified three residents with COVID and were treated with an antimicrobial. There were no listed infections or resident infection	F 880	4. What is the date of completion? January 17th, 2024		

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F 880	Continued From page 41 symptoms which were not treated with antibiotics (i.e. common cold symptoms, viral infections). The facility failed to provide an analysis of the infections to include patterns or what interventions were implemented to reduce incidences of further infection including UTI's, respiratory, skin infections and COVID. The monthly infection control log (line list) for December 2024 was requested, but not received. During an interview on 12/5/24 at 4:50 p.m., (LPN)-B stated she did the infection prevention surveillance on a spreadsheet form. LPN-B tracked antibiotic usage and tracked COVID on the same form. There was a different spread sheet she would track high risk symptoms on, (a copy of the spread sheet was requested but not received). LPN-B got information daily from the day nurses on each of the units, by reading progress notes and looking for new antibiotics prescribed. LPN-B would have expected staff would chart pertinent information regarding resident showing sign or symptoms of illness. Which included fever, nausea, vomiting, diarrhea, cough. There were not any high-risk symptoms happening at this time and she was not tracking anything. It was important to monitor for loose stools when resident had been on antibiotics because they were at a higher risk to develop C. Diff. which is very contagious. LPN-B was not aware R277 was having loose stools the past few days and would have expected staff to share the information with her. She did not know of the residents who had loose stools and was not monitoring them. During an interview on 12/5/24, at 5:31 p.m., the director of nursing (DON) stated she would have	F 880			

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F 880	Continued From page 42 expected staff to document signs and symptoms of infection and for the infection preventionist to have followed up to ensure health of all residents. The facility's Surveillance policy dated 9/3/24 identified surveillance is designed to identify and report evidence of infection. Collecting, documenting and analyzing data will be done by the infection preventionist or the designated staff member. EBP: R10's significant change MDS dated 11/4/24, identified R10 was cognitively intact and had diagnoses that included quadriplegia, type 2 diabetes, and neuromuscular dysfunction of bladder. R10 had a stage 4 pressure ulcer, a colostomy and an indwelling catheter and was receiving intravenous medications. R10's care plan revised 11/19/24, identified R10 had an infection to a sacral wound (a region located at the base of the spine in the pelvic area) wound and had a need for enhanced barrier precautions due to indwelling urinary catheter and chronic wound. The following interventions were identified: - Post signage on door or wall outside of resident room - PPE available immediately outside of resident room. Staff to wash their hands upon entering and leaving room. PPE to be doffed prior to leaving resident room. - Provide education to resident or representative on the need for and duration of EBP. Encourage resident or representative to discuss feelings			F 880			

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F 880	Continued From page 43 reoardino EBP. - Physical and occupational therapy to use EBP in common areas when therapy activities have risk for repeated contact, including but not limited to transfer practice, ambulation, balance training, toileting practice. - Standard precautions along with gown and gloves during high contact resident care activities such as: dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, repositioning, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.) and wound care (any skin opening requiring a dressing). PPE to be doffed prior to exiting room. R2's quarterly MDS dated 9/30/24, identified R2 had a severe cognitive impairment and diagnoses that included traumatic brain injury and quadriplegia. R2 used a feeding tube for all his nutritional needs. R2's care plan revised 10/16/24, identified R2 had a need for enhanced barrier precautions do to having a feeding tube. The following interventions were identified: - Post signage on door or wall outside of resident room - PPE available immediately outside of resident room. Staff to wash their hands upon entering and leaving room. PPE to be doffed prior to leaving resident room. - Provide education to resident or representative on the need for and duration of EBP. Encourage resident or representative to discuss feelings reoardino EBP. - Physical and occupational therapy to use EBP in common areas when therapy activities have risk for repeated contact, including but not limited to			F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2024
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F 880	Continued From page 44 transfer practice, ambulation, balance training, toileting practice. - Standard precautions along with gown and gloves during high contact resident care activities such as: dressing bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, repositioning, device care or use (central line, urinary catheter, feeding tube, tracheostomy, etc.) and wound care (any skin opening requiring a dressing). PPE to be doffed prior to exiting room. During an observation on 12/4/24 at 10:39 a.m., there was an enhanced barrier sign and a plastic three drawer cart containing gowns outside R10's door. Nursing assistant (NA)-C entered R10's room without donning a gown and provided R10 with assistance for morning cares, emptied R10's colostomy bag into a graduate lined with a trash bag, provided catheter care came into close contact with R10 and R10's bed, wheelchair and belongings. - At 10:41 a.m., NA-C picked up R10's ceiling lift sling from the floor and placed the sling under R10. - At 10:56 a.m., NA-C provided R10 his call light and left the room. - At 10:58 a.m., NA-C returned to the room accompanied by NA-A. Neither NA-C or NA-A donned a gown and assisted to transfer R10 into his wheelchair via a full body mechanical lift. NA-C and NA-A came into close contact with R10 and R10's bed and wheelchair. - At 11:10 a.m., NA-C and NA-A left the room and went to R2's room. There was a enhanced barrier precautions sign and a plastic three drawer cart containing gowns outside R2's door. Neither NA-C or NA-A donned a gown. NA-C and NA-A assisted with repositioning R2 and NA-C left the	F 880			

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

PRINTED: 01/03/2025
FORM APPROVED
OMB NO. 0938-0391

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F 880	Continued From page 45 room while NA-A assisted R2 with his hand/arm braces. - At 11:12 am., NA-C pointed to the enhanced barrier precautions sign hanging outside R2's door and stated whenever staff went into a room with that sign and there was a cart available, staff needed to put on a gown and gloves during cares. Staff always donned a gown and gloves every time, however, NA-C stated she "must have forgot" to donn a gown prior to entering R10 or R2's room. - At 11:16 a.m., NA-A pointed to the enhanced barrier sign outside R2's door and stated the only time staff needed to wear a gown was when staff changed R2's incontinent brief or "something where you're going to have contact with bodily fluids." NA-A did not donn a gown prior to going into R10 or R2's room because "I didn't get into anything like that." However, NA-A then pointed to the sign again and stated "according to that, evidently you need to wear a gown for everything." During an interview on 12/5/24 at 8:09 a.m., licensed practical nurse (LPN)-A stated, when a resident was placed on enhanced barrier precautions, staff were expected to wear a gown and gloves whenever they're going to be in contact with the residnet; like cares. Anything where they're going to touch the resident. During an interview on 12/5/24 at 11:34 a.m., registered nurse (RN)-A stated staff were expected to follow enhanced barrier precautions guidelines to the prevent the potential transmision of microorganisms. During an interview on 12/5/24 at 2:35 p.m., the director of nursing (DON) stated staff were			F 880			

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F 880	Continued From page 46 expected to follow enhanced barrier precautions guidelines for any resident with an invasive device, wound care and/or an multi-drug resistant organism (MDRO). Gowns and gloves were expected any time a resident needed care that required contact with the resident. The facility provided Multidrug-Resistant Organisms, MRSA VRE CRE and ESBL policy revised 4/12/24, identified Enhanced Barrier Precautions would be used for all residents with any of the following: - wounds an/or indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status - infection or colonization with a noval or targeted MDRO when Contact Precautions did not apply Facilities may consider applying Enhanced Barrier Precautions to residents infected or colonized with other epidemiologically important MDROs based on facility policy The personal protective equipment (PPE) would be used during high contact resident care activities: - dressing - bathing/showering - transferring - providing hygiene - changing linens - changing briefs or assisting with toileting - device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator) - wound care: any skin opening requiring a dressing The policy identified the PPE required included gown and glove prior to high contact care activity (change PPE before caring for another resident) (Face protection may also be needed if			F 880			

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F 880	Continued From page 47 performing activity with risk of splash or spray) MASKS: On 12/3/24 at 7:03 a.m., registered nurse (RN)-B stated there was one staff member and one resident that tested positive for COVID over the weekend. The facility tested the units where the staff member worked including Mulberry, Huckleberry and Strawberry. The three units were in outbreak status due to the positive staff member. All residents on these units tested negative on 12/1/24. One resident was positive prior to admission 12/1/24. An email to all facility staff from licensed practical nurse (LPN)-B dated 11/18/24, identified all neighborhoods/units remained in COVID outbreak status due to continued staff and resident positive cases and identified all staff were required to wear a mask in all neighborhoods. During interview on 12/4/24 at 11:36 a.m., LPN-B stated the facility was currently in a COVID outbreak due to multiple staff and a resident being positive. The most recent positive result was a staff member who completed a home test over the past weekend. During observation on 12/5/24 at 9:23 a.m.,			F 880			

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F 880	Continued From page 48 dietary aide (DA)-A was in the Huckleberry unit kitchenette pouring drinks and dishing food onto a plate for a resident. DA-A's face mask was under the chin and not covering the mouth or nose. DA-A proceeded to carry the drink and plate of food to the table where residents were seated, returned to the kitchenette, poured a cup of liquid from the dispenser and carried the cup to the resident. DA-A was not observed to pull the mask over nose prior to dishing up or delivering the food, or upon returning to the kitchenette. On 12/5/24 at 9:25 a.m., DA-A was standing in the kitchenette and as state surveyor (SA) approached, DA-A pulled the mask over his mouth and nose. DA-A stated staff were supposed to wear face masks that securely covered the mouth and nose all the times including during prepping, cooking, dishing, and serving food, and when in close proximity to residents. DA-A stated he worked on all units in the facility and was aware that three of the units were required to wear PPE because of a COVID outbreak. DA-A stated he recently worked on Mulberry, which was COVID positive at the time, but did not answer when asked the date he last worked on Mulberry. DA-A stated staff were to wear face masks to prevent the spread of germs to residents, themselves, and other staff. DA-A stated he worked on all units prepping, cooking and serving food to the residents. Further, DA-A stated he was not wearing his face mask over the mouth or nose while pouring drinks, prepping, or delivering food to residents and had only pulled the mask up because SA had approached. On 12/5/24 at 10:33 a.m., RN-A stated the facility was currently in COVID outbreak and all staff, including dietary staff, were required to wear face			F 880			

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F 880	Continued From page 49 masks under the chin and over the nose whenever working at the facility. RN-A stated all staff had been trained on how to appropriately wear PPE including face masks. On 12/5/24 at 10:43 a.m., the facilities manager (F)-A stated the facility followed recommendations from the infection preventionist regarding when to wear PPE including face masks. Staff were directed to wear face masks at all times and to ensure the mask was under their chin and over their nose. the F-A stated dietary staff were educated and instructed to wear face masks at all times including when prepping, cooking, dishing food, serving food, at all times when they were in the kitchen/kitchenette and where residents were and especially now since the facility was currently in a COVID outbreak.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883			1/17/25

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F 883	Continued From page 50 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			F 883			

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F 883	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide offer and provide risk vs benefits of receiving or declining immunizations per Center for Disease Control and Prevention (CDC) guidance for 1 of 5 residents (R38) reviewed for immunizations. Findings include: R38's quarterly Minimum Data Set (MDS) dated 9/24/24, identified R38 was 91 years old and had severe cognitive impairment with a diagnosis of malignant neoplasm of the prostate (cancer). R38's immunization record dated 12/8/23, identified the following immunizations were received at an outside care setting, COVID-19 vaccination on 2/23/21 and on 2/2/21; pneumococcal vaccinations on 7/13/16 and 1/1/99, however, did not indentify the type of pneumococcal vaccination received. R38's medical record lacked evidence the following vaccinations were offered/ in conjunction with the medical provider and educated on the risk versus benefits of the vaccination: most recent booser for COVID-19, annual influenza, and pneumococcal vaccinations including PCV15, PCV20 and or PCV21. During an interview on 12/5/24 at 4:49 p.m., licensed practical nurse (LPN)-B (the infection preventionist) identified the process for reviewing immunizations was upon admission and on a regular basis. When immunizations were discussed the resident or resident's representative thou document they received education regarding the immunizations and a			F 883	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #38 POA was contacted on 12/13/2024 and provided education regarding resident vaccinations. On 12/24/2024 POA decided to not administer vaccinations at this time. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by this deficient practice. Infection Prevention nurse conducted an immunization status audit on all current residents on 12/13/2024 to identify any needed vaccinations. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure sustained systemic change, the DON/designee will ensure all current residents are offered required vaccines by January 10, 2025. New admissions will be offered vaccines upon admission, with required vaccine consents integrated into the admission process. The DON/designee will maintain a tracking tool for required vaccinations. All nursing staff will be educated on the vaccine process, including Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, and other relevant policies (AL, R/S, LTC, HBS-Enterprise).		

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F 883	Continued From page 52 consent form would be signed whether to receive or decline the immunizations. The consent form would have identified the education given and if the resident or resident's representative would agree to the immunizations. LPN-B stated she missed offering the immunizations and education the COVID-19 vaccination, influenza vaccination, or pneumococcal vaccinations and did not get a consent signed. During an interview on 12/5/24 at 5:31 p.m. the director of nursing (DON) expected the policy for immunizations would be followed. The facility's Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, and other policy dated 11/20/24, identified the purpose is to provide the resident the opportunity to receive immunizations and provide guidance recommenced immunizations. Each resident's immunizations will be reviewed upon admission and on an ongoing basis. Provide the Vaccination Information Statement (VIS) for influenza, pneumococcal, and COVID-19. Document education on the benefits and potential side effects of the vaccinations for which the resident was eligible.	F 883	Education will be completed by January 10, 2025, during staff meetings. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, the DON/designee will audit all new admissions for vaccination documentation weekly, for 6 weeks. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. What is the date of completion? January 17th, 2025		

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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 12/04/2024. At the time of this survey, 12/04/2024 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

Electronically Signed

TITLE

(X6) DATE

12/27/2024

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. Neilson Place was constructed in 2004, is 2-stories, without a basement and was determined to be of a Type I (332) construction. In 2009, 3 additions were constructed, a services wing to the south and connecting links to an apartment building to the north. The two connecting links into the north assisted living building are 1-story, Type II (111) construction. The building is divided into 3 smoke zones on each floor by 1 hour fire barriers.	K 000			

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K 000	Continued From page 2 The facility has corridor smoke detection and smoke detection in all common use spaces installed in accordance with NFPA 72 "The National Fire Alarm Code". All sleeping rooms have single station smoke detectors with annunciation in the corridor and at the nurse's station that serves that room with additional automatic fire detection in all rooms. The fire alarm is monitored for automatic fire department notification. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a capacity of 78 beds and had a census of 72 at the time of the survey.	K 000			
K 321 SS=F	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: 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.	K 321		12/31/24	

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NAME OF PROVIDER OR SUPPLIER NEILSON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ANNE STREET NORTHWEST BEMIDJI, MN 56601		
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K 321	Continued From page 3 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 Hazard - see K322) This REQUIREMENT is not met as evidenced by: 1) Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/04/2024 between 8:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors Leading to the following smoke compartments: 1) South link - Memory Care Hallway 2) Doors leading to main meeting room 3) Elderberry Wing Doors 2) Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code,	K 321	1. All smoke partitions will be inspected and penetrations filled by 12-27-24. A door closure was added to the therapy storage room door by 12-17-24. 2. The deficiency could have a widespread impact on residents. 3. Training will be done with all maintenances staff to ensure proper sealing of smoke barriers. Monthly inspections of storage areas and fire walls on TELS 4. Audits will be completed weekly x 4, monthly x 2 and quarterly x 1 by the manager of facility operations or designees. To ensure smoke barriers are free of penetration. 5. Date of substantial completion 12-31- 24		

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K 321	Continued From page 4 sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/04/2024 between 8:00am and 12:00pm, it was revealed by observation that the room marked hydrotherapy has been converted into a storage room. This storage room did not have a self-closing device. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 321			
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	K 353		1/8/25	

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K 353	Continued From page 5 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 12/04/2024 between 8:00am and 12:00pm, it was revealed by observation that storage 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: 1) Activities storage room by vending machines. 2) General Storage Room 3) Huckleberry Housekeeping storage room An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 353	1. All storage areas will be checked for storage items within 18 inches of a sprinkler head by 12/31/24 2. All residents could be affected by the deficient storage around sprinkler heads. 3. All staff will be trained by 1-8-25 to keep all items in storage areas at least 18 inches from a sprinkler head. 4. Audits of storage areas will be completed weekly x 4, monthly x 2, quarterly x 1 by the manager of facility operations or designee. 5. Date of substantial completion 1-8-25		
K 761 SS=F	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	K 761		3/4/25	

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K 761	Continued From page 6 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 12/04/2024 between 8:00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags and/or have door tags that have been painted over. 1) Fire doors leading to Main Meeting Room across from main entrance. 2) Fire Doors leading to First Floor resident wings 3) Fire Doors leading to Second Floor resident wings An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 761	1. All fire doors will be checked by vendor to make sure the rating plate is in place and unobstructed by 3-4-25. 2. This deficiency could have a widespread impact on residents in the facility. 3. All maintenance staff will be educated on the importance of not obstructing door rating plates by 12-31-24. Quarterly checks of fire doors will be completed and recorded on TELS. 4. Audits will be completed weekly x 4, monthly x 2, quarterly x 1. by the manager of facility operations or designee to ensure placement and the unobstructed nature of rating plates 5. Date of substantial completion 3-4-25.		

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K 920 SS=D	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: 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 an isolated impact on the residents within the facility. Findings include:	K 920	1. All resident rooms will be audited and extension cords or power strips that are being used in a way prohibited by NFPA code will be removed by 1-10-25 2. This deficiency has the potential to affect all residents. 3. Staff will be trained in the proper use of electoral receptacles by 1-8-25 All rooms and common areas will be checked yearly through TELS to ensure the use of receptacles following NFPA code.	1/10/25	

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K 920	Continued From page 8 On 12/04/2024 between 8:00am 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 Strawberry Nursing Office An interview with the Director of Maintenance verified these deficient findings at the time of discovery.			K 920	4. Audits will be completed weekly x4, monthly x 2 and quarterly x 1 by the manager of facility operations or designee. 5. Date of substantial completion 1-10-25		