Electronically delivered

November 27, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

RE: CCN: 245427
Cycle Start Date: October 25, 2024

Dear Administrator:

On November 6, 2024, we informed you that we may impose enforcement remedies.

On November 5, 2024, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required. In addition, at the time of this survey, we identified the following deficiencies:

F580, F656, F684

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 12, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 12, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 12, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 12, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Bethesda will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 12, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 25, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

HZahler

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

(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 10/31/24, 11/4/24, and 11/5/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H54279920C (MN00107882) with a deficiency cited at F580, F656, and F684. 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 that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		12/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Electronically Signed | | 12/06/2024

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 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow the physician order to notify the medical provider of weight changes for 1 of 3	F 580	Corrective Action for Residents Affected by Deficient Practice: Resident is no longer a current resident.	

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F 580

Continued From page 2
(R1) residents reviewed for change of condition.

Findings include:

R1's admission minimum data set (MDS) dated 9/26/24, indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. R1's medications included a diuretic (medication to get rid of excess fluid).

R1's Nutrition Assessment dated 10/2/24, identified R1's admission weight was 177 pounds with usual body weight of 180 pounds. The assessment further identified R1's dehydration risk factors were use of a diuretic, thickened liquids/modified diet, total feeding assistance, dysphagia (difficulty swallowing), renal disease, and incontinence.

R1's Orders Discharge Report dated 9/26/24, included the following orders:
spironolactone 25 milligrams (mg) tablet daily for heart failure. (medication to remove excess fluid)
torsemide 20mg tablet; take ½ tablet by mouth in the morning for heart failure May take additional tablets as directed by the HF [heart failure] clinic. (medication to remove excess fluid).
Weigh daily and report change of three (3) pounds overnight or five (5) pounds in a week.

R1's Treatment Administration Record (TAR) dated 10/1/24 to 10/31/24 indicated to weigh daily

F 580

Identification of Other Residents Having the Potential to be Affected by Deficient Practice:

All current resident weights were reviewed to identify any significant weight changes and ensure MDs had been notified if needed.

Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur:

Tracking Weight Changes Policy and Change in Condition Policy were reviewed and revised. IDT meeting structure was adjusted in short-term therapy to have Dietician attend and report on weights.

Tracking Weight Changes Policy and Change in Condition Policy training and re-education was provided to all nursing staff. RNs educated on updating specialty clinics as needed.

How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur:

Culinary Director and Dietician or designee will complete 8 random audits/month x 3 months to review any significant weight changes and if appropriate interventions and follow-up were implemented, including reviewing vitals and updating the MD when necessary. These audits will be presented to the facility Quality Assurance committee

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F 580	Continued From page 3 every day shift related to chronic systolic (congestive) heart failure and to report change of three (3) lbs. [pounds] overnight or 5 lbs. [pounds] in a week per heart failure clinic with a start day of 9/27/24. Weights were completed 10/1/24 to 10/18/24 and identified the following: 10/1/24 weight was 177.2 and 10/7/24 weight was 169.9 to reflect a 7.3-pound weight loss in a week. 10/7/24 weight was 169.9 and 10/8/24 weight was 166.9 to reflect a 3-pound weight loss overnight. 10/8/24 weight was 166.9 and 10/15/24 weight was 160.1 to reflect a 6.8-pound weight loss in a week. R1's clinical record lacked notification to the physician or the heart failure clinic for the weight fluctuations as ordered. During an nterview on 11/5/24 at 9:15 a.m., the director of nursing (DON) verified R1's weight changes should have been reported to the medical provider but were not reported as ordered. During an interview on 11/5/24 at 10:00 a.m., R1's primary care physician (PCP) indicated he was not notified of R1's weight loss and usually would be notified of a significant weight loss. Further indicated R1's weights should have been reported to the heart failure clinic to adequately manage R1's diuretic and heart failure. During an interview on 11/5/24 at 10:28 a.m., registered nurse (RN) from the heart failure clinic verified they had not been notified of the weight fluctuations and should have been. The RN further indicated any weight fluctuations of three pounds in one day and five pounds in one week	F 580	to verify that compliance has been attained. DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure that interventions related to changes in condition are completed according to the care plan, including updating the MD when necessary. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 580	Continued From page 4 would require an evaluation and possible changes in medications to prevent fluid overload or too much fluid loss.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		12/12/24

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F 656	Continued From page 5 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive care plan was developed within the required timeline for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1's admission minimum data set (MDS) dated 9/26/24, indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. The MDS also identified R1 was at risk for pressure ulcers, had a history of falls, was on a texture modified diabetic diet, and had unclear speech. The MDS further identified high risk medications as antianxiety, antidepressant, diuretic, and antiplatelet medications.	F 656	Corrective Action for Residents Affected by Deficient Practice: Resident is no longer a current resident. Identification of Other Residents Having the Potential to be Affected by Deficient Practice: An audit will be completed of all residents who admitted in November to identify that a comprehensive care plan was completed within 7 days of the CAAs. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Care Planning Policy and Baseline Care Plan was reviewed and revised. Training and re-education was completed for all staff responsible for creating comprehensive care plans. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is	

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F 656	Continued From page 6 R1's Communication Care Area Assessment (CAA) dated 10/8/24, identified R1 had expressive aphasia and unclear speech and was only able to answer yes or no questions and had attempted to use a whiteboard for making needs known. Also identified R1 was working with speech therapy (ST) and would proceed with care planning for continuity of care. R1's Cognitive Loss/Dementia CAA dated 10/7/24, identified R1 was not able to complete the brief interview for mental status (BIMS) because of R1's communication deficit. The CAA also indicated would proceed with care planning for continuity of care. R1's Visual Function CAA dated 10/8/24, identified R1 wore reading glasses and a possible right field vision cut related to cerebral vascular accident (CVA) and would proceed with care planning for continuity of care. R1's Urinary Incontinence CAA dated 10/8/24, identified R1 had bladder incontinence and needs were anticipated 24 hours a day. Further indicated R1 would have a routine toileting schedule to minimize incontinence and would proceed with care planning for continuity of care. R1's Falls CAA dated 10/8/24, identified R1 had right sided hemiplegia, was total assist with all activities of daily living (ADL)s, has difficulty verbalizing needs, and required assistance of a Hoyer (full body mechanical lift). The CAA also indicated the goal was to minimize the risk of falls and would proceed with care planning for continuity of care. R1's Pressure Ulcer CAA dated 10/8/24, identified	F 656	Being Corrected and Will Not Recur: DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure comprehensive care plans are completed within appropriate time frames. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained. Culinary Director and Dietician or designee will complete 8 random audits/month x 3 months to ensure any residents who are at risk for dehydration is addressed in the comprehensive care plan and interventions are in place. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 656	Continued From page 7 R1 did not have any pressure ulcers but was at risk for developing pressure ulcers due to R1's impaired mobility, incontinence, and total assist of staff for transfers. The CAA indicated the goal was to minimize the risk and would proceed with care planning for continuity of care. R1's Psychotropic Drug Use CAA dated 10/8/24, identified R1 received antidepressant medications with new medications started during hospitalization. The CAA further identified R1 had a risk of complications related to medication use and would proceed with care planning for continuity of care. R1's baseline Individual Resident Care Plan developed on 9/26/24, identified R1 was a fall risk, had a wound on the inner right bicep, was on an anticoagulant, was at risk for dehydration, and was on a diabetic pureed diet. R1's nutrition care plan dated 10/2/24, identified R1 had a nutritional risk related to diagnosis diabetic diet with interventions identified. The care plan also identified R1 was independent in planning her leisure time with interventions identified. The care plan did not include any of the other potential or actual risk areas identified on the comprehensive assessments or the CAAs. The care plan did not identify any goals or interventions to mitigate the risks of the identified risk care areas. During an interview on 10/31/24 at 2:35 p.m., registered nurse (RN)-A indicated she was filling in as t R1's case manager and was not aware R1's care plan had not been completed but verified it was not comprehensive or complete.	F 656		

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F 656	Continued From page 8 During an interview on 11/5/24 at 9:15 a.m., the director of nursing (DON) indicated a baseline care plan was completed but verified the comprehensive care plan was not comprehensive or complete. The DON indicated their team thought they had 21 days from admission and was not aware of the seven (7) day after CAAs were completed timeline. The facility policy titled, Care Planning dated 2/2024, indicated the purpose was to provide an individualized and comprehensive interdisciplinary plan of care for each individual that promote quality of care and lift. The policy identified the comprehensive care plan is developed with in 21 days of the admission date.	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify, monitor, and comprehensively assess for dehydration and significant weight loss for 1of 3 residents (R1) reviewed for change of condition. The facility's failures resulted in harm for R1 who had a 20 pound weight loss in 18 days and was subsequently admitted to the hospital for	F 684	Corrective Action for Residents Affected by Deficient Practice: A care conference was held on the afternoon of 10/17/24 with family, nursing, therapy and social services. Discussion was held regarding resident□s condition, poor intake, fatigue, and overall condition. No request for immediate evaluation was received by the	12/12/24

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dehydration, acute renal failure, and later died.

Findings include:

R1's admission minimum data set (MDS) dated 9/26/24, indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. The MDS also identified R1 was at risk for pressure ulcers, had a history of falls, was on a texture modified diabetic diet, and had unclear speech. The MDS further identified high risk medications as antianxiety, antidepressant, diuretic, and antiplatelet medications.

R1's baseline care plan dated 9/26/24 identified R1 was at risk for dehydration. The care plan did not identify associated interventions.

R1's nutritional care plan dated 10/2/2024, identified R1 was at nutritional risk related to diagnosis of diabetes with a goal of R1 will maintain weight at 177 pounds or gradual weight loss and would not show signs/symptoms of dehydration. Will meet nutritional needs through oral intake of >50% of most meals. Interventions included: diet and supplements per doctor order, honor food choices, hydration per facility protocol, record food and fluid intake, and obtain weights per facility policy.

R1's physician orders included the following -Spironolactone (medication to remove excess

F 684

family at that time. Comfort/hospice care was discussed. Resident was sent to Emergency room on 10/18/24. Staff had been offering various forms of fluids and fluid-based foods in the week prior to the meeting due to poor intake.

Resident is no longer a current resident.

Identification of Other Residents Having the Potential to be Affected by Deficient Practice:

All current resident weights were reviewed to identify any significant weight changes. All residents at risk for dehydration were audited to ensure that all interventions were in place.

Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur:

Hydration Policy, Food and Fluid Intake Policy, Tracking Weight Changes Policy, and Change in Condition Policy were reviewed and revised. Intake form was reviewed and revised. Intake process was revised to include increased supervision. Training and re-education were provided to Nursing on Hydration, Food and Fluid Intake, Tracking Weight Changes and Change in Condition. Training and re-education were provided to Culinary on Hydration and Food and Fluid Intake.

How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur:

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F 684	Continued From page 10 fluid) 25 milligrams (mg) tablet daily for heart failure (start date 9/27/24) -Torsemide (medication to remove excess fluid) 20mg tablet; take ½ tablet by mouth in the morning for heart failure May take additional tablets as directed by the HF [heart failure] clinic (start date 9/27/24) -Weigh daily and report change of three (3) pounds overnight or five (5) pounds in a week (start date 9/27/24). R1's Admission Note dated 9/26/24, identified R1 was admitted following hospitalization for a short-term rehabilitation stay. Further identified R1 had demonstrated decision-making capacity and participated in admission decisions. R1 had a goal to return home. R1's Progress Note dated 10/1/24, indicated R1 was alert and able to answer writer with short words. R1's Nutrition Assessment dated 10/2/24, indicated R1's weight (wt) was 177 pounds (lbs) and was close to reported usual body weight. The assessment identified R1 was at risk for dehydration due to required staff assist with eating; diagnosis of diabetes, dementia, renal disease; diuretic and psychotropic medications; dysphagia (difficulty swallowing), thickened liquids, and modified texture diet. The assessment indicated R1's required an estimated 1500-1800 Kcals daily and required 1500-1800 milliliters (ml) of fluid daily. Interventions identified noted in the section "Additional Nutritional Comments" included but were not limited to: fluids offered and encouraged through the day. Water mug available at bedside.	F 684	DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure that interventions related to changes in condition are completed according to the care plan, including reviewing vitals and updating the MD when necessary. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained. Culinary Director and Dietician or designee will complete 8 random audits/month x 3 months to ensure food intake logs are completed after each meal. Culinary Director and Dietician or designee will also complete 8 random audits/month x 3 month to identify any significant weight changes and if appropriate interventions and follow-up were implemented, including updating the MD when necessary. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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R1's weights recorded on the October 2024 treatment administration record (TAR) identified the following:
On 10/1/24 wt. was 177.2 lbs.
On 10/2/24 wt. was 175.6 lbs.
On 10/3/24 wt. was 170.9 lbs.
On 10/4/24 wt. was 170.7 lbs.
On 10/5/24 wt. was 171.3 lbs.
On 10/6/24 wt. was 170.1 lbs.
On 10/7/24 wt. was 169.9 lbs., which identified R1 had 7.3 lb weight loss since 10/1/24.

R1's meal and fluid intake sheet for October 2024 included the direction; if a resident shows sign of decrease in appetite, let the supervisor know.
R1's food and fluid consumption's between 10/1/24 through 10/7/24 identified the following:
-10/1/24 through 10/4/24 there was no recorded entries for food and fluid intake.
-10/5/24 total fluid intake 240 ml, a deficit of at least 1260 ml. Food intake: 25% for lunch.
-10/6/24 total fluid intake possibly 60-100 ml for breakfast (entry was not legible), a deficit of at least 1400 ml. Food intake: for 25% breakfast.
-10/7/24 total fluid intake 380 ml, a deficit of at least 1120 ml. Food intake: breakfast "bites", 100% lunch and dinner.

R1's Physician Visit Note dated 10/7/24, indicated R1 was seen by her primary care physician via video visit for hospital follow-up. R1 received a change in antidepressant medication with no other orders. The note did not address R1's fluid or nutritional status

In review of R1's record between 10/2/24 through 10/7/24, it was not evident R1's physician and/or heart failure clinic had been notified of the 7.3 lb. weight loss. Although, it was identified R1 was at

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risk for dehydration and weight loss, the record did not identify a comprehensive hydration and nutritional assessment was completed to determine if the weight loss was contributed to nutrition or as a result of fluid loss secondary to diuretic medications and low fluid intake. Additionally, after the nutritional assessment was completed on 10/2/24, there was no indication interventions were implemented nor evident R1's fluid and food deficits were comprehensively assessed to determine appropriate interventions.

R1's daily Focus Charting dated 10/8/24 to10/13/24 did not indicate any concerns and noted R1 to be alert. The documentation did not address R1's low food or fluid consumption.

R1's Skilled Note on 10/15/24, noted R1 to be alert on and off, no facial grimacing, smiled on and off, pleasant mood, no behaviors, no vision, or hearing concerns. The documentation did not address R1's low food or fluid consumption.

R1's Focus Charting Note dated 10/16/24, noted R1 to be alert. The documentation did not address R1's low food or fluid consumption.

R1's weights recorded on the October 2024 TAR identified the following
On 10/8/24 wt. was 166.9 lbs; wt loss of 3 lbs from 10/7/24
On 10/9/24 wt. was 167.6 lbs
On 10/10/24 wt. was 164.8 lbs
On 10/11/24 wt. was 164.9 lbs.
On 10/12/24 wt. was 162.9 lbs.
On 10/13/24 wt. was 161.2 lbs.
On 10/14/24 wt. was 160.1 lbs.
On 10/15/24 wt. was 160.1 lbs.
On 10/16/24 wt. was 158.6 lbs.

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On 10/18/24 wt. was 157.2 lbs.; identifying a total weight loss of 20.0 lbs in 18 days since 10/1/24.

R1's meal and fluid intake sheet for October 2024 included the direction; if a resident shows sign of decrease in appetite, let the supervisor know.
R1's food and fluid consumption's between 10/8/24 and 10/17/24 identified the following:
-10/8/24, total fluid and food intake could not be calculated; no documentation was recorded for the evening meal. However the record identified for breakfast and lunch R1 did not have any fluid or food intake.
-10/9/24, total fluid and food intake could not be calculated; no recorded entries for lunch and evening meal. However, the record identified for breakfast R1 consumed 180 ml of fluid and 75% of her meal.
-10/10/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However, the record identified R1 consumed 240 ml of fluid and ate 25% of lunch and 25% of evening meal.
-10/11/24, total fluid intake 520 ml; a deficit of 980 ml. Food intake breakfast 3/3 [sic], lunch-75%, and 100% for the evening meal.
-10/12/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However the record identified total fluid for breakfast and lunch was 600 ml. Food intake for breakfast 50% and lunch 100% was consumed.
-10/13/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However the record identified total fluid for lunch was 200 ml. Food intake for breakfast was 25% and zero (0) for lunch.
-10/14/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However, the recorded entries identified R1 did

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not consume any food or fluids for breakfast and lunch.
-10/15/24, total fluid and food intake could not be calculated; no recorded entries for the evening meal. However,the record identified R1 had zero (0) fluid intake for breakfast and zero (0) for lunch, R1 consumed 25% of lunch meal.
-10/16/24, total fluid intake 520 ml, a deficit of 980 ml. Food intake for breakfast was not legible, R1 ate 100% of her lunch and dinner.
-10/17/24, total fluid intake 520 ml, a deficit of 980 ml. Food intake recorded breakfast 75%, lunch 75%, and evening meal 100%.

In review of R1's record between 10/8/2024 through 10/17/24 revealed no indication the physician or the congestive heart failure clinic were notified of R1's continued weight loss and overall weight loss of 20 lbs in 18 days. Additionally, the record continued to not identify comprehensive assessments for fluid balance, dehydration, or nutrition nor evident the care plan was revised.

R1's Focus Charting Note dated 10/17/24, noted R1 to be alert.

R1's General Note dated 10/17/24 at 5:27 p.m., indicated a meeting was held with R1's family, nursing, and therapies to discuss R1's increased lethargy and weakness the past several days with minimal verbal responses. R1's family requested a urinary analysis (UA) to rule out urinary tract infection. R1's family reported R1 was uncomfortable, facial grimacing, restlessness. R1 was reported to not be progressing in therapies and discussed further options.

R1's Focus Charting Note dated 10/18/24 at 1:58

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p.m. noted R1 to be sleepy, less responsive, and not swallowing medications. Urine specimen obtained and sent to lab at 1:45 p.m. R1's urine was noted to be dark amber in color.

R1's Speech Therapy discharge note dated 10/18/24, identified R1 participated and was demonstrating progress with improved efficiency of swallow phases and using left hand for drinking and eating at time but recently R1 had overall decline, decreased participation in therapies, lethargic.

R1's Discharge Record dated 10/18/24 at 6:15 p.m. indicated R1 was transferred to the hospital and her condition was unstable. "Resident sent to ER due to decline in condition. Decreased oral intake, sleeping more. Admitted to the hospital for multiple conditions."

R1's hospital emergency room note dated 10/18/24, indicated R1 presents with generalized weakness/ and fatigue secondary to dehydration. R1's family reported R1 had become weaker and not participating as much in the past week since 10/11/24. R1's urine is dark and foul smelling and appears dehydrated upon arrival. R1's critical condition was renal failure (acute) and hypernatremia (critical high sodium levels in the blood) and required fluid resuscitation. Sodium level was 169 (normal range 136-146), Creatinine 4.54 (normal range 0.57-1.11), and BUN was 157.0 (normal range 7.0-20.1) R1 was also noted to have a blood sugar of 659 (normal is approximately 80-130 according to www.cdc.gov) and urinalysis positive for an acute urinary tract infection (UTI).

R1's death certificate indicated R1 died on

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10/23/24 in the hospital.

During an interview on 10/31/24 at 10:32 a.m., family member (FM-A) indicated around 10/11/24, R1 was less alert and appeared more depressed. On 10/13/24, R1 was not participating in therapy as much, had decreased fluid intake, and was not eating as well. FM-A stated on 10/16/24, R1's "eyes were sunken in, mouth was dry, and lips were chapped" and requested a urinary analysis (UA) as R1 had a history of UTI's. FM-A attended the care conference and indicated therapies reported that R1 was participating and improving until there was "a shift on Monday" (10/14/24).

During an interview on 11/4/24 at 4:40 p.m., nursing assistant (NA)-A indicated R1 was alert during the first part of her stay and then a couple of weeks before R1 was hospitalized she would not eat much, slept more, stopped answering questions, and her urine would have a strong odor sometimes. NA-A reported telling the charge nurse about her increased sleepiness and not eating but was not sure what they did with that information.

During an interview on 11/4/24 at 5:15 p.m., NA-B indicated R1 was alert and "bubbly" when she first arrived and communicated mostly with her facial expressions. NA-B indicated about a week before R1 went to the hospital "things got weird" and clarified R1 got "super tired", would drop her head back and be difficult to arouse during meals, and just stopped eating. NA-A indicated the nurse was notified and they were directed to "lay her down and monitor it for a few days". NA-A further explained R1 would let fluids run out of her mouth and not swallow anything and R1's family was concerned about a UTI and then R1

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went to the hospital.

During an interview on 11/4/24 at 5:50 p.m., licensed practical nurse (LPN)-A indicated she worked as a charge nurse on all facility units and described R1 as making some overall progress and then started to decline and was more tired. LPN-A said the expectation was that NAs were to notify the charge nurse with any change of resident condition and the charge nurse was to assess the resident and their actions were dependent on their findings. LPN-A further explained if a resident's weight was three (3) pounds different from the previous one, the resident would be reweighed and if it was accurate, the nurse should notify the case manager, the doctor, and interdisciplinary team (IDT). LPN-A identified she was not aware if R1 was ordered to have daily weights or aware of R1's weight loss.

During an interview on 10/31/24 at 2:15 p.m., registered nurse (RN)-B indicated the case manager for R1's unit was no longer employed at the facility and was assisting on R1's unit the day that R1's daughter brought up concerns about a possible UTI and requested an order. RN-B further indicated she was not aware of R1's weight loss or overall decline.

During an interview on 11/5/24 at 11:20 a.m., the dietary manager (DM) stated the dietary staff was responsible for monitoring food and fluid intakes during mealtimes and were to document on the intake sheet. The DM verified that 21 meal and fluid intakes had not been documented during the period of 10/1/24 to 10/18/24 and stated, "they were blank because someone was not doing their job".

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F 684	Continued From page 18 During an interview on 11/5/24 at 11:30 a.m., the registered dietician (RD) indicated she could not remember if she was notified of R1's weight loss. The RD further identified the nurses were to review the weights and report any weight changes to her. The RD indicated a weight loss of 20 pounds in 18 days was a significant weight loss and should have been reported to her. During an interview on 10/31/24 at 2:00 p.m., therapist (OT)-A indicated R1 initially was "bright and alert" and would answer yes and no questions but started to decline about a week prior to hospitalization. OT-A verified R1's decline was reported to nursing during that week but was unsure what additional assessment or follow up was done. During an interview on 10/31/24 at 2:05 p.m., physical therapy (PT)-A indicated R1 was more responsive and had a sense of humor but then started to decline, was refusing therapy, not tolerating sitting up, not eating as much. PT-A indicated their department was in constant communication with nursing and the decline was reported to nursing as it was occurring. During an interview on 11/4/24 at 3:30 p.m., the speech language pathologist (SLP) indicated R1 was initially participating and about a week before R1's hospitalization, R1 had a notable decline in her overall condition and was not participating in therapies, had a poor intake, and would not take medications during the final days before hospitalization. The SLP further indicated she told RN-A and the charge nurse about the decline.	F 684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(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 684	Continued From page 19 During an interview on 10/31/24 at 2:35 p.m., the assistant director of nursing (ADON) indicated the protocol for recognizing a change in condition is the nursing assistants (NA)'s or the med nurses bring their concern to the charge nurse, or the RN case manager and the resident would further be evaluated by a RN, then they would notify the physician and the family. The ADON indicated she was filling in as RN case manage on R1's unit during that time. ADON further identified during R1's last week in the facility, R1's intake decreased but denied any other possible changes of condition were reported to nursing until 10/16/24. During an interview on 11/5/24 at 11:05 a.m., the heart failure clinic RN indicated she reviewed R1's record and their clinic was not notified of R1's weight losses. The RN further stated, "it would be important to know there was a weight loss because it would need to be evaluated and depending on what she [R1] was on for a diuretic, they [heart failure clinic] may want to change that". During an interview on 11/5/24 at 9:15 a.m., the director of nursing (DON) verified R1's weight changes should have been reported to the medical provider but were not reported as ordered. During an interview on 11/5/24 at 10:00 a.m., R1's primary care physician (PCP) reported conducting a video visit with R1 on 10/7/24 and changed some depression medication with hopes R1 would have a mood boost that would also increase her appetite. R1's PCP indicated he was not notified of R1's weight loss, decreased oral intake, or change of condition after that	F 684		

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F 684	Continued From page 20	F 684		

10/7/24 visit. The PCP also indicated it would be an expectation that a significant change in condition would be reported to a physician Further indicated R1's weights should have been reported to the heart failure clinic to adequately manage R1's diuretic and heart failure.

During an interview on 11/5/24 at 9:30 a.m., the medical director identified R1's primary drivers of the significant weight loss as dehydration, poor oral intake, and continued use of diuretics which should have been reported to R1's primary doctor. The medical director also stated, "the facility should have intervened a few days earlier which would not have changed R1's demise but the clinical course would have been extended if R1's family wanted to do a feeding tube or constant intravenous (IV) fluids."

The undated facility document titled Communication indicates NAs are trained to report any concerns or changes with residents directly to the nurse on duty, while nurses are instructed to report to their supervisor if there are any concerns or changes that need higher-level attention. This reporting structure ensures that issues are address in a timely and coordinated manner to promote resident safety and well-being.

The facility policy titled Food and Fluid Intake Documentation last reviewed 11/2024, indicated the facility will document the resident's food and fluid intake to assist in assessing the resident's current nutritional status. Food and fluid intake will be completed daily by nursing or culinary team members for all three meals, as assigned. It is the responsibility of the dietitian/culinary director to audit the intake documentation to

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F 684	Continued From page 21	F 684		

assure that they are accurately and properly completed by staff.

The facility policy titled Change in Condition Policy and Procedure last reviewed 11/2024, indicated it is the policy of the facility to immediate inform the resident; consult with the resident's physician; and notify the resident's legal representative or emergency contact when there is:

" A significant change in the resident physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications).

" A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

The policy further lists the procedure as follow:

" Assess any changes noted through direct observation or through others' observations.

" Obtain any other data necessary for a complete assessment (blood sugar check, neurocheck, vitals, etc.) and as ordered by the physician.

" Notify the physician or nurse practitioner of the change. If unable to reach the physician, follow-up with another message.

" If unable to contact the physician, contact a MD (medical doctor) on-call at their clinic or call the hospital and/or 911 as appropriate.

" Notify the resident's legal representative or emergency contact of the change and actions taken.

" Notify the administrator, director of nursing, designed or building supervisor of the change as appropriate.

" Chart in electronic health record the

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F 684	Continued From page 22 assessment data, observations, discussions with the resident, physician notification (include the number of attempts made and when), any new orders, interventions, and family notifications. " Follow up should continue as ordered by the physician or until the resident has stabilized. Continue to update the resident, physician, and resident legal representative of any deterioration or improvement.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

Re: State Nursing Home Licensing Orders
Event ID: U6GX11

Dear Administrator:

The above facility was surveyed on October 31, 2024 through November 5, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

HZahler

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/31/24, 11/4/24, and 11/5/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1	2 000		

have reviewed these orders and identify the date when they will be completed.

The following complaint was reviewed: H54279920C with a licensing order issued at 0265, 0565, and 0830.
Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		12/12/24

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2 265	Continued From page 3	2 265		

D. a decision to transfer or discharge the resident from the nursing home; or

E. expected and unexpected resident deaths.

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to follow the physician order to notify the medical provider of weight changes for 1 of 3 (R1) residents reviewed for change of condition.

Corrected

Findings include:

R1's admission minimum data set (MDS) dated 9/26/24, indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. R1's medications included a diuretic (medication to get rid of excess fluid).

R1's Nutrition Assessment dated 10/2/24, identified R1's admission weight was 177 pounds with usual body weight of 180 pounds. The assessment further identified R1's dehydration risk factors were use of a diuretic, thickened liquids/modified diet, total feeding assistance, dysphagia (difficulty swallowing), renal disease, and incontinence.

R1's Orders Discharge Report dated 9/26/24, included the following orders:
spironolactone 25 milligrams (mg) tablet daily for

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2 265	Continued From page 4	2 265		

heart failure. (medication to remove excess fluid) torsemide 20mg tablet; take ½ tablet by mouth in the morning for heart failure May take additional tablets as directed by the HF [heart failure] clinic. (medication to remove excess fluid).
Weigh daily and report change of three (3) pounds overnight or five (5) pounds in a week.

R1's Treatment Administration Record (TAR) dated 10/1/24 to 10/31/24 indicated to weigh daily every day shift related to chronic systolic (congestive) heart failure and to report change of three (3) lbs. [pounds] overnight or 5 lbs. [pounds] in a week per heart failure clinic with a start day of 9/27/24. Weights were completed 10/1/24 to 10/18/24 and identified the following:
10/1/24 weight was 177.2 and 10/7/24 weight was 169.9 to reflect a 7.3-pound weight loss in a week.
10/7/24 weight was 169.9 and 10/8/24 weight was 166.9 to reflect a 3-pound weight loss overnight.
10/8/24 weight was 166.9 and 10/15/24 weight was 160.1 to reflect a 6.8-pound weight loss in a week.

R1's clinical record lacked notification to the physician or the heart failure clinic for the weight fluctuations as ordered.

During an nterview on 11/5/24 at 9:15 a.m., the director of nursing (DON) verified R1's weight changes should have been reported to the medical provider but were not reported as ordered.

During an interview on 11/5/24 at 10:00 a.m., R1's primary care physician (PCP) indicated he was not notified of R1's weight loss and usually would be notified of a significant weight loss. Further indicated R1's weights should have been

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2 265	Continued From page 5 reported to the heart failure clinic to adequately manage R1's diuretic and heart failure. During an interview on 11/5/24 at 10:28 a.m., registered nurse (RN) from the heart failure clinic verified they had not been notified of the weight fluctuations and should have been. The RN further indicated any weight fluctuations of three pounds in one day and five pounds in one week would require an evaluation and possible changes in medications to prevent fluid overload or too much fluid loss. SUGGESTED METHOD OF CORRECTION: The DON or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. TIME PERIOD FOR CORRECTION: Thirty (30) days	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure a comprehensive care	2 565	Corrected	12/12/24

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2 565	Continued From page 6	2 565		

plan was developed within the required timeline for 1 of 3 residents (R1) reviewed for change of condition.

Findings include:

R1's admission minimum data set (MDS) dated 9/26/24, indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. The MDS also identified R1 was at risk for pressure ulcers, had a history of falls, was on a texture modified diabetic diet, and had unclear speech. The MDS further identified high risk medications as antianxiety, antidepressant, diuretic, and antiplatelet medications.

R1's Communication Care Area Assessment (CAA) dated 10/8/24, identified R1 had expressive aphasia and unclear speech and was only able to answer yes or no questions and had attempted to use a whiteboard for making needs known. Also identified R1 was working with speech therapy (ST) and would proceed with care planning for continuity of care.

R1's Cognitive Loss/Dementia CAA dated 10/7/24, identified R1 was not able to complete the brief interview for mental status (BIMS) because of R1's communication deficit. The CAA also indicated would proceed with care planning for continuity of care.

R1's Visual Function CAA dated 10/8/24,

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2 565	Continued From page 7	2 565		

identified R1 wore reading glasses and a possible right field vision cut related to cerebral vascular accident (CVA) and would proceed with care planning for continuity of care.

R1's Urinary Incontinence CAA dated 10/8/24, identified R1 had bladder incontinence and needs were anticipated 24 hours a day. Further indicated R1 would have a routine toileting schedule to minimize incontinence and would proceed with care planning for continuity of care.

R1's Falls CAA dated 10/8/24, identified R1 had right sided hemiplegia, was total assist with all activities of daily living (ADL)s, has difficulty verbalizing needs, and required assistance of a Hoyer (full body mechanical lift). The CAA also indicated the goal was to minimize the risk of falls and would proceed with care planning for continuity of care.

R1's Pressure Ulcer CAA dated 10/8/24, identified R1 did not have any pressure ulcers but was at risk for developing pressure ulcers due to R1's impaired mobility, incontinence, and total assist of staff for transfers. The CAA indicated the goal was to minimize the risk and would proceed with care planning for continuity of care.

R1's Psychotropic Drug Use CAA dated 10/8/24, identified R1 received antidepressant medications with new medications started during hospitalization. The CAA further identified R1 had a risk of complications related to medication use and would proceed with care planning for continuity of care.

R1's baseline Individual Resident Care Plan developed on 9/26/24, identified R1 was a fall risk, had a wound on the inner right bicep, was on

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an anticoagulant, was at risk for dehydration, and was on a diabetic pureed diet.

R1's nutrition care plan dated 10/2/24, identified R1 had a nutritional risk related to diagnosis diabetic diet with interventions identified. The care plan also identified R1 was independent in planning her leisure time with interventions identified. The care plan did not include any of the other potential or actual risk areas identified on the comprehensive assessments or the CAAs. The care plan did not identify any goals or interventions to mitigate the risks of the identified risk care areas.

During an interview on 10/31/24 at 2:35 p.m., registered nurse (RN)-A indicated she was filling in as t R1's case manager and was not aware R1's care plan had not been completed but verified it was not comprehensive or complete.

During an interview on 11/5/24 at 9:15 a.m., the director of nursing (DON) indicated a baseline care plan was completed but verified the comprehensive care plan was not comprehensive or complete. The DON indicated their team thought they had 21 days from admission and was not aware of the seven (7) day after CAAs were completed timeline.

The facility policy titled, Care Planning dated 2/2024, indicated the purpose was to provide an individualized and comprehensive interdisciplinary plan of care for each individual that promote quality of care and lift. The policy identified the comprehensive care plan is developed with in 21 days of the admission date.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee should

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2 565	Continued From page 9 review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify, monitor, and	2 830	Corrected	12/12/24

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2 830	Continued From page 10 comprehensively assess for dehydration and significant weight loss for 1of 3 residents (R1) reviewed for change of condition. The facility's failures resulted in harm for R1 who had a 20 pound weight loss in 18 days and was subsequently admitted to the hospital for dehydration, acute renal failure, and later died. Findings include: R1's admission minimum data set (MDS) dated 9/26/24, indicated R1 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADL)'s. Further identified R1 had diagnoses that included cerebral vascular accident (CVA), heart failure, chronic kidney disease, diabetes mellitus (inability to regulate blood sugars), aphasia (difficulty speaking), hemiparesis (one sided paralysis), history of urinary tract infections (UTI)s. The MDS also identified R1 was at risk for pressure ulcers, had a history of falls, was on a texture modified diabetic diet, and had unclear speech. The MDS further identified high risk medications as antianxiety, antidepressant, diuretic, and antiplatelet medications. R1's baseline care plan dated 9/26/24 identified R1 was at risk for dehydration. The care plan did not identify associated interventions. R1's nutritional care plan dated 10/2/2024, identified R1 was at nutritional risk related to diagnosis of diabetes with a goal of R1 will maintain weight at 177 pounds or gradual weight loss and would not show signs/symptoms of dehydration. Will meet nutritional needs through oral intake of >50% of most meals. Interventions included: diet and supplements per doctor order, honor food choices, hydration per facility protocol,	2 830		

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record food and fluid intake, and obtain weights per facility policy.

R1's care plan did not include interventions associated with R1's risk for dehydration as identified on the baseline care plan dated 9/26/24.

R1's physician orders included the following
-Spironolactone (medication to remove excess fluid) 25 milligrams (mg) tablet daily for heart failure (start date 9/27/24)
-Torsemide (medication to remove excess fluid) 20mg tablet; take ½ tablet by mouth in the morning for heart failure May take additional tablets as directed by the HF [heart failure] clinic (start date 9/27/24)
-Weigh daily and report change of three (3) pounds overnight or five (5) pounds in a week (start date 9/27/24).

R1's Admission Note dated 9/26/24, identified R1 was admitted following hospitalization for a short-term rehabilitation stay. Further identified R1 had demonstrated decision-making capacity and participated in admission decisions. R1 had a goal to return home.

R1's Progress Note dated 10/1/24, indicated R1 was alert and able to answer writer with short words.

R1's Nutrition Assessment dated 10/2/24, indicated R1's weight (wt) was 177 pounds (lbs) and was close to reported usual body weight. The assessment identified R1 was at risk for dehydration due to required staff assist with eating; diagnosis of diabetes, dementia, renal disease; diuretic and psychotropic medications; dysphagia (difficulty swallowing), thickened liquids, and modified texture diet. The

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assessment indicated R1's required an estimated 1500-1800 Kcals daily and required 1500-1800 milliliters (ml) of fluid daily. Interventions identified noted in the section "Additional Nutritional Comments" included but were not limited to: fluids offered and encouraged through the day. Water mug available at bedside.

R1's weights recorded on the October 2024 treatment administration record (TAR) identified the following:
On 10/1/24 wt. was 177.2 lbs.
On 10/2/24 wt. was 175.6 lbs.
On 10/3/24 wt. was 170.9 lbs.
On 10/4/24 wt. was 170.7 lbs.
On 10/5/24 wt. was 171.3 lbs.
On 10/6/24 wt. was 170.1 lbs.
On 10/7/24 wt. was 169.9 lbs., which identified R1 had 7.3 lb weight loss since 10/1/24.

R1's meal and fluid intake sheet for October 2024 included the direction; if a resident shows sign of decrease in appetite, let the supervisor know. R1's food and fluid consumption's between 10/1/24 through 10/7/24 identified the following:
-10/1/24 through 10/4/24 there was no recorded entries for food and fluid intake.
-10/5/24 total fluid intake 240 ml, a deficit of at least 1260 ml. Food intake: 25% for lunch.
-10/6/24 total fluid intake possibly 60-100 ml for breakfast (entry was not legible), a deficit of at least 1400 ml. Food intake: for 25% breakfast.
-10/7/24 total fluid intake 380 ml, a deficit of at least 1120 ml. Food intake: breakfast "bites", 100% lunch and dinner.

R1's Physician Visit Note dated 10/7/24, indicated R1 was seen by her primary care physician via video visit for hospital follow-up. R1 received a change in antidepressant medication with no

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other orders. The note did not address R1's fluid or nutritional status

In review of R1's record between 10/2/24 through 10/7/24, it was not evident R1's physician and/or heart failure clinic had been notified of the 7.3 lb. weight loss. Although, it was identified R1 was at risk for dehydration and weight loss, the record did not identify a comprehensive hydration and nutritional assessment was completed to determine if the weight loss was contributed to nutrition or as a result of fluid loss secondary to diuretic medications and low fluid intake. Additionally, after the nutritional assessment was completed on 10/2/24, there was no indication interventions were implemented nor evident R1's fluid and food deficits were comprehensively assessed to determine appropriate interventions.

R1's daily Focus Charting dated 10/8/24 to10/13/24 did not indicate any concerns and noted R1 to be alert. The documentation did not address R1's low food or fluid consumption.

R1's Skilled Note on 10/15/24, noted R1 to be alert on and off, no facial grimacing, smiled on and off, pleasant mood, no behaviors, no vision, or hearing concerns. The documentation did not address R1's low food or fluid consumption.

R1's Focus Charting Note dated 10/16/24, noted R1 to be alert. The documentation did not address R1's low food or fluid consumption.

R1's weights recorded on the October 2024 TAR identified the following
On 10/8/24 wt. was 166.9 lbs; wt loss of 3 lbs from 10/7/24
On 10/9/24 wt. was 167.6 lbs
On 10/10/24 wt. was 164.8 lbs

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2 830	Continued From page 14 On 10/11/24 wt. was 164.9 lbs. On 10/12/24 wt. was 162.9 lbs. On 10/13/24 wt. was 161.2 lbs. On 10/14/24 wt. was 160.1 lbs. On 10/15/24 wt. was 160.1 lbs. On 10/16/24 wt. was 158.6 lbs. On 10/18/24 wt. was 157.2 lbs.; identifying a total weight loss of 20.0 lbs in 18 days since 10/1/24. R1's meal and fluid intake sheet for October 2024 included the direction; if a resident shows sign of decrease in appetite, let the supervisor know. R1's food and fluid consumption's between 10/8/24 and 10/17/24 identified the following: -10/8/24, total fluid and food intake could not be calculated; no documentation was recorded for the evening meal. However the record identified for breakfast and lunch R1 did not have any fluid or food intake. -10/9/24, total fluid and food intake could not be calculated; no recorded entries for lunch and evening meal. However, the record identified for breakfast R1 consumed 180 ml of fluid and 75% of her meal. -10/10/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However, the record identified R1 consumed 240 ml of fluid and ate 25% of lunch and 25% of evening meal. -10/11/24, total fluid intake 520 ml; a deficit of 980 ml. Food intake breakfast 3/3 [sic], lunch-75%, and 100% for the evening meal. -10/12/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However the record identified total fluid for breakfast and lunch was 600 ml. Food intake for breakfast 50% and lunch 100% was consumed. -10/13/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However the record identified total fluid for lunch	2 830		

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was 200 ml. Food intake for breakfast was 25% and zero (0) for lunch.
-10/14/24, total fluid and food intake could not be calculated; no recorded entries for evening meal. However, the recorded entries identified R1 did not consume any food or fluids for breakfast and lunch.
-10/15/24, total fluid and food intake could not be calculated; no recorded entries for the evening meal. However,the record identified R1 had zero (0) fluid intake for breakfast and zero (0) for lunch, R1 consumed 25% of lunch meal.
-10/16/24, total fluid intake 520 ml, a deficit of 980 ml. Food intake for breakfast was not legible, R1 ate 100% of her lunch and dinner.
-10/17/24, total fluid intake 520 ml, a deficit of 980 ml. Food intake recorded breakfast 75%, lunch 75%, and evening meal 100%.

In review of R1's record between 10/8/2024 through 10/17/24 revealed no indication the physician or the congestive heart failure clinic were notified of R1's continued weight loss and overall weight loss of 20 lbs in 18 days. Additionally, the record continued to not identify comprehensive assessments for fluid balance, dehydration, or nutrition nor evident the care plan was revised.

R1's Focus Charting Note dated 10/17/24, noted R1 to be alert.

R1's General Note dated 10/17/24 at 5:27 p.m., indicated a meeting was held with R1's family, nursing, and therapies to discuss R1's increased lethargy and weakness the past several days with minimal verbal responses. R1's family requested a urinary analysis (UA) to rule out urinary tract infection. R1's family reported R1 was uncomfortable, facial grimacing, restlessness.

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2 830	Continued From page 16 R1 was reported to not be progressing in therapies and discussed further options. R1's Focus Charting Note dated 10/18/24 at 1:58 p.m. noted R1 to be sleepy, less responsive, and not swallowing medications. Urine specimen obtained and sent to lab at 1:45 p.m. R1's urine was noted to be dark amber in color. R1's Speech Therapy discharge note dated 10/18/24, identified R1 participated and was demonstrating progress with improved efficiency of swallow phases and using left hand for drinking and eating at time but recently R1 had overall decline, decreased participation in therapies, lethargic. R1's Discharge Record dated 10/18/24 at 6:15 p.m. indicated R1 was transferred to the hospital and her condition was unstable. "Resident sent to ER due to decline in condition. Decreased oral intake, sleeping more. Admitted to the hospital for multiple conditions." R1's hospital emergency room note dated 10/18/24, indicated R1 presents with generalized weakness/ and fatigue secondary to dehydration. R1's family reported R1 had become weaker and not participating as much in the past week since 10/11/24. R1's urine is dark and foul smelling and appears dehydrated upon arrival. R1's critical condition was renal failure (acute) and hypernatremia (critical high sodium levels in the blood) and required fluid resuscitation. Sodium level was 169 (normal range 136-146), Creatinine 4.54 (normal range 0.57-1.11), and BUN was 157.0 (normal range 7.0-20.1) R1 was also noted to have a blood sugar of 659 (normal is approximately 80-130 according to www.cdc.gov) and urinalysis positive for an acute urinary tract	2 830		

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infection (UTI).

R1's death certificate indicated R1 died on 10/23/24 in the hospital.

During an interview on 10/31/24 at 10:32 a.m., family member (FM-A) indicated around 10/11/24, R1 was less alert and appeared more depressed. On 10/13/24, R1 was not participating in therapy as much, had decreased fluid intake, and was not eating as well. FM-A stated on 10/16/24, R1's "eyes were sunken in, mouth was dry, and lips were chapped" and requested a urinary analysis (UA) as R1 had a history of UTI's. FM-A attended the care conference and indicated therapies reported that R1 was participating and improving until there was "a shift on Monday" (10/14/24).

During an interview on 11/4/24 at 4:40 p.m., nursing assistant (NA)-A indicated R1 was alert during the first part of her stay and then a couple of weeks before R1 was hospitalized she would not eat much, slept more, stopped answering questions, and her urine would have a strong odor sometimes. NA-A reported telling the charge nurse about her increased sleepiness and not eating but was not sure what they did with that information.

During an interview on 11/4/24 at 5:15 p.m., NA-B indicated R1 was alert and "bubbly" when she first arrived and communicated mostly with her facial expressions. NA-B indicated about a week before R1 went to the hospital "things got weird" and clarified R1 got "super tired", would drop her head back and be difficult to arouse during meals, and just stopped eating. NA-A indicated the nurse was notified and they were directed to "lay her down and monitor it for a few days". NA-A further explained R1 would let fluids run out

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2 830	Continued From page 18 of her mouth and not swallow anything and R1's family was concerned about a UTI and then R1 went to the hospital. During an interview on 11/4/24 at 5:50 p.m., licensed practical nurse (LPN)-A indicated she worked as a charge nurse on all facility units and described R1 as making some overall progress and then started to decline and was more tired. LPN-A said the expectation was that NAs were to notify the charge nurse with any change of resident condition and the charge nurse was to assess the resident and their actions were dependent on their findings. LPN-A further explained if a resident's weight was three (3) pounds different from the previous one, the resident would be reweighed and if it was accurate, the nurse should notify the case manager, the doctor, and interdisciplinary team (IDT). LPN-A identified she was not aware if R1 was ordered to have daily weights or aware of R1's weight loss. During an interview on 10/31/24 at 2:15 p.m., registered nurse (RN)-B indicated the case manager for R1's unit was no longer employed at the facility and was assisting on R1's unit the day that R1's daughter brought up concerns about a possible UTI and requested an order. RN-B further indicated she was not aware of R1's weight loss or overall decline. During an interview on 11/5/24 at 11:20 a.m., the dietary manager (DM) stated the dietary staff was responsible for monitoring food and fluid intakes during mealtimes and were to document on the intake sheet. The DM verified that 21 meal and fluid intakes had not been documented during the period of 10/1/24 to 10/18/24 and stated, "they were blank because someone was not doing their	2 830		

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job".

During an interview on 11/5/24 at 11:30 a.m., the registered dietician (RD) indicated she could not remember if she was notified of R1's weight loss. The RD further identified the nurses were to review the weights and report any weight changes to her. The RD indicated a weight loss of 20 pounds in 18 days was a significant weight loss and should have been reported to her.

During an interview on 10/31/24 at 2:00 p.m., therapist (OT)-A indicated R1 initially was "bright and alert" and would answer yes and no questions but started to decline about a week prior to hospitalization. OT-A verified R1's decline was reported to nursing during that week but was unsure what additional assessment or follow up was done.

During an interview on 10/31/24 at 2:05 p.m., physical therapy (PT)-A indicated R1 was more responsive and had a sense of humor but then started to decline, was refusing therapy, not tolerating sitting up, not eating as much. PT-A indicated their department was in constant communication with nursing and the decline was reported to nursing as it was occurring.

During an interview on 11/4/24 at 3:30 p.m., the speech language pathologist (SLP) indicated R1 was initially participating and about a week before R1's hospitalization, R1 had a notable decline in her overall condition and was not participating in therapies, had a poor intake, and would not take medications during the final days before hospitalization. The SLP further indicated she told RN-A and the charge nurse about the decline.

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2 830	Continued From page 20 During an interview on 10/31/24 at 2:35 p.m., the assistant director of nursing (ADON) indicated the protocol for recognizing a change in condition is the nursing assistants (NA)'s or the med nurses bring their concern to the charge nurse, or the RN case manager and the resident would further be evaluated by a RN, then they would notify the physician and the family. The ADON indicated she was filling in as RN case manage on R1's unit during that time. ADON further identified during R1's last week in the facility, R1's intake decreased but denied any other possible changes of condition were reported to nursing until 10/16/24. During an interview on 11/5/24 at 11:05 a.m., the heart failure clinic RN indicated she reviewed R1's record and their clinic was not notified of R1's weight losses. The RN further stated, "it would be important to know there was a weight loss because it would need to be evaluated and depending on what she [R1] was on for a diuretic, they [heart failure clinic] may want to change that". During an interview on 11/5/24 at 9:15 a.m., the director of nursing (DON) verified R1's weight changes should have been reported to the medical provider but were not reported as ordered. During an interview on 11/5/24 at 10:00 a.m., R1's primary care physician (PCP) reported conducting a video visit with R1 on 10/7/24 and changed some depression medication with hopes R1 would have a mood boost that would also increase her appetite. R1's PCP indicated he was not notified of R1's weight loss, decreased oral intake, or change of condition after that	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00792	A. BUILDING: ______ B. WING ______	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 21 10/7/24 visit. The PCP also indicated it would be an expectation that a significant change in condition would be reported to a physician Further indicated R1's weights should have been reported to the heart failure clinic to adequately manage R1's diuretic and heart failure. During an interview on 11/5/24 at 9:30 a.m., the medical director identified R1's primary drivers of the significant weight loss as dehydration, poor oral intake, and continued use of diuretics which should have been reported to R1's primary doctor. The medical director also stated, "the facility should have intervened a few days earlier which would not have changed R1's demise but the clinical course would have been extended if R1's family wanted to do a feeding tube or constant intravenous (IV) fluids." The undated facility document titled Communication indicates NAs are trained to report any concerns or changes with residents directly to the nurse on duty, while nurses are instructed to report to their supervisor if there are any concerns or changes that need higher-level attention. This reporting structure ensures that issues are address in a timely and coordinated manner to promote resident safety and well-being. The facility policy titled Food and Fluid Intake Documentation last reviewed 11/2024, indicated the facility will document the resident's food and fluid intake to assist in assessing the resident's current nutritional status. Food and fluid intake will be completed daily by nursing or culinary team members for all three meals, as assigned. It is the responsibility of the dietitian/culinary director to audit the intake documentation to assure that they are accurately and properly	2 830		

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2 830	Continued From page 22 completed by staff. The facility policy titled Change in Condition Policy and Procedure last reviewed 11/2024, indicated it is the policy of the facility to immediate inform the resident; consult with the resident's physician; and notify the resident's legal representative or emergency contact when there is: " A significant change in the resident physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). " A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy further lists the procedure as follow: " Assess any changes noted through direct observation or through others' observations. " Obtain any other data necessary for a complete assessment (blood sugar check, neurocheck, vitals, etc.) and as ordered by the physician. " Notify the physician or nurse practitioner of the change. If unable to reach the physician, follow-up with another message. " If unable to contact the physician, contact a MD (medical doctor) on-call at their clinic or call the hospital and/or 911 as appropriate. " Notify the resident's legal representative or emergency contact of the change and actions taken. " Notify the administrator, director of nursing, designed or building supervisor of the change as appropriate. " Chart in electronic health record the assessment data, observations, discussions with the resident, physician notification (include the	2 830		

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2 830	Continued From page 23 number of attempts made and when), any new orders, interventions, and family notifications. " Follow up should continue as ordered by the physician or until the resident has stabilized. Continue to update the resident, physician, and resident legal representative of any deterioration or improvement. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for monitoring weight loss. Nursing staff could be educated as necessary to the importance of monitoring weight loss. The DON or designee, could audit any/all resident's weights located in have interventions in place. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: (21) days.	2 830		