STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and document review the facility failed to ensure a self-administration of medication assessment (SAM) was completed to allow residents to safely administer their own medications for 1 of 1 (R140) resident observed with medications at bedside. Findings include: R140's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). If further indicated R140 required partial assistance with most activities of daily living (ADL). R140's physician's orders dated 2/5/25, indicated Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 microgram (MCG)/ACT (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day for chronic obstructive pulmonary disease (COPD). Rinse mouth after each use. Notify the nurse manager if R140 refuses or unable to rinse. It further included an order dated 2/5/25, indicating Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for shortness of breath (SOB). R140's physician's orders lacked an order to self administer medication. R140's medical record lacked an assessment to self administer medications. R140's care plan lacked documentation R140 was able to self administer his medications. During observation on 2/10/25 at 2:15 p.m., R140 was sitting in his room in his wheelchair. On the nightstand were 3 inhalers, two of which were Breo Ellipta inhalers and one was an albuterol inhaler. During observation and interview on 2/10/25, at 2:18 p.m. registered nurse (RN)-C verified R140 had medications (3 inhalers) at bedside. RN-C also verified R140 was not able to administer his own medications and they should not be kept at bedside or in his room unless he had been assessed for safety and there was a doctor's order, which he didn't have. RN-C explained to R140 that it was important to not keep medications in his room without a lock box in case a resident wandered into his room and decided to take it. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/14/25 at 10:15 a.m., the director of nursing (DON) stated in order for a resident to be able to administer their own medications they would need to be assessed to determine if it was safe to do so, and then they would need to obtain a physician's order. The DON further indicated medications should not be kept at bedside even if the resident has been deemed safe to self administer their medications. They need to be kept in a lock box in the resident's room in order to prevent another resident from possibly wandering in there and taking the wrong medications. Also if resident's are self administering their medications without being assessed, they may take the wrong dose or at the wrong time, etc. The facility's policy regarding the self administration of medications dated 10/29/24, indicated the procedure for determining if a resident could self adminster their medications was as follows: 1. Complete the Resident Self-Administration of Medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do this safely. It is also recommended that the initial MDS be completed prior to this review. Areas of the MDS that may impact the team ' s decision include B, C, D, E and J. A query could be used by the team to review MDS coding on these and other areas. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to selfadminister medication(s). When responding to question 3 - numbers 2 through 6 will create a progress note for Teaching - Resident/Family. 3. The interdisciplinary team will also determine where medications will be stored. This can be at the nurses ' station, in a locked medication cart, a locked compartment or locked drawer in the resident ' s room. If the medication is stored at the resident ' s bedside, an additional key must be kept by nursing employees. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self administering. 5. The interdisciplinary team will determine who will document the medication administration (e.g., the resident or the nursing employees). If the resident will be documenting his or her medication, it is recommended that the Resident Self-Administration Record (GSS #261) be used and scanned into 6. The interdisciplinary team ' s determination that the resident can safely selfadminister medications must be documented in the Resident Self- Administration of Medication UDA. 7. A physician ' s order must be obtained prior to the resident self-administering medications. a. The order must be specific to the medications being self-administered (e.g., Bengay ointment tid prn for leg discomfort. May be kept at bedside for self-administration or, May have all oral medications at bedside for self-administration). Update with new orders as needed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. The care plan must indicate which medications the resident is selfadministering, where they are kept, who will document the medication and the location of administration, if applicable. Document quarterly on PN - Care Plan Review. 9. The resident ' s ability to continue to safely self-administer medication must be reviewed during the care planning process. It is recommended that this be done at least quarterly and with any significant change. If the resident is no longer able to self-administer medications safely, the physician must be notified, and medication will then be administered by nursing employees. 10. All medications that the resident stores in his or her room must be reconciled (counted or observed for amount used, e.g., ointments and inhalers) and documented by a licensed nurse at least weekly on the MAR. 11. Medication errors made by the resident during self-administration are not to be counted in the location ' s medication error rate. 12. Some states have specific rules regarding self-administration of medications. Please check your state regulations for additional information. Periodic verification with the individual state regulations is encouraged due to potential changes.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 During observation, interview, and document review the facility failed to clean and maintain residents wheelchairs for 2 of 2 residents (R3, R33). Findings include: R3 R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, and diagnoses of Huntington's disease (HD), dementia, dependence on a wheelchair, and was dependent on staff for most activities of daily living (ADL) and mobility. R3's care plan dated 1/16/25, indicated R33 had limited physical mobility and was at risk for falls related to HD as evidenced by neededing assistance for mobility. Frequently refused to wear shoes, slippers or diabatic shoes. Had a history of putting himself on the floor and scooting. Also had a history of alleging falls and getting himself up from. Assist to propel Broda Chair as needed. It further included an intervention of mobility: Broda Chair with pressure redistribution cushion and self releasing front latching seat beat. Uses Broda chair for ambulation. R33 R33's quarterly Minimum Data Set (MDS) dated [DATE] indicated, moderately impaired cognition and diagnoses of Huntington's disease, dementia, uses a wheelchair, and requires substantial assistance with mobility. R33's care plan dated 2/7/25, indicated limited physical mobility related to Huntington's disease (HD), chorea as evidenced by using a wheelchair. It further indicated an intervention of mobility: R33 was able to propel self in Broda wheelchair for short distances, required total assist of 1 to propel for long distances. During observation on 2/12/25 at 8:19 a.m., R33 was sitting at the table in the dining room in her Broda chair. There was copius amounts of dried on and built up food on both of the wheelchair wheels, specifically in between the spokes. During observation on 2/12/25, at 8:25 a.m., R3 was sitting in the dining room in his wheelchair. There was copious amounts of dried food spilled on both wheels, and several large clumps of a dried white substance on the right wheel. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 2/12/25 at 9:41 p.m., registered nurse (RN)-E was shown the copious amounts of food on R3's wheelchair, stating I'll care of it. RN-E further stated the nursing assistants (NA) on the overnight shift were responsible for cleaning the resident's wheelchairs and there was a schedule of which resident's wheelchair was supposed to be cleaned each day. The surveyor also asked about R33's wheelchair and she stated I just cleaned hers last night! The surveyor and RN-E went into R33's room to look at her wheelchair and RN-E verified there was still dried, built up food on the right wheel in between the spokes. During interview on 2/14/25 at 10:15 a.m. the director of nursing (DON) stated the nursing staff who worked on the overnight shift were responsible for cleaning the resident's wheelchairs and there was a schedule to determine which resident's wheelchairs should be cleaned on which night. The wheelchairs were typically cleaned once a week and if they need it washed more often, maintenance should take care of it. The Woodlands assistive device washing schedule last updated on 1/5/25, indicated R3's wheelchair was supposed to be cleaned on Thursday every other week (week 1) and R33's wheelchair was also supposed to be cleaned on Thursday's every other week (week 2). It further indicated 226 and 227 (room numbers) are to be washed every night which was hand written on the schedule. A facility policy regarding cleaning the resident's wheelchairs was requested but the Administrator stated they do not have a specific policy for wheelchair cleaning.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42584 Based on observation, interview and document review, the facility failed to ensure residents knew how to file a grievance and that grievance forms were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R29, R32, R37 and R39) reviewed for grievances. This had the potential to affect all residents residing in the facility. Findings include: On 2/12/25 at 11:00 a.m., a resident council meeting was held with four residents which included R29, R32, R37 and R39. During the resident council meeting, all four residents indicated they were not aware of how to file a grievance or where to find a grievance form. All four residents stated that they knew they could talk to the previous social worker, but since he left none of them felt they could discuss grievances with social services director (SSD). During interview on 2/13/25 at 9:45 a.m., SSD stated the grievance filing process was often covered in the resident council meetings for those who attended and for everyone else there were signs posted and grievance forms located in the main lobby. SSD further stated any resident could ask her for assistance and she would provide a grievance form and help the resident fill it out. During observation and interview on 2/13/25 at 10:23 a.m., there were no grievance forms within sight or public access in the main lobby. Reception desk personnel (RDP) stated there were usually pamphlets describing the grievance process and grievance forms on a small table located on one side of the lobby. RDP stated there were none their now due to not having enough time to any out. RDP stated upon admission the resident should have also received the pamphlet in their admission packet and if they did not have one the resident or family could ask the SSD who would provide one. During interview on 2/13/25 at 11:25 a.m., administrator stated residents should be completing a complaint (grievance) form when concerns could not be easily resolved. Administrator stated residents and families could pick up a complaint form at the front desk and at all of the nursing stations and that anyone could request assistance in completing the form from staff or SSD. Administrator confirmed there was nowhere in the facility to drop of the completed form anonymously but though perhaps there was a way to complete a grievance form anonymously online through the facility website. During interview on 2/13/25 at 11:56 a.m., registered nurse (RN)-B stated if the resident had a concern, he would report it to the supervisor and that there were also forms they could give the resident to complete. RN-B looked around the nurses station as well as the small office behind the nurses station and was unable to locate a grievance form. RN-B stated he would have to refer the resident to the front lobby to retrieve a form since there were none on the unit. Facility pamphlet, Problem Resolution and Grievance Procedure dated 12/21, instructed resident or family to complete the form and then, Sign the form and Present the form to the grievance official as identified in the grievance procedure. The form identified that for a grievance regarding the facility, to Return to Social Worker or Administrator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy Grievances, Suggestions or Concerns-Rehab/Skilled, dated 12/2/24, indicated, A resident has the right to voice grievances orally, in writing and anonymously without discrimination or reprisal.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and record review the facility failed to notify the physican of a change in condition for 1 of 2 residents (R6) with a significant weight gain. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of central cord syndrom, spinal stenosis, and chronic pain syndrom. It further indicated R6 required substantial assistance with most activites of daily (ADL) and mobility. R6's physician's orders dated 2/5/25, indicated weekly weights to notify the physician for greater than (>) 5 pound weight gain in a week, (every evening shift every Wednesday) for edema. R6's care plan dated 12/20/24, indicated a nutritional diagnoses of obesity class III related to excessive calorie intake with an intervention to monitor changes in weight. R6's treatment administration record (TAR) for the month of February, indicated on 2/5/25, R6 weighed 397. 5 pounds (lbs) and on 2/12/25 weighed 406.1 lbs. This was a weight gain of 8.6 lbs. in one week. R6's progress notes and electronic medication administration report (emar) notes for the month of February lacked documentation of the physician being notified of a change in condition regarding the resident weight gain of 8.6 lbs. in one week. During interview on 2/13/25 at 10:25 a.m., RN-B verified R6's TAR indicated a weight gain of 8.6 lbs. in a week but felt they were using the wrong size sling to weigh R6 so he wanted to re-weigh her. RN-B further stated he did not re-weigh her right away because the NA (unknown) was leaving for the evening he was scheduled to come back the next day, so they would just reweigh R6 then. RN-B verified there was no documentation and the provider had not been notified. RN-B stated they would re-weigh her this evening. R6's progress note dated 2/13/2025 at 12:23 p.m., indicated a change in condition as evidenced by edema (new or worsening) and shortenss of breath (SOB) that appears different than usual. It further included a weight of 406.1 lbs. and a recommendation to send R6 to the hosptial for evaluation. During interview on 2/13/25 at 2:49 p.m., RN-F stated there's a reason why the physician ordered weekly weights so if there was a problem with the resident's weight, they should be re-weighed right away, notify the provider, and document. During interview on 2/14/25 at 8:42 a.m., RN-I stated if a resident needed to be re-weighed it should be completed right away, the provider should be notified if there was a problem, and documentation should occur. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During interview on 2/14/25 at 8:52 a.m., LPN-B stated if a resident needed to be re-weighed for some reason, it should be done as soon as possible. If there was still an issue he would notify the provider and document it. During interview on 2/14/25 9:16 a.m., RN-A stated if a resident needed to be re-weighed, it should be done right away and if there was an issue they would notify the provider and document. During interview on 2/14/25 at 10:15 a.m. the director of nursing (DON) stated if a resident needed to be re-weighed it should be done as soon as possible and if there's a problem, the physician should be notified, and it should be documented. A facility policy regarding weighing residents was requested and received however it did not pertain to the citation.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure pressure ulcer (PU) prevention interventions were in place for 1 of 2 residents (R66) reviewed for pressure ulcers. Findings include: R66's admission Minimum Data Set (MDS) dated [DATE], indicated R66 was cognitively intact, required partial to moderate assistance with mobility and most activities of daily living (ADLs), had one or more unhealed PU and at risk for developing more, and did not exhibit rejection of care behaviors. R66's diagnoses included congestive heart failure (CHF), type 2 diabetes mellitus, and dementia without behavioral, psychotic, or mood disturbance. R66's care plan dated 1/23/25, indicated R66 had an actual impairment to skin integrity due to diagnoses and had potential for further PU development due to decreased mobility. The care plan instructed staff to elevate heels off bed with heel protector boot to left leg. R66's Braden assessment (predicting pressure sore risk) dated 2/11/25, indicated R66 was at moderate risk for developing pressure sores. Intervention guide for moderate risk included heel protection. R66's physician order summary printed 2/13/25, indicated, Bilateral heels: Elevate Heels with heel suspension boots at all times. R66's February care card indicated, Elevate legs and feet when sitting. Bilateral heels: Elevate heels with heel suspension boots at all times. The care card indicated sign off two shifts per day and had been signed as completed for two shifts per day for each day in February. The care cared did not indicate R66 refused at any time. R66's Wound Evaluation and Management Summary dated 2/6/25, indicated, Patient has wound on her left lateral leg; left shin; left heel. The summary further indicated, Stage 3 pressure wound of the left heel full thickness .recommendations: off-load wound; float heels in bed; pressure off-loading boot; elevate legs During observation on 2/10/25 at 5:03 p.m., R66 was sleeping in her recliner, with legs elevated and feet resting directly on footrest. Pressure reducing blue boot not being used and sitting on R66's bed. During interview on 2/10/25 at 6:13 p.m., R66 stated the boot was supposed to be on her left foot but staff did not usually apply it. R66 stated she did not refuse when staff offered to place the boot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During observation on 2/12/25 at 7:33 a.m., registered nurse (RN)-J answered R66's call light. R66 requested assistance to the bathroom. RN-J assisted R66 to a standing position and pivot and transfer to wheelchair and into bathroom. After toilet use, RN-J assisted R66 back to the recliner. R66 raised the footrest. RN-J did not offer any pillows or to place the boot and left R66's room. During interview on 2/12/25 at 8:00 a.m., R66 stated did not have the boot on at all during the night. During observation on 2/12/25 at 8:04 a.m., RN-J re-entered R66's room to provide a water pitcher and again left the room without offering to don the boot or place pillows under R66's legs to float heels. During observation on 2/12/25 at 1:52 p.m., R66 was in bed with heels resting directly on the mattress. The blue boot was sitting on top of R66's cabinet-not in use. During observation on 2/13/25 at 8:09 a.m., R66 was in bed with heels resting directly on the mattress. The blue boot was sitting on top of R66's cabinet and not in use. During observation and interview on 2/13/25 at 8:22 a.m., nursing assistant (NA)-C confirmed R66's boot was not currently on her. NA-C further stated she had checked on R66 at the start of her shift and the boot was not on R66 at that time either and that her heels were not floated with pillows either. NA-C stated could not remember the last time she saw R66 using the blue boot. During interview on 2/13/25 at 8:27 a.m., RN-F stated resident's care plans should be followed. If R66's care plan instructed staff to ensure her heels were floated or in the boot, that staff should be doing so. RN-F stated was ultimately the nurse's responsibility to ensure this was being done. RN-F stated R66 had current wounds and was at risk for developing more and should have her heels protected. RN-F stated any refusals by residents should be documented in the electronic medical record (EMR). During observation and interview on 2/13/25 at 8:45 a.m., RN-C stated orders and care plans should be followed and expectation for R66's heel to be protected and not resting on the bed. RN-C stated any care refusals by residents should be documented. During observation and interview on 2/13/25 at 8:54 a.m., RN-C confirmed and stated R66's heels were not currently being off-loaded with a boot or any pillows. During interview on 2/13/25 at 9:13 a.m., wound doctor stated R66's heel wound was healed but would continue to recommend her heel be off loaded and protected with the use of the blue boot as long as a resident in the facility. During interview on 2/13/25 at 10:54 a.m., director of nursing (DON) stated expectation residents should have pressure relieving boots on as ordered and any refusals should be documented. Facility policy Pressure Ulcers-R/S, LTC, Therapy & Rehab dated 3/7/24, indicated, A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and document review the facility failed to ensure a urinary catheter was secured to facilitate urine flow and positioned below the bladder for 1 of 1 resident reviewed for catheter cares. ensure the proper use of a catheter for 1 of 1 resident (R68). Findings include: R68's annual Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of chronic kidney disease and retention of urine. It further indicated R68 required setup/cleanup assistance with toileting, was independent with mobility, had a catheter, was occasionally incontinent of bowel. R68's physician's order dated 1/9/25, indicated Foley catheter:16F catheter 10cc balloon change as necessary every 45-90 days, as needed for urinary retention. The order lacked documentation R68's leg bag did not need to be positioned below the bladder. R68's care plan dated 10/16/24, indicated R68 had an indwelling catheter related to an acute kidney injury (AKI) evidenced by urinary retention. It further indicated an intervention to monitor/document for pain/discomfort due to catheter. R68's care plan lacked interventions to ensure the catheter was positioned below the bladder. During observation on 2/10/25 at 7:44 a.m., R68 was lying in bed, wearing a leg catheter bag which was attached to his leg and even with his bladder. The leg bag was over halfway full of clear amber colored urine and there was urine in the tubing in between his bladder and the leg bag. During observation and interview on 2/10/25 at 7:58 a.m., nursing assistant (NA)-B stated she started her shift at 6:30 a.m. and hadn't done anything with R68's catheter. NA-B verified R68's drainage bag was not below his bladder and stated R68 wears a leg drainage bag all the time because he walked around a lot. During interview on 2/13/25 at 2:49 p.m., RN-F verified when a resident had a catheter, the drainage bag should be positioned below the bladder and if for some reason it wasn't able to be, the provider should be notified. During interview on 2/10/25 at 8:04 a.m., RN-G stated R68 used a leg bag all the time for his safety and because he walks around a lot. RN-G stated he wasn't sure if the physician's order indicated it was okay for R68's leg bag all the time. During interview on 2/10/25 at 8:21 a.m. RN-H stated R68 wears a leg bag all the time per his preference and preferences should be care planned. During interview on 2/13/25 at 10:25 a.m., RN-B stated a resident's catheter drainage bag should be positioned below the bladder but if for some reason they need to wear a leg bag all the time, the provider should be notified in order to consult with them. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During interview on 2/14/25 at 8:42 a.m., RN-I stated catheter drainage bags are supposed to be positioned below the bladder and anytime nursing staff are doing something different from what the physician's order indicates, they should notify the physician. This is important, so everyone knows why they are doing it. During interview on 2/14/25 at 8:52 a.m. licensed practical nurse (LPN)-B stated catheter drainage bags were supposed to be positioned below the bladder and if there was a reason why it wasn't able to be, nursing staff were responsible for notifying the provider. LPN-B further stated a catheter should be treated like a medication, when it was used outside it's intended purpose, it was important to notify the provider because they should be involved. During interview on 2/14/25 at 10:15 a.m., the director of nursing (DON) stated nurses were responsible for checking with the provider in order to change the way the catheter was being used. In this case, the catheter leg drainage bag was being worn all the time (even during the night while sleeping) and wasn't positioned below the bladder. The DON further indicated it was R68's preference to use the leg and preferences should be care planned and documented. A facility policy regarding catheter care dated 7/30/24, indicated leg bags may be used with a physician's order, catheter tubing is secured to the residents leg, coiled on bed with no kinks or obstructions and the rest of the tubing should be in a straight line into urinary drainage bag. Non-obstructed downhill flow is always maintained. When catheters with technical designs other than downhill flow are used, manufacturers instructions are followed. Always make sure drainage bag and tubing remain below level of catheter, bladder and coil tubing to promote drainage.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview and document review, the facility failed to ensure beverages were served in the appropriate consistency for 1 of 1 resident (R12) reviewed for therapeutic diets. Findings include: R12's State Optional Minimum Data Set (MDS) dated [DATE], indicated R12 had severe cognitive impairment, was independent after set-up with meals, worked with speech therapy from 1/15/25 through 1/27/25, and did not exhibit rejection of care behavior. R12's diagnoses included pneumonitis due to inhalation of food and vomit, other symptoms and signs concerning food and fluid intake, and type 2 diabetes. R12's annual MDS dated [DATE], indicated R12 required Mechanically altered diet - require change in texture of food or liquids [e.g. pureed food, thickened liquids]. R12's nutrition care area assessment (CAA) dated 1/19/25, indicated R12 required pureed textures and mildly thick liquids due to dysphagia. R12's care plan last revised 2/6/25, indicated R12 was at risk for altered nutrition/hydration and interventions included, Resident has order for thickened liquids. The care plan further instructed staff to monitor closely for swallowing difficulties. R12's Dietician assessment dated [DATE], indicated, Diet: CCHO diet/pureed textures/mildly thick [level 2] liquids. R12's Kardex dated 2/10/25, indicated, Mildly Thick consistency. All fluids must be thickened including water, coffee, pop. R12's physician order dated 1/14/25, indicated, CCHO [controlled carbohydrate] diet 4 Pureed texture, 2 Mildly Thick consistency. R12's Outpatient Video Fluoroscopic Swallowing Study (VFSS) dated 2/10/25, indicated, Plan/Goals: SLP [speech language pathologist] recommending modified oral diet consisting of IDDSI 6 Soft & Bite Sized Foods and IDDSI 2 Mildly Thick Liquids .Based on today's findings, patient would benefit from a repeat instrumental assessment to assist in diet upgrades given silent aspiration of thin liquids observed during today's VFSS. R12's medical record lacked evidence of a risks and benefits for non-compliance of ordered diet. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 2/10/25 at 2:04 p.m., a dry erase board just inside the entrance of R12's room indicated, pureed diet mildly thick liquid. R12 stated she just had another swallow study done today and was on a modified diet. R12 stated she did not like the pureed diet and thickened liquids, but that was what they provided. R12 stated risks and benefits of not following the prescribed diet had never been discussed. There was a can of soda on her bedside table out of reach with a straw that she stated was empty and wanted another one. During observation on 2/10/25 at 2:18 p.m., R12 activated call light to request a beverage. At 2:19 p.m., the administrator entered R12's room and inquired about her request. R12 stated she wanted a can of soda from the refrigerator in her room. Administrator removed a can of soda, opened it, and provided a new straw. Administrator handed R12 the soda, pushed the bedside table close to the bed and discarded the old can of soda. Administrator left the room. R12 confirmed the soda was 'normal' and had not been thickened. During interview on 2/10/25 at 2:59 p.m., registered nurse (RN)-A stated R12 required a diabetic diet, mechanically altered and thickened liquids. During interview on 2/10/25 at 3:00 p.m., RN-C stated R12 was on a CCHO diet with pureed and mildly thick consistency. RN-C stated all liquids should be thickened and that the family had supplied R12 with soda and that they know it should be thickened. RN-C stated if staff provide R12 with one of the sodas, they should be thickening it prior to serving. RN-C stated R12 could sometimes refuse but staff should always offer and encourage her to take thickened liquids due to her swallowing issues. During interview on 2/10/25 at 3:08 p.m., administrator stated she thought R12 was on thickened liquids but would have to refer to her orders to be sure. Administrator stated, I think she is non-compliant with her diet . but yes if she had thickened liquid diet ordered, then I should have offered to thicken it. Administrator further stated if R12 refused the ordered diet, R12 should be educated on risks and benefits. During interview on 2/12/25 at 9:46 a.m., family member (FM)-A stated she provided R12 with the soda but understood that it had to be thickened and would expect staff to be doing that prior to giving to R12 due to her risk of aspiration. FM-A stated a risks and benefits of not following the prescribed diet had never been discussed. During interview on 2/12/25 at 1:27 p.m. SLP stated R12 had just completed a swallow study a couple days earlier and that her diet recommendation continued as mildly thick liquids due to silent aspiration noted on study. During interview on 2/12/25 at 1:37 p.m., director of nursing (DON) stated expect residents to received diets as ordered with the correct texture and liquid consistency. R12 should have received mildly thickened liquids as ordered. Facility policy Acceptance of Therapeutic and/or Texture-Modified Diet-Food and Nutrition Service dated 5/14/24, indicated, acceptance of therapeutic or texture-modified diet and dietary interventions when there is a nutritional or swallowing concern. The policy further indicated staff would provide appropriate diet unless resident or resident representative refused, in which case evidence of refusals, education provided, and risks and benefits discussion would be documented in the resident's medical record and an order for a liberalized diet would have to be obtained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42584 Based on observation, interview and document review, the facility failed to ensure dishwasher temperatures were within range to ensure resident dishes were sanitized for 4 of 5 unit (Boundary Waters, Arrowhead, Lakes, Woodland) kitchenettes that housed and utilized dishwashers. In addition, the facility failed to maintain the coffee machine in a sanitary manner to prevent potential food-borne illness. These practices had the potential to affect all residents residing in these units. Findings include: Dishwasher Temperatures: During observation on 2/12/25 at 10:36 a.m., dishwasher temperature log in the Lakes unit kitchenette had temperatures documented for the following dates/meals (breakfast-B, lunch-L, dinner-D): 1/31/25-L, 2/1/25-B, L D, 2/2/25-B and L, and 2/4/25-L. During interview on 2/12/25 at 10:40 a.m., dietary aide (DA)-A stated it was the responsibility of the dietary staff working in the kitchenette for that shift to check and document the dishwasher temperatures. DA-A stated she thought they needed to be checked at least twice a day and confirmed the log in the Lakes unit was not complete or up to date. During observation on 2/12/25 at 10:50 a.m., Woodland unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 1/31/25-L, 2/1/25-B, L, D, 2/2/25-B, L, D, 2/4/25-L, and 2/10/25-L. During observation on 2/12/25 at 11:34 a.m., Boundary Waters unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 2/1-B,L,D, 2/2-B,L,D, 2/3-D, 2/4-D, 2/5-B,L,D, 2/6-B, 2/7B,L, 2/11-B,L,D. During observation on 2/12/25 at 11:37 a.m., Arrowhead unit kitchenette dishwasher log had temperatures documented for the following dates/meals: 2/1-B,L,D, 2/2-B,L,D, 2/4-D, 2/5-B,L,D, 2/6-L, 2/7-B,L, 2/11-B,L,D, 2/12-B. During interview on 2/13/25 at 11:17 a.m., KM stated expectation for staff to check wash and rinse cycle temperatures on the unit dishwashers twice a day and document the findings on a dishwasher log and take appropriate action if not up to proper temperature. Coffee maker cleanliness: During observation on 2/12/25 at 10:36 a.m., the coffee/hot water dispenser is dirty with splashed liquids- the overflow basin has water with some white foamy substance floating on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/12/25 at 10:40 a.m., DA-A stated it was the kitchen staff's responsible for maintaining and cleaning the unit kitchenettes. SA-A confirmed the coffee reservoir was not clean and stated it looked like mold floating on top of the liquid. DA-A stated that the coffee maker was supposed to be cleaned daily. During interview on 2/12/25 at 11:45 a.m., kitchen manager (KM) stated the dietary staff serving meals in each of the kitchenettes were responsible to clean and maintain a sanitary environment each shift. Staff had a checklist and were expected to sign and date when each task was completed. KM confirmed the Lakes unit kitchenette coffee maker reservoir was full of liquid and had an unknown white and black foamy substance floating on top of the liquid. KM stated it appeared that the reservoir had not been cleaned in 7-14 days. KM further confirmed the Lakes Kitchenette cleaning log had not been signed off as having the coffee maker cleaning completed. During interview on 2/13/25 at 12:09 p.m., administrator stated expectation for dishwasher temperatures be monitored and documented daily to ensure proper temperatures for sanitation. Administrator further stated expectation for staff to ensure kitchenettes were maintained and cleaned daily to ensure proper sanitation conditions. Facility Cleaning list (TASK) sheet for Lakes unit Kitchenette dated 2/9/25 - 2/15/25 indicated, Sanitize all counters Clean Coffee [sic] MACHINE CHECK COFFEE FOR REPLACEMENT and DISH WASHING & CLEANING STARS [sic] IMMEDIATELY AFTER, (BREAKFAST (LUNCH & (DINNER) THERE IS NO WAITING PERIOD. The list further indicated, PLEASE MAKE SURE YOU ARE DOING YOUR CLEANING & POSTED JOB DETAIL. ALL DIETARY EMPLOYEES MUST DOCUMENT TEMPERATURES. COMPLETE POSTED FLOOR ASSIGNMENTS/JOB DETAIL, PLEASE INITIAL ASSIGNED JOB DETAIL WHEN DONE. Facility policy Ware Washing-Mechanical and Manual-Food and Nutrition dated 3/25/24, indicated good ware washing (cleaning and sanitizing of utensils and food-contact surfaces of equipment) was to promote good practice regarding prevention of foodborne illness. The policy indicated, Food and nutrition employees ensure that food preparation equipment, dishes and utensils are effectively cleaned, sanitized to destroy potential disease carrying organisms. The policy further indicated temperatures of the wash and rinse cycle should be monitored and documented on the Dish Machine Temperature Log. Facility policy Cleaning Schedule-Food and Nutrition Services dated 11/21/24, indicated employees were responsible for knowing and completing assigned cleaning duties and to document completion on the Cleaning Schedule log each day. Guidelines for Kitchen and Equipment Cleaning .1. Check each equipment item in kitchen for cleanliness and that it is in good repair.