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F 000	INITIAL COMMENTS The Centers for Medicare and Medicaid Services (CMS) conducted a comparative Federal Monitoring Survey (FMS) on 10/21/24 through 10/24/24. Refer to State Survey Agency (SSA) Event ID D8E911. Deficiencies were cited. Census: 42	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents (R) were free from physical and verbal abuse related to resident-to-resident altercations for 1 of 1 (R31) resident reviewed. The facility failed to thoroughly investigate and implement interventions to prevent R31 from physically and verbally abusing fellow residents. R31 had a history of behaviors towards fellow residents including verbal harassment and threats,	F 600	1. Corrective Action: The facility acknowledges the incident between R31 and R40 and recognizes that the actions by R31 were based on a reasonable person standard, with no intent to harm, and were not willful. No physical or emotional harm was observed as a result of this altercation to support staff. R31 has since been discharged to a geriatric psychiatric facility as of 11/6/24 to ensure appropriate support. All relevant staff and the guardian involved in the resident's care were informed of the incident, the discharge decision, and the facility's ongoing commitment to resident safety and prevention of abuse.	11-15-24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bailyn Hildestad Bailyn Hildestad	CEO/Administrator	11-13-2024

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 600	Continued From page 1 physically aggressive behaviors, and use of derogatory remarks including yelling and arguing. The facility failed to prevent resident-to-resident abuse when facility staff witnessed R31 grab R40's arm and proceeded to push R40 back against the wall. The failure had the potential to affect all residents. Findings include: The facility policy Abuse, Neglect, and Exploitation revised 8/24, revealed in pertinent part: - every resident had the right to be treated with respect and dignity and to be free from verbal, sexual, physical, or mental abuse. - Abuse-the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish, and can include resident-to-resident altercation. Instances of abuse, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. - Mental abuse-including, but not limited to, humiliation, harassment, threats of punishment, or deprivation. - Physical abuse-including, but not limited to hitting, slapping, punching, biting, and kicking. - Verbal-use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, within hearing distance regardless of their age, ability to comprehend, or disability. - In the case of resident-to-resident abuse, staff would intervene immediately to separate and protect both residents, incident reports completed to assist in tracking behavior. - Incidents of resident abusive behaviors towards	F 600	2. Identify Other Residents: The facility recognizes that all residents could potentially be affected by similar incidents. To address this, a review was conducted to identify any residents who may exhibit behavioral issues that could lead to similar interactions. This proactive approach will help in implementing targeted interventions to prevent future occurrences. 3. Measures put in Place: Abuse, Neglect, and exploration policy was reviewed and updated 11-1-2024. New abuse documentation forms and an incident checklist have been developed to standardize the process of reporting, investigating, and documenting all abuse-related incidents, including resident-to-resident interactions. In-services will be conducted for Charge Nurses, RN On-Call Nurses, and the interdisciplinary team which will cover the use of the new forms and checklist, accurate documentation, criteria for reportable incidents, and completion of each checklist item.	

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F 600	Continued From page 2 residents would be documented in the medical record and an incident report completed. - Appropriate interventions for prevention and protection of other residents would be care planned and communicated to staff. Review of R31's Quarterly Minimum Data Set assessment (MDS-federally mandated assessment) with an assessment reference date (ARD) of 8/4/24, identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS revealed the resident had verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) 1 to 3 days in the previous 7 days. The resident was independent with ambulation and did not use an assistive device. The MDS listed diagnoses of dementia, anxiety, depression, and psychotic disorder. Review R31's Care Plan with a date of 11/4/22, identified the resident had a history of inappropriate comments and touching, assisting other residents, and going into other resident rooms. Interventions included: check in per social worker ongoing to assess if interventions need to be adjusted or another plan changed, seen by psychiatrist routinely, if consistently goes into a room that a resident feels they do not want a visitor to put a stop sign or barrier across the door, medications as ordered, re-direct if expressed inappropriate comments as needed, praise for indication the resident progress/improvement in behavior, re-direct and remind that unwanted touching not appropriate, staff provide education to resident about safety of helping residents and risks involved and to not assist other residents, staff to monitor sexual behaviors and comments and follow-up as	F 600	4. Monitoring: The Director of Nursing, or designee, will conduct random audits of five (5) residents weekly for the first two weeks, followed by biweekly audits for the next two weeks, and then monthly for two months. The ongoing frequency will be determined by the Quality Assurance (QA) program to ensure compliance with the updated abuse documentation forms and checklist. Each audit will confirm that all documentation is accurately completed, all checklist steps are followed, and incidents are reported promptly and correctly. If no incidents are available during the audit period, this will be documented to maintain an accurate record of compliance monitoring. Results from each audit will be submitted to the Director of Nursing and reviewed by the QA Committee to monitor compliance, identify gaps, and make procedural adjustments as needed to maintain consistent adherence to the new protocols. In cases of non-compliance, additional training or procedural revisions will be implemented. 5. Compliance Date: 11-15-2024	

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needed, and update provider of behaviors.
On 9/12/24 interventions updated and/or added included:
-BRO team (behavioral recovery outreach) declined to pick resident up for services
-Depo-Provera (hormone injection with off label use for behaviors) for hypersexuality per psychiatric provider and increase in dose and frequency as needed, order updated.
-Staff provide frequent checks and intervene as necessary.

During medication administration on 10/22/24 at 8:27 AM, R31 was in recliner, in room, watching television, and well groomed. R31 stated he had gotten teeth pulled the day before and was taking "easy today."

During an interview on 10/23/24 at 10:55 AM, R31 stated he had lived in a different facility prior to admission to the facility and had gotten in a "hassle" with "a psychotic guy, had to transfer, and moved here." R31 stated he had gotten into a "squabble," with a previous roommate. The resident stated he would prefer to go back to the previous facility due to more activities being available, including fishing. The resident denied any concerns with fellow residents and stated he had never had a physical altercation with a fellow resident. R31 stated he had not observed fellow residents hitting the facility staff and if he had observed he would "just separate them" like he would with a "bar fight."

Review of the Progress Notes for R31 revealed on:
-1/23/24 at 3:30 PM, the resident was walking to the dining room and a fellow resident was sitting in the hallway near the dining room. The facility

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staff overheard the residents yelling at each other and using profane language. The residents were told to break it up and R31 went to the dining room. No further intervention needed as the resident walked away after being told to break it up.
-1/26/24 at 6:32 AM, facility staff witnessed R31 call another resident a "cock sucker," and initiating an argument. The residents were separated and R31 then returned to the resident and attempted to instigate another argument.
-1/26/24 at 8:28 AM, facility staff witnessed R31 approached another resident in the dining room, called him a name, and swore at him. The staff asked R31 to step away and be nice.
-1/26/24 at 4:58 PM, staff witnessed R31 and a fellow resident swearing at each other in the hall. The residents separated after being asked by the staff.
-5/15/24 4:05 PM, during care plan review with guardian discussed psychiatrist had been updated on behaviors such as inappropriate statements, touching, and entering other resident's rooms. Guardian reported behaviors were not new for the resident.
-7/24/24 at 9:00 AM, the staff observed the R31 approach another resident and become aggressive towards the resident, yelling and attempting to hit. R31 stated the resident had stolen "his stuff." The staff intervened and separated the 2 residents. The resident that R31 yelled at was upset.
-8/1/24 at 1:14 PM, staff witnessed R31 saying disrespectful and taunting comments to another resident. Staff re-directed the other resident away, who became agitated with the comments from R31.
-9/2/24 at 10:46 AM, on 9/1/24 was reported that R31 was in the west hallway when another

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resident was highly agitated and had struck a staff member. R31 grabbed the resident (R40) and pushed him against the wall and yelled at him. The staff member present told R31 to go to his room and the staff would handle the matter, that it was inappropriate for R31 to yell or hurt other residents. The behavior was distressful to the other resident, pushed against wall and agitated.
-9/3/24 at 10:56 AM, R31's psychiatric provider and guardian were updated on increased agitation and physical aggression towards another residents.

Review of the facilities investigation included the following documents:
-Incident Investigation, Abuse-Complainant statement signed 9/3/24, revealed date incident occurred 9/1/24 at 8:00 PM and reported to the charge nurse 9/2/24 at 2:30 PM. Written statement by CNA1 (Certified Nurse Aide) stated she was assisting R40 away from another resident room when he hit out at her. R31 observed the encounter and came to assist CNA1, telling R40 he should not hurt people. CNA1 indicated she asked R31 to walk away and go to his room. R31 went to his room and R40 was assisted to the dining room. CNA1 documented she informed the charge nurse on 9/2/24 at 1:30 PM and the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) on 9/3/24.
-Note dated 9/2/24 stated, was not reported to the state due to the situation not causing harm physically or mentally to another resident. Per staff, R31 was re-directable and went back to his room.
-Progress Note for R40 created on 9/4/24 at 11:39 AM, stated no negative physical or mental

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harm/outcome to resident or staff occurred because of the incident. Other resident (R31) attempted to intervene but was re-directed back to his room without further issues.
-Description of Action Taken, undated, stated Aide directed other resident (R31) to go back to room that the situation was being handled and R40 taken to the dining room. R40 went with the aide still agitated but calmed down with re-direction. Identified that the behavior lasted 20 minutes. Interventions involved: re-direction, therapeutic communication, and fibbing. R40 had hit staff but R31 was involved and re-directed per CNA1 interview.
Follow-up clarification on note related to the incident with the nurse as did not match the interview with the aide involved, the charge nurse did not witness the event.
Clarification Progress Note added on 9/3/24 by the DON. Education/Support provided to CNA1 and Charge Nurse and additional check-in's with CNA1 to ensure no injuries.

During an interview on 10/23/24 at 9:17 AM, the Administrator stated she was aware of the resident-to-resident incident between R31 and R40 on 9/1/24 and had done a lot of research, however, the staff had intervened and there was no physical contact between the two residents. The Administrator stated R31 was in the hallway and approached CNA1 and R40 due to being worried about the staff and was asked to leave, R31 was re-directed. The Administrator stated R31 did not physically lay hands on R40. The Administrator stated the incident between R31 and R40 was not reported to the state agency due to there being no physical contact between the two residents. The Administrator stated she would not be able to provide the facilities

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investigation due to being a closed record and would determine what parts of the investigation she could share.

During an interview on 10/23/24 at 10:20 AM, the Administrator and the DON provided the Progress Notes for R40, stated they had provided the part of the investigation that was not a closed record. Explained to the Administrator and the DON that the survey team were allowed access to all records and investigations.

During an interview on 10/23/24 at 12:16 PM, the Social Services (SS) stated she did not witness the incident between R31 and R40 and had not been a part of the investigation. The SS stated when R31 was admitted to the facility he had behaviors towards staff, however, she was unaware of the resident having to transfer from another facility due to physical behaviors towards fellow residents. The SS stated R31's psychiatrist has been involved and adjusted medications as able due to the resident's guardian not approving adding certain medications (risperidone, antipsychotic medication). The SS stated she believed R31's behaviors were improved following last medication adjustment. The SS stated there were times the facility staff would implement hourly checks due to his increased behaviors towards other residents, when he attempted to rub the shoulders of a fellow female resident and caused the female resident to be uncomfortable. The SS stated she had contacted numerous other facilities, including several Veteran homes and services, and they refused to accept R31. The SS stated the facility offered R31 counseling services and he refuses.

On 10/23/24 at 1:06 PM, message left for

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Licensed Practical Nurse 1 (LPN1) and no return call.

During an interview on 10/23/24 at 3:00 PM, CNA1 stated she had been assisting R40 in the hallway when he became physically aggressive towards her and hit her in the head. CNA1 stated she was yelling for assistance due to her walkie talkie not working and being unable to get assistance while R40 was hitting her. CNA1 stated R31 then approached her and R40 during the incident and R31 told R40 not to hit people and proceeded to grab R40 by the arm and push him against the wall. CNA1 stated she immediately intervened before the situation escalated further and asked R31 to go to his room, told him that the staff would handle R40, and the nurse would come. CNA1 stated R31 went to his room without further incident. CNA1 stated "he just thought he was helping me." CNA1 stated R40 had a history of being aggressive towards staff. CNA1 stated she was not aware of R40 having any red marks or bruising to his arm, however, R40 had increased agitation following the incident. CNA1 stated she assisted R40 to the dining room for ice cream, where he eventually calmed down. CNA1 stated two other residents came out of their room while the altercation was occurring due to the yelling, however, returned to their room. CNA1 stated the two residents were not interviewable due to their cognition (confirmed). Jointly reviewed the nurse entry in the R31's progress notes of the incident and CNA1 confirmed what the nurse documented was accurate, R31 grabbed R40 by the arm, pushed him against the wall, and yelled at him. CNA1 stated she was not aware of any other resident-to-resident issues with R31, stated R31 got along well with others, but did keep to himself.

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CNA1 stated the Assistant Director of Nursing (ADON) was the only staff that followed up with her after the incident.

During an interview on 10/23/24 at 4:25 PM, the Administrator stated R31 was easily re-directed back to his room and stayed in his room following the incident. The Administrator stated she was not aware R31 had physically grabbed R40 by the arm and pushed him against the wall due to not being in CNA1's statement of the investigation. The Administrator stated the ADON completed the investigation and then reviewed with the Administrator and the Administrator had been informed there was no physical touching during the incident.
The Administrator stated R31 approached R40 and CNA1 and told R40 to stop hitting staff and CNA1 asked R31 to go back to his room and staff would handle the situation. The Administrator stated she had done education with the CNA1 to notify the ADON sooner regarding the incident and reviewed the steps to take in the process of a resident-to-resident altercation. The Administrator stated the incident occurred on a Sunday and she was made aware on Tuesday, due to a holiday weekend. The Administrator stated R31 was provided one to one's by the staff until the investigation was completed. When the Administrator was questioned about the discrepancy in documentation by LPN1 in R31's medical record and CNA1's statement, the Administrator stated she felt she did what she was supposed to with the information she had, "what's in our investigation is what we knew, and I went off of that."

During an interview on 10/24/24 at 8:35 AM, the ADON stated the resident-to-resident incident

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between R31 and R40 occurred on Sunday 9/1/24 and she was made aware upon her return on Tuesday 9/3/24. The ADON stated the DON had initiated the investigation and that she had only followed up with CNA1 when she failed to complete part of the report and sign. The ADON stated she called CNA1 to complete the report and confirmed she had no injuries. The ADON stated her, and the DON completed the risk report together and turned into the Administrator. The ADON stated she knew R40 had hit CNA1 and R31 attempted to intervene, however, was not aware of R31 grabbing R40's arm and pushing him against the wall.

During an interview on 10/24/24 at 8:39 AM, the DON stated she completed the investigation of the resident-to-resident incident between R31 and R40. The DON stated she was made aware of the incident on Tuesday 9/3/24 and was triggered by the documentation in the progress note by LPN1 and knew she needed to follow-up. The DON stated she interviewed CNA1 and LPN1, however, R31 was not able to recall what had occurred. The DON stated LPN1 informed her she did not witness the incident. The DON stated she then spoke with CNA1 to see if she had any injuries or concerns with what had occurred. The DON stated when she spoke with staff at the time of the investigation, R31 came out of his room due to hearing CNA1 and R40 and observed R40's behaviors and hitting CNA1. The DON stated the decision was made due to R31 being easily re-directed back to his room and at the time did not understand there was physical contact between R31 and R40. The DON was asked multiple times about the documentation in R31 and R40's medical record and she stated she had interviewed CNA1 and LPN1 and then

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F 600	Continued From page 11 the DON documented in the medical record there was not contact between the two residents. The DON stated she had asked about the discrepancy and determined R31 was easily re-directed to his room and R40 was taken to the dining room.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609	1.Corrective Action: The facility acknowledges the incident between R31 and R40 and recognizes that the actions by R31 were based on a reasonable person standard, with no intent to harm, and were not willful. No physical or emotional harm was observed as a result of this altercation to support staff. R31 has since been discharged to a geriatric psychiatric facility as of 11/6/24 to ensure appropriate support. All relevant staff and the guardian involved in the resident's care were informed of the incident, the discharge decision, and the facility's ongoing commitment to resident safety and prevention of abuse. 2. Identify Other Residents: The facility recognizes that all residents could potentially be affected by similar incidents.	11-15-24

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	355108	A. BUILDING _____ B. WING _____	10/24/2024

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F 609	Continued From page 12 Based on record review and interview, the facility failed to report a resident-to-resident abuse for 1 of 1 resident (R) reviewed for abuse (R31). The facility failed to report to the State Survey Agency when facility staff witnessed R31 grab R40's arm and proceeded to push R40 back against the wall. The failure had the potential to affect all residents. Findings include: The facility policy Abuse, Neglect, and Exploitation revised 8/2024, revealed in pertinent part: - Abuse-the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish, and can include resident-to-resident altercation. Instances of abuse, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. - Physical abuse-including, but not limited to hitting, slapping, punching, biting, and kicking. - All cases of suspected abuse must be reported to the State Survey Agency, as required by regulation, immediately upon receiving the allegation and again within five working days of the allegation with a complete written final report of the investigation. Confirmed cases of abuse may also be reported to the local police as appropriate. - Employee training topics to include identifying what constitutes abuse, reporting process of abuse, and understanding behavioral symptoms of residents that may increase the risk of abuse. - If there was a reasonable suspicion of a crime against any individual who is a resident, law enforcement would be notified. A report would be	F 609	3. Measures put in Place: A new policy implemented reporting allegations of abuse / neglect / exploitation with education to all staff. Specific in-services will be conducted for Charge Nurses, RN On-Call Nurses, and the interdisciplinary team which will Emphasize the importance of reporting all incidents of abuse, including those involving resident-to-resident interactions, to the State Survey Agency within the required timeframes. Review of Memorandum 04-2023 and appendix PP. 4. Monitoring The Director of Nursing, or designee, will conduct random audits of five (5) residents weekly for the first two weeks, followed by biweekly audits for the next two weeks, and then monthly for two months. The ongoing frequency will be determined by the Quality Assurance (QA) program to ensure compliance with the updated abuse documentation forms and checklist. Each audit will confirm that all documentation is accurately completed, all checklist steps are followed, and incidents are reported promptly and correctly. If no incidents are available during the audit period, this will be documented to maintain an accurate record of compliance monitoring.	

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F 609	Continued From page 13 made immediately, or not later than two after after forming the suspicion, if the events that caused the suspicion resulted in seriously bodily injury and not later than 24 hours if the events that caused the suspicion does not result in bodily injury. Review of R31's Quarterly Minimum Data Set assessment (MDS-federally mandated assessment) with an assessment reference date (ARD) of 8/4/24, identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS revealed the resident had verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) 1 to 3 days in the previous 7 days. The resident was independent with ambulation and did not use an assistive device. The MDS listed diagnoses of dementia, anxiety, depression, and psychotic disorder. Review R31's Care Plan with dated of 11/4/22, identified the resident had a history of inappropriate comments and touching, assist other residents, and go into other resident rooms. Interventions included: check in per social worker ongoing to assess if interventions need to be adjusted or another plan changed, seen by psychiatrist routinely, if consistently goes into a room that a resident feels they do not want a visitor to put a stop sign or barrier across the door, medications as ordered, re-direct if expressed inappropriate comments as needed, praise for indication the resident progress/improvement in behavior, re-direct and remind that unwanted touching not appropriate, staff provide education to resident about safety of helping residents and risks involved and to not assist other residents, staff to monitor sexual	F 609	Results from each audit will be submitted to the Director of Nursing and reviewed by the QA Committee to monitor compliance, identify gaps, and make procedural adjustments as needed to maintain consistent adherence to the new protocols. In cases of non-compliance, additional training or procedural revisions will be implemented. 5. Compliance Date: 11-15-2024	

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behaviors and comments and follow-up as needed, and update provider of behaviors. On 9/12/24 interventions updated and/or added included:
- BRO team (behavioral recovery outreach) declined to pick resident up for services
- Depo-Provera (hormone injection with off label use for behaviors) for hypersexuality per psychiatric provider and increase in dose and frequency as needed, order updated.
- Staff provide frequent checks and intervene as necessary.

Review of the Progress Notes for R31 revealed on:
- 9/2/24 at 10:46 AM, on 9/1/24 was reported that R31 was in the west hallway when another resident was highly agitated and had struck a staff member. R31 grabbed the resident (R40) and pushed him against the wall and yelled at him. The staff member present told R31 to go to his room and the staff would handle the matter, that it was inappropriate for R31 to yell or hurt other residents. The behavior was distressful to the other resident, pushed against wall and agitated.
- 9/3/24 at 10:56 AM, R31's psychiatric provider and guardian were updated on increased agitation and physical aggression towards another resident.

Review of the facilities investigation provided included the following documents:
- Incident Investigation, Abuse-Complainant statement signed 9/3/24, revealed date incident occurred 9/1/24 at 8:00 PM and reported to the charge nurse 9/2/24 at 2:30 PM. Written statement by CNA1 (Certified Nurse Aide) stated she was assisting R40 away from another

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resident room when he hit out at her. R31 observed the encounter and came to assist CNA1, telling R40 he should not hurt people. CNA1 indicated she asked R31 to walk away and go to his room. R31 went to his room and R40 was assisted to the dining room. CNA1 documented she informed the charge nurse on 9/2/24 at 1:30 PM and the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) on 9/3/24.
- Note dated 9/2/24 stated was not reported to the state due to the situation not causing harm physically or mentally to another resident. Per staff, R31 was re-directable and went back to his room.
- Progress Note for R40 created on 9/4/24 at 11:39 AM, stated no negative physical or mental harm/outcome to resident or staff occurred because of the incident. Other resident (R31) attempted to intervene but was re-directed back to his room without further issues.
- Description of Action Taken, undated, stated Aide directed other resident (R31) to go back to room that the situation was being handled and R40 taken to the dining room. R40 went with the aide still agitated but calmed down with re-direction. Identified that the behavior lasted 20 minutes. Interventions involved: re-direction, therapeutic communication, and fibbing. R40 had hit staff but R31 was involved and re-directed per CNA1 interview. Follow-up clarification on note related to the incident with the nurse as did not match the interview with the aide involved, the charge nurse did not witness the event. Clarification Progress Note added on 9/3/24 by the DON. Education/Support provided to CNA1 and Charge Nurse and additional check-in's with CNA1 to ensure no injuries.

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During an interview on 10/23/24 at 9:17 AM, the Administrator stated she was aware of the resident-to-resident incident between R31 and R40 on 9/1/24 and had done a lot of research, however, the staff had intervened and there was no physical contact between the two residents. The Administrator stated R31 was in the hallway and approached CNA1 and R40 due to being worried about the staff and was asked to leave, R31 was re-directed. The Administrator stated R31 did not physically lay hands on R40. The Administrator stated the incident between R31 and R40 was not reported to the state agency due to there being no physical contact between the two residents. The Administrator stated she would not be able to provide the facilities investigation due to being a closed record and would determine what parts of the investigation she could share.

During an interview on 10/23/24 at 10:20 AM, the Administrator and the Director of Nursing (DON) provided the Progress Notes for R40, stated they had provided the part of the investigation that was not a closed record. Explained to the Administrator and the DON that the survey team were allowed access to all records and investigations.

During an interview on 10/23/24 at 3:00 PM, CNA1 stated she had been assisting R40 in the hallway when he became physically aggressive towards her and hit her in the head. CNA1 stated she was yelling for assistance due to her walkie talkie not working and being unable to get assistance while R40 was hitting her. CNA1 stated R31 then approached her and R40 during the incident and R31 told R40 not to hit people and proceeded to grab R40 by the arm and push

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him against the wall. CNA1 stated she immediately intervened before the situation escalated further and asked R31 to go to his room, told him that the staff would handle R40, and the nurse would come. CNA1 stated R31 went to his room without further incident. CNA1 stated "he just thought he was helping me." CNA1 stated R40 had a history of being aggressive towards staff. CNA1 stated she was not aware of R40 having any red marks or bruising to his arm, however, R40 had increased agitation following the incident. CNA1 stated she assisted R40 to the dining room for ice cream, where he eventually calmed down. CNA1 stated two other residents came out of their room while the altercation was occurring due to the yelling, however, returned to their room. CNA1 stated the two residents were not interviewable due to their cognition (confirmed). Jointly reviewed the nurse entry in the R31's progress notes of the incident and CNA1 confirmed what the nurse documented was accurate, R31 grabbed R40 by the arm, pushed him against the wall, and yelled at him. CNA1 stated she was not aware of any other resident-to-resident issues with R31, stated R31 got along well with others, but did keep to himself. CNA1 stated the Assistant Director of Nursing (ADON) was the only staff that followed up with her after the incident.

During an interview on 10/23/24 at 4:25 PM, the Administrator stated R31 was easily re-directed back to his room and stayed in his room following the incident. The Administrator stated she was not aware R31 had physically grabbed R40 by the arm and pushed him against the wall due to not being in CNA1's statement of the investigation. The Administrator stated the Assistant Director of Nursing (ADON) completed the investigation and

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then reviewed with the Administrator and the Administrator had been informed there was no physical touching during the incident. The Administrator stated R31 approached R40 and CNA1 and told R40 to stop hitting staff and CNA1 asked R31 to go back to his room and staff would handle the situation. The Administrator stated she had done education with the CNA1 to notify the ADON sooner regarding the incident and reviewed the steps to take in the process of a resident-to-resident altercation. The Administrator stated the incident occurred on a Sunday and she was made aware on Tuesday, due to a holiday weekend. The Administrator stated R31 was provided one to one's by the staff until the investigation was completed. When the Administrator was questioned about the discrepancy in documentation by LPN1 in R31's medical record and CNA1's statement, the Administrator stated she felt she did what she was supposed to with the information she had, "what's in our investigation is what we knew, and I went off of that."

During an interview on 10/24/24 at 8:35 AM, the ADON stated the resident-to-resident incident between R31 and R40 occurred on Sunday 9/1/24 and she was made aware upon her return on Tuesday 9/3/24. The ADON stated the DON had initiated the investigation and that she had only followed up with CNA1 when she failed to complete part of the report and sign.

During an interview on 10/24/24 at 8:39 AM, the DON stated she completed the investigation of the resident-to-resident incident between R31 and R40. The DON stated she was made aware of the incident on Tuesday 9/3/24 and was triggered by the documentation in the progress

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F 609	Continued From page 19 note by LPN1 and knew she needed to follow-up. The DON stated she interviewed CNA1 and LPN1, however, R31 was not able to recall what had occurred. The DON stated LPN1 informed her she did not witness the incident. The DON stated she then spoke with CNA1 to see if she had any injuries or concerns with what had occurred. The DON stated when she spoke with staff at the time of the investigation, R31 came out of his room due to hearing CNA1 and R40 and observed R40's behaviors and hitting CNA1. The DON stated the decision was made due to R31 being easily re-directed back to his room and at the time did not understand there was physical contact between R31 and R40. The DON was asked multiple times about the documentation in R31 and R40's medical record and she stated she had interviewed CNA1 and LPN1 and then the DON documented in the medical record there was not contact between the two residents. The DON stated she had asked about the discrepancy and determined R31 was easily re-directed to his room and R40 was taken to the dining room.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610	1.Corrective Action: The facility acknowledges the incident between R31 and R40 and recognizes that the actions by R31 were based on a reasonable person standard, with no intent to harm, and were not willful. No physical or emotional harm was observed as a result of this altercation to support staff. R31 has since been discharged to a geriatric psychiatric facility as of 11/6/24 to ensure appropriate support.	11-15-24

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F 610	Continued From page 20 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a thorough investigation and failed to maintain and/or provide documentation that a thorough investigation was conducted for a resident-to-resident abuse for 1 of 1 resident (R) reviewed for abuse (R31). The facility failed to thoroughly investigate when facility staff witnessed R31 grab R40's arm and proceeded to push R40 back against the wall. The failure had to potential to affect all residents. Findings include: The facility policy titled Abuse, Neglect, and Exploitation revised 8/24, revealed in pertinent part: - In the case of resident-to-resident abuse, staff would intervene immediately to separate and protect both residents. Incident reports would be filled out to assist in tracking the behavior. Care planning would occur to develop approaches to address the behavior. - Incidents of resident abusive behaviors towards residents would be documented in the resident medical record and an incident report filled out. - Any employee who sees or suspects abuse would report immediately to the nurse on duty, nurse manager on call who will notify the Administrator. - The investigation would include interviews with person reported to have been abused, person	F 610	All relevant staff and the guardian involved in the resident's care were informed of the incident, the discharge decision, and the facility's ongoing commitment to resident safety and prevention of abuse. 2. Identify Other Residents The facility recognizes that all residents could potentially be affected by similar incidents. 3. Measures put in Place: New abuse documentation forms and an incident checklist have been developed to standardize the process of reporting, investigating, and documenting all abuse-related incidents, including resident-to-resident interactions. In-services will be conducted for Charge Nurses, RN On-Call Nurses, and the interdisciplinary team which will cover the use of the new forms and checklist, accurate documentation, criteria for reportable incidents, and completion of each checklist item.	

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F 610	Continued From page 21 who submitted the initial report of the allegation, any individual who may have knowledge surrounding the allegation, and the suspected abuser for their description of the event. - A summary of the investigation must be completed following the investigation of all alleged abuse situations. The summary must be in writing and includes summaries of all interviews and any other investigation activities. Review of R31's Quarterly Minimum Data Set assessment (MDS-federally mandated assessment) with an assessment reference date (ARD) of 8/4/24, identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS revealed the resident had verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others) 1 to 3 days in the previous 7 days. The resident was independent with ambulation and did not use an assistive device. The MDS listed diagnoses of dementia, anxiety, depression, and psychotic disorder. Review R31's Care Plan with dated of 11/4/22, identified the resident had a history of inappropriate comments and touching, assist other residents, and go into other resident rooms. Interventions included: check in per social worker ongoing to assess if interventions need to be adjusted or another plan changed, seen by psychiatrist routinely, if consistently goes into a room that a resident feels they do not want a visitor to put a stop sign or barrier across the door, medications as ordered, re-direct if expressed inappropriate comments as needed, praise for indication the resident progress/improvement in behavior, re-direct and remind that unwanted touching not appropriate,	F 610	4. Monitoring: The Director of Nursing, or designee, will conduct random audits of five (5) residents weekly for the first two weeks, followed by biweekly audits for the next two weeks, and then monthly for two months. The ongoing frequency will be determined by the Quality Assurance (QA) program to ensure compliance with the updated abuse documentation forms and checklist. Each audit will confirm that all documentation is accurately completed, all checklist steps are followed, and incidents are reported promptly and correctly. If no incidents are available during the audit period, this will be documented to maintain an accurate record of compliance monitoring. Results from each audit will be submitted to the Director of Nursing and reviewed by the QA Committee to monitor compliance, identify gaps, and make procedural adjustments as needed to maintain consistent adherence to the new protocols. In cases of non-compliance, additional training or procedural revisions will be implemented. 5. Compliance Date: 11-15-2024	

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staff provide education to resident about safety of helping residents and risks involved and to not assist other residents, staff to monitor sexual behaviors and comments and follow-up as needed, and update provider of behaviors. On 9/12/24 interventions updated and/or added included:
- BRO team (behavioral recovery outreach) declined to pick resident up for services
- Depo-Provera (hormone injection with off label use for behaviors) for hypersexuality per psychiatric provider and increase in dose and frequency as needed, order updated.
- Staff provide frequent checks and intervene as necessary.

During an interview on 10/23/24 at 10:55 AM, R31 stated he had lived in a different facility prior to admission to the facility and had gotten in a "hassle" with "a psychotic guy and had to transfer and moved here." R31 stated he had gotten into a "squabble," with a previous roommate. The resident stated he would prefer to go back to the previous facility due to more activities being available, including fishing. The resident denied any concerns with fellow residents and stated he had never had a physical altercation with a fellow resident. R31 stated he had not observed fellow residents hitting the facility staff and if he had observed he would "just separate them" like he would with a "bar fight."

Review of the Progress Notes for R31 revealed on:
-9/2/24 at 10:46 AM, on 9/1/24 was reported that R31 was in the west hallway when another resident was highly agitated and had struck a staff member. R31 grabbed the resident (R40) and pushed him against the wall and yelled at

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SMP HEALTH - MARYHILL	110 HILLCREST DR ENDERLIN, ND 58027

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him. The staff member present told R31 to go to his room and the staff would handle the matter, that it was inappropriate for R31 to yell or hurt other residents. The behavior was distressful to the other resident, pushed against wall and agitated.
-9/3/24 at 10:56 AM, R31's psychiatric provider and guardian were updated on increased agitation and physical aggression towards another resident.

Review of the facilities investigation provided included the following documents:
- Incident Investigation, Abuse-Complainant statement signed 9/3/24, revealed date incident occurred 9/1/24 at 8:00 PM and reported to the charge nurse 9/2/24 at 2:30 PM. Written statement by CNA1 (Certified Nurse Aide) stated she was assisting R40 away from another resident room when he hit out at her. R31 observed the encounter and came to assist CNA1, telling R40 he should not hurt people. CNA1 indicated she asked R31 to walk away and go to his room. R31 went to his room and R40 was assisted to the dining room. CNA1 documented she informed the charge nurse on 9/2/24 at 1:30 PM and the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) on 9/3/24.
- Note dated 9/2/24 stated was not reported to the state due to the situation not causing harm physically or mentally to another resident. Per staff, R31 was re-directable and went back to his room.
- Progress Note for R40 created on 9/4/24 at 11:39 AM, stated no negative physical or mental harm/outcome to resident or staff occurred because of the incident. Other resident (R31) attempted to intervene but was re-directed back

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to his room without further issues.
- Description of Action Taken, undated, stated Aide directed other resident (R31) to go back to room that the situation was being handled and R40 taken to the dining room. R40 went with the aide still agitated but calmed down with re-direction. Identified that the behavior lasted 20 minutes. Interventions involved: re-direction, therapeutic communication, and fibbing. R40 had hit staff but R31 was involved and re-directed per CNA1 interview. Follow-up clarification on note related to the incident with the nurse as did not match the interview with the aide involved, the charge nurse did not witness the event. Clarification Progress Note added on 9/3/24 by the DON. Education/Support provided to CNA1 and Charge Nurse and additional check-in's with CNA1 to ensure no injuries.

During an interview on 10/23/24 at 9:17 AM, the Administrator stated she was aware of the resident-to-resident incident between R31 and R40 on 9/1/24 and had done a lot of research, however, the staff had intervened and there was no physical contact between the two residents. The Administrator stated R31 was in the hallway and approached CNA1 and R40 due to being worried about the staff and was asked to leave, R31 was re-directed. The Administrator stated R31 did not physically lay hands on R40. The Administrator stated the incident between R31 and R40 was not reported to the state agency due to there being no physical contact between the two residents. The Administrator stated she would not be able to provide the facilities investigation due to being a closed record and would determine what parts of the investigation she could share.

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During an interview on 10/23/24 at 10:20 AM, the Administrator and the Director of Nursing (DON) provided the Progress Notes for R40, stated they had provided the part of the investigation that was not a closed record. Explained to the Administrator and the DON that the survey team were allowed access to all records and investigations.

During an interview on 10/23/24 at 3:00 PM, CNA1 stated she had been assisting R40 in the hallway when he became physically aggressive towards her and hit her in the head. CNA1 stated she was yelling for assistance due to her walkie talkie not working and being unable to get assistance while R40 was hitting her. CNA1 stated R31 then approached her and R40 during the incident and R31 told R40 not to hit people and proceeded to grab R40 by the arm and push him against the wall. CNA1 stated she immediately intervened before the situation escalated further and asked R31 to go to his room, told him that the staff would handle R40, and the nurse would come. CNA1 stated R31 went to his room without further incident. CNA1 stated "he just thought he was helping me." CNA1 stated R40 had a history of being aggressive towards staff. CNA1 stated she was not aware of R40 having any red marks or bruising to his arm, however, R40 had increased agitation following the incident. CNA1 stated she assisted R40 to the dining room for ice cream, where he eventually calmed down. CNA1 stated two other residents came out of their room while the altercation was occurring due to the yelling, however, returned to their room. CNA1 stated the two residents were not interviewable due to their cognition (confirmed). Jointly reviewed the nurse entry in the R31's progress notes of the incident

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and CNA1 confirmed what the nurse documented was accurate, R31 grabbed R40 by the arm, pushed him against the wall, and yelled at him. CNA1 stated she was not aware of any other resident-to-resident issues with R31, stated R31 got along well with others, but did keep to himself. CNA1 stated the Assistant Director of Nursing (ADON) was the only staff that followed up with her after the incident.

During an interview on 10/23/24 at 4:25 PM, the Administrator stated R31 was easily re-directed back to his room and stayed in his room following the incident. The Administrator stated she was not aware R31 had physically grabbed R40 by the arm and pushed him against the wall due to not being in CNA1's statement of the investigation. The Administrator stated the Assistant Director of Nursing (ADON) completed the investigation and then reviewed with the Administrator and had been informed there was no physical touching during the incident.
The Administrator stated R31 approached R40 and CNA1 and told R40 to stop hitting staff and CNA1 asked R31 to go back to his room and staff would handle the situation. The Administrator stated she had done education with the CNA1 to notify the ADON sooner regarding the incident and reviewed the steps to take in the process of a resident-to-resident altercation. The Administrator stated the incident occurred on a Sunday and she was made aware on Tuesday, due to a holiday weekend. The Administrator stated R31 was provided one to one's by the staff until the investigation was completed. When the Administrator was questioned about the discrepancy in documentation by LPN1 in R31's medical record and CNA1's statement, the Administrator stated she felt she did what she

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was supposed to with the information she had, "what's in our investigation is what we knew, and I went off of that."

During an interview on 10/24/24 at 8:35 AM, the ADON stated the resident-to-resident incident between R31 and R40 occurred on Sunday 9/1/24 and she was made aware upon her return on Tuesday 9/3/24. The ADON stated the DON had initiated the investigation and that she had only followed up with CNA1 when she failed to complete part of the report and sign. The ADON stated she called CNA1 to complete the report and confirmed she had no injuries. The ADON stated her, and the DON completed the risk report together and turned into the Administrator. The ADON stated she knew R40 had hit CNA1 and R30 attempted to intervene, however, was not aware of R31 grabbing R40's arm and pushing him against the wall.

During an interview on 10/24/24 at 8:39 AM, the DON stated she completed the investigation of the resident-to-resident incident between R31 and R40. The DON stated she was made aware of the incident on Tuesday 9/3/24 and was triggered by the documentation in the progress note by LPN1 and knew she needed to follow-up. The DON stated she interviewed CNA1 and LPN1, however, R31 was not able to recall what had occurred. The DON stated LPN1 informed her she did not witness the incident. The DON stated she then spoke with CNA1 to see if she had any injuries or concerns with what had occurred. The DON stated when she spoke with staff at the time of the investigation, R31 came out of his room due to hearing CNA1 and R40 and observed R40's behaviors and hitting CNA1. The DON stated the decision was made due to

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F 610	Continued From page 28 R31 being easily re-directed back to his room and at the time did not understand there was physical contact between R31 and R40. The DON was asked multiple times about the documentation in R31 and R40's medical record and she stated she had interviewed CNA1 and LPN1 and then the DON documented in the medical record there was not contact between the two residents. The DON stated she had asked about the discrepancy and determined R31 was easily re-directed to his room and R40 was taken to the dining room.	F 610		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of	F 801	1.Corrective Action: We designated an interim director of food and nutrition services who meets the qualifications outlined in §483.60(a)(2). This individual will be responsible for overseeing the food and nutrition services until the current in-training Dietary Coordinator completes the Certified Dietary Manager (CDM) course and obtains certification. 2. Identify Other Residents: We recognize the critical importance of having a qualified CDM to maintain ongoing compliance and excellence in dietary services. We will continue to conduct regular assessments and gather feedback from residents to identify any potential areas for improvement.	11-15-24

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F 801	Continued From page 29 supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services	F 801	3. Measures put in Place: Interim Director of Food and Nutrition Services expectation guidelines for duties and professional management functions/ responsibilities during this dedicated timeframe was signed 11-7-2024. The interim director of food and nutrition services will have oversight and be replaced from her activity position in this interim capacity to provide oversight, complete required duties, support in the kitchen, ensuring compliance with dietary regulations and assisting with staff training. In training Dietary Coordinator (Enrolled in CDM Training Program) will be provided with additional support and resources to expedite the completion of the CDM course. This includes access to study materials, scheduled study sessions, and mentorship from dietitian within the UND program, Maryhill's consultant dietitian, and interim director of food and nutrition. The PIP outlines specific goals and timelines for the in training dietary coordinator to achieve CDM certification, with a target completion dates for each lesson and final national credentialing exam by the end of the year (1-1-2025).	

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F 801	Continued From page 30 in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interviews, personnel file review, and review of the job description, the facility failed to ensure a qualified person was designated to serve as the director of food and nutrition services for 41 of 42 census residents. This failure had the potential to affect kitchen sanitation and resident quality of care related to food and nutrition. Findings include: Review of the Dietary Coordinator job description, revised 2/2/23, revealed the minimum qualifications included "Certified Dietary Manager (CDM)/ CNA [Certified Nurse Aide] Certification in North Dakota kept in good active standing." Handwritten section to include: "PIP [Performance Improvement Project] in place= active in CDM course work and support from [name of activity staff with current CDM]." Review of the personnel record for the Dietary Coordinator (DC) included active CNA and	F 801	4. Monitoring: The dietary coordinator in training will provide weekly updates for the duration of the coursework to complete the CDM program through email to track the progress of progression to stay on-track with target goal dates to complete CDM credentials. Results/status updates will be submitted to the administrator and reviewed by the QA Committee to monitor compliance, identify gaps, and make procedural adjustments as needed to maintain consistent adherence until the dietary coordinator in training is fully certified. 5. Compliance Date: 11-15-2024	

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Medication Aide (MA) licenses. No additional education included, aside from CDM coursework.

During an interview on 10/23/24 at 9:06 AM, the DC stated she did not have her CDM. She stated she used to have a Serv safe certification, but it expired. She stated she was currently in the CDM course and still had a few lessons with two exams left to complete.

During an interview on 10/23/24 at 10:17 AM, the Administrator stated that the only CDM in the facility was working as an Activity Aide (AA). She stated they had been working with the state agency on a plan for the CDM. She stated she was unsure how often the Registered Dietitian (RD) was in the facility. She stated the AA was there for support for the DM and helped with training. She stated the goal for the DC was to have a CDM by the end of the year. She stated the previous CDM (AA) stepped down in October 2023.

Review of the Performance Improvement Project, start date 10/1/23 with a completion date of 4/25, revealed the AA provided oversight for compliance related to care plans, IDT [Interdisciplinary Team], education for dietary staff, and support in the kitchen when needed. There was no documentation to include PIP meeting minutes or state agency interactions.

During an interview on 10/23/24 at 11:14 AM, the AA stated she thought she had stepped down from the DC position about two years ago. She stated they kept her as CDM to do a little in the kitchen and activities. She stated she was working full-time in activities. She stated she looked in the dining room at meals to help make

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F 801	Continued From page 32 sure the staff were doing what they needed to do. She stated the current DC was "management" in the kitchen. She stated a lot of the staff were unaware she was a CDM. She stated she did not do anything related to the Minimum Data Set (MDS) assessments, weights, or pressure ulcers. She stated she had access and would sometimes look to see if there were residents with weight loss. During an interview on 10/23/24 at 11:29 AM, the Dietary (D) 1 stated the dietitian came into the kitchen, but not that often. During an interview on 10/23/24 at 11:30 AM, D2 stated the dietitian came into the kitchen, maybe once a week. During an interview on 10/23/24 at 12:49 PM, the DC stated she talked to nursing about resident weight loss along with the dietitian. She stated she completed MDS assessments with oversight from the dietitian.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	1. Corrective Action: Immediate corrective actions have been taken as follows: • The expired coleslaw and heavy whipping cream were immediately disposed of in accordance with facility policy in front of the surveyor on 10/23/2024. • The ice machine was thoroughly cleaned and sanitized by Dakota Registration on Oct 25th, 2024. • Education was conducted on October 25th, 2024, with the dietary cook on the importance of checking and recording food temperatures before and during meals service to ensure compliance with food safety standards.	11-15-24

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F 812	Continued From page 33 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure food was not expired, the ice machine was cleaned and ensure proper food temperatures during meal service for 41 of 41 census residents. This failure had the potential to affect kitchen sanitation and the quality of care for residents related to food and nutrition. Findings include: Review of the facility's undated Food Storage Guidelines provided by the facility, revealed a typed addition to the top of the form which revealed "All expired foods shall be disposed of in the facility dumpster located by the facility garage." Review of the facility's undated policy titled, Food Safety: Ice revealed "Ice machines will be maintained in a clean and sanitary condition to prevent contamination ...Ice machines and containers will be cleaned and sanitized monthly." Review of an invoice, dated 8/27/24 and provided by the facility, revealed the kitchen ice machine was cleaned and sanitized on this date. Review of the facility's undated policy titled, Food Temperatures revealed "All hot food items must	F 812	2. Identify Other Residents: An audit of all food storage areas, including refrigerators and freezers, was conducted to identify and dispose of any additional expired food items. The audit will also ensure that the ice machine was cleaned and sanitized. This has helped prevent any potential impact on the quality of care for all residents. 3. Measures put in Place: An in-service education program will be conducted by the Interim director of food and nutrition services with all dietary staff on November 14th, 2024. • The facility's Date Making for Food Safety, Food Storage and Food Safety Guidelines, & sanitation inspection policies have been updated to include specific procedures for checking expiration dates and cleaning schedules for ice machines. An inspection report is completed weekly which is submitted to the QA committee. • A revised food temperature policy has been re-educated to all dietary staff to take and document food temperatures at the start of meal service and they conducted regular intervals of temping the food during the meal service. This includes both hot and cold food items.	

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F 812	Continued From page 34 be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F [Fahrenheit] ...All cold food items must be stored at a temperature of 41 degrees F or below ...Temperatures should be taken periodically to assure hot foods stay above 135 degrees F and cold foods stay below 41 degrees F during the holding and plating process ..." 1. During an observation on 10/23/24 at 9:05 AM, the top of the right-sided rack in the walk-in refrigerator had a four-pound container of coleslaw with a use by date of 10/16/24. The tall refrigerator near the tray line had a one-quart container of heavy whipping cream on the top rack with a date marked 10/17/24. The inside of the ice machine was dirty with a dark brown-black substance on the right side and the partitions were dirty. During an interview on 10/23/24 at 9:06 AM, the Dietary Manager (DM) stated they used the date on the container as the expiration date. The DM confirmed the coleslaw and heavy whipping cream were expired and needed to be thrown out. The DM also confirmed the ice machine was dirty. She stated an outside company cleaned the ice machine every six weeks and they [dietary staff] were supposed to clean it every month. 2. During an observation on 10/23/24 at 11:49 AM, Dietary (D) 1 took the egg salad out of the cold storage and it was placed on the countertop. At 11:51 AM, the tray line started with no food temperatures taken. At 12:06 PM, D1 made an egg salad sandwich for a resident. At 12:19 PM, D1 placed some of the egg salad on a plate for a resident.	F 812	4. Monitoring: The interim director of food and nutrition services will conduct: • Five (5) random temperatures (hot & cold items) on the service line for the first two weeks, followed by biweekly audits for the next two weeks, and then monthly for two months. • Weekly audits of food storage areas and ice machines for the first two weeks, followed by biweekly audits for the next two weeks, and then monthly for two months. Ongoing frequency determined by the Quality Assurance (QA) program to ensure compliance. Results from each audit will be reviewed by the QA Committee to monitor compliance, identify gaps, and make procedural adjustments as needed to maintain consistent adherence to the new protocols. 5. Compliance Date: 11-15-2024	

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F 812	Continued From page 35 During an interview on 10/23/24 at 12:21 PM, D1 stated she took temperatures of the food when it came out of the oven but confirmed she had not taken any temperatures prior to meal service. During an observation and interview on 10/23/24 at 12:40 PM, D2 took the egg salad and moved it to another location so that she could make more. She took the temperature of the egg salad, and it was 45.8 degrees. She stated the temperature needed to be 35-40 degrees. During an observation and interview on 10/23/24 at 12:46 PM, D1 took the temperature of the broccoli at the end of tray line service, and she stated it was 140 degrees. Upon observation of the thermometer, the temperature read 126 degrees. D1 stated the temperature for hot food needed to be 165 degrees. During an interview on 10/23/24 at 12:49 PM, the DM stated the food temperatures needed to be less than 41 degrees for cold food. She stated the ice machine was marked off as cleaned by dietary staff for September 2024. At 1:28 PM, she stated maintenance did not clean the ice machine located in the kitchen. She stated it was cleaned by the dietary staff.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the	F 867	1. Corrective Action: We are pleased to have received positive feedback from federal surveyors, noting the absence of dietary or food complaints from residents, which is a significant recognition of our commitment to quality.	11-15-24

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F 867	Continued From page 36 following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that	F 867	To address identified gaps in our Quality Assurance Performance Improvement (QAPI) program, we have implemented steps to ensure an effective Performance Improvement Project (PIP) for the Dietary Coordinator's Certified Dietary Manager (CDM) certification. An interim CDM has been appointed to oversee dietary services temporarily, ensuring continuity and compliance. Additionally, we have reviewed and updated our QAPI policies to ensure that future PIPs include specific, measurable goals, progress tracking, and adherence to regulatory standards. 2. Identify Other Residents While no dietary complaints were reported, we recognize the critical importance of having a qualified CDM to maintain ongoing compliance and excellence in dietary services. We will continue to conduct regular assessments and gather feedback from residents to identify any potential areas for improvement.	

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F 867	Continued From page 37 improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and	F 867	3. Measures put in Place: To strengthen oversight of dietary services, we have developed a revised PIP with clear, SMART goals for the Dietary Coordinator's upcoming lessons and exams, including the completion of the CDM certification. Dietary Quality Assurance and Performance Improvement policy has been updated and educated to the interim director of food and nutrition services, in-training dietary coordinator, and consultant dietitian. In-service education will be conducted for the interdisciplinary team on Nov 13th, 2024, including covering QAPI oversite and understanding performance improvement projects. 4. Monitoring: The Dietary Coordinator in training will provide weekly progress updates via email throughout the duration of the CDM program. These updates will track progression against target goal dates for completing CDM credentials. The Administrator will review these updates, and the QA Committee will monitor compliance, identify gaps, and make procedural adjustments as needed. This process will continue until the Dietary Coordinator in training is fully certified, ensuring consistent adherence to our high standards. 5. Compliance Date: 11-15-2024	

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available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure an effective quality assurance performance improvement (QAPI) program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety.

Specifically, the facility failed to effectively implement a plan of action to develop an effective performance improvement project (PIP) including periodic progress updates, to correct not having a

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F 867	Continued From page 39 qualified Certified Dietary Manager (CDM). Findings include: Review of facility policy, Quality Assurance and performance Improvement (QAPI), revised 4/24 revealed in pertinent part, - "3. The QAPI plan will address the following elements: ... vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed." - "4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: ... c. Data collection and analysis at regular intervals. d. Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities." Review of facility policy, QAPI Change process, revised 4/24 revealed in pertinent part, - "4. Corrective Action - ... b. Corrective action plans include: ... ii. Measurable goals; ... and iv. A description of how the QAA committee will monitor to ensure changes yield the expected results." - "7. Performance Tracking - ... a. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained." Review of facility Job Description for Dietary Coordinator, last revised 2/2/23 revealed in pertinent part, - "The Dietary Coordinator organizes, coordinates, directs and participates in the activities of the food service staff. They also plan therapeutic diets to meet the daily nutritional	F 867		

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needs of the residents of Maryhill, while ensuring the residents receive food that is tasty and appealing. The Dietary Coordinator also plays a major role in ensuring that the environment in the dining room is conducive to a pleasant dining experience and that residents are offered as much choice as possible in food selections, times that they eat, and the dining setting."
- "Certificate/License: Certified Dietary Manager (CDM) I CNA (Certified Nursing Assistant) certification in North Dakota kept in good active standing."

Review of facility Process Improvement Plan (PIP), dated 1 October 2023 revealed in pertinent part,
- "Project Title: CMD Requirements. Start Date: 10/1/23. Goal Date: 4/2025."
- "Plan ... Need to send someone through CDM coursework - this is a 2 year program."
- "Dietary Coordinator: Working on obtaining her CDM with support from everyone listed below. Works with others list below to keep Maryhill's dietary department complaint."
- "CDM and Activity Assistant (AA) at [facility name]: Oversight for compliance related to [facility name] care plans, IDT (Interdisciplinary Team), education for dietary staff, & supports in the kitchen when needed. [AA name] does most of her work on education [Dietary Coordinator name] to continue to help her succeed [sic].
- "Mentor for CMD training support for [Dietary Coordinator name]: Sister Facility full-time dietitan [sic]."
- "Dietician: Supports [facility name] with all Dietitian [sic] oversite."
- "Goal Review: <blank>"
- "Note: *Status change still in effect as of Oct 1st, 24 as [Dietary Coordinator name] work

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towards CDM. [AA name] is aware."

PIP does not reveal plan for scheduled or adhoc status updates, measurable goals nor expected program status update timeline. The only goal was completion of CDM certification approximately 2 years from PIP implementation.

Review of the personnel record for the Dietary Coordinator (DC) included active CNA and Medication Aide (MA) licenses. No additional education included, aside from CDM coursework.

During an interview on 10/23/24 at 9:06 AM, the DC stated she did not have her CDM. She stated she used to have a Serv safe certification, but it expired. She stated she was currently in the CDM course and stated she started the CDM course last year. She stated she just started unit 3, and she has 4 units left with 2 exams - including the final exam.

During an interview on 10/23/24 at 10:17 AM, the Administrator stated that the only CDM in the facility was working as an Activity Aide (AA). She stated they had been working with the state agency on a plan for the CDM. She stated she was unsure how often the Registered Dietitian (RD) was in the facility. She stated the AA was there for support for the DM and helped with training. She stated the goal for the DC was to have a CDM by the end of the year. She stated the previous CDM (AA) stepped down in October 2023.

Review of the Performance Improvement Project, start date 10/1/23 with a completion date of 4/25, revealed the AA provided oversight for compliance related to care plans, IDT

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[Interdisciplinary Team], education for dietary staff, and support in the kitchen when needed. There was no documentation to include PIP meeting minutes or state agency interactions.

During an interview on 10/23/24 at 11:14 AM, the AA stated she thought she had stepped down from the DC position about two years ago. She stated they kept her as CDM to do a little in the kitchen and activities. She stated she was working full-time in activities. She stated she looked in the dining room at meals to help make sure the staff were doing what they needed to do. She stated the current DC was "management" in the kitchen. She stated a lot of the staff were unaware she was a CDM. She stated she did not do anything related to the Minimum Data Set (MDS) assessments, weights, or pressure ulcers. She stated she had access and would sometimes look to see if there were residents with weight loss.

During an interview on 10/23/24 at 11:29 AM, the Dietary (D) 1 stated the dietitian came into the kitchen, but not that often.

During an interview on 10/23/24 at 11:30 AM, D2 stated the dietitian came into the kitchen, maybe once a week.

During a follow up interview on 10/24/24 at 9:07 AM with the Administrator and DON stated that the facility has a PIP in place to get the Dietary Coordinator certified as a Certified Dietary Manager. They said the plan was to have the Dietary Coordinator complete the approved 2-year program coursework for the CDM certification by April 2025. The Administrator stated that the PIP and its elements were

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reviewed with the State Agency (SA), and were given the "Ok," and told that the PIP met the requirements. The Administrator said most status updates provided to the SA were via telephone, but they would provide what email communications they had to demonstrate what progress updates were provided to the SA. The Administrator also stated that the quarterly QAPI minutes would not document PIP progress notes, only "PIP updates were discussed."

The Administrator stated that the AA (former CDM) provides support to the Dietary Coordinator with updating and developing resident Care Plans and Interdisciplinary Team (IDT) documentation.

Review of an email provided by the facility Administrator, dated 13 October 2023 at 11:39 AM between the Administrator and the SA revealed in pertinent part, "our previous dietary coordinator still works for us in a full-time role and her CDM license is active."

During an interview on 10/24/24 at 10:04 AM the State Agency staff referred to an email dated 13 October 24, from the facility Administrator, the Administrator wrote, "My current dietary coordinator is in her course work to get her CDM that is supposed to be finished in April of 2024."

Review of a series of emails, provided by the facility Administrator after survey exit revealed,
-- An email dated 10/26/24 at 2:50 PM revealed,
- PIP program status update statement, dated 10/25/24 from the Dietary Coordinator.
- Undated Preceptor Evaluation Forms for lessons 1-4, 6-10, and 12.
- A list of outstanding quizzes and tests from the CDM program as well as grades for quizzes and

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F 867	Continued From page 44 tests completed. - An Employee Status Change form for [AA name] documenting, "Req change -> CDM for care plan/IDT" and signed 9/29/23 by AA and the Administrator. There was also an added note documented and signed by AA and the Dietary Coordinator, "With [sic] Oct 1st regulation changes, [AA name] is CDM overseeing care planning processes for dietary and IDT process. [Dietary Coordinator name] is currently in her CDM in training courses with [institution] with a finished completion date of May 8th, 2024. [Dietary Coordinator name] is being mentored by a full-time dietitian [Dietician name] from [sister facility name]. [Dietary Coordinator name] will still be in charge of staffing and support [AA name] as a designee." - QA Committee minute review 1 October 24 - "[Dietary Coordinator's name] CDM coursework update on status - Next exam at the end of the month. Goal to finish by 1-1-2025." 6 August 24 - "[Dietary Coordinator's name] CDM coursework update on status." 2 April 24 - "[Dietary Coordinator's name] CDM coursework update on status. Next Unit Exam Scheduled for June." 2 January 24 - "[Dietary Coordinator's name] CDM coursework update on status." The QA Committee minutes reveal little in PIP progress. Cross reference F801	F 867		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883	1.Corrective Action: Immediate corrective action was taken, and the Infection Preventionist (IP) coordinated with the pharmacy, the resident, the resident's guardian, and the physician to facilitate the administration of the PCV20 vaccine on October 24, 2024, the same day the surveyors exited.	11-15-24

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F 883	Continued From page 45 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883	2. Identify Other Residents An audit will be conducted for all current residents to review their immunization records and ensure they are up to date with pneumococcal vaccinations according to CDC recommendations. Any residents identified as needing additional vaccinations will be promptly offered the appropriate immunization. 3. Measures put in Place: The facility will revise its pneumococcal vaccine policy to include a detailed protocol for reviewing and updating residents' immunization status upon admission and during quarterly assessments. A new vaccination checklist will be implemented to prompt staff to review and document immunization status during each resident's quarterly Minimum Data Set (MDS) assessment. In-service education will be conducted for IP/MDS Coordinator, clinical security, and nursing staff to receive training on the updated policy and CDC guidelines for pneumococcal vaccinations to ensure compliance.	

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F 883	Continued From page 46 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, Centers for Disease Control and Prevention (CDC) guidelines, and interview the facility failed to ensure residents were offered the pneumococcal immunization for 1 of 5 eligible residents (R) reviewed for the immunizations (R31). Findings Include: Types of pneumococcal vaccines: PCV13 (Prevnar 13) = pneumococcal conjugate vaccine that practices against 13 types of bacteria that can cause pneumococcal disease. PCV15 (Prevnar 15) = pneumococcal conjugate vaccine that practices against 15 types of bacteria that can cause pneumococcal disease. PCV20 (Prevnar 20) = pneumococcal conjugate vaccine that practices against 20 types of bacteria that can cause pneumococcal disease. PPSV23 (Pneumovax 23) = pneumococcal conjugate vaccine that practices against 23 types of bacteria that can cause pneumococcal disease. Professional reference from the CDC,	F 883	4. Monitoring: The Director of Nursing, or designee, will conduct a monthly audits of resident immunization records for six months to ensure compliance with the updated policy and CDC guidelines with ongoing frequency determined by the Quality Assurance (QA) program to ensure compliance. Results from each audit will be submitted to the Director of Nursing (DON) and reviewed by the QA Committee to monitor compliance, identify gaps, and make procedural adjustments as needed to maintain consistent adherence to the new protocols. 5. Compliance Date: 11-15-2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 47	F 883		

Pneumococcal Vaccine Recommendations, reviewed 10/23/24 from https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html revealed the CDC recommended the administration of one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose or give one more dose of PPSV23 at least 1 year after PCV13 and at least 5 years after previous PPSV23 dose.

The facility policy titled Influenza, Pneumococcal and COVID (coronavirus) Vaccine revised 5/2024, stated the pneumococcal vaccine would be offered upon admission and as needed per the facilities standing orders and CDC recommendations. Upon admission, the resident would have the opportunity to consent to taking the pneumococcal vaccine. Immunization history would be documented in the resident's electronic health record and the facility would provide the pneumococcal vaccine for those residents who had not been previously vaccinated or need to be revaccinated.

The Quarterly Minimum Data Set (MDS-federally mandated comprehensive assessment) for R31 with an assessment reference date of 8/4/24, revealed a date of birth of 11/12/54. The MDS diagnoses included: hypertension and diabetes. The MDS identified R31 being up to date on the pneumococcal vaccine.

The Immunization Report printed on 10/23/24, for R31 identified the resident had received the PPSV23 on 11/1/18 and a Pneumovax dose on 7/13/17.

The Long-term Transfer Summary dated 11/3/22, identified R31 received PCV13 on 7/13/17 and

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F 883	Continued From page 48 PPV23 on 11/1/18. Review of R31's medical record revealed no evidence that R31 was offered additional vaccinations to complete the series. During an interview on 10/23/24 at 9:23 AM, the Infection Preventionist (IP) stated she would need to review R31's immunization record and call the pharmacy for guidance. The IP stated the facility reviewed resident's immunization records upon admission and reviewed with the pharmacy. During a follow-up interview on 10/23/24 at 2:11 PM, the IP stated R31 was a younger resident and upon admission noted he had received the PPSV23 and did not proceed. The IP stated she spoke with the pharmacy and recommended R31 receive PCV20. The IP stated she spoke with R31, his guardian and the physician and the resident would obtain PCV20.	F 883		