STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to protect the residents' rights to be free from neglect when the facility did not provide care, comfort, and safety. This resulted in immediate jeopardy (IJ) for 3 of 4 residents (R1, R2, R3) who experience mental anguish, and emotional distress when care and services were not provided to assist these dependent residents to get out of bed. In addition, the facility failed to provide care and services for R5 who was dependent on staff to get out of bed. The immediate jeopardy began on 2/28/25, when the facility failed to provide care, comfort, and safety. This resulted in mental anguish, and emotional distress when care and services were not provided to R1, R2, and R3 to get out of bed. These residents were dependent on staff for bed mobility. The Chief Operating Officer, the [NAME] President of Clinical, the Director of Nursing, and Administrator were notified of the IJ on 2/28/25 12:42 p.m. and the immediacy was removed on 3/3/25 at 4:10 p.m. However noncompliance remained at the lower scope and severity level 2 (D isolated.) which indicated no actual harm with potential for more than minimal harm Findings include: R1's nursing progress note dated 12/12/24, taken from a hospital encounter on 12/10/24, indicated R1's podiatrist recommended R1 to be non-weight bearing and to use a wheelchair or a foot scooter. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.). R1's care plan dated 1/2/25, indicated R1 was a total assistance of two staff and the use of a full body lift for transfers. The care plan did not identify what lift to use or the sling size to be used. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025

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Highland Chateau Health and Rehabilitation Center	2319 West Seventh Street Saint Paul, MN 55116

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan dated 1/4/25, indicated staff were to assist R1 with ambulation and transfers, and utilize therapy recommendation. The care plan did not indicate what the therapy recommendations were. Upon interview with R1 on 2/26/25 at 2:12 p.m., R1 began crying stating he needed help; he had not gotten out of bed since December. R1 stated when he first came to the facility, the staff tried to get him out of bed, but the machine did not work, and no one has tried since. R1 was told he was non-weight bearing and had made two appointments with his doctor to find out why and if he could get cleared to bear weight. On both occasion the facility was not able to get him to his appointment because there was something wrong with transportation due to his size. R1 did not think he had any skin impairments. R1 continued to cry throughout the interview. R1 stated the only activity he has been provided is the television in his room and on occasion the facility will offer bingo or a group activity, but he is unable to get there since they can't get him out of bed. R1's wife brought him a handheld game device and a book. R1 expressed the need to be outside with access to fresh air. Upon observation and interview on 2/27/25 at 10:12 a.m., R1 put on his call light and requested to sit in his wheelchair. Nursing assistant (NA)-A told R1 she was not sure how to get him up and left to get the nurse. NA-A and registered nurse, (RN)-A returned to R1's room telling R1 they needed more assistance and the mechanical lift. t. NA-A, NA-B, RN-A and the certified occupational therapist (OTA)-A returned with a different mechanical lift, rolled the resident from side to side placing the sling for the mechanical lift under R1. When the staff connected the sling to the mechanical lift, the mechanical lift base would not fit under the bed frame. Staff again left, returned with the director of nursing (DON) who directed staff to use a different mechanical lift to see if the base of that lift would fit under R1's bed. Staff returned with a different mechanical lift, connected the sling to the lift, and were able to begin lifting R1. R1 screamed in pain stop, stop, my legs are being pinched R1 was laid flat in bed, staff placed towels between R1's upper thighs and the sling and retried the lift. R1 told staff that is not helping, the sling is too small. Staff laid R1 back in bed and said they were not able to transfer him out of bed because the sling was too small. The sling size was XXXL, which is the largest size the facility had. After the failed attempt to lift R1 out of bed, R1 began crying again stating he did not feel safe at the facility. If there was an emergency, he would not be able to get out. The director of nursing on 2/27/25 at 3:10 p.m. stated she was not aware R1 had not been transferred out of bed since admission in December 2024. The facility would need a new mechanical lift and a sling size that fit R1 to move him from his bed. If there was an emergency or a fire the facility would not be able to transfer or move R1, the facility would need to call 911 for assistance. Upon interview on 2/27/25 at 12:07 p.m., the physician assistant (PA) stated the beginning of 2/2025 was the first time he saw R1 and was aware staff hadn't been walking him. Instead of having R1 leave the facility to see Podiatry he ordered an in-house x-ray of R1's foot to ensure there were no fractures. R1's order was changed from a non-weight bearing status to ok to bear weight. The PA was not aware staff had not been getting R1 out of bed at all. There was no reason he could not have gotten up to his wheelchair, even with a non-bearing order. PA stated The facility should not admit a bariatric resident if they can't take care of them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon interview on 2/28/25 at 9:35 a.m., R1 stated after the staff attempted to get him out of bed on 2/27/25 he panicked and lost sleep due to feelings of anger and anxiety that he should have been getting out of bed to his wheelchair daily despite being told he could not due to a non-weight bearing status. He had been having thoughts of self-harm over the past month due to feeling isolated and being in bed. The self-harm thoughts increased after the attempt to get him out of bed on 2/27/25. Upon interview on 2/28/25 at 10:27 a.m. the Social Worker designee (SW) stated R1 had always maintained a happy and positive attitude until about a week ago he expressed feelings struggling that he hadn't gotten out of bed since December. He didn't mention suicidal ideation to the SW, she did not ask him specifically if he was suicidal. R2 R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. MDS did not indicate R2's functional mobility. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid severe obesity due to excess calories, reduced mobility, chronic pain and pre-diabetes. R2's weight was 435 lbs. Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was an obese lady dressed in a hospital gown in bed who had just finished lunch. She stated the only time she had been out of bed was when she was transferred to the hospital in early February. She stated she feels the reason is because of her obesity. Staff cannot handle her because at times it takes four staff members just to assist her to wash up. She cried during the visit stating the only thing she had in her room is her bible. She wanted to at least see the facility she is living in and get some fresh air. Upon observation and interview on 2/27/25 at 11:26 a.m., R2 pressed her call light and requested to licensed practical nurse (LPN)-A answered the call light and R2 requested to get her out of bed. LPN-A explained to R2, she was unable to get her out of bed until she spoke with the therapy department. Also, R2 didn't have a wheelchair to sit in, and LPN-A didn't know what size sling, for the mechanical lift, to use on R2. Upon interview on 2/27/25 at 12:07 p.m., the PA stated there was no reason R2 should not be getting out of her bed daily. Upon interview with R2 on 2/26/27 at 12:12 p.m., R2 stated she has not gotten out of her bed since admission until she had to go to the hospital for respiratory distress. Staff attempted to use the mechanical lift once and set her back down on the bed because the lift was not stable. R2 stated she worked with physical therapy upon admission, they were able to sit her up in bed, which she said, felt wonderful. Staff have not gotten her out of bed since that one time on early admission. R2 stated she put on her call light to request getting out of bed, the staff turn off her call light, tell her they are going to get staff, then never come back. R2 stated she wanted to return to physical therapy and be able to get out of bed. R2 became tearful stating she lived in fear because the only time she was out of bed was when the paramedics took her to the hospital. PT stopped working with R2 due to her getting to her optimum level and when her arm strength was good enough PT would see her again R3 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not identify what type of lift or what size sling to be used on R3. R3's quarterly MDS dated [DATE], indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified. Upon interview on 2/27/25 2:18 p.m., R3 stated he hadn't been out of his bed since 12/2024. He stated he would like to get up, but he is transferring out of the facility soon and was tired of arguing with staff every day. R3 pointed to a small wheelchair and stated he couldn't get up if he wanted to because he didn't fit in the chair. R3 began to cry and stated it was a daily fight with the staff to even ask to sit in his chair and if discharge to an assisted living facility does not happen soon, he will throw himself to the floor and crawl out naked. R3 stated he did not feel safe, in the event of an emergency he would be on his own and have to crawl out to safety. Upon interview with the 2/27/25 at 12:07 p.m. the P.A. was concerned with R3 being in bed all the time and wrote orders for a prophylaxis antibiotic for concerns of returning cellulitis, a pressure relieving mattress, and every other day bathing since he found out R3 had not had a bath or shower in over three months. Upon observation and interview on 2/28/25 at 10:15 a.m., R3 was in bed in hospital gown, five urinals were on a garbage can next to his bed, three of them had urine in them, there was an odor of urine in the room. R3's hair appeared greasy. He stated he felt like a, beast in a cage losing health every day. He stated in the fall of 2024 he was standing and able to ambulate a few steps and that was the last time he ambulated. He believed staff had gotten him out of bed in December of 2024, but could not recall a specific date. Currently his legs could not hold him and required the use of a mechanical lift. Upon interview on 2/26/25 at 4:08 p.m., the director of nursing (DON) stated she was aware that in 12/2024 R1 had difficulty with the full body lift rated to lift 500 lbs., so she instructed the staff to use the full body lift rated to lift 600 lbs. She hadn't heard anything since she instructed the staff to use the lift rated for use at a higher weight. DON was not aware they had not gotten R1 out of bed. The DON also stated she wasn't aware that R2 wasn't getting out of bed, and she wasn't certain of the status of R3, if he was a full body lift or if he was transferring on his own. Staff had not reported any concerns to her about R1, R2 or R3. Her expectation was staff would report an inability to get residents out of bed and/or equipment concerns to her immediately. R5 R5's admission MDS dated [DATE], indicated a BIMs score was nine indicating moderate cognitive impairment. R5 was dependent on two or more staff for toileting hygiene, shower/bathing, and upper body dressing and all transfer activity. Lower body dressing was not attempted. R5's pertinent diagnoses were morbid obesity and heart failure. R5's weight was 377 lbs. R5's nursing progress note dated 2/17/25 at 12:29 p.m., indicated R5 was sent to the hospital for confusion, extreme fatigue, and pulse oximeter saturation of 80% (normal 92-100%). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon interview on 2/28/25, R5's family member (FM)-A stated R5 left the facility due to a stroke and would not be returning to the facility because the entire time she was at the facility she did not get dressed or out of her bed. When FM-A visited in the late morning or afternoon R5 would not be dressed and was still in bed. R5 was a joyful happy person, but the isolation at the facility made her depressed. FM-A would call the facility and attempt to speak with staff but would not be able to speak with anyone. Her reason for calling was to find out if R5 had gotten up for the day, but never received an answer. Upon a telephone interview on 2/28/25 at 4:42 p.m., R5 stated she never got out of bed while at the facility. She felt the staff couldn't handle a bigger gal. She refused to go back to the facility after her hospital stay because she recalled crying everyday at the facility. Upon interview on 3/3/25 at 9:05 a.m., nursing assistant NA-B stated he didn't recall R5 getting out of bed, and she was a full body lift resident. He couldn't recall the reason. He stated, he didn't know if it was a therapy concern, if she refused or if they didn't have a sling for her. Upon interview on 3/3/25 at 4:05 p.m., the OTA, therapy manager stated R5 required the use of full body mechanical lift. She was not certain if staff was getting R5 up or not. She stated she didn't feel the facility should have admitted such heavy residents if staff can't get all the residents out of bed in a given day. The residents should be getting up daily unless they have a special circumstance such as an illness. -On 1/17/25 at 3:40 p.m. the immediate jeopardy was removed when the facility: -Had Physical therapy reassess R1, R2 and R3 on their transfer status -Updated R1, R2, and R3's care plans. -Educated staff about the need to follow the care plan. -Ensured the facility had the proper equipment in working order. A facility policy titled Abuse and Neglect - Clinical Protocol indicated neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan. The care plans for 3 of 3 residents (R1, R2, and R3) failed to indicate specifically which mechanical lift and sling was to be used during transfers. In addition R3 had conflicting information on his care plan of how he was to transfer out of his bed. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.). R1's care plan dated 1/2/25 indicated R1 was a total assistance of two staff and the use of a full body lift. The care plan did not indicate what weight limit on the lift was to be used or which sling was to be used. Upon interview on 2/28/25 at 8:52 a.m. nursing assistant (NA)-B stated he worked with R1 almost daily. He stated he didn't know what lift to use, however R1 was not getting out of bed because he believed R1 was a non-bearing status and not getting up. He stated he would use the 600 lb. lift as he could visually see R1was heavy. In regard to the sling each resident has their own sling left in their room. There is a color code chart on each lift that identified which sling to use if the NA knows the residents weight. Upon observation on 2/28/25 at 3:40 p.m. each lift did have a color-coded chart for which sling to use. R2 R2's care plan dated 1/21/25, indicated R2's bed mobility was two-person total assistance. R2 required the use of a full body lift for transfers. The care plan did not indicate what weight limit on the lift to use or the sling size. R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid, severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon observation on 2/26/24 at 12:56 p.m., R2 did not have a sling in her room. A lift with 500 lb. limit was outside her room. R2 stated she didn't know what lift or what sling was to be used because the facility hadn't only attempted to get her up once, shortly after admission. Upon observation and interview on 2/27/25 at 11:26 a.m., licensed practical nurse (LPN)-A, confirmed R2's care plan did not indicate what weight limit on the lift or sling size was to be used. She stated staff weren't getting R2 up anyway because R2 didn't have a large enough wheelchair for R2 to be transferred to. LPN-A stated she wasn't certain what size sling to use on R2 as the facility wasn't able to get R2's weight. R3 R3's quarterly MDS dated [DATE], indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's was dependent in toilet, showering/bathing. Upper and lower body dressing and bed mobility was not assessed. R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not indicate what weight limit on the lift was to be used or sling size to be used. R3's care plan dated 7/28/24, indicated R3 was to be transferred using a stand pivot transfer to wheelchair with assistance of one staff member. Upon interview on 2/27/25 at 2:18 p.m., R3 stated he used a mechanical lift as he would not feel comfortable without a mechanical lift. He stated since he hadn't gotten out of bed since 12/2024 he wasn't certain which sling the staff would be using. He wasn't certain what his care plan indicated for transferring Upon interview on 3/3/25 at 9:05 a.m., NA-B stated R3 would be a mechanical lift however he had not gotten him out of bed. He stated he would ask the supervisor before using a lift to find out which lift and which sling to use. Upon interview on 3/3/25 at 2:32 p.m. the director of nursing stated she was aware the care plan didn't indicate which lift was to be used or the color of the sling to be used on each resident. She added that information to R1, R2, R3 as part of the abatement plan from the immediate jeopardy of the survey. A comprehensive care plan policy was requested however none obtained.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44649 Based on interview, and record review the facility failed to carry out activities for 1 of 3 (R3) dependent residents reviewed for assistance with activities of daily living (ADLs). Findings include: R3's provider order dated 2/25/25, indicated R3 was to be assisted with bathing every other day. R3's eMAR dated 2/1/25 - 2/28/25, indicated R3 was to be assisted with bathing every other day. No document was obtained to indicate R3 received assistance with bathing. Upon observation and interview on 2/28/25 at 2:18 p.m., R3 was in bed, in a hospital gown. R3 had shoulder length, thick greasy hair and a full beard. R3 stated he complained to the Physician Assistant (PA) he hadn't had his hair washed since he was in the hospital in 12/2024. He stated he hadn't been in the actual shower ever at the facility and maybe got a bed bath weekly without his hair being washed. Upon interview on 2/28/25 at 3:09 p.m., PA stated R3 complained to him about not getting cleaned-up at the facility and not having his hair washed since had been in the hospital in 12/2024. The PA wrote an order on 2/25/28, for R3 to be get assistance with bathing every other day. R3's care plan dated 3/4/24, indicated R3 was totally dependent on one staff member to provide bath or shower. The plan did not indicate the frequency of every other day bathing order from 2/25/25. R3's eMAR dated 3/1/25 - 3/4/25, indicated R3 was supposed to receive assistance with bathing every other day. No document was obtained that R3 received assistance with bathing. Upon interview on 3/4/25 at 2:32 p.m., the director of nursing (DON) stated she was not aware R3 was not getting assistance with bathing as ordered by PA. DON confirmed R3 had complained about his hygiene and had a specialized provider order for every other day bathing. No policy on activities of daily living in reference to bathing was obtained upon request.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review, the facility failed to support the facility-sponsored and individual activities for residents preference to support their physical, mental and psychosocial well-being for 3 of 3 residents (R1, R2, & R3) who were dependent on staff for activities. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.). R1's progress notes dated 12/11/24 at 3:40 p.m., indicated it was very important to have books, magazines and newspapers to read. It was very important to be around animals such as pets and it was somewhat important to do things with groups of people. It was very important to go outside to get fresh air based on an activity assessment. R1's care plan dated 12/16/24 indicated R1 did well with one-on-one activities and was working on coming out to other activities. R1's progress note dated 1/6/25 at 12:00 p.m. R1 had stated I just want someone to talk to. R1's activity Point of Care (POC) response history dated 1/26/25, indicated R1 did not participate in any activities over the past 30 days. Upon observation and interview on 2/26/25 at 2:12 p.m., R1 was laying in bed, in a hospital gown. He started weeping at the beginning of the interview as he stated he hadn't been out of his bed since his admission on 12/11/24. He felt isolated and alone. R1 had not been given activities to keep him occupied except for the television in his room, a handheld video game and a book his wife had brought for him. R1 recalled he had one one-to-one activity with the activity department early on in his admission. R1 would like to meet other residents, get outside for fresh air and attend group activities to help the time pass. Upon interview on 2/27/25 at 9:44 a.m., the director of activities stated she had completed a one-to-one activity with R1. She stated she could not recall the date and provided an undated form indicating she had completed a one-to-one and R1 would like to try to play bingo soon. The activity director believed this encounter had taken place around a month and a half ago and that was the last time she had complete a one-to-one with him. She stated she couldn't get residents to group activities if the nursing staff couldn't get the residents out of bed to attend the activities. R2 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Highland Chateau Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2319 West Seventh Street Saint Paul, MN 55116	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses was morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's care plan dated 1/13/25 indicated R2 liked self-initiated activities such as reading spiritual books. No facility-initiated group activities identified. Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was in her bed wearing a hospital gown. She had a bible on her tray table. R2 stated the only time she had been out of her bed was during a hospital stay on or about 2/10/25. She stated her days get confused as they are all the same. R2's only activity was her bible that she borrowed from her sister. R2 would have liked to play Bingo, see the rest of the facility, and go to a bible class that nursing assistant (NA) provides. R2 had never had an activity one-to-one visit. Upon interview on 2/27/25 at 9:44 a.m., the activity director stated she had not completed any one-on-one visits with R2, and nursing was unable to get R2 out of bed to attend any of the group activities. R3 R3's care plan dated 3/5/24 indicated R3 needed one-to-one bedside-in-room visits and activities to if he is unable to attend out of room events. Staff was to invite/encourage R3's family members to attend activities with residents in order to support participation. R3's quarterly MDS dated [DATE] indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified. Upon observation and interview on 2/27/25 at 2:18 p.m., R3 was in his bed dressed in a hospital gown. R3 stated he had not been out of his bed since 12/24. He had been at the facility for about a year and had created his own activities because the facility had not given him any. He would like to get into his wheelchair and go outside as he can hear others chatting outside from his room. I sit here all day and waste away. R3 played video games with a family member remotely every evening and his family member visited on weekends, otherwise he diddles with his laptop all day. Upon interview on 2/27/25 at 2:30 p.m., the activity director stated R3 spends his time on his laptop all day. He is unable to get out of bed and can not get to group activities. He had been offered books or magazines but declined. The activity director did not have an assist. Upon interview on 3/4/25 at 2:32 p.m., the Administrator stated all residents are to receive group or individual activities. She stated the activity director documents the activities. Any staff can perform activities, and her expection was for staff to assist dependent residents with activities. She was not aware that staff was not getting R1, R2, or R3 out of bed to attend activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Activity Programs with a revision date of 1/20/25 indicated all activities are documented in the resident's medical record. The activities program is ongoing and included facility-organized group activities, independent individual activities and assisted individual activities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to weigh residents per their standing order guidelines for 2 of 3 residents (R1 and R2) reviewed for weekly weights. Findings include: R1's standing orders dated 12/10/24, indicated R1 was to have weekly weights taken. R1's care plan dated 12/16/24, indicated R1 was to be weighed per facility protocol. R1's electronic medication administration record (eMAR) dated 12/1/24 - 12/31/24, indicated R1 was to be weighed every seven days on 12/11/24, 12/18/24, and 12/25/24. The record indicated on 12/11/24, a chart code of drug refused was entered and no weight was documented. On 12/18/24, a weight of 548 lbs. was documented. On 12/25/24, a chart code indicated to other / progress notes. No weight documented. R1's electronic medication administration record (eMAR) dated 1/1/25 - 1/31/25, indicated R1 was to be weighed weekly on 1/8/25, 1/15/25, 1/22/25 and 1/29/25. On 1/15/25 the record indicated R1 weighed 548 lbs. On 1/8/25, 1/22/25 and 1/29/25 the record indicated a chart code of other / see progress notes and no weights were documented. R1's eMAR dated 2/1/25 - 2/28/25, indicated R1 was to be weighed every week on 2/6/25, 2/11/25, 2/19/25 and 2/26/25. On 2/6/25, the record indicated a chart code other /see progress notes, no weight was documented. On 2/12/25 and 2/19/25, a chart code indicated drug refused, no weight was documented. On 2/26/25, a chart code indicated non-applicable, no weight was documented. Upon interview on 2/26/25 at 2:12 p.m., R1 stated the had not gotten out of bed since his admitted [DATE]. He stated the staff had attempted to get him up with a mechanical lift with a weight limit of 500 lbs. in 12/2024, but it didn't work. He stated he wasn't certain if he was too heavy for the lift as he thought he weighted around 550 lbs. but hadn't been weighed at the facility. Upon interview on 2/28/25 at 8:52 a.m., nursing assistant (NA)-B stated he worked with R1 almost daily and had not weighed him or witnessed him being weighed. He stated he wasn't certain how R1 would be weighed since he was not able to get up and the bed didn't have a scale. R2 R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses included morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's standard order sheet dated 2/7/25, indicated R2 was to be weighed weekly. R2's care plan dated 1/14/25, indicated to obtain R2's weight per facility policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's eMAR dated 1/1/25 - 1/31/25, indicated R2 was to have weekly weights on 1/10/25, 1/17/25, 1/24/25 and 1/31/24. On 1/10/25, no weight was documented. The weight for 1/17/25, chart code indicated as other/ see nursing note with no weight documented. The weight for 1/24/25, was documented as 435 lbs. and the weight for 1/31/25 indicated R2 was hospitalized . Upon interview on 2/26/25 at 12:56 p.m., R2 stated she had never been weighed and the facility, she felt she had lost some weight and would like to know her current weight. Upon interview on 2/27/25 at 8:15 a.m., licensed practical nurse (LPN-A) stated she had not weighed R2 and if the note says she did it must have been an error. She stated all residents on the transitional care unit (TCU) were to be weighed weekly. Upon observation on 3/3/25 at 1:30 p.m., R2 was lifted out of bed with a mechanical lift. The weight limit indicated on the mechanical lift was 600 lbs. R2 asked the staff what she weighed and was informed the lift she was required to use did not have a scale on it. A facility Policy titled Weight Assessment and Intervention indicated resident weights are monitored for undesirable or unintended weight loss or gain.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and record review the facility failed to attempt to try alternative devices before using bedrails on resident's beds for 5 of 5 residents (R1, R2, R3, R6, & R7) when the facility failed to accurately assess the resident for risk of entrapment by assessing residents' medical diagnoses, height and weight, cognition, communication, mobility, and risk of falling. In addition, the facility failed to provide ongoing assessments to assure the bedrail was used to meet the resident's needs. Findings include: Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated October 2023 indicated a physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material, or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident. R1's Bed Rail/Assist bar evaluation dated 12/11/24 at 4:35 p.m., was blank, no questions were answered. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively impaired. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.). R1's bed rail was not indicated. R1's care plan dated 12/16/24 - 3/3/25, did not indicated the use of bedrails. R1's bed mobility was extensive assistance/one person physical assist. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon observation and interview on 2/26/25 at 2:12 p.m., R1 had bilateral 1/4 upper bed rails. The bed rails were permantly affixed to the bed and could be lowered. R1 stated he would hold the rails when staff was turning him with cares. He did not use the rails to independently reposition himself in bed. He did not recall a formal assessment completed for the use of the bed rails. R1 could not remove the bed rails on his own. R2 R2's Bed rail/Assist Bar evaluation dated 1/21/25 at 9:29 p.m., was blank, no questions were answered. R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses wee morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs. R2's bed rail was not indicated. R2's care plan dated 1/21/25 - 3/3/25, did not indicate the use of bedrails. R2's bed mobility was a two person total assistance. Upon observation and interview on 2/26/25 at 12:56 p.m., R2 was laying in bed. She had an upper 1/4 bed rail on the left side of her bed. The rail was permanently affixed to the bed, but could be lowered. She stated she had two bed rails, but the right one was removed when she went to the hospital and hadn't been replaced. R2 stated she needed the right bed rail put back on her bed to assist her with bed mobility. She had been asking staff; however, the bed rail had not been replaced. She was not able to remove or lower the rail on her own. R3 R3's Bed rail/Assist Bar evaluation dated 5/15/24, indicated R3 had a bed rail to assist with bed mobility and safety. R3 expressed the desire to have the rail, had no fluctuations in level of consciousness or a cognitive deficit. R3 was able to follow directions and he had a history of falls. He did not have poor balance, trunk control or hypotension (low blood pressure). The bedrail did help R1 to rise from a supine (lying) position to a standing position and R3 was not able to climb over the bar and had no medications that would require safety precautions. The form was not signed by the resident or the physician. Review of R3's medical record lacked indication if further bedrail evaluations had been completed since 5/15/24. R3's quarterly MDS dated [DATE] indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's was dependent in toilet, showering/bathing. Upper and lower body dressing and bed mobility was not assessed. R3's nursing progress note dated 3/4/24 at 8:25 p.m., indicated R3's bed rail/assist evaluation had been completed, based on the evaluation, the bed rail or assist bar is indicated and will serve as an enabler to promote independence. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's care plan dated 3/4/24 - 3/3/25, did not indicate the use of bedrails. R3 required limited assistanceof one staff to turn and reposition in bed. Upon observation and interview on 2/27/25 at 2:18 p.m., R3 stated when he had gotten out of bed using a gait belt and staff assistance, he used the bed rail to assist himself to a standing position. He used the bed rails to reposition himself in bed. R3 did not recall a formal staff assessment for the bed rails or any measuring of them. R3's bed rails were bilateral 1/4 rails permanently affixed by the head of his bed. He could not lower or remove the bedrails on his own. R6 R6's Bed rail/Assist Bar evaluation dated 10/23/24 at 11:59 a.m., did not indicate what type of rail was being used, interventions and care plan updated or a signature from resident or the physician. The evaluation did indicate R6 did not desire to have bed rails/assist bar when in bed for safety or comfort and based on the summary a bed rail or assist bar was not indicate at that time. Review of R6's record lacked indication if further bed rail evaluations had been completed since 10/23/24. R6's admission MDS dated [DATE], indicated R3 had a BIMs of 15 indicating she was cognitively intact. R6 was independent with toileting hygiene, dressing and mobility. R6's pertinent diagnoses were bipolar disorder, paranoid personality disorder, lack of coordination, and adult failure to thrive. R6's bed rail was not indicated. R6's unsigned clinical physician orders dated 10/22/24 - 3/3/25, did not indicate the use of bed rails. R6's care plan dated 10/22/24 - 3/3/25, did not indicate the use of bed rails. R6 was independent with bed mobility. Upon observation and interview on 2/28/25 at 1:08 p.m., R6's bed rails were bilateral 1/4 rails permanently affixed by the head of his bed. She could not lower or remove the bedrails on his own She stated she didn't use them as she was independent. She thought the rails were there to keep her from falling out bed when she slept. She didn't mind the rails as they made her feel safe while sleeping. R6 did not recall any formal assessments by the staff for the rails. R7 R7's Bed rail/Assist bar evaluation dated 8/9/24 at 8:32 p.m., indicated R7 had not requested and did not have bed rail in use. R7's annual MDS dated [DATE], indicated R7's BIMs score was 15, indicating he was cognitively intact. R7's pertinent diagnoses were chronic congestive heart failure, acquired absence of left leg below the knee. R7's bed rails were not identified. R7's unsigned clinical physician order dated 4/9/24 - 3/3/25, did not indicate the use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's care plan dated 4/9/24 - 3/3/25, did not indicate the use of bed rails. R7 was indendent with bed mobility. Upon observation and interview on 2/28/25 at 1:19 p.m., R7's bed rails were bilateral 1/4 rails permanently affixed by the head of his bed. He could not lower or remove the bedrails on his own, He stated he uses them to get up and could not get up without them. He was not certain how staff assessed the bed rails. Upon interview on 2/28/25 at 12:07 p.m., the physician assistant, PA stated he believed the provider had to signed orders for all bed rails and/or grab bars. Upon interview on 3/4/25 at 2:32 p.m., the Administrator stated that bed rails could only be used for mobility purposes. She was not aware that the facility assessments had not been completed. A facility policy titled Bed Safety and Bed Rails dated 10/18/22 indicated: 1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. 3. Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. 4. Bed dimensions are appropriate for the resident's size. 5. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. 6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. 7. The maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee. 8. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications. 9. Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.). 10. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. Use of Bed Rails 1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one- quarter, or one-eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. For the purpose of this policy bed rails include: a. side rails; b. safety rails; and c. grab/assist bars. 2. Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. a. The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint. 3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling off the bed. 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. input from the resident and/or representative; and d. consultation with the attending physician. 6. The resident assessment to determine risk of entrapment includes, but is not limited to: a. medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. size and weight; c. sleep habits; d. medication(s); e. acute medical or surgical interventions; f. underlying medical conditions; g. existence of delirium; h. ability to toilet self safely; i. cognition; j. communication; k. mobility (in and out of bed); and l. risk of falling. 7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: a. Accident hazards: (1) The resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or (2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress. b. Restricted mobility: (1) Hinders residents from independently getting out of bed thereby confining them to their beds; (2) Creates a barrier to performing routine activities such as going to the bathroom or retrieving items in his/her room, eating, hydration and/or walking; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Highland Chateau Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2319 West Seventh Street Saint Paul, MN 55116	

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3) Decline in resident function, such as muscle functioning/balance; and/or (4) Skin integrity issues. c. Psychosocial outcomes: (1) Creates an undignified self-image and alters the resident's self-esteem; (2) Contributes to feelings of isolation; and/or (3) Induces agitation or anxiety. 8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons. 9. The staff shall report to the director of nursing and administrator any accidents or incidents associated with a bed or related equipment including the bed frame, side or bed rails, and mattresses. The administrator shall ensure that reports are made to the Food and Drug Administration or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review, the facility failed to update their facility assessment when they no longer provided restorative nursing (continuous specialized approach in nursing care to maintain and improve physical and emotional wellbeing of individuals who have experienced a decline in function abilities) at the facility. Two of two residents (R1 and R2) had the potential to benefit from restorative nursing. This failure had the potential to affect all 56 residents who resided at the facility. Findings include: The facility assessment dated [DATE], indicated under the category of activities of daily living, the specific care of practices of residents needs indicated restorative nurse was offered at the facility. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 pounds (lbs.). R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs. Upon interview on 2/27/25 at 2:47 p.m., the physical therapist (PT) stated he worked with R1 and R2. R1 had reached his goals in becoming independent in bed. Therapy was going to re-admit R1 when he was able to bear weight and gain upper body strength. R2 had the same scenario where she met her goals of being independent in bed, however her arms were too weak to move further with therapy at that point. PT confirmed Both R1 and R2 would have benefited from restorative nursing, however the facility didn't offer it anymore. PT could not recall how long it had been since the facility had been without restorative nursing. Upon interview on 2/27/25 at 3:15 p.m. the physician assistant stated he was not aware the facility did not have restorative nursing however believed R1, R2 and many others could benefit from restorative nursing especially when therapy ends. Restorative nurse would reduce the [NAME] for deterioration of the residents when therapy is no longer able to work with them. It also can strengthen and make better outcomes for residents. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Upon interview on 2/27/25 p.m. at 4:01 p.m. the director of nursing (DON) stated the facility did not have restorative nursing. The DON wasn't certain when restorative nursing stopped. Upon interview on 3/3/25 at 4:26 p.m. the Medical Director (MD) stated the facility needed to follow whatever is on their facility assessment. He wasn't certain if the facility had restorative nursing in place or not. Upon interview on 3/4/25 at 2:32 p.m. the Administrator stated the facility did not have a restorative nursing program, however had a function maintenance program. She did not provide any documented information on that program. The functional maintenance program had the nursing assistants continuing care with residents following therapy. The facility did not have any residents utilizaing the program and no documented was provided regarding the program when requested. The Administrator was not certain when restorative nursing was stopped or if residents and family were notified as she could not recall if the change was was made when she was the Administrator. A policy titled Facility assessed dated 8/9/22 indicated the team is resposible for reviewing and updating the facility assessemnt including rehabiliation services.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on observation, interview, and document review, the facility failed to ensure the Medical Director (MD) assisted in the implementation and guidance of resident care policies, coordination, and admission of three bariatric residents (body weight greater than 100 poiunds (lbs.) of ideal body weight) residents (R1, R2 and R3). The facility was unable to safely manage these residents due to lack of guidance upon admission and provided cares received at the facility. This had the potential to affect all 56 residets who resided at the facility. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had a Brief Inventory of Mental status (BIMs) score of 15 indicating R1 was cognitively intact. R1 was dependent upon staff for toileting hygiene. He required moderate assistance with dressing the upper body and personal hygiene. Lower body dressing, sitting to lying position change, lying to sitting position change, and sit to stand were not attempted due to medical condition or safety concerns. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1's pertinent diagnoses were chronic ulcer of the left foot with necrosis (death) of the muscle, diabetes, and morbid obesity. R1's weight was 547 lbs. R1's care plan dated 1/2/25, indicated R1 was a total assistance of two staff and the use of a full body lift. The care plan did not indicate what type of lift was to be used or sling size. R1's care plan dated 1/4/25, indicated staff were to assist R1 with ambulation and transfers, utilization of therapy recommendation. The care plan did not indicate what the therapy recommendations were. R1's nursing progress notes dated 12/11/24 - 3/3/25, did not indicate R1 had gotten out of bed while at the facility or why he had not gotten out of bed. Upon observation and interview on 2/26/25 at 2:12 p.m., R1 was laying in bed, in a hospital gown. He started weeping at the beginning of the interview as he hadn't been out of his bed since his admission on 12/11/24. R1 was waiting for the facility to have him see a podiatrist so he could bear weight. R1 did not understand why he wasn't getting out of bed to a seated position in his wheelchair since that didn't require him to weight bear. Upon observation and interview on 2/27/25 at 10:21 a.m., R1 requested to be transferred from his bed to his wheelchair. Nursing assistant (NA)-A stated she couldn't get R1 up because she had never gotten him up before and wanted assistance from the therapy team. Upon observation and interview on 2/27/25 at 10:21 a.m., occupational therapy assistant (OTA) stated R1 had some issues with his orders, so nobody worked with him. She stated at an unknown date in 12/2024 the staff tried to get him up with a 600 lbs. mechanical lift and he had to be laid back down in bed, so his transferring was at a standstill. She did not know what the facility would do in an emergency to safely get R1 out of his room. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Upon observation and interview on 2/27/25 at 11:12 a.m,. five staff members attempted to transfer R1 from his bed to a wheelchair with a 600 lb. lift that uses a sling and lifts residents up and sits them down without having to stand. R1 was lifted approximately 4 inches off his bed, and he started screaming that his legs were being pinched. He was placed back down on his bed and the staff attempted to place towels between his legs and the stand and lift again. Again he screamed his legs were being pinched. He was laid back down on his bed. The OTA stated the facility would need to get a larger sling for R1 therefore there was not a way to get him out of bed. R1 began to cry and stated he did not feel safe at the facility knowing the staff did not have the capability to remove him from his bed. Upon interview on 2/27/25 at 12:07 p.m., the physician assistant (PA) stated the beginning of 2/2025 was the first time he saw R1 and was aware staff hadn't been walking him. Instead of having R1 leave the facility to see Podiatry he ordered an inhouse x-ray of R1's foot and there were no fractures. R1's order was changed from a non-weight bearing status to o.k. to bear weight. PA was not aware staff had not been getting R1 out of bed at all. There was no reason he could not have gotten up to his wheelchair with a non-bearing order. The facility should not admit a bariatric resident if they can't take care of them. R2 R2's re-admission MDS dated [DATE], indicated R2 had a BIMs score of 15 indicating R2 was cognitively intact. R2 used a wheelchair. The MDS did not indicate R2's functional mobilities. R2 was frequently incontinent of bowel and bladder. R2's pertinent diagnoses were morbid severe obesity due to excess calories, reduced mobility, chronic pain and prediabetes. R2's weight was 435 lbs. R2's nursing progress notes dated 1/11/25 - 3/3/25, did not indicate R2 had gotten out of her bed or why she hadn't gotten out of bed. R2's care plan dated 1/21/25 - 3/3/25, did not indicate the use of bedrails. R2's bed mobility was a two person total assistance. R2 required the use of a fully body lift for transfers. The care plan did not indicate what type of lift of sling size required. Upon observation and interview on 2/27/25 at 11:26 a.m., R2 pressed her call light and requested to get out of her bed to licensed practical nurse (LPN)-A. LPN-A told R2 that she was unable to get her out of bed until she spoke with the therapy department and R2 didn't have a wheelchair to sit in. LPN-A did not know what size sling to use for R2's transfer. Upon interview on 2/27/25 at 12:07 p.m., PA stated there was no reason R2 should not be getting of her bed daily. R3 R3's care plan dated 7/1/24, indicated R3 required a full body lift and two staff members. The care plan did not indicate what type of lift was to be used, or the size of the sling. R3's quarterly MDS dated [DATE], indicated R3 had a BIMs score of 15 indicating R3 was cognitively intact. R3's pertinent diagnoses were muscle weakness, acute respiratory failure, and morbid obesity. R3's activities of daily living were not identified. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Upon interview on 2/27/25 2:18 p.m., R3 stated he hadn't been out of his bed since 12/2024. He stated he would like to get up, but he is transferring out the facility soon and was tired of arguing with staff every day. R3 pointed to a small wheelchair and stated he couldn't get up if he wanted to because he didn't fit in the chair. Upon interview on 2/27/25 at 3:39 p.m., PA stated R3 had deconditioned in the facility. In the fall of 2/2024 R3 had been walking around his room and now the staff would need to use a lift with him. He was worried about R3's skin condition and loss of muscle mass. Upon interview on 3/3/25 at 4:26 p.m., Medical Director (MD) stated he was aware there was an immediate jeopardy called at the facility on 2/28/25 at 12:42 p.m., due to one resident not getting out of bed. He was not aware that the immediate jeopardy was for the neglect of three residents. He stated he was not involved in admission of the residents to the facility. MD stated the facility needed to follow their facility assessment for admission and cares. MD did not know the exact criteria for admitting bariatric residents and denied the facility requesting recommendations regarding R1, R2 and R3 prior to admission, the facility did not have proper equipment and the ability or inability to fully care for the residents following admission. Upon interview on 3/4/25 at 1:15 p.m. PA stated he had not had any correspondence with MD. I don't even know his name. Upon interview on 3/4/25 at 2:32 p.m. the administrator stated MD was very responsive to text messages or phone calls. He was told everything about the immediate jeopardy and how the facility got the abatement. She stated the MD attends QAPI and would come to the facility if asked. Administrator stated the MD doesn't have involvement in the facility admissions. If the facility has concerns about whether the facility can accommodate a resident or not, they reached out to the corporate nurse not the MD. The facility did not reach out to the MD when they found out the residents were not getting out of bed. A policy titled Medical Director dated 3/2/25 indicated the Medical Director is responsible for all aspects of medical oversight of the facility.