STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245063	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Park Home Inc	2237 Commonwealth Avenue Saint Paul, MN 55108

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. ROOM KNOCK During observation and interview on 5/27/25 at 2:34 p.m., R62 was in their bed in a shared room near the window and furthest from the door. Nursing assistant (NA)-I peeked into the room without knocking, made an unheard comment, and then brought in linens and set them on a chair close to the door before exit. R62 confirmed they did not hear a knock on the door. Surveyor exited the door after interview with R62, and NA-I entered R62's shared room without knocking and went into the bathroom. During interview on 5/27/25 at 2:55 p.m., NA-I acknowledged not knocking on R62's door. During interview on 5/28/25 at 2:13 p.m., R62 stated he was bothered by staff entering the room when not knocking and stated the action made him feel vulnerable. During interview on 5/29/25 at 8:17 a.m., NA-F stated staff should knock on residents' doors before entering, introduce themselves with their name, and explain why they are there. During interview on 5/29/25 at 1:46 p.m., registered nurse (RN)-E expected staff to knock and announce themselves when entering a room. During interview on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON) stated they would not want anyone barging in their home and could be scary if staff did not have permission to enter. The facility Quality of Life - Dignity policy dated 4/17/24, indicated residents' private space and property shall be respected at all times. The policy directed staff to knock and request permission before entering residents' rooms. Based on observation, interview and document review, the facility failed to provide a dignified dining experience by serving meals on hard plastic trays which had the potential to affect all residents who ate in the dining room. Additionally, the facility failed to ensure all staff knocked on individual resident bedroom doors and introduced themselves prior to entry for 1 of 1 residents (R62) reviewed with concerns with staff entering their room. Findings include: DIGNIFIED DINING: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47's quarterly Minimum Data Set (MDS) assessment, dated 4/11/25, indicated R47 was severely cognitively impaired with no hallucinations or delusions. Further indicated R47 was set up assistance for eating. During an observation on 2nd floor dining room on 5/27/25 at 8:41 a.m., residents were observed to be eating breakfast. On the table in front of each resident was a breakfast meal that sat on a hard plastic tray. During an observation on 3rd floor dining room on 5/27/25 at 8:44 a.m., residents were observed to be in the dining room eating breakfast. In front of all residents, were a hard plastic tray that contained breakfast items. R40 was observed to be seated in his wheelchair with his head down on his plate which sat on a hard plastic tray. Unidentified staff prompted him to sit up and eat. R40's hard plastic tray, which contained breakfast items, was moved from directly in from on him and R40 put his head back on the table. On 5/27/25 at 12:03 p.m., the lunch meal service on the first floor was observed in the main dining room. The room had multiple tables present with residents seated at each and, in the middle of the room, was a large metallic mobile cart which had meal trays inside them. The staff members removed the trays from the mobile cart, brought them to another table and set them down while they prepared drinks, and then took the drinks and place them back onto the hard-plastic meal tray. The entire hard-plastic tray was then delivered to the seated resident at their table. However, the hard-plastic service trays were then left on the table with plates, cutlery and drinks on top of them. During this time, no staff serving trays were observe to ask or offer to remove the items from the tray and place them onto the table. At 12:07 p.m., R13 was observed eating from the hard-plastic meal tray despite sitting at the table. When asked about using a tray despite being at the table, R13 shrugged his shoulders and responded aloud, I don't mind it. R13 added, Given the clientele here, on the plate [removed from tray] would be too messy. At 12:09 p.m., a single table positioned by the hallways was observed which had three residents present along with nursing assistant (NA)-A and NA-B whom were seated at the same table. The three residents each had a hard-plastic meal tray placed in front of them on the table and were being assisted with eating by NA-A and NA-B. NA-A and NA-B were asked about the trays being used and both responded meals were always served on them, adding items weren't removed from the trays and placed on the tables as everything comes together on the tray from the kitchen. Further, NA-A and NA-B expressed nobody from management had ever told them to offer to remove items from the trays for residents when served. During an observation on 3rd floor dining room on 5/27/25 12:08 p.m., residents were observed coming to the dining area for lunch. Lunch carts were brought to 3rd floor and delivered to the 2nd floor dining room by unknown dietary staff. Each lunch cart was an enclosed metal cart on wheels with slots which held hard plastic trays that contained resident meals. Each slot could hold two hard plastic trays which could be slid from the front or back of the approximately 6-foot metal cart. The hard plastic trays each contained a paper slip that identified who the meal was intended for, and a plate of food that was sitting on a plate warmer covered with a hard plastic dome shaped lid. The tray contained a set of silverware along with a napkin. Staff grabbed the trays from the lunch cart, added the drinks that were requested from a different cart, and delivered the entire tray to residents sitting at the table. Staff left the food and drinks on the hard plastic tray that contained the entire meal including the drinks and silverware. At 12:23 p.m., R47 was served lunch on the hard plastic tray, just as all residents were. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47 was non-interviewable. During an observation on 5/27/25 at 12:28 p.m., all residents (approximately 15) seated in the second-floor dining room were observed at dining tables with filled cups and plates placed on top of hard gray plastic trays. During interview on 5/27/25 at 12:41 p.m., registered nurse (RN)-B stated resident food and drinks came on trays so they were served in the same manner. RN-B stated residents usually seemed to eat okay with their food and drinks on the trays and was not aware of any concerns with food or dining. During an interview on 5/27/25 at 12:51 p.m., nursing assistant (NA)-F stated it was the nursing assistant's responsibility to serve the residents the meals during mealtimes, make sure they get what they need, and give them their preferences. NA-F stated all meals were served on hard plastic trays as that is how we are supposed to do it. NA-F stated the meals came up from the kitchen that way and it was expected to serve it that way. NA-F stated it was more dignified to serve meals on hard plastic trays but was not able to explain this. On 5/28/25 at 11:29 a.m., the dietary manager (DM) was interviewed, and they verified each floor's meal service was done on hard-plastic serving trays. DM stated they had, prior, attempted to remove the trays and leave items on the table but then some residents got upset. As a result, they just served all meals on the trays to everyone, however, DM expressed removing the items and placing them on the table was more dining etiquette. DM stated the management had a discussion about this, however, it was not recorded or documented adding they had discussed potentially care-planning which residents wanted or didn't want the trays kept on the table. Further, DM stated they had not ever brought the issue to the resident council for review or input, either, adding aloud, I never thought about that. During an interview on 5/29/25 at 12:58 p.m., the administrator and director of nursing (DON) verified residents had not been individually assessed for preferences on meals served on hard plastic trays. Furthermore, they stated it has not been discussed during resident council meetings. DON stated after the last annual survey they discussed dining with residents but did not recall if the conversations were related to serving meals on the hard plastic trays and how that related to a dignified dining experience, nor did they have documentation of any such conversations. DON stated no resident care plans had been updated to reflect preferences regarding a resident's preference to keep their meals on a hard plastic tray. DON and administrator verified it was important to have a dignified, home-like dining experience for residents as this was their home. A policy regarding dignified dining was requested and not received.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, for 4 of 4 residents (R56, R10, R40, R47) reviewed for use of psychotropic medications. Findings include: R56 R56's significant change in status Minimum Data Set (MDS), dated [DATE], identified R56 had both long-term and short-term memory impairment, demonstrated hallucinations during the review period, and had episodes of rejection of care behaviors. The MDS recorded R56 as consuming multiple psychotropic medications and being on hospice care while a resident. R56's Order Summary Report, signed 5/2/25, identified R56's current provider-ordered medications and treatments. These included lorazepam (anti-anxiety medication) 0.5 milligrams (mg) three times a day scheduled and every 4 hours as needed (PRN), haloperidol (anti-psychotic medication) 0.5 mg every 4 hours PRN, and Dilaudid (narcotic medication) 1 mg every hour as needed for pain/shortness of breath. In addition, R56's Medication Administration Record (MAR), dated 5/2025, identified R56's medications and treatments along with spacing to record their administration or refusals. The MAR recorded multiple administrations of the PRN medication(s) including: On 5/5/25 at 10:23 a.m., R56 was given a PRN dose of haloperidol which had a response recorded as, U [unknown]. A corresponding progress note, dated 5/5/25, identified the medication was given with symptoms recorded, agitated yelling help help. On 5/19/25 at 4:31 a.m., R56 was given a PRN dose or lorazepam which was recorded as effective. However, R56's medical record was reviewed and lacked evidence a signed consent for use of the medication was obtained prior to them being provided. Further, the record lacked evidence the risks of expected benefits of the medication regimen had been reviewed or discussed with R56 or his responsible family member prior to initiation of the medications. On 5/29/25 at 8:34 a.m., a telephone call was placed to R56's family member (FM). However, they were unable to be reached. When interviewed on 5/29/25 at 9:30 a.m., licensed practical nurse (LPN)-A explained the medical provider who ordered the medication was responsible to review the medication risks and benefits with the resident adding the direct care nurses rarely, if ever, do it. LPN-A added, Usually we don't [do that]. LPN-A reiterated, Usually the nurse practitioner does. LPN-A stated any conversation on the medications, including consent or risks and benefits, would be charted in the progress notes. R10 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10's quarterly Minimum Data Set (MDS), dated [DATE], indicated R10 was cognitively intact, had no hallucinations, delusions, behaviors and did not refused cares. MDS indicated R10 was independent with activities of daily living and mobility. MDS indicated diagnoses of Alzheimer's disease, hypertension, anemia and arthritis. R10's Clinical Orders, printed 5/28/25, indicated orders for quetiapine fumarate (antipsychotic medication used to treat schizophrenia, bipolar disorder and depression) 125 milligram (mg) tablets via gastric tube for anxiety, paranoia related to bipolar disorder currently in remission. R10's electronic medical record lacked a consent including risk and benefits related to the anti-psychotic medication. During interview on 05/28/25 at 1:48 p.m., LPN-A stated she was not sure if R10 had a consent to take a psychotropic medication. R40 R40's annual MDS assessment, dated 3/21/25, indicated R40 was moderately cognitively impaired with no hallucinations or delusions, no behaviors, wandering or rejection of care. MDS indicated R40 was on an antidepressant. Relevant diagnoses included: depression. R40's Order Summary Report, printed 5/27/25, included the following orders: -duloxetine HCL (antidepressant medication) give 60 milligrams (mg) by mouth one time a day for depression R40's May's Medication Administration Record (MAR), printed 5/28/25, included the following orders: -DULoxetine HCl Oral Capsule Delayed Release Particles (Duloxetine HCl) Give 60 mg by mouth one time a day for depression -Start Date- 10/10/2024. Documentation indicated administered as ordered. A review of R40's progress notes in the electronic medical record (EMR), dated 11/27/24 to 5/28/25, lacked documentation of education being provided regarding duloxetine. Review of R40's entire EMR lacked evidence of a signed consent for antidepressant medication which would include risks, benefits and alternatives. R47 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47's quarterly Minimum Data Set (MDS) assessment, dated 4/11/25, indicated R47 was severely cognitively impaired with no hallucinations or delusions, no behaviors or rejection of care. MDS did note R47 wandered daily. Further, identified R47 was on an antidepressant. R47's relevant diagnoses included: Parkinson's disease without dyskinesia and without fluctuations (a disorder of the central nervous system that affects movement, often including tremors), orthostatic hypotension (condition when blood pressure decreases when rising from sitting or lying down causing dizziness, lightheadedness or fainting), dementia (a group of thinking and social symptoms that interferes with daily functions), depression, psychotic disorder, hypopituitarism (condition where the pituitary gland doesn't produce enough hormones), benign neoplasm of pituitary gland, and tremor. R47's Order Summary Report, printed 5/29/25, included the following orders: -Celexa (antidepressant medication) give 10 mg by mouth one time a day for major depressive disorder with a start day of 5/13/25. R47's May Medication Administration Record (MAR), printed 5/29/25, included the following: - CeleXA Oral Tablet 10 MG (Citalopram Hydrobromide) Give 10 mg by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, IN FULL REMISSION (F33.42). Start celexa after zoloft is d/c [discontinued]-Start Date- 05/13/2025. Documentation indicated administered as ordered. - Sertraline (antidepressant medication) HCl Tablet 25 MG Give 25 mg by mouth one time a day for Major Depression Disorder related to MAJOR DEPRESSIVE DISORDER, RECURRENT, IN FULL REMISSION (F33.42) for 7 Days -Start Date- 05/06/2025. Documentation indicated it was administered all scheduled days except 5/11/25 and 5/12/25 when it was coded as 6 indicating R47 was hospitalized . -Sertraline HCl Tablet 25 MG Give 50 mg by mouth one time a day for Major Depression Disorder related to MAJOR DEPRESSIVE DISORDER, RECURRENT, IN FULL REMISSION (F33.42) -Start Date- 11/21/2023 0900 -D/C Date- 05/05/2025. Documentation indicated administered as ordered. During an observation on 5/27/25 at 12:30 p.m., R47 was observed sitting at the dining room table for lunch. During an observation on 5/28/25 at 9:04 a.m., R47 was observed sitting in the dining room in his wheelchair with his eyes closed. R47 does not respond to questions when asked. A voicemail was left for resident representative (RR)-B on 5/29/25 at 9:35 a.m. requesting a call back. No return call was received. A review of R47's progress notes in the EMR, dated 4/1/25 to 5/29/25, lacked documentation of notification of starting new antidepressant (Celexa), decreased doses of sertraline, or notification to the RR-B. Furthermore, lacked documentation of risks vs benefits of medications or alternatives. Review of R47's EMR lacked evidence of a signed consent for antidepressant medication which would include risks, benefits and alternatives. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 10:23 a.m., registered nurse (RN)-A stated that floor nurses did not obtain consents for any psychotropic medications. RN-A stated she was unaware of who did that and added I know we (floor nurses) don't do that. On 5/29/25 at 12:50 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed the medical records for R56, R10, R40, and R47. ADON acknowledged the lack of a clear signed, informed consent for several of the residents' psychotropic medications and explained the standard practice was to notify family when a medication was started and to document that. ADON verified the records lacked evidence of this, and explained they were currently trying to develop a consent form to record this moving forward. ADON stated consent was important as residents and families have the right to choose if they want to take that medication or not. During interview on 05/29/25 at 1:34 p.m., director of nursing (DON) stated their QAPI (Quality Assurance and Performance Improvement) team had been talking about psychotropic medications. DON stated the facility needed to get consents and educate the residents and families about psychotropic medications to ensure residents were aware of the risks and benefits, and it was documented. A facility policy on residents rights regarding medications was requested and not received.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a medication was administered safely for 1 of 1 resident (R10) who had been assessed as unable to safely self-administer medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], indicated R10 was cognitively intact, had no hallucinations, delusions, behaviors and did not refused cares. MDS indicated R10 was independent with activities of daily living and mobility. MDS indicated diagnoses of Alzheimer's disease, hypertension, anemia and arthritis. R10's Clinical Orders printer 5/28/25, indicated orders for levothyroxine sodium 75 micrograms (mcg) by mouth once a day in the evening without a diagnosis for this medication. Levothyroxine is prescribed for hypothyroidism. R10 also had and order for NPO (nothing per mouth) except for pleasure foods in liquid form. All other medications were ordered to be administered via tube feeding (TF). R10's care plan printed 5/28/25, indicated she had impaired cognition/thought processes related to Alzheimer's disease and bipolar disorder and directed staff to administer medications as ordered. Also, the care plan indicated R10 had hypothyroidism and directed staff to give thyroid replacement therapy as ordered. R10's Self Administration of Medications Assessment (SAM) dated 3/16/25, indicated resident did not want to self-administer her medications and was not able to identify the expiration date of each medication. During observation and interview on 5/27/25 at 10:36 a.m., R10 was in her room sitting at the edge of the bed. Two round pills were observed on the floor. R10 stated sometimes the nurses leave my thyroid medication in a small cup, and I take it on my own. Sometimes the pill slips out of my hand, falls on the floor, and I often forget to tell the nurses, and they don't ask if I took it. R10 added, I don't take the medication in front of the nurses, they leave the room. I put the pill in my mouth, take a sip of water and let the pill dissolve and I swallow it. During interview on 5/27/25 at 10:46 a.m., licensed practical nurse (LPN)-B stated R10 can swallow a little bit and takes the pill with water. LPN-10 stated she did not know why R10 took this medication by mouth when all other medications were administered through her TF. During interview on 5/28/25 at 1:48 p.m., LPN-A stated she usually worked in the evenings, and R10 took her levothyroxine by mouth. LPN-A stated the nurses tried to give it, but sometimes R10 couldn't take it or wanted to take it later. I leave the medication with her, I go back to her room and if the medication is no longer in the medication cup, it means she [R10] took the medication. I don't see her taking the medication. LPN-A stated R11 had never reported dropping the medication on the floor. LPN-A verified the SAM indicated R10 was not able to self-administer medications and had no order for self-administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/28/25 at 2:21 p.m., nurse manager/registered nurse (RN)-E verified R10 did not have a physician's order to self-administer medications. RN-E also verified R10's SAM indicated she was not capable of self-administering medications. During interview on 05/29/25 at 1:25 p.m., director of nursing (DON) stated on admission a SAM was completed for all residents. DON stated if a resident requested to self-administer their own medications, the nursing staff will determine if it's appropriate and call the physician to obtain an order for self-administration of medications. DON stated the expectation was for nurses to administer the medications as ordered and never leave the medications at bed side without an order for self-administration. Facility's policy titled Self-Administration of Medications dated 12/13/21, indicated as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on interview and document review, the facility failed to ensure resident personal fund accounts were insured with adequate surety bond coverage (a contract or promise by a surety or guarantor to pay a certain amount if a second party fails to meet the obligation) to cover the total account balance. This had potential to affect all residents identified to have an account with a positive balance. Findings include: During interview on 5/29/25 at 8:42 a.m., the administrative assistant (AA) stated the total amount of resident funds in the facility was $91,117.79. Immediately after interview with AA, the administrator was asked to provide the facility's surety bond amount. A Resident Trust Fund Surety Bond dated 3/10/25, indicated the facility had a surety bond in place for up to $50,000 with an effective date of 5/1/25. During an interview on 5/29/25 at 2:45 p.m., the administrator stated their bond amount was based on an average of their 12-month balance. The administrator stated one resident had a recent property sale which made the resident balance higher than usual and accounted for $40,000 in resident accounts. The administrator acknowledged the $91,117.79 total resident fund amount and $50,000 surety bond and stated they would provide more current documents. In an email sent on 5/30/25 at 6:04 p.m., the administrator identified R17 and one other resident's balance made up more than $58,000 of the total resident fund amount balance. The email included the following attachments: -R17's Resident Statement Landscape dated 5/30/25, identified a balance of $20,995.70 after a $20,656.46 credit from a bank on 5/23/25. -A facility Trial Balance document dated 5/28/25, identified 166 residents (included residents with no balance) had an account at the facility. The total amount of these accounts was recorded as $91,117.79. The facility Deposit of Resident Funds policy dated 8/15/23, indicated resident personal funds held and managed by the facility would be safeguarded. The policy lacked information about a resident trust fund surety bond.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and document review, the facility failed to ensure the most recent recertification survey along with subsequent complaint investigation results were readily available and accessible within the care center. This had potential to affect all residents, staff, and visitors whom could wish to review the information. Findings include: The Centers for Medicare and Medicaid (CMS) Aspen Central Office (ACO) database identified the most recent standard recertification survey was exited on 8/7/2024, with 15 health (i.e., F-Tags) issued. Further, the ACO database identified an abbreviated complaint survey was exited on 10/8/24, which had immediate jeopardy (IJ) findings cited. On 5/28/25 at 1:56 p.m., an interview was completed with resident (R18) whom often attended the monthly resident council meeting. R18 stated they were unsure where in the care center the most recent state agency (SA) survey results were kept. Immediately following, on 5/28/25 at 2:06 p.m., a tour of the care center main floor was completed. A white-colored binder labeled, Annual Survey Results 2023-2024, was found on a lower shelf down by the administrators office. This binder was inspected, however, neither the most recent recertification survey (exited 8/7/24) nor the abbreviated complaint survey (exited 10/8/24) results were contained in the public binder for review. On 5/28/25 at 2:11 p.m., the administrator was interviewed. He verified the white-colored binder kept adjacent to his office was the only location on the campus where the survey results were posted. The administrator reviewed the binder, and verified it lacked the most recent standard survey (exited 8/7/24) or the abbreviated survey (exited 10/8/24). The administrator stated he was responsible to update the binder and the lack of those results were an oversight. The administrator verified the most recent results should be available for public review without having to ask for them. A facility provided Survey Results, Examination Of policy, dated 4/2024, identified a copy of the most recent standard survey along with a state-approved plan of correction (POC) would be kept, . in a 3-ring binder located in an area frequented by most resident, such as the main lobby or resident activity room.

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St Anthony Park Home Inc	2237 Commonwealth Avenue Saint Paul, MN 55108

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure symptoms of potential psychiatric distress were recorded; and non-pharmacological interventions were attempted then documented prior to the use of as-needed (i.e., PRN) psychotropic medication to improve continuity of care for 1 of 5 residents (R56) reviewed for unnecessary medication use. Findings include: R56 R56's significant change in status Minimum Data Set (MDS), dated [DATE], identified R56 had both long-term and short-term memory impairment, demonstrated hallucinations during the review period, and had episodes of rejection of care behaviors. The MDS recorded R56 as consuming multiple psychotropic medications and being on hospice care while a resident. On 5/28/25 at 7:36 a.m., R56's morning cares were observed with nursing assistant (NA)-A and NA-B involved. R56 was lying in bed which had an air-pressure mattress in place; along with staff helping to wash him up. R56 would converse with staff as they provided care, however, it was not always sensical to the situation including, A bridge of bread, that's perfect for ya. NA-A and NA-B completed R56's morning cares without R56 having any visible, physical behaviors towards them. R56's care plan, dated 9/2024, identified R56 had behaviors including yelling, cursing, accusations and physical aggression. The care plan listed multiple non-pharmacological interventions which could be attempted including redirection, distraction, and providing a calm environment. The care plan continued and identified R56 consumed psychotropic medications due to sleep issues and behavioral needs. The care plan directed to administer the medications as ordered, monitor for their effectiveness, and monitor/record occurrences of R56's target behaviors and interventions. R56's Order Summary Report, signed 5/2/25, identified R56's current provider-ordered medications and treatments. These included lorazepam (anti-anxiety medication) 0.5 milligrams (mg) three times a day scheduled and every 4 hours PRN, haloperidol (anti-psychotic medication) 0.5 mg every 4 hours PRN, and Dilaudid (narcotic medication) 1 mg every hour as needed for pain/shortness of breath. R56's Medication Administration Record (MAR), dated 5/2025, identified R56's medications and treatments along with spacing to record their administration or refusals. The MAR recorded multiple administrations of the PRN medication(s) including: On 5/5/25 at 10:23 a.m., R56 was given a PRN dose of haloperidol which was recorded as, U [unknown]. A corresponding progress note, dated 5/5/25, identified the medication was given with symptoms recorded, agitated yelling help help. However, again, the note lacked what, if any, non-pharmacological interventions were attempted or offered prior to the medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/25 at 4:31 a.m., R56 was given a PRN dose or lorazepam which was recorded as effective. A corresponding progress note, dated 5/19/25, identified the medication was given, however, lacked any symptoms R56 displayed to warrant the medication nor what, if any, non-pharmacological interventions were attempted prior to help calm or settle R56 down. Further, the MAR recorded on 5/19/25 at 4:30 a.m. (same time), R56 was provided Dilaudid for a pain rating of six (6) and was recorded as effective. However, again, the record lacked information or evidence on what symptoms R56 displayed, rationale why both medications were provided at nearly the same time nor what, if any, non-pharmacological interventions were attempted prior to multiple PRN(s) being given. R56's POC (Point of Care) Response History, printed 5/29/25, identified spacing for staff to record behaviors and interventions attempted to reduce them. This identified: On 5/5/25, R56 was recorded as having no behaviors present by the nursing assistant (NA) staff members. The corresponding response of interventions attempted recorded, Response Not Required. On 5/19/25, R56 was recorded as having no behaviors present by the NA staff members. However, the corresponding response of interventions recorded staff attempted providing a calm environment but the behavior was unchanged. This entry of the intervention attempted was recorded at 6:43 p.m. (over 12 hours after the PRN medication was given). When interviewed on 5/29/25 at 9:30 a.m., licensed practical nurse (LPN)-A stated R56 demonstrated behaviors like calling out and would, at times, become immediately aggressive with staff adding, It can be challenging [to care for him]. LPN-A stated R56 was hard of hearing which they felt contributed to his behaviors, and expressed staff often had to leave him alone and then reproach him to get cares done. LPN-A stated giving R56 snacks seemed to help with his behaviors. LPN-A explained if a PRN medication needed to be given, staff should attempt non-pharmacological interventions prior and those should be documented in the progress notes. LPN-A stated PRN medications should only be given one at a time and rarely, if ever, should multiple ones be given at the same time. LPN-A stated it was important document symptoms and the non-pharmacological interventions attempted so as to see if that will help and stuff before you give the medication. LPN-A added, Maybe he just needs someone to talk to, or maybe he's hungry. On 5/29/25 at 12:50 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed R56's medical record. ADON stated, I saw what you saw, and verified the lack of consistent symptom or non-pharmacological charting with the PRN medication use. ADON stated the charting was a PIP (performance improvement project) they were addressing and verified staff should be attempting and charting symptoms and non-pharmacological interventions with PRN psychotropic medication use. ADON stated this was important to help the IDT see what's working and not working for the resident. ADON added medication may not always be needed if non-pharmacological interventions were attempted prior.

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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** Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan for hospice care and services was developed and/or readily available to promote continuity of care for 1 of 1 resident (R56) reviewed for hospice services. Findings include: R56's significant change in status Minimum Data Set (MDS), dated [DATE], identified R56 had both long-term and short-term memory impairment and demonstrated hallucinations and rejection of care behaviors. Further, the MDS outlined R56 received hospice services while a resident. On [DATE] at 7:19 a.m., R56 was observed lying in bed while in his room. R56 could be heard from the hallway speaking aloud and had mostly non-sensical speech, however, at times would have statements which could be understood such as, Thank you very much, goodbye, and, What's the subject matter? R56 would also, at times, shout loudly with, Help me! A female staff member did enter R56's room and expressed staff would be down shortly to help get him up and ready for the day. R56's facility care plan, dated [DATE], identified R56 was at the end stage(s) of life and using hospice or palliative care services. The plan listed a goal which read, The resident will be comfortable, along with interventions including calling hospice when new physician orders were received, coordinating with hospice and other end-of-life services, and others which read: Hospice pastoral care visits are scheduled for: See hospice binder at nursing station, Hospice social service visits are scheduled for: See hospice binder at nursing station, The Hospice [sic] staff will provide bathing services on: See hospice binder at nursing station, Medications will be ordered through: See hospice binder at nursing station, and, Supplies will be ordered through: See hospice binder at nursing station. The facility' care plan lacked any further specifics on these services nor how often they'd be provided for R56 while at the care center. A white-colored binder was located at the nursing station which was labeled, Our Lady of Peace Hospice & Home Care, along with a telephone number to contact them. This binder was inspected and R56's name was recorded inside. The binder contained various medical paperwork including a POLST (Provider's Orders for Life Sustaining Treatment), hospice emergency contact information, and multiple 'summary' notes completed by hospice staff when they visited. The binder included a yellow-colored copy of the Service Agreement and Election of Hospice Benefit, dated [DATE], which identified a hospice registered nurse (RN), social worker (SW), and chaplain would visit along with anticipated frequencies (i.e., 1-2 times/month); however, lacked information on what services these disciplines would be doing or performing while onsite with R56. R56's medical record and hospice binder both lacked a complete, comprehensive care plan detailing what services the outside hospice agency would provide. SEE F684 FOR ADDITIONAL INFORMATION. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:07 a.m., licensed practical nurse (LPN)-B was interviewed, and explained they were waiting for a call back from hospice as some of R56's as-needed medication supply had expired. LPN-B stated there was no hospice aide coming in to see R56 to their recall and the hospice nurse (HRN) they'd see about once a week, if I'm lucky. LPN-B stated the HRN typically visited with R56 for a bit and then left again adding such was what a majority of them do. LPN-B stated they couldn't recall ever seeing a hospice care plan in R56's binder of information but then added, I can't say I've looked, either. When interviewed on [DATE] at 10:02 a.m., HRN stated they visited the campus once or twice a week, and the hospice SW would visit once or twice a month. HRN stated they typically obtained R56's vital signs and reviewed him for pain control when they visited. HRN stated they'd also, at times or if needed, visit with R56's family members on his condition. HRN stated the hospice care plan was usually housed in their own electronic record which was just for us with no care center staff having access to it. HRN stated a copy should have likely been printed and placed into R56's binder of information. On [DATE] at 1:30 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had looked into R56's hospice binder and medical record. ADON stated the care center had hospice outlined on their own care plan, however, the interventions were somewhat generic and mostly directed to the hospice binder for information. ADON verified the hospice care plan was not provided prior to survey and expressed it was important to have both the care center and hospice plans together and available so staff were on the same page. A provided Care Plans - Comprehensive policy, dated 6/2022, identified an individualized, comprehensive care plan with measurable objectives and timetables would be developed for each resident. This care plan was to be developed within seven (7) days after the completion of the comprehensive MDS.

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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** Based on observation, interview, and document review, the facility failed to coordinate care with an outside hospice agency to ensure ongoing, consistent care delivery and promote comfort for 1 of 1 resident (R56) reviewed for hospice services. In addition, the facility failed to assess and appropriately monitor developing bruising to ensure healing for 1 of 1 resident (R46) reviewed who had visible bruising on their skin. Findings include: R56 R56's significant change in status Minimum Data Set (MDS), dated [DATE], identified R56 had both long-term and short-term memory impairment and demonstrated hallucinations and rejection of care behaviors. Further, the MDS outlined R56 received hospice services while a resident. On 5/28/25 at 7:19 a.m., R56 was observed lying in bed while in his room. R56 could be heard from the hallway speaking aloud and had mostly non-sensical speech, however, at times would have statements which could be understood such as, Thank you very much, goodbye, and, What's the subject matter? R56 would also, at times, shout loudly with, Help me! A female staff member did enter R56's room and expressed staff would be down shortly to help get him up and ready for the day. R56's facility care plan, dated 4/16/25, identified R56 was at the end stage(s) of life and using hospice or palliative care services. The plan listed a goal which read, The resident will be comfortable, along with interventions including calling hospice when new physician orders were received, coordinating with hospice and other end-of-life services, and multiple others including, Hospice pastoral care visits are scheduled for: See hospice binder at nursing station, and, Medications will be ordered through: See hospice binder at nursing station. However, the facility' care plan lacked any further specifics on these services nor how often they'd be provided for R56 while at the care center. A white-colored binder was located at the nursing station which was labeled, Our Lady of Peace Hospice & Home Care, along with a telephone number to contact them. This binder was inspected and R56's name was recorded inside. The binder contained various medical paperwork along with a yellow-colored copy of the Service Agreement and Election of Hospice Benefit, dated 4/3/25, which identified a hospice registered nurse (RN), social worker (SW), and chaplain would visit along with anticipated frequencies (i.e., 1-2 times/month); however, lacked information on what services these disciplines would be doing or performing while onsite. SEE F656 FOR ADDITIONAL INFORMATION. The binder contained a single, white-colored calendar page labeled, 2025 [space] April [space] 2025, along with hospice' staff names handwritten on 4/3, 4/4, 4/9, and 4/14, respectively. This calendar showed a total of three nurse visits and two social worker visits were completed. On the reverse side of the calendar, a handwritten label was made reading, May, along with, Mon May 5 - [staff name] SW. The entire binder lacked any further calendar(s) or direction on when hospice staff would be visiting the campus. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 9:07 a.m., licensed practical nurse (LPN)-B was interviewed, and explained they were waiting for a call back from hospice as some of R56's as-needed medications had expired and needed to be renewed. LPN-B stated R56 had been on hospice a couple months now and they were unsure when hospice would visit most of the time prior to them arriving adding they'd see the hospice nurse once a week, if I'm lucky. LPN-B explained R56's as-needed lorazepam (anxiety medication) needed to be renewed before it could be given adding if staff were not Johnny on the spot with watching it then this would happen where the timeframe to give it would lapse. LPN-B reiterated the hospice staff would never tell care center staff prior to coming, rather, just show up which had been the practice since they came onboard. LPN-B stated the calendar used in the binder was for staff to write their names on when they visited, not beforehand, and expressed the hospice staff never seemed to stay very long when they did visit. LPN-B stated they rarely, if ever, even looked in the hospice binder at the calendar or notes adding they only had it with them now to get the number to call about the expired medication. During the interview, at 9:12 a.m., hospice registered nurse (HRN) then entered into the building. LPN-B and HRN then discussed the expired medications before HRN left the desk to see R56. When interviewed on 5/28/25 at 10:02 a.m., HRN stated they visited R56 one to two times per week, and the hospice social worker would visit one or two times per month. HRN stated they couldn't recall another time when R56's medication prescriptions lapsed like had just happened, and expressed they tried to always ask staff when they visit if they needed anything, like prescriptions renewed, at their visits. However, HRN stated it was ultimately care center staff whom were responsible to ensure they don't lapse the medication availability. HRN stated they felt there was collaboration between hospice and the care center adding it was good for what it is here. HRN stated R56 was their only patient at the campus and things were still being worked out adding, It still feels like new, adding there was always opportunity to communicate better. HRN stated they were going to adjust R56's Seroquel order today, and acknowledged the lack of a hospice care plan being readily available for the care center staff. HRN then reviewed the provided calendars in their hospice binder which was left for the care center. HRN acknowledged it lacked a May 2025 calendar (despite being almost June) and it did not outline upcoming visits for care center staff to be aware of adding, I'm not very good at this part. HRN stated having a more routine, set schedule in writing for staff to see would be an area of opportunity, too. On 5/28/25 at 1:30 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed R56's medical record. ADON explained they didn't typically work with R56's hospice agency and verified the hospice care plan had not been provided to the campus prior to survey. ADON stated one should have been adding it was important to ensure the care plans were available and meshing together so staff were all on the the same page. ADON verified a calendar had also just been placed into the binder to help show when hospice would be visiting more easily adding, prior, it had been a struggle to know exactly what day they're coming. ADON stated the hospice staff should be reviewing R56's medication supplies and prescriptions when onsite to ensure they don't lapse with availability adding, The hospice nurse would catch this [assumed]. ADON verified the importance of coordinating care with a hospice provider adding they should be working together to take care of this resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility provided Hospice Program policy, dated 7/2017, identified the care center would have written agreements with hospice providers and those providers would be held to the same professional standards of service as other contracted agencies or individuals. The policy outlined responsibilities of both the hospice and the care center, however, the spacing to record a person designated to coordinate with the hospice was left blank and not filled out with text reading, 12. Our facility has designated _____ (Name) _____ (title) to coordinate care provided to the resident by our facility staff and the hospice staff. R46 R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 had moderately impaired cognition and no hallucinations, delusions, or rejection of cares. R46 required partial and/or moderate assistance to roll left and right, required substantial/maximal assistance with upper body dressing and transfers, and was dependent with lower body dressing and toileting hygiene. R46's diagnoses included peripheral vascular disease, arthritis, hip fracture, dementia, Parkinson's Disease, and depression. R46's anticoagulant care plan, revised 4/23/25, indicated R46 was on anticoagulant therapy related to atrial fibrillation. Interventions directed staff to complete labs as ordered and report abnormal lab results to the provider and administer anticoagulant medications as ordered by physician and observe for side effects and effectiveness every shift. R46's skin integrity care plan, revised 4/23/25, indicated R46 had an impairment to skin integrity related to new colostomy and surgical wound on abdomen and surgical incision on right hip. R46 had the potential for further skin integrity concerns related to redness on coccyx and groin. Interventions directed staff to use barrier cream after each incontinent episode, keep skin clean and dry, use lotion but not to open areas, use pressure relieving/reducing cushion to protect the skin while in wheelchair and mattress to protect the skin while in bed. R46's care plan lacked resident specific interventions to prevent bruising. R46's Order Summary Report printed 5/28/25, indicated: -11/18/24, apixaban (an anticoagulant medication used to treat and prevent blood clots) oral tablet 2.5 mg by mouth two times a day. -11/18/24, weekly skin check and complete the weekly skin review assessment in the electronic health record every Saturday day shift. -5/28/25, anticoagulant medication- monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code Other/ See Nurses Notes and progress note findings three times a day related to long term (current) use of anticoagulants. R46's progress notes indicated: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/1/25 at 2:07 p.m., R46 had multiple bruises on bilateral upper extremity. -3/22/25 at 12:35 p.m., R46 had a bruise on back of left hand, and staff would continue to monitor. R46's assessments and other documents viewable in the electronic health record lacked information on bruising assessment and monitoring. During observation on 5/27/25 at 9:28 a.m., R46 was in bed and had bruising on both hands. During observation on 5/29/25 at 8:08 a.m., R46 sat at a dining room table. R46 had general discoloration and a bruise approximately less than one inch by one inch to his left hand and general discoloration and a bruise approximately greater than one inch by one inch to his right hand. R46's right hand had a dark bluish-black scab with reddish drainage between his first and middle finger. During interview on 5/29/25 at 8:23 a.m., nursing assistant (NA)-F stated they notified a nurse when they saw a bruise on a resident. NA-F stated they worked with R46 once in a while and was not aware of bruising to R46. When asked about the new area on R46's right hand, NA-F stated they thought R46 bumped their hand this morning and notified the nurse right away. During interview on 5/29/25 at 1:46 p.m., registered nurse (RN)-E stated staff followed-up on bruises to residents' hands on a case-by-case basis. RN-E stated R46 was on a blood thinner, and staff should evaluate bruises for a potential cause. RN-E stated staff documented new skin concerns in risk management. RN-E stated R46 came out of their room a lot and sat in their wheelchair, and RN-E would have to review R46's progress notes and risk management documents to comment further on R46's skin or bruising. During follow-up interview on 5/29/25 at 2:31 p.m., RN-E stated they looked at RN-E's hands and offered skin protectors or gloves, and R46 declined. RN-E stated R46's hands lined up with the dining table when he sat in his wheelchair and stated R46 was able to move in their wheelchair. RN-E stated they reviewed R46's progress notes and did not see follow-up on R46's bruising. RN-E reviewed R46's risk management documents and stated on 3/5/25, R46 had a scratch from a call light clip, and on 3/28/25, a skin tear was identified on R46's left forearm. RN-E did not see a risk management entry related to bruising. During interview on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON) expected bruises to be documented in risk management and staff to assess the root cause to prevent future bruises and monitor until healed to ensure the skin does not worsen. R46's skin assessments were requested from the facility. The facility provided Integrated Wound Care progress notes, which lacked documentation of bruising, and did not send any documentation related to the weekly skin assessments. The facility Prevention of Skin Breakdown policy dated 7/2/18, indicated the care plan was to be evaluated and revised based on response, outcomes, and needs of the resident. The facility policy Anticoagulation - Clinical Protocol undated, directed the staff and physician to monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively reassess to help determine what, if any, additional interventions were required to promote healing and reduce the risk of complication after an in-house acquired pressure injury developed for 1 of 2 residents (R56) reviewed for pressure ulcer care. Findings include: R56's significant change in status Minimum Data Set (MDS), dated [DATE], identified R56 had both short-term and long-term memory impairment, demonstrated hallucinations, and had rejection of care behaviors one (1) to three (3) days during the review period. The MDS recorded R56 was enrolled in hospice care and had several medical conditions including high blood pressure, coronary artery disease (CAD), and Alzheimer's Disease. Further, the MDS contained a section labeled, Section M - Skin Conditions, which recorded R56 was at risk of developing pressure ulcers, however, had no current pressure ulcers during the review period. R56's most recent Braden Scale For Predicting Pressure Sore Risk, dated 4/4/25, identified R56 scored a cumulative score of 19.0 which was not considered to be 'at risk' for pressure ulcer development. In addition, R56's Quarterly Resident Review, dated 4/7/25, identified a review of R56's health status (i.e., vital signs, oral status, respiratory status) which included a section labeled, L. Skin[.] This outlined R56 had no current, unhealed pressure injuries adding, Does the resident have any skin integrity issues? answered with, 2. No. However, R56's progress note, dated 4/17/25, identified R56 had irritated skin areas which included, . has got a reddened spot at the sacral area. The note identified R56 was assisted with repositioning and staff continued to monitor the skin integrity. A subsequent Integrated Wound Care (IWC) note, dated 5/5/25, identified R56 was being seen and treated for multiple burns but now outlined, 5/5/25: Burns to bilateral thighs are improving. Staff noticed blistering to sacrum in the last few days. There was no clear cause. The IWC note continued and listed a section labeled, Wound(s):[,] which recorded a pressure ulcer to R56's sacrum including, Stage 2, and, 4.2 X 1.3 X 0 [cm], adding further, 50% Blood blister. A subsequent section of the note labeled, Plan, directed to apply barrier cream with pericares and as-needed; and start an offloading mattress. The note outlined factors which could affect wound healing and directed, Medical management per primary team, and, Optimize nutrition. An additional IWC note, dated 5/26/25, identified a timeline of R56's wound history including the developed pressure ulcer on his sacrum. The note dictation included, 5/12/25 . His sacral ulcer has now evolved into a stage 3 with slough as base, do not suspect any further injury in the past week. Will update orders to a silicone foam border dressing changed M,W, F and [as needed]. Pressure reducing mattress ow [sic] in place. The timeline continued and outlined, 5/16/25 . Burns and pressure ulcer to sacrum have improved in size. Furthermore, the timeline then outlined, 5/26/25 . PU [pressure ulcer] to sacrum has stalled, some stool has seeped under bandage, will change POC [plan] to Triad paste without cover dressing to avoid this. (continued on next page)

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	245063	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 7:36 a.m., R56's morning cares were observed with nursing assistant (NA)-A and NA-B involved. R56 was lying in bed which had an air-pressure mattress in place; along with staff helping to wash him up. R56 would converse with staff as they provided care, however, it was not always sensical to the situation including, A bridge of bread, that's perfect for ya. R56 was assisted to turn onto his right side which exposed his coccyx and buttocks. R56 had a visible pressure ulcer present on the medial aspect of his coccyx which was approximately 50-cent piece sized, nearly symmetrical in shape, and had a dark-red colored center with lighter pink-colored peri-wound perimeter. The wound bed was not immediately visible and the wound, as a whole, had a visible white-colored, semi-hardened paste-like substance both around and in the wound. NA-A stated they thought the wound looked a little bit better and expressed staff often attempted to get R56 to lay down between meals, however, he was not always cooperative and would refuse at times. NA-A and NA-B stated R56 was repositioned every couple hours which had been the same both before and since the pressure injury developed adding aloud, I think it's the same. NA-B stated the wound had different treatments being applied, too, adding aloud, [It's] sometimes a dressing, sometimes cream. NA-A and NA-B both stated they were unsure what, if any, other interventions being done to help heal the developed ulcer except R56's bed having an air mattress placed on it. NA-A then took a tube of medicated cream labeled, Remedy Protect Zinc Oxide Paste, from R56's bedside table and applied it to R56's coccyx. NA-A then placed a new incontinence product underneath R56 and secured it before helping him to pull up the pants. NA-A and NA-B then finished R56's morning cares. R56's Medication Administration Record (MAR), dated 5/2025, identified R56's current physician-ordered medications and treatments along with staff initials to demonstrate their administration or refusal. This included an order which read, Mighty shakes . two times a day for weight loss, which ended on 5/12/25. These intakes were recorded and ranged from 0 (ml) to 170 ml with multiple spaces just recording, NA [not applicable]. The MAR lacked any further supplement use. On 5/28/25 at 9:22 a.m., licensed practical nurse (LPN)-B was interviewed, and verified they provided care to R56 prior. LPN-B stated R56 developed the sacral pressure ulcer back in May 2025, and was currently getting Triad cream applied to the wound. LPN-B explained when a new pressure ulcer is identified, the staff finding it should report it to the assistant director of nursing (ADON) who would then update the wound nurse adding it would then be looked at and reviewed on their next visit (i.e., Mondays). LPN-B stated staff who find the wound would in the mean time just update the physician and get an order until that happened. LPN-B stated the floor nurse didn't usually review nutrition or do any other comprehensive review of the person or their pressure ulcer risk adding, I don't go over that with anybody. LPN-B stated R56 was not real mobile and used a Broda-type wheelchair for mobility adding R56 would, at times, be combative with staff and resistive to cares. LPN-B reiterated any type of comprehensive evaluation of pressure ulcer risk or determining what interventions were needed for them was not their responsibility adding aloud, It's not my wheel house. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/28/25 at 10:02 a.m., R56's hospice registered nurse (HRN) stated they were aware of R56's sacral pressure ulcer adding he developed it a few weeks prior. HRN stated they believed the ulcer was improving and looking good as of late. HRN recalled they believed R56 was on a nutritional supplement and expressed interventions for pressure ulcer care was always tough adding they were always walking that line between comfort and restorative. HRN stated they believed the sacral ulcer developed from extended periods of sitting in his wheelchair adding, He's in his chair a lot, and further, There's only so much repositioning you can do. HRN verified they had provided R56 with his current wheelchair and believed it had a cushion present but added, I can follow up on that. Further, HRN stated nobody from the care center had discussed R56's cushion or what, if any, other options were available since R56 developed the ulcer. R56's medical record was reviewed and lacked evidence R56 had been comprehensively reassessed by the care center to determine what, if any, additional or proactive interventions were needed (i.e., protein supplement, different wheelchair cushion) or could be used to help promote healing of the developed pressure ulcer; nor evidence the facility had reviewed R56's nutrition to determine potential nutritional interventions to promote wound healing despite the IWC note directing to optimize nutrition. On 5/28/25 1:30 p.m., the ADON was interviewed. ADON verified R56's sacral ulcer was in-house acquired, and explained when a new ulcer is found the staff notify the provider for immediate orders and place them on the wound team listing to be seen at next visit. ADON stated a comprehensive review, like which would be done with the interdisciplinary team (IDT), would in theory be located in the risk management charting and contain the facility' investigation and reports about it. However, this was not routinely done for pressure ulcer development for some reason. ADON verified there was nothing they could locate in the risk management section of the record regarding R56's sacral pressure ulcer. ADON verified the record lacked a comprehensive evaluation of R56's skin risk since the ulcer developed and expressed their approach had been more just kinda constant reminders to staff about offloading and repositioning him, however, these were also not documented and just more verbal discussions. ADON acknowledged the need to re-assess after a pressure ulcer develops and expressed doing so was important to help prevent further injury adding aloud, If it's not documented, it's not done. A facility-provided Prevention Of Pressure Ulcers policy, dated 3/2025, identified the resident should be assess for pressure ulcer risk upon admission with the assessment repeated weekly and . upon any changes in condition. The policy outlined a comprehensive skin assessment should be done with each risk assessment, as indicated, according to the resident's risk factors and prior to their discharge.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess for, and implement as appropriate, a nursing functional maintenance program to ensure 1 of 3 residents (R15) maintained and/or improved their highest level of range of motion (ROM). Findings include: R15's quarterly MDS dated [DATE], indicated R15 had severely impaired cognition and required staff assistance with all activities of daily living (ADLs). The MDS indicated R15 had a Functional Limitation in Range of Motion on all extremities. The MDS indicated R15 was not on a restorative nursing program during the look-back period (LBP). R15's care plan, dated 3/20/25, indicated R15 had an ADL performance deficit related to Alzheimer ' s disease and inability to perform self-cares. The care plan outlined R15's daily routine as, she prefers to remain in bed as long as possible, getting up as close to breakfast and lunch as possible, laying back down as soon as possible after meals, and remaining in bed for dinner. The care plan did not include R15's current ROM status or specific interventions or exercises to ensure R15 maintained her ROM and prevented further decline. R15's medical record (including Tasks) was reviewed and did not include an assessment of R15's specific ROM status or interventions/exercises to ensure R15 maintained her ROM if needed. During an interview and observation on 5/27/25 at 2:09 p.m., R15 was observed lying in bed on her back, slightly reclined with no obvious contractures observed. Resident representative (RR)-A stated he commonly assisted R15 with her ADLs and had noticed that R15's legs appeared to have stiffened up. RR-A stated he was concerned as he did not think staff were completing exercises to stop R15's leg stiffening from getting worse. During an interview on 5/28/25 at 11:55 a.m., nursing assistant (NA)-E confirmed she was R15's aide for the day and stated she did not do any passive or active ROM activities with R15. NA-E stated she had not been instructed to complete these with R15 and thought the therapy department did these activities. During an interview on 5/29/25 at 8:54 a.m., registered nurse (RN)-B confirmed he was R15's nurse for the shift, and stated he was not aware of any functional maintenance program for R15 or if she had been assessed for one but recommended asking therapy about it. During an interview on 5/29/25 at 8:59 a.m., the director of rehabilitation (DOR, an occupational therapy assistant) stated her department would make recommendations for a restorative nursing program after discharge from therapy. The DOR stated the therapy department was also happy to assist in screening residents for maintenance programs if consulted by the nursing department, but this did not commonly occur. The DOR stated she did not think that they had created or been consulted to create a maintenance program for R15. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 10:08 a.m., physical therapist (PT)-A stated they do not commonly create restorative or functional maintenance nursing programs but would be willing to if asked. PT-A stated assessing for and following functional maintenance programs would help prevent a rapid decline in functional status as well as help to improve a resident ' s quality of life, especially for residents with degenerative diseases. During an interview on 5/29/25 at 12:26 p.m., the assistant director of nursing (ADON) stated usually the nursing department got their nursing restorative programs for residents after a resident was discharged from therapy. The ADON stated they would then add the program to the care plan and the aides' tasks on the electronic health record (EHR). The ADON stated first she has heard anything regarding a functional maintenance program for R15 and confirmed she did not think R15 had been assessed for her specific ROM status or the need/appropriateness for a maintenance program as needed. The ADON stated usually the nursing department would consult therapy for a functional program if it was something the provider had ordered or if a resident had increased/developed contractures but was not usually completed preventatively unless requested. The facility's Rehabilitative Nursing Care policy dated 5/25/25, indicated nursing personnel were to be trained in rehabilitative nursing care which would be developed and coordinated through the resident's care plan including position changes in bed and routine range of motion exercises.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to complete ongoing pain assessments and timely intervention when signs of pain were observed for 1 of 4 residents (R15) reviewed for pain, with severely impaired cognition. Findings include: R15's quarterly MDS dated [DATE], indicated R15 had severely impaired cognition and required staff assistance with all activities of daily living (ADLs). The MDS indicated R15 was on a scheduled pain medication regimen but had not received any PRN pain medications during the look-back period (LBP). The MDS indicated R15 had non-verbal sounds (crying, whining, gasping, moaning, or groaning) of pain during the LBP, and these indicators occurred three to four days out of the last five days of the LBP. R15's Medical Diagnosis list dated 1/5/24, indicated R15 was diagnosed with Alzheimer's disease, pain in her thoracic spine, and other chronic pain. R15's care plan dated 3/20/25, indicated R15 had chronic pain related to a history of fractures and chronic thoracic back pain. R15's care plan indicated the nursing assistants were to monitor, record, and report to the nurse any signs of non-verbal pain including vocalizations such as grunting, moans and yelling out, irritability, restlessness, tearing, crying, grimacing, etc. but did not include how quickly this should be completed. The care plan indicated R15 had severe cognitive impairment, and impaired thought processes related to late-onset Alzheimer's disease and indicated R15 required assistance with all decision-making and was dependent on staff for meeting all her emotional, sensory, physical, spiritual, and social needs. R15's progress notes from 4/28/25 to 5/28/25, were reviewed and did not include an indication R15's pain had been assessed during the period. R15's Medication Administration Record (MAR) dated 5/1/25 through 5/27/25, indicated R15 received the following pain medications: -one 12 micrograms/hr (mcg/hr) Fentanyl (a narcotic pain medication) patch applied every three days. -five milligrams (mg) of oxycodone (a narcotic pain medication) four times a day. -650 mg of acetaminophen (an over-the-counter pain medication) four times a day. -five mg of oxycodone every four hours as needed, which had not been administered during the period. -650 mg of acetaminophen daily as needed which had not been administered during the period R15's Pain Level record printed on 5/28/25, indicated the last pain score taken was on 3/6/25 and was 1 out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/25 at 1:38 p.m., resident representative (RR)-A stated he felt that the facility staff didn't follow R15's care plan and did not know her well enough due to the number of agency staff used. RR-A stated he had a camera in R15's room and although he didn't watch it all the time, he felt she was not getting pain intervention as often as she should because he would see her yelling out on the camera and not see anyone intervening. RR-A stated that R15 could no longer tell anyone she was in pain, but she used to often tell him her back was killing her and now he could tell she was in pain when she was yelling out. RR-A stated that RR-A had compression fractures to the vertebrae, and he was very concerned that her pain was not being managed when he was not at the facility. During continuous observation and interview on 5/28/25 from 9:15 a.m. to 11:44 a.m., R15 was observed lying in bed on her back with her room door open. At 9:44 a.m., R15 was observed loudly (heard from the hallway) moaning. R15 continued intermittently moaning as heard from the hallway. Nursing assistant (NA)-E and NA-F were observed intermittently passing by R15's room as she loudly moaned. At 10:34 a.m., NA-E and NA-F were observed entering R15's room and closing the door. On interview, NA-F stated they had not assisted R15 but solely were helping her roommate. At 10:46 a.m., as R15 loudly moaned, NA-E was observed entering R15's room and a few seconds later exited. At 10:50 a.m., NA-E was observed to quickly walk a few feet into R15's room as R15 loudly moaned and then walked away. R15 continued to loud moan. Unless noted above, staff were not observed to enter R15's room. During an interview on 5/28/25 at 11:55 a.m., NA-E stated she worked with a staffing agency and was not super familiar with R15 but had worked with her before. NA-E stated she had heard R15 make these moaning sounds previously and thought it was normal for her, so had not completed any nonpharmacological pain interventions for her. NA-E stated she had notified the nurse of the moaning but was not sure of the exact time she had done so. During an interview on 5/28/25 at 12:55 p.m., registered nurse (RN)-D confirmed she was R15's nurse for the shift. RN-D stated that R15 was nonverbal and was unable to tell facility staff when she was in pain. RN-D stated that R15's resident representative was very involved with her care and would sometimes call the facility and ask them to check on her because he would see signs of R15 in pain on the camera he had placed in her room. RN-D stated she could tell R15 was in pain when she was moaning, restless, moving around a lot, or making sounds. RN-D had said that NA-E had notified her of R15 having signs of pain around noon, so she had administered her scheduled pain medication and confirmed she had not completed a formal pain assessment. RN-D stated she would expect the aides to notify her immediately if signs of pain were noticed so she could complete an assessment and intervene as needed. RN-D stated for some residents an assessment prompt was given to complete an assessment with pain medication administration, but she did not see that this was in place for R15, so she had not been completing pain assessments. RN-D stated sometimes they would put pain assessments in the progress notes but confirmed she had reviewed the medical record and was unable to find that regular pain assessments were being completed for R15. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 1:13 p.m., the assistant director of nursing (ADON) stated pain assessments were completed quarterly or as needed when as needed pain medications were given. The ADON stated if an NA had observed signs of possible pain in a resident, she would expect them to immediately notify the nurse so the resident could be assessed. The ADON stated she would expect staff to complete a progress note if they had noted something out of the ordinary but confirmed they did not have a process for ensuring pain assessments were being completed more regularly than quarterly for residents receiving scheduled pain medications who were unable to verbally notify staff of their pain. The facility's Pain Assessment and Management policy dated 10/7/21, indicated acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. The policy indicated that staff should assess residents with stable chronic pain at least weekly.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and document review, the facility failed to comprehensively assess and attempt alternatives for 1 of 1 resident (R46) reviewed who had grab bars affixed to their bed. Findings include: R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 had moderately impaired cognition and no hallucinations, delusions, or rejection of cares. R46 required partial and/or moderate assistance to roll left and right, required substantial/maximal assistance with upper body dressing and transfers, and was dependent with lower body dressing and toileting hygiene. R46's diagnoses included peripheral vascular disease, arthritis, hip fracture, dementia, Parkinson's Disease, and depression. R46's Order Summary Report printed 5/28/25, indicated okay for bilateral assist bars to serve as an enable to promote independence with order date of 11/18/24. R46's bedrail care plan revised 4/14/25, indicated R46 used bedrails related to need for assistance with bed mobility. Interventions included to anticipate and meet needs, be sure call light within reach and respond promptly to all requests for assistance, educate resident/representative on benefits and risk of bed rail/grab bar use, inspect grab bar per manufacturer direction, and reassess/evaluate use of grab bar quarterly and as needed. R46's quarterly Bed Rail/Assist Bar Evaluation dated 4/5/25, indicated no bed rail or assist bar/grab bar was in use and the need for bed rails was not indicated at the time of the assessment. R46's progress notes lacked indication of risk and benefit conversation of grab bars with resident and/or representative. During observation on 5/28/25 at 8:57 a.m., nursing assistant (NA)-D and NA-H assisted R46 with cares. R46 had two grab bars affixed to bed and used them to roll from side to side while cares were performed. During interview on 5/28/25 at 1:37 p.m., NA-D stated R46 had grab bars since he was in the room and helped him with movement. Further document review of Bed Rail/Assist Bar Evaluations indicated: -11/18/24, R46 admitted on [DATE] and assist bar/grab bar was requested and/or currently in use. New Admit was indicated in the area to describe which alternative was attempted prior to request. Evaluation factors were noted, and summarized findings indicated bed rail or assist bar was indicated and served to promote independence. The resident/family notification areas were left blank. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/3/25, indicated assist bar/grab bar was requested and/or currently in use, and the areas to describe alternatives and resident/family notification were blank. Evaluation factors were noted, and summarized findings indicated bed rail or assist bar was indicated and served to promote independence. -1/6/25, indicated assist bar/grab bar was requested and/or currently in use, and the areas to describe alternatives and resident/family notification were blank. Evaluation factors were noted, and summarized findings indicated bed rail or assist bar was indicated and served to promote independence. During interview on 5/29/25 at 12:30 p.m., registered nurse (RN)-E stated grab bars were assessed prior to installation and assessments were completed quarterly. RN-E reviewed the Assist Bar Evaluations and acknowledged the lack of documentation of alternatives and family notification. RN-E stated there were ongoing conversations about risks and benefits of grab bars with the resident/family and documentation of conversations would either be in the progress notes or assessments. RN-E stated grab bar assessments were important to ensure resident used the grab bars appropriately and safely. During interview and document review on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON) stated the facility had an admission consent form and education for grab bars, which included a spot to enter alternatives trialed. The ADON stated there were inconsistencies with who completed grab bar assessments. The ADON provided and reviewed R46's Side Rails/Grab Bar Informed Consent and Release form dated 11/18/24. The document identified a resident/representative signature, and the areas listed for alternatives attempted but failed and alternatives considered but not attempted were blank. The ADON stated the facility usually trialed pillows and encouraged residents to grab the edge of the bed before grab bar installation. The ADON stated grab bars were different than bed rails but still had slight risks to residents.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Deficiency Text Not Available

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	245063	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Park Home Inc	2237 Commonwealth Avenue Saint Paul, MN 55108

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure resident choice with meal preferences was attempted and/or honored to promote quality of life for 1 of 1 resident (R35) reviewed who wanted to have fried eggs (i.e., runny yolk) and was told they could not have them. Findings include: The Centers for Medicare and Medicaid (CMS) State Operations Manual Appendix PP, dated 4/2025, identified the Federal regulatory requirements long-term care facilities must abide by in accordance with Federal law. These regulations included F812 which outlined, . To accommodate residents choice for items such as 'sunny side up [eggs]' the facility must use pasteurized eggs only. On 5/27/25 at 8:13 a.m., an initial tour of the kitchen was completed. A series of boxes were stacked on the floor next to the [NAME] walk-in cooler which had been delivered by the food service vendor. Amongst these were two boxes labeled, Pasteurized Eggs. R35's quarterly Minimum Data Set (MDS), dated [DATE], identified R35 had intact cognition and demonstrated no delusional thinking. On 5/27/25 at 9:13 a.m., R35 was observed lying in bed while in his room. R35 had a meal tray placed on a bedside table which extended across his body and on the plate was a stack of pancakes with fruit, along with one hard-boiled (whole) egg. R35 was interviewed and stated his only complaint about the care center was they wouldn't let him have fried eggs with a runny yolk. R35 added, They won't let me have easy-over eggs. R35 stated it was frustrating to him as others were served them adding aloud, It just doesn't make any sense. R35 stated he had asked for them repeatedly but the management kept telling him no adding, They override me. R35's progress note, dated 4/10/25, was authored by the campus dietary manager (DM) and outlined they had spoken to R35 and informed him they couldn't served over-easy eggs adding, . all eggs will be fully cooked. The note recorded R35 accepted the information and enjoyed the food at the campus. However, the note lacked any rationale on why R35 was unable to have fried eggs despite the campus having pasteurized eggs available for use. R35's nutritional care plan, last revised 4/2025, identified R35 had potential for nutritional risk due to a history of infection, multiple sclerosis, diabetes and a high BMI (Body Mass Index). A goal was listed for R39 to maintain his weight around 200 pounds (lbs) and multiple interventions were listed to help him meet this goal including weights per order, and a protein supplement as directed/ordered. However, the care plan lacked information on why R39 was not allowed to consume fried eggs as outlined in the progress note (dated 4/10/25). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following day, on 5/28/25 at 8:29 a.m., R35 was again observed laying in bed while in his room. R35 had a meal tray placed on the bedside table which R35 expressed staff had just brought in. The tray had a single plate which had French Toast, two hard-boiled eggs, and a small bowl of oatmeal present. A white-colored menu slip was also present on the tray which read several food categories including, Egg: _____, and opposite the slip on the same line, 1 each. The menu slip lacked information on which type of prepared egg(s) R35 wanted. R35 reiterated he wanted fried eggs and expressed aloud, Maybe I will have to call up Denny's [restaurant chain] or something. Immediately following this, at 8:33 a.m., the second floor main dining room was observed. The room had multiple tables present with various residents seated around them including another male resident who was eating eggs on a regular plate which had a visible yellow-colored, runny yolk smeared on the plate. When interviewed on 5/28/25 at 8:36 a.m., nursing assistant (NA)-C stated they were assigned care for R39. NA-C explained R39 typically ate breakfast is his room and thought he (R39) was usually served fried eggs. NA-C stated they were unsure why R39 had been served hard-boiled eggs for the past few days but reiterated they felt R39 was typically served fried eggs. On 5/28/25 at 10:31 a.m., cook (CK)-A was interviewed, and verified they often helped prepare the breakfast meals for residents. CK-A stated they recalled R39 wanting to have fried eggs adding staff had been battling for a couple months with him about it. CK-A stated they believed fried eggs were acceptable to serve as long as pasteurized eggs were used to make them which CK-A verified were available. CK-A stated R39 would eat fried eggs for every meal if allowed, and recalled DM had visited with him about it in the past. CK-A stated, to their knowledge, R39 was not allowed to have fried eggs due to the facility owner not allowing it adding, The owner didn't want to do it. CK-A stated they were unsure of the rationale and advised the DM likely would have more information about it. When interviewed on 5/28/25 at 11:05 a.m., the assistant director of nursing (ADON) stated there had been discussion through an email thread about R39 wanting to consume fried eggs. ADON explained they originally had believed R39 couldn't consume fried eggs due to other regulations (i.e., F812), however, the food service vendor then corrected them saying fried eggs could be made as long as pasteurized eggs were used. ADON stated the interdisciplinary team (IDT) had discussed this just the week prior but still had not come to an ultimate decision on how, when or if R39 would be allowed to consume fried eggs as he wanted. ADON acknowledged resident' choice being important with meal items adding, It's their right to have choice, and staff should do the best we can to accommodate this. On 5/28/25 at 11:29 a.m., the DM was interviewed, and verified they were aware R39 wanted to consume fried eggs with some meals. DM explained if R39 had his way he'd get fried eggs with each meal adding R39 had reported them to her as comfort food. DM verified pasteurized eggs were available and expressed they were still trying to figure out how or if they'd serve them to R39 adding aloud, It's a battle. DM expressed some of the issue was other departments not wanting R39 to have them and it created a situation where they had to decide do we allow resident satisfaction and [or] not. DM acknowledged not being provided foods of choice could be a resident rights violation. A facility' policy on meal choices was requested, however, none was received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a low-temperature sanitization commercial dishwasher used in 1 of 1 main production kitchen was adequately monitored (i.e., every shift) to ensure effective chemical concentration and dishware sanitization to reduce the risk of foodborne illness. This had potential to affect all 72 residents, staff and visitors who consumed food from the kitchen. Findings include: On 5/27/25 at 8:13 a.m., an initial kitchen tour was completed of the main production kitchen located in the basement-level of the care center. The kitchen had a single CMA low-temperature commercial dishwasher placed along the wall with various chemicals positioned below in bottles and connected to the machine via clear tubing. These chemicals included rinsing aid(s) and sodium hypochlorite (used as a chemical sanitizer). Later, at 8:22 a.m., dietary aide (DA)-A was present at the machine and rinsing soiled dishware before placing it onto hard-plastic racks and into the machine causing the machine to activate upon the entry door closure. DA-A stated the care center had just gotten this new dishwasher installed a few months prior and verified it was a low-temperature sanitization machine. DA-A pointed to a single gauge positioned below the machine which displayed the water temperature during each cycle. This gauge displayed a washing temperature of 126 degrees Fahrenheit (F) and a rinse temperature of 140 F. DA-A stated they checked the machine for chemical concentration using a Hydrion strip and showed this process to the surveyor. DA-A removed a strip from the packaging and placed one-half of it into pool water in the base of the machine after the dishwasher stopped. The strip turned a purple-color which DA-A compared to the packaging showing a concentration of 50 parts-per-million (PPM). DA-A stated the concentration should be like 50 to 100 [PPM] to ensure sanitization adding the machine was checked every day in the morning before cooking and food service started. DA-A provided a flow sheet labeled, St [NAME] Park Home, which was dated, May 2025, and had columns to record the date, wash temperature, chlorine concentration (i.e., PPM), rinse temperature and staff initials. This identified only a single recording for each date (5/12 to 2/27) and only listed a PPM reading being completed/documented since 5/21 (i.e., six times) with each days' reading being recorded, 50 [ppm]. There were no other recorded ppm checks on the flow sheet. DA-A verified the flow sheet lacked any additional readings and expressed, Maybe they [staff] forgot. DA-A reiterated the machine was only checked once a day to their knowledge for a PPM reading, and they verified the strips were the only testing mechanism used to check the PPM. Later, on 5/27/25 at 2:02 p.m., dietary aide (DA)-B was interviewed. DA-B verified they worked the evening (i.e., second) shift and helped with washing dishes using the CMA commercial dishwasher in the main kitchen from the supper meal. DA-B stated the machine was just installed a few months prior and the morning shift was responsible to check the machine for PPM concentration. DA-B verified they do not complete any checks of the PPM using the Hydrion strips or any other mechanical indicators adding aloud, I don't do that, no. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/28/25 at 11:26 a.m., the dietary manager (DM) was interviewed, and they verified the dishwasher was only checked once-a-day for ppm concentration of the sanitizing solution. DM acknowledged the flow sheets used to record this process only started having a documented PPM check on 5/21/25, and expressed it took awhile for staff to get used to running the machine and checking it for function and sanitization. DM stated they would adjust the flow sheet to ensure a twice-a-day check (i.e., every shift) was completed and recorded. DM stated it was important to ensure the machine was checked adequately for sanitization so as to make sure the chemicals are at equal levels to make sure the dishes are getting sanitized. A facility provided Cleaning Dishes/Dish Machine policy, undated, outlined all flatware, dishes and cookware would be cleaned, rinsed, and sanitized after each use adding, The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The policy outlined a process to ensure sanitization for both a high-temperature sanitization machine and a low-temperature machine. This directed a 50 PPM hypochlorite reading should be obtained, however, the policy lacked a frequency for how often to test this PPM reading.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** HAND HYGIENE AND GLOVE USE R62's quarterly Minimum Data Set (MDS) dated [DATE], indicated R62 had intact cognition and no hallucinations, delusions, behaviors, or rejection of cares. R62 had impairment to both lower extremities, required partial and/or moderate assistance for upper body dressing and to roll left and right, and was dependent on toileting hygiene and lower body dressing. R62's diagnoses included heart failure, hypertension, malnutrition, anxiety, depression, post traumatic stress disorder, respiratory failure, and chronic obstructive pulmonary disease. During observation on 5/28/25 at 11:10 a.m., nursing assistant (NA)-G wore gloves, unhooked R62's incontinent product, and completed peri-cares. NA-G disposed of R62's incontinent product soiled with urine and used the same gloves to apply a clean brief and clean bed pad. NA-G removed their gloves, did not perform hand hygiene, exited the room, and grabbed a clean gown from the floor's clean linen area. NA-G returned to R62's room with the gown, applied new gloves, and assisted R62 to apply the gown. NA-G bagged soiled linen and garbage, removed gloves, and washed their hands. During interview on 5/28/25 at 11:22 a.m., NA-G stated they changed their gloves after changing R62's incontinent product. NA-G acknowledged they did not complete hand hygiene with glove change or when they exited room to get clean gown. During interview on 5/29/25 at 1:46 p.m., registered nurse (RN)-E expected staff to change gloves and complete hand hygiene after a dirty process and before touching clean products. During interview on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON), who was the facility's infection preventionist, stated hand washing was the best form of infection prevention. The facility Handwashing/Hand Hygiene policy dated 1/18/22, directed staff to complete hand hygiene after removing gloves, before and after direct contact with resident, before moving from a contaminated body site to a clean body site during resident care, and after contact with blood or bodily fluids. BLOOD GLUCOSE MACHINE The Medline Evencare G2 Blood Glucose Monitoring System dated 2017, included the following cleaning instructions: Wash hands with soap and water, inspect the machine for blood debris, etc., clean the machine with a validated disinfecting wipe, allow it to air dry, and if cracking of the plastic housing is noted, stop using the device. R40's annual Minimum Data Set (MDS) dated [DATE], indicated R40 had moderately impaired cognition and was diagnosed with kidney disease and diabetes. The MDS indicated R40 received insulin (an injection used to lower blood sugar) during the look-back period (LBP). R40's order summary dated 5/29/25, indicated R40 had orders for: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Insulin Lispro (fast-acting insulin) three times a day per sliding scale based on blood glucose level (70 - 149, zero units; 150 - 199, 2 units; 200 - 249, 4 units; 250 -299, 6 units; 300 - 349, 8 units; 350 - 399, 10 units; 400 or greater, 12 units and notify provider) -Humulin 70/30 insulin (combination of insulin isophane and regular, both short and intermediate-acting insulin), 52 units in the morning and 44 units in the evening. During an interview and observation on 5/28/25 at 8:13 a.m., registered nurse (RN)-F stated R40 had insulin due this morning, so he was going to check his blood sugar. RN-F was observed to take a Medline Evencare G2 blood glucose machine which had about an inch-long crack in the plastic housing on the left side of the machine, sporadic white building up on the machine, and was missing a back battery cover which was instead covered with clear medical tape. RN-F was observed to complete hand hygiene, apply gloves, and use the machine to take R40's blood glucose reading. RN-F confirmed this machine was used for the floor and not solely for R40. RN-F stated he was unsure how long the machine had been cracked. During an interview on 5/28/25 at 12:45 p.m., RN-E, the unit nurse manager, stated she was unsure if the blood glucose machine was still a cleanable surface but was going to take the machine out of service and see if they had a different blood glucose machine to use instead. During an interview on 5/29/25 at 12:38 p.m., the director of nursing (DON) stated if a blood glucose machine was cracked, she would expect nursing staff to take it out of service as it was no longer a cleanable surface and could affect the accuracy of the measurements. The facility's Obtaining a Fingerstick Glucose Level policy dated 9/30/21, indicated that blood glucose monitoring equipment was to be cleaned and disinfected according to manufacturer's instructions and current infection control standards of practice. Based on record review and interview, the facility failed to report a suspected Norovirus outbreak to the State Agency (SA) as required. This had the potential to affect all 72 residents residing in the facility. In addition, the facility failed to ensure a blood glucose machine was kept in good repair to ensure the surface could be adequately disinfected and for 1 of 4 residents (R40) reviewed for medication administration. The facility also failed to ensure proper hand hygiene and glove use was utilized for 1 of 2 residents (R62) observed during personal cares. Findings include: NOT REPORTING SUSPECTED NOROVIRUS OUTBREAK TO STATE AGENCY According to 2024-2025 Norovirus Information for long-term care facilities from www.health.state.mn.us, By Minnesota state law ([NAME]. Rules part 4605.7050), any pattern of cases, suspected cases, or increased incidence of any illness beyond the expected number of cases in a given period shall be reported immediately to MDH. This includes suspected outbreaks, increases in GI illnesses, or unusual disease activity at your facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Antibiotic Surveillance and Symptom Tracker report, printed 5/28/24, was reviewed. The log included the following information: resident names, date of birth , unit, room numbers, onset date of symptoms, diagnostic order and results, current prescription, infections, isolation, organism, status and signs and symptoms. The report identified between 1/31/25 -2/16/25, 14 residents were suspected of Norovirus. One resident was also identified on 2/26/25 and another on 4/18/25. Recorded signs and symptoms included vomiting, diarrhea, nausea, abnormal bowel movement and GI complaints. Isolation precautions were listed as contact for all residents listed for Norovirus. During an interview on 5/28/25 at 1:57 p.m., assistant director of nursing (ADON) stated she was the facilities infection preventionist (IP) and had been in the IP role for over a year. ADON stated she did all the required reporting for any suspected outbreaks in the facility. ADON stated the facility had a Norovirus outbreak in February, however she did not have any documentation that the outbreak was reported to the state agency as she did not report the outbreak and was unsure if it was required to report a Norovirus outbreak. ADON stated she thought one resident was tested for Norovirus but any residents with symptoms were treated as though they had Norovirus. During an interview on 5/29/25 at 12:52 p.m., director of nursing (DON) stated it was the facilities responsibility to report any suspected outbreak to the state agency. DON stated there was a Norovirus outbreak in February and it should have been reported. A facility policy titled Reporting Communicable Diseases, undated, indicated the infection preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable diseases.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor appropriateness of antibiotic including prophylactic antibiotic use to prevent antibiotic resistance and help prevent the spread of infectious diseases. This had the potential to affect all 72 residents residing in the facility. In addition, the facility failed to ensure an ongoing review of prophylactic antibiotic use for 1 of 1 residents (R51) reviewed for oral antibiotic use. R51 R51's admission Minimum Data Set (MDS) dated [DATE], indicated R51 had intact cognition and had been admitted to the facility on [DATE]. R51's provider note dated 5/20/25, indicated R51 was diagnosed with anemia and wounds of the left and right ankle. The note did not indicate that R51 had a history of urinary tract infections or an indication of review for the continued use of cephalexin. R51's Order Summary Report dated 5/27/25, indicated R51 had an order for cephalexin (an antibiotic) 250 milligrams (mg) daily for urinary tract infection (UTI) prophylaxis. R51's medical record was reviewed and did not indicate that R51' s order for prophylactic cephalexin had been reviewed with indication for its continued use. During an interview on 5/27/25 at 8:46 a.m., R51 stated she had seen a urologist sometime in 2023 after she had fallen and broken her pelvis, and he had started the cephalexin because she had multiple UTIs. R51 stated thought the urologist had told her to keep taking the cephalexin until the body heals but did not recall being told an exact duration of use. During an interview on 5/28/25 at 1:27 p.m., the assistant director of nursing (ADON), also in the role of infection preventionist, confirmed she had reviewed R51' s medical record and was unable to find documentation that the Cephalexin had been reviewed by the provider for the appropriateness of continued use. The ADON stated she would prefer to get rid of prophylactic antibiotics when a resident was admitted to the facility but had been struggling with getting provider participation in reviewing these medications for residents. During an interview on 5/29/25 at 2:27 p.m., nurse practitioner (NP)-A stated R51 had been admitted with the cephalexin, and she had thought R51 had been taking the medication for years and she tend[s] to leave it[those medications] alone. NP-A stated that R51 was currently on a transitional care unit status, so she was not going to review if the continued use of the cephalexin was appropriate for R51, until she transitioned to long-term care as was her practice. NO PROPHYLACTIC ANTIBIOTIC MONITORING (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Antibiotic Surveillance and Symptom Tracker report, printed 5/28/25, was reviewed. The log included the following information: resident names, date of birth , unit, room numbers, onset date, diagnostic order and results, current prescription, infection, isolation, organism, signs and symptoms and status. The report lacked prophylactic antibiotic tracking. During an interview on 5/28/25 at 1:57 p.m., assistant director of nursing (ADON) stated she was the facilities infection preventionist (IP). ADON stated she has been in the IP role for over a year. ADON stated she was not tracking any prophylactic antibiotics in the facility and verified they were not included on the antibiotic tracking sheet which was reviewed in QAPI (Quality Assurance and Performance). ADON stated she was currently not reviewing prophylactic antibiotics and was not able to state the number of residents on prophylactic antibiotics. ADON stated she had not determined where or how she was going to track them. ADON stated she relied on the pharmacy to review the prophylactic antibiotics but was unsure how this was completed. ADON stated it was important to monitor prophylactic antibiotics as according to a lot of people they are not effective. During an interview on 5/29/25 at 1:56 p.m., consulting pharmacist (CP)-A stated that during her monthly audits of resident charts, she reviewed antibiotics to ensure they were the appropriate dose for the resident. CP-A stated she did not review for the duration of the antibiotic and stated, I would leave it up to the provider to determine how long the resident should be on a prophylactic antibiotic. During an interview on 5/29/25 at 12:51 p.m., director of nursing (DON) stated it was important to track prophylactic antibiotics to make sure they were appropriate for why they were prescribed. A facility policy titled Antibiotic Stewardship Policy, dated 10/4/21, indicated The Infection Control Nurse will complete monthly chart reviews of all ordered and administered antimicrobials for the residents. The data will be recorded and presented at the Quarterly Quality Assurance Committee Meeting. A review of possible trends will be discussed at this time. The Consulting Pharmacist will complete a monthly review for indications and justification of use to verify that antibiotics are used in accordance with CDC recommended guidelines.