STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

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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 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. 49035 Based on observation and interview, the facility failed to provide a dignified dining experience in the locked memory care unit dining room. This had the potential to effect all 36 residents and visitors. Findings include: During observation on 7/8/24 at 5:25 p.m., three residents were eating in the hall outside of the dining room on tray tables next to the nurse's station. Staff would occasionally provide cueing assistance. One resident was sitting in a chair in the corner eating off a knee height side table. Another resident sitting in a chair along the wall eating off a tray table. All spots at the tables in the dining room are utilized by other residents. During observation on 7/10/24 at 8:31 a.m., all residents are served meals on tray tables. All trays are left under the plates during the meal. Food is brought to unit on a cart, which is left in the dining room during the meal service. Three carts are present in the dining room by the door after all residents were served. All residents on the same table are not served at the same time. One resident had her food in front of her and stated I'm waiting for my friend to be served when asked why she was not eating. Resident waited over 10 minutes before her tablemate was served and they both ate. One resident sat in the corner with his food tray on his walker. R149 was eating off a low side table. Table was below his knee height, and he had to bend at the waist to eat. During interview on 7/10/24 at 9:06 a.m., R149 confirmed he would eat at a normal table if he could. R149 stated he had not been offered a spot at a normal height table. During interview on 7/10/24 at 11:10 a.m., R149's family member (FM)-B confirmed he has seen R149 eating at a low side table. FM-B stated it looked uncomfortable. FM-B stated R149 previously ate meals at a dining room table and thinks he would continue to do so if able. FM-B stated he did not think there was room with all the wheelchairs. During interview on 7/11/24 at 3:40 p.m., registered nurse (RN)-G stated some residents needed to be in the hallway so the nurses could supervise while they were eating. RN-G stated there are 5 tables and they could get a max of 4 people at most of the tables, and they could make room for anyone who wanted to eat at a table. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 7/11/24 at 3:34 p.m., director of nursing (DON) stated she did not know why residents did not eat at traditional tables. She stated she did rounds to each unit daily but did not provide a date of the last time she observed a meal on the unit. DON stated she was unsure why some residents did not eat at traditional tables. DON stated she was unsure if there was enough room for all residents who wished to be seated at tables to do so.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview and document review, the facility failed to ensure physician's orders for self-administration of medication (SAM) and SAM occurred at the appropriate time for 1 of 1 resident (R173) reviewed for self-administration of medication. Findings include: R173's quarterly Minimum Data Set (MDS) dated [DATE], indicated R173 had intact cognition and diagnoses of cancer, respiratory failure, and chronic obstructive pulmonary disease (long-term lung disease which restricts airflow and causes breathing problems). MDS indicated R173 had no rejection of care and was independent with activities of daily living. R173 required tracheostomy care and suctioning. R173's physician's orders dated 7/11/24, identified Belbuca buccal (applied in the inner cheek) film 300 micrograms (mcg) with directions to place and dissolve 1 film buccally two times a day for pain. R173's physician's orders lacked orders for self-administration of medication. R173's SAM assessment dated [DATE], identified R173 knew their medications, including Belbuca, and was able to self-administer after set-up. R173's care plan lacked information about self-administration of medication. During observation and interview on 7/8/24 at 1:45 p.m., R173 was in bed and had an unopened square packet on their bedside table which was labeled Belbuca 300 mcg. R173 picked up the packet which they showed to the surveyor and stated they preferred staff to bring the medication unopened so they could open and take the medication without staff assistance. During interview on 7/8/24 at 1:58 p.m., RN-L stated R173 was independent and called when needed medications. R173's medication administration record identified Belbuca buccal film 300 mcg to be given at 8:00 a.m. and 8:00 p.m During interview on 7/8/24 at 5:20 p.m., registered nurse (RN)-I stated the medication administration record (MAR) or treatment administration record (TAR) indicated which residents could keep medications in their room. RN-I stated most residents on the respiratory care unit had feeding tubes and were not able to speak, so the nurse gave residents medication at the ordered times. RN-I was not aware of any residents with physician orders to self-administer their medications. During interview on 7/8/24 at 5:24 p.m., R173 stated they took their medication, and the film went between their cheek and gum where it dissolved. R173 stated they were scheduled to receive their second scheduled Belbuca in one to two hours for pain, and no one checked if they took medication besides their breathing treatments. (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 7/8/24 at 5:27 p.m., RN-J stated there were no residents on the respiratory care unit who self-administered their medications. RN-J stated residents were assessed using a form to ensure correct self-medication administration before being allowed to do so. In addition, a physician's order was required for self-medication administration. RN-J reported staff watched residents take narcotic medications, and narcotic medications were not to be left in a resident's room. RN-J verified R173 did not have an order for self-administration of medications, and staff supervised R173 take the narcotic. RN verified Belbuca was a narcotic and signed out on the narcotic log 7/8/24 at 8:07 a.m. by RN-K. During interview on 7/8/24 at 5:39 p.m., RN-L stated they did not have any residents on the respiratory care unit with orders for self-administration. Residents needed education, assessment with return demonstration, and doctor's order prior to self-administration. RN-L stated self-administration of narcotics was not appropriate. RN-L verified Belbuca film was a narcotic, and R173 did not have an order or care plan for self-administration. RN-L stated there was risk for resident to not take medication at right time or not at all and throw it away. During further interview on 7/8/24 at 6:03 p.m., RN-L stated they would watch R173 take narcotic medication and educate them. RN-L stated R173 had not taken the medication because they had fallen asleep, and R173 had a scissors to open the medication packet. During interview on 7/9/24 at 8:17 a.m., RN-K stated residents needed an order for self-administration of medication. R173 had a self-administration of medication assessment and knew their medications and could leave medications with R173, including the Belbuca used for pain. RN-K stated R173 refused for staff to open their narcotic and had their own scissors. RN-K stated the morning prior R173 told RN-K to leave the Belbuca at bedside, and RN-K did not check back to ensure R173 had taken their medication. RN-K stated it was important to ensure residents take their medication. During interview on 7/11/24 at 9:25 a.m., RN-L stated they called the provider and gave the 8:00 p.m. Belbuca later and educated R173 about importance of taking medication an hour before or after the scheduled time. During interview on 7/11/24 at 1:25 p.m., consulting pharmacist (CP) expected staff to follow their procedures on self-administration and included narcotics. CP stated ideally medications would be taken an hour before or up to an hour after its scheduled time. CP expected staff to check back within one to two hours to ensure R173 took the narcotic. CP stated R173 could have increased pain when narcotic not taken at scheduled time. During interview on 7/11/24 at 3:08 p.m., director of nursing (DON) stated facility policies did not specifically address self-administration of narcotics, and residents could self-administer narcotics if deemed safe per assessment. DON expected nurses to check if narcotic was taken after an hour of administration. DON stated resident could have adverse effect if take stockpile of narcotic medication. A facility policy titled Self-Administration of Drugs dated 10/23, directed staff and practitioner to assess residents' mental and physical abilities, which included comprehension of the purpose and proper dosage and administration time for medication, to determine whether a resident was capable of self-administering medications.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 49035 Based on document review and interview, the facility failed to provide smoking opportunities for 1 of 1 residents (R581) reviewed for choices. Findings Include: R581's Admission Record printed 7/11/24, included diagnosis of weakness and dementia without behavioral disturbance. R581's Nursing Admission Evaluation dated 6/20/24, included a section for tobacco use with a selected answer of yes for flame lite tobacco use. Smoking evaluation dated 7/1/24, included R581 wished to smoke during her stay at the facility. Resident wished to ulitized flame lit cigarettes. Resident was marked safe to smoke with limitations. R581's progress note dated 7/1/24, included the resident was observed smoking cigarettes in the hallway of the facility. Progress note dated 7/2/24, included the resident was able to express ideas and wants. Progress note dated 7/2/24, included the resident spent a lot of time looking for cigarettes and propelling self around until asking for cigarettes. Progress note dated 7/9/24, included the resident was asking to go out to smoke several times during the shift. R581's care plan failed to address wishes to smoke. During interview on 7/10/24 at 7:25 a.m., R581 stated she was a smoker and would smoke if she had the opportunity. She stated she was outside yesterday but did not have any cigarettes to smoke. During interview on 7/9/24 at 2:25 p.m., licensed practical nurse (LPN)-B stated no one on the unit smoked cigarettes. If a resident wished to smoke, they would have been assessed by a nurse manager for safety. During interview on 7/10/24 at 1:29 p.m., registered nurse (RN)- E stated no residents on memory care smoked. Residents would need an escort if they wanted to smoke. RN-E stated a hand off report would be completed if a resident was transferred from another unit. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/10/24 at 1:57 p.m., director of nursing (DON) stated a smoking assessment would be completed on all new residents who wished to smoke while at the facility. Resident on memory care would be assessed on a case-by-case basis when developing a smoking plan. She stated the facility did not provide escorts for memory care resident's who wished to smoke, however other alternatives would be explored. DON confirmed R581 wished to be a smoker based on resident assessment and progress notes. Facility document titled Smoking Policy dated January 2023, included a safety risk assessment would be completed by nursing staff upon admission, re-admission, quarterly and as deemed necessary. Residents deemed unsafe to smoke independently would require supervision by staff members.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview and document review, the facility failed to ensure an appropriate safety plan was in place to protect residents of the facility while there was an ongoing investigation for an allegation of abuse. This had the ability to effect all residents on the units the allegated perpetrator worked on. Findings include: R145's significant change Minimum Data Set (MDS) dated [DATE], identified R145 had intact cognition and demonstrated no hallucination or delusional behaviors. During an interview on 7/9/24 at 3:34 p.m., R145 stated that a nurse worked on 7/6/24, and did her wound care was excessively rough poking and prodding unnecessarily into her wound causing more pain than usually occurred. R145 felt that the nurses were causing the extra pain on purpose and trying to abuse her physically. This was reported to the administrator so they could investigate the allegation of physical abuse. Review of wound care documentation from 7/6/24, indicated licensed practical nurse (LPN)-E was the nurse who performed R145's wound care on 7/6/24. Review of the facility abuse investigation file related to R145 showed the facility had identified LPN-E as the alleged perpetrator (AP). Review of the facility schedule dated 7/8/24 to 7/11/24, indicated LPN-E was scheduled to work 8 hours each day while the investigation of abuse was ongoing. On 7/11/24 at 9:16 am. LPN-E was observed passing medication to R145. R145 was the only staff member in the room while she performed those actions. On 7/11/24 at 10:38 a.m., LPN-E was observed completing wound cares with R145. After wound care was complete, LPN-E left R145's room and entered several other resident rooms without another staff present with her. During an interview on 7/11/24 at 1:42 p.m., LPN-E stated the assistant director of nursing (ADON) had talked to her about the alleged abuse on 7/10/24. The ADON took down all the information that was obtained during the interview and then let her return back work. LPN-E stated she had worked on the floor every day from 7/9/24 to 7/11/24, with mulitple residents on all units of the facility. LPN-E also confirmed she was never required to work along side another staff member while in resident room. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at 4:16 p.m., the director of nursing (DON) confirmed R145's allegation was still an active investigation and the ADON was the staff member who led the investigation. During an investigation, if an AP is identified, then the AP would be suspended until the investigation was complete and a determination was made. The DON stated she had not assisted with the investigation so far, but did review the investigation file and acknowledged LPN-E had been determined to be the AP. LPN-E had not been suspended or assigned to work with another staff member in pairs. The expecation was the person who performed the investigation, and determined the AP was to ensure the AP was suspended until the investigation ended. This was for the resident in question and all residents in the facility's safety. During an interview on 7/11/24 the administrator confirmed LPN-E had worked each day that week on different units of the facility and provided direct resident care. Facility policy Abuse Prevention Program last reviewed 9/23, identified the facility administration and staff were committed to protecting residents from abuse. Comprehensive policies and procedures have been developed to aid the facility administration to prevent abuse, neglect, or mistreatment. The abuse prevention program provides policies and procedures that govern at minimum various parts of abuse protection which included the protection of residents during abuse investigations.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49654 Based on interview and document review, the facility failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of facility-initiated transfers for 2 of 2 residents (R45, R143) who had been hospitalized . Findings include: R45's nurse's note dated 6/25/24, indicated R45 had been sent to the emergency room due to confusion and was admitted with possible sepsis. The physician's progress noted dated 7/3/24, indicated R45 was hospitalized with sepsis from 6/24/24 -7/1/24. The medical record lacked evidence notice of the transfer was provided to the OOLTC. R143's hospital discharge summary dated 6/26/24, indicated R143 was hospitalized with sepsis from 6/17/24-6/26/24. The medical record lacked evidence of written notification of transfer were provided to the OOLTC. The June 2024 Ombudsman Report dated 7/1/24, identified 4 residents who had been transferred to the hospital in June 2024 . However, the report did not include R45 or R143. During interview on 7/11/24 at 11:41 a.m., the director of nursing (DON) stated the nursing staff updated the OOLTC monthly and electronically. All residents who are discharged or transferred from the facility were to be included in the electronic communication to the OOLTC. The DON reviewed the Ombudsman Report dated 7/1/24, and confirmed R45 and R143 were omitted from the list. Documentation of Transfers/Discharges policy dated 9/2023, directed staff to notify residents representative and primary provider at time of transfer/discharge. The policy lacked instructions to notify the OOLTC of facility initiated or emergency transfers within 30 days.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and document review, the facility failed to provide notification to the resident and/or resident representative of the facility bed hold policy within 24 hours of an emergency transfer for 1 of 2 residents (R45) who required an emergency transfer to the hospital. Findings include: R45's nurse's note dated 6/25/24, indicated R45 had been sent to the emergency room due to confusion and was admitted with possible sepsis. The physician's progress noted dated 7/3/24, indicated R45 was hospitalized with sepsis from 6/24/24 -7/1/24. During interview on 7/8/24 at 03:21 p.m., R45 stated they had been recently hospitalized with sepsis but could not recall being notified of the facility bed hold policy. During interview on 7/10/24 at 09:08 a.m., registered nurse (RN)-H stated the nurse transferring a resident out of the facility was to notify the resident or their representative of the bed hold policy at time of transfer. RN-H confirmed R45's record lacked a bed hold notification for the 6/24/24, hospitalization . During interview on 7/11/24 at 11:41 a.m., the director of nursing (DON) stated each resident, or their representative were to receive bed hold notification at time of transfer or within 24 hours of discharged . The DON confirmed R45's clinical record lacked documentation of a bed hold for the hospitalization on [DATE]. The Bed Hold policy dated 6/20/24, directed the staff to provide the resident and/or their representative with information on bed holds at the time of discharge.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 44651

Based on observation, interview, and record review, the facility failed to include individualized approaches for care, including non-pharmacological interventions to aid in the management of mood and behavior, in the comprehensive care plan for 1 of 5 residents (R67) reviewed for unnecessary medications. In addition, the facility failed to ensure dementia care was incorporated into the care plan for 1 of 2 residents (R184) reviewed for dementia care and failed to ensure accurate orders for 1 of 1 residents (R190) reviewed for range of motion.

Findings include:

R67:

R67's significant change Minimum Data Set (MDS) dated [DATE], included R67 was cognitively intact, had diagnoses of Alzheimer's disease and depression, and took antipsychotic and antidepressant medications. The MDS indicated R67 did not exhibit any behaviors.

R67's provider History and Physical dated [DATE], included R67 had severe major depressive disorder with psychotic features.

R67's care plan dated [DATE], included R67 used psychotropic medications for behavior management and depression, and R67 had a behavior problem relating to sitting in a chair with a blanket over their head. The care plan lacked resident-specific interventions to address R67's mood and behaviors.

R67's Psychotropic Drug Use Care Area assessment dated [DATE], included R67 took olanzapine for mood and Prozac for depression, and nursing staff monitored for side effects and effectiveness.

R67's Medication Administration Record (MAR) dated [DATE], included R67 received fluoxetine HCl (Prozac - an antidepressant), 20 milligrams (mg) daily, and olanzapine (an antipsychotic) 5 mg daily at bedtime for mood disorder.

R67's progress notes included the following:

-[DATE] - R67's spouse died recently and R67 did not have any children.

-[DATE] - R67's family member informed the facility R67 was grieving the loss of their spouse and was having a hard time adjusting.

-[DATE] - R67 was easily irritated with cares and medication administration.

-[DATE] - R67 was informed they would not be able to return to their assisted living facility.

-[DATE] at 7:32 a.m., - R67 often covered their head with a blanket while in their chair.

-[DATE] at 2:56 p.m., - R67 refused to get out of bed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 1:10 p.m., nursing assistant (NA)-B stated if a resident exhibited signs of depression or began having behaviors, they would speak calmly and offer water, and if that didn't work, they would inform the nurse. They stated they did not know what worked best to calm each individual resident, so they just used a soft approach. NA-B stated R67 had some repetitive behaviors such as rummaging through their closet, but they were unaware of any specific interventions in the care plan to help address R67's mood and behaviors. During interview on [DATE] at 1:18 p.m., licensed practical nurse (LPN)-D stated they referred to the care plan to get any helpful hints in addressing a resident's mood and/or behavior issues, and if there was nothing specific, they just tried different things, or talked to other staff who might know the resident better. LPN-D stated they thought R67 was in bed a lot when they first arrived at the facility but was unaware of other behaviors. They reviewed R67's care plan in the electronic record and confirmed it lacked resident-specific interventions to address R67's needs. During interview on [DATE] at 1:38 p.m., social worker (SW)-A stated R67 went through a time where it was obvious they weren't doing well after losing their spouse and after they learned they could not return to their previous home. SW-A indicated the clinical mangers were responsible for updating the care plan with mood and behavior interventions as needed. During interview on [DATE] at 2:21 p.m., registered nurse (RN)-D stated staff referred to the care plan to know what worked best to address residents' mood and behavior concerns. The interventions were based on the diagnosis at admission and were updated as the staff learned more about the resident over time. They indicated staff could not simply give a medication and expect a psychological condition to go away. RN-D confirmed R67 did not have resident-specific interventions in place on the care plan and indicated and it was important to help staff support the residents' mental well-being. During interview on [DATE] at 2:41 p.m., director of nursing (DON) stated it was important to get to know a resident and identify personalized interventions to help relieve symptoms because what works for one person may not work for another. These interventions should be added to the care plan so staff could reference it when needed. The Psychotropic Drug Use F757 F758 policy dated ,d+[DATE], included staff should complete an evaluation of the resident prior to starting a standing order of a psychotropic including non-pharmacological interventions attempted and address them in the care plan. The Using the Care Plan policy dated ,d+[DATE], included the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. 47263 R184: R 184's quarterly Minimum Data Set (MDS) dated [DATE], quarterly indicated R184 had moderate cognitive impairment with the diagnoses of chronic obstructive disease, major depressive disorder recurrent, and dementia. The medication section indicated R184 received antipsychotic, antidepressant, and a hypnotic on a regular basis. A gradual dose reduction was identified as contraindicated for R184. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R184's care plan listed as last reviewed on [DATE], lacked evidence of individualized interventions to support R184's dementia diagnosis. In addition, the care plan lacked evidence of interventions for mental health needs and management. R184's electronic medication administration (EMAR) record dated Jun 2024, had an order for Olanzapine Oral Tablet 2.5 mg [milligrams] give every 24 hours as needed for mood disorder. R184 received a prn dose of Olanzapine 2.5 mg on [DATE] at 8:03 a.m. The chart lacked documentation of non-pharmacological interventions prior to administration and did not identify why R184 had received olanzapine. R184' behavior documentation during the month of [DATE], through [DATE], had zero behaviors documented. During an interview on [DATE] at 1046 a.m., registered nurse (RN)-A confirmed R184's care plan and orders did not provide alternative non-pharmacological interventions to try prior to the administration of the as needed (PRN) antipsychotic medication olanzapine nor did the olanzapine order indicate what target behaviors/symptoms the prn medication should be administered for. RN-A confirmed R184 had a diagnosis of dementia and a history of suicide attempt/ideation. After review of the electronic medical record (EMR) and the paper chart, RN-A confirmed R184's care plan did not include interventions for dementia care or mental health needs related to safety. During an interview on [DATE] at 2:10 p.m., the director of nursing (DON) stated the care plan should have interventions that are developed specific to the resident to support dementia and mental health needs. If a resident has a history of suicide ideation or an attempt, the care plan should have interventions in place to address the resident's safety. The DON confirmed R184's care plan did not include interventions that addressed R184's dementia and behavior health needs. The DON confirmed PRN psychiatric medications should have the indication for use identified in the order on the MAR. R190: R190's quarterly Minimum Data Sets (MDS) dated [DATE], indicated R190 was cognitively intact. R190's Admission Record face sheet dated [DATE], included the following diagnosis of palmar fascial fibromatosis also known as Dupuytren's contracture [hand condition that affects the palmar fascia, the tissue beneath the skin of the palmar fascia, resulting in finger contractures]. R190's orthopedic consult dated [DATE], included orders for R190 to wear a glove and brace at night. R190's medical record lacked evidence of a directive for staff to apply glove and brace at night. During an observation/interview on [DATE] at 10:46 a.m., R190 had a black brace on his left arm. There was a glove on the bedside table. R190 stated they were given the brace and glove when they were at their ortho appointment about 6 or 7 days ago. R190 stated they had to get the brace on without help. The nurses had not informed R190 the brace and glove were ordered to be worn at night, nor had anyone checked or assisted R190 to put the brace and glove on. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:33 p.m., registered nurse (RN)-A had R190's electronic medical record (EMR) open and stated there was not an order in the EMR for R190 to wear a brace and glove at night. Normally the health unit coordinator would put the order in to trigger a task for nursing. RN-A confirmed there was a paper order for the application of the glove and brace at night. RN-A stated it was important for R190 to wear the brace because orthopedics had ordered the brace and glove to support R190's wrist, and to prevent contracture and inflammation in R190's hand and wrist. R190's care plan should have been updated to include the brace and glove application at night. During an interview on [DATE] at 11:01 a.m., the director of nursing (DON) stated the brace and glove should be part of 190's care plan and explained the order had been entered in the EMR on [DATE], by the HUC, and had been in cue for the charge nurse to sign off on the order which they did on [DATE]. The DON stated when they reviewed the order on [DATE] they noted the order had not been routed correctly, so they had corrected the routing so the brace and glove would show up as a treatment for the nurse to complete. The DON stated a seven day turn around for the order to be released was too long, and indicated the brace and glove should have been added to the plan of care before 7 days. The DON stated they had a double nurse sign off incorporated into their order process and they expected this process would catch routing and order entry errors before they were released in the EMR.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49654 Based on interview and document review, the facility failed to revise and update a comprehensive care plan for 1 of 2 residents (R45) reviewed for hospitalization s, and 1 or 3 residents (R45) reviewed for dialysis for services provided per plan of care. Findings include: R45's undated face sheet indicate R45 was admitted to the facility 2/28/24 with diagnoses including anemia (not having enough healthy red blood cells), heart failure (progressive heart disease that affects the pumping action of the heart), high blood pressure, and end stage renal failure (ESRD-advanced stage of chronic kidney disease when the kidneys can no longer filter wastes and fluids from the blood). R45's physician progress noted dated 7/3/24, indicated R45 was hospitalized with sepsis from 6/24/24 -7/1/24. R45's hospital discharge summary dated 7/1/24 indicated R45 was hospitalized with bacteremia due to infected PCAD (a device used for dialysis) and subsequently had this device surgically removed on 6/25/24. R45's care plan included a problem dated 2/23/24, needs dialysis (hemo) r/t renal failure. Interventions included check and change dressing daily at access site. Document.; Do not draw blood or take B/P in arm with graft.; Monitor/document shunt site for abnormal bleeding, bruit, and thrill or s/so of infection (redness, swelling, warmth or drainage). Apply pressure to graft site if bleeding. Monitor/document/report to MD PRN for s/sx of the following: bleeding, hemorrhage, bacteremia, septic shock, fatigue, seizures, nausea, pulmonary edema, fever, headache, dizziness, diarrhea, hyper/hypotension, flushing, itching dated 2/23/24. R45's physicians orders with start date of 2/23/24 included the following: Monitor for signs and symptoms of infect at AV shunt, vascular cath and/or perm cath every shift. Site: R arm No blood pressure taking and venipuncture on right arm. Hemodialysis: Permacath dressing: do not change unless soiled: change using aseptic technique and place transparent dressing over site (no gauze); keep site dry, sponge bath only (no showers) Hemodialysis: send meal with resident on dialysis days Hemodialysis (3) times per week on Tue-Thur-Sat. Venous access sit: Venous access site care and dressing change during dialysis days and as needed. Assess for thrill and bruit each shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's July 2024 electronic medication and treatment record (eMAR/TAR) indicated under the orders for assess thrill and bruit each shift; hemodialysis (3)times per week Tues-Thur-Sat venous access site care and dressing change during dialysis days and as needed every shift for dialysis care; hemodialysis-do not change unless soiled: change using aseptic technique and place transparent dressing over site(no gauze); keep site dry, sponge bath only every shift.; monitor for signs and symptoms of infection at AV shunt, vascular cath and/or perm cath every shift. Site: right arm every shift for monitoring if bleeding noted from shunt site, apply pressure, call 911 and transport to there, notify the MD. Do not remove the dressing from the shunt site.; no blood pressure taking and venipuncture on right arm every shift for blood pressure monitoring nursing staff had documented completion of all treatment orders pertaining to dialysis and dialysis access site from 7/1/24 thru 7/8/24. During interview on 07/10/24 at 09:08 a.m., kidney care unit manager registered nurse (RN-H) stated if a resident was in the hospital longer than 24 hours the resident would be readmitted to the facility. The admission nurse or the floor nurse did a full assessment and entered all the orders after being hospitalized . When R45 came back she told me she wasn't getting dialysis anymore and they had removed her fistula. I reviewed all her discharge paperwork and orders when she came back. According to her discharge paper her access device was removed. Her orders and care plan should have been updated when she came back on 7/1/24. During interview on 7/11/24 at 11:41 a.m., director of nursing (DON) stated R45's discharge summary indicated seem her dialysis port was removed on 6/25/24. DON went on to state that she expected nursing staff to do a full head to toe assessment with every readmission and to update resident orders and care plans with any changes within 24 hours of readmission. DON further stated this is important to ensure the residents are receiving the appropriate care in the manner it is ordered. Facility policy Using the Care Plan with last review date of 09/23, indicated changes of condition should be reported per community protocol, care plan updated accordingly.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on observation , interview and document review, the facility failed to provide bathing for 1 of 1 residents (R166) reviewed for activities of daily living (ADL's). Findings include: R166's admission minimum data set (MDS) dated [DATE], identified R166 was cognitively intact with diagnoses including depression, anxiety, end stage renal disease (ESRD), and unsteady gait. R166 was also identified as requiring partial assistance (staff does less than half of the effort) with bed mobility, transfers, and personal hygiene. R1 was totally dependent on staff for toileting. The MDS did not identify R166's ability to complete full baths or showers and indicated R166 did not display behaviors including refusal of cares. R166's care plan dated 4/10/24, directed the two staff members to assist with personal hygiene. The plan directed extensive assistance with bathing. During interview on 7/8/24, at 6:23 p.m. R166 stated they had not had a shower since arriving at the facility. R166 stated the therapy staff had tried to assist her one time. A nursing assistant (NA) had assisted with one bed bath but had not received any other assistance with bathing. R166's hair appeared stringy and greasy. R166'2 electronic medication and treatment record (eMAR/TAR) for July 1-8, 2024, indicated R166 had received weekly baths. R166's Bathing Task Report (nursing assistant documentation) dated July 1-8, 2024, indicated R166 had received 10 baths which were signed as complete. The documentation did not indicate R166 had refused baths . During interview on 07/10/24 at 09:57 a.m., certified nursing assistant (NA)-C stated R166 was assisted with morning and evening cares. However, the therapy staff provided R166 with full showers. NA-C stated the bathing task report was signed off by the nursing assistants even though they did not complete the task. NA-C stated R166 did not refuse assistance with bathing. During interview on 07/10/24 at 11:39 a.m., certified occupational therapy assistant (COTA)-A stated the therapy staff attempted to assist R166 with one shower, however, R166 became very anxious and they were not able to complete a full shower. The therapy staff assisted R166 to wash at the bathroom sink and had not attempted to assist with full bathing since that time. R166 received zero full baths by therapy. During interview on 07/11/24 at 08:51 a.m., NA-D stated R166 received assistance with personal cares by the therapy staff or they completed the task independently. NA-D stated the nursing assistant documentation was to be completed by the end of the shift, therefore, they signed off the cares but didn't complete them. NA-D stated R166 did not have a history of refusing cares. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 07/10/24 at 09:08 a.m., registered nurse (RN)-H stated the nursing staff were not responsible for assisting R166's bathing as the therapy staff were providing the care. R166 would become anxious and required support, encouragement to express feelings and would at times, require the use of PRN anti-anxiety medications. RN-H was unaware the therapy staff were no longer assisting R166 with cares and was not aware of any concerns as the bathing documentation indicated the cares had been provided. During interview on 7/11/24 at 11:41 a.m., the director of nursing (DON) stated all residents were screened prior to admission to determine if the facility was able to provide the level of care each resident would require. Once admitted to the facility, the residents received a comprehensive admission assessment and from that an individualized care plan was established. All staff were expected to complete the personal cares and document which cares were completed each shift. If the staff did not complete an identified care, they were to do document why the care was not provided and communicate concerns to the unit manager or appropriate supervisor. If the care was to be provided between two departments such as nursing and therapy, the DON's expectation was to have the two departments to communicate with each other to ensure the resident received all appropriate care. The DON was unaware R166 had not received personal cares due to a lack of communication between the two departments. Personal hygiene/bathing was important not only for psychosocial enhancement, but also for monitoring of the resident's skin integrity. The Quality of Life-Activities of Daily Living F676, F 677 policy dated 9/2023, directed the staff to ensure residents who are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. The policy also directed the staff to educate the resident of the benefits and risks of not accepting interventions and to document such in the residents medical record.

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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** 45842 Based on interview and document review, the facility failed to ensure residents received timely follow-up treatment and care in accordance with professional standards of practice and provider's recommendations for 1 of 1 residents (R121) reviewed for appointments. The facility also failed to follow provider orders and administer a blood pressure medication only when outside certain parameters for 1 of 1 residents (R40) reviewed for quality of care. Additionally the facility failed to monitor vital signs as ordered for 2 of 3 residents (R73, R138) reviewed for nutrition and recognize nursing staff were documenting colostomy care as being provided to a resident that did not have a colostomy for 1 of 1 resident (R190). R40's quarterly Minimum Data Set (MDS) dated [DATE], indicated R57 was severely cognitively impaired. Diagnoses included hypertension and end stage renal disease, R40's provider orders dated 5/9/24 indicated R40 was started on Midodrine (a medication to increase the blood pressure when low), 5 milligrams (mg) 3 times a day for low blood pressure. Parameters included systolic blood pressure (SBP)- the top number of a blood pressure reading-less than (<) 100 or diastolic blood pressure (DBP)- the bottom number of a blood pressure reading- <60. R40's electronic medication administration record (EMAR) indicated doses of Midodrine were scheduled for 6:00 a.m., 2:00 p.m. and 8:00 p.m. Documentation indicated R40 received Midodrine at 6:00 a.m., on the following dates: 7/1/24, 7/4/24, 7/5/24, 7/8/24, 7/10/24, and 711/24. R40 received 8:00 p.m. doses of Midodrine on 7/1/24, 7/8/24, and 7/10/24. R40's documented blood pressure (BP) readings from 7/1/24 to 7/11/24 revealed the following: -7/1/24, There was no AM time period BP taken and the PM BP was122/67. There were no BPs outside the ordered parameters documented. -7/4/24, The AM BP was 121/76. There were no BPs outside the parameters documented for the morning blood pressure. -7/5/24, The AM BP was 120/83.There were no BPs outside the ordered parameters documented for the morning blood pressure. -7/8/24, The AM BP was 132/81 and the PM BP was 122/60. There were no BPs outside ordered parameters documented. -7/10/24, The AM BP was113/77 and the PM BP was 122/68. There were no BPs outside ordered parameters documented. -7/11/24, The AM BP was 119/72. There were no BPs outside the parameters documented for AM shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 1:59 a.m., registered nurse (RN)-M stated R40 reviewed R40's orders and acknowledged the Midodrine order was 5mg 3 times a day for SBP <100 or DSP <60. RN-K stated that BP medication orders that had certain parameters meant the nurse working the cart would check the BP, document it and then given the medication if outside of the ordered parameters. RN-M reviewed the EMAR and confirmed he had given R40 the Midodrine dosage around 7:15 a.m. When RN-M reviewed the blood pressure readings for 7/11/24, he stated he had taken a different BP reading, but could not produce it or remember it when asked. During an interview on 7/11/24 at 4:16 p.m., the director of nursing (DON) reviewed R40's medications and BPs documented and stated the Midodrine should not have been given since the BP was higher than they allowable parameters to give the medication. The DON expected all nursing staff would follow the provider orders and only given medication when outside the ordered parameters. Facility policy Documentation of Medication Administration last revised 9/12 lacked documentation of BP's needed to be taken prior to giving BP medication with parameters and what to do if outside the ordered parameters. 49617 R121: R121's admission Minimum Data Set (MDS) dated [DATE], indicated she had moderate cognitive impairment and was taking antibiotics. MDS indicated R121 had diagnoses including infection following a procedure, wound infection, malnutrition, and chronic pain. R121's current physician orders included the following: - amoxicillin oral suspension reconstituted 400 milligrams (mg)/5 milliliters (mL), Give 6.3mL enterally (directly into the digestive tract) three times a day for infection, dated 6/24/24. R121's medication administration record (MAR) dated 6/2024, revealed an order for a 48-72 hour antibiotic re-assessment dated [DATE] and discontinued 6/24/24. The MAR also revealed a discontinued antibiotic order for ampicillin-sulbactam sodium (Unasyn) intravenous solution reconstituted 3 (201) gram (GM), to use 2 gram intravenously every 6 hours for sepsis dated 6/2/24 and discontinued 6/18/24. R121's care plan lacked documentation of antibiotic monitoring. A progress note dated 6/11/24, indicated R121 left the facility to an infectious disease appointment and was brought to the emergency department and admitted to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An emergency center note dated 6/11/24, indicated R121's recent history included recurrent falls and multilevel lumbar and cervical spondylosis and stenosis or a narrowing of the spinal canal that can cause nerve damage. The emergency center note indicated R121 underwent two spinal surgical procedures and had a related wound infection with bacteremia (infection in the bloodstream). Furthermore, the note indicated R121 underwent an incision and drainage (I and D) where the infectious disease team found deep surgical site infection. The note indicated after a follow up appointment with the infectious disease team on 6/11/24, R121 had severe back pain and was sent to the emergency department for further evaluation. The note indicated at her infectious disease appointment, the plan was to continue the antibiotic Unasyn through 6/18/24 and start amoxicillin on 6/19/24. A progress note dated 6/21/24, indicated R121 was readmitted to the nursing facility from the hospital. A progress note dated 6/25/24, indicated R121 continued antibiotics for infection and her vital signs were within her baseline and she was stable with no concerns noted. A provider progress note dated 6/25/24, indicated under the assessment and plan header for R121's infection following a procedure, continue to monitor, continue amoxicillin, follow up with infectious disease. R121's electronic health record (EHR) lacked provider progress note(s) from infectious visit from 6/11/24 or later. R121's EHR lacked documentation of future appointments scheduled with infectious disease. During interview on 7/11/24 at 10:20 a.m., licensed practical nursed (LPN)-A stated when a resident is taking an antibiotic without an end date, usually that resident will have a follow up appointment with their provider to monitor their antibiotic usage. LPN-A stated staff should monitor a resident's vital signs, any reaction to the medication, how the resident is tolerating the medication, any new behaviors or changes to their baseline, and any skin or urine changes. LPN-A stated if there was a change to a resident's baseline, staff should complete a full assessment of the resident, update the provider and document in a progress note. LPN-A stated upcoming appointments are entered into the orders as well as in the calendar of Point Click Care (PCC), the facility's charting system. During interview on 7/11/24 at 10:37 a.m., registered nurses (RN)-C and D stated they expected staff to monitor vital signs, especially temperatures, changes from a resident's baseline, and anything that could warrant a provider update for residents taking antibiotics. RNs-C and -D stated they reviewed progress notes and provided updates on their residents during daily interdisciplinary team (IDT) meetings. RN-C stated the in-house provider was updated about R121's current antibiotic with no end date and her need for an infectious disease follow-up appointment. RN-C stated the in-house provider deferred to infectious disease. RN-C stated the unit coordinator attempted to schedule an appointment with infectious disease. RN-C and RN-D stated they expected staff to have a turnaround time for appointments as soon as possible and take the first appointment available, then let the resident and/or their resident representative know and arrange for transportation. RN-C stated, I am 100% she is still working on getting that appointment scheduled. RNs-C and -D stated the medical records (MR) staff person oversaw the unit coordinators. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/11/24 at 11:16 a.m., the infection preventionist (IP) explained the normal process when a resident returned from an appointment, the unit coordinator would review any paperwork returned with the resident and note any new orders and appointments that were or needed to be scheduled before scanning the paperwork into the resident's chart. The IP verified there were no appointments scheduled for R121, but she was following with infectious disease. Furthermore, the IP verified there were no recent infectious disease progress notes in R121's EHR. The IP expected the unit coordinator to follow up on appointments with infectious disease. During interview on 7/11/24 at 2:50 p.m., MR was able to locate the infectious disease progress note for R121 but stated it could not be printed due to computer and printer issues. The progress note dated 6/11/24, indicated the assessment and plan for R121 was to continue Unasyn through 6/18/24 and start amoxicillin on 6/19/24. Consider chronic suppressive therapy. Safety labs reviewed. Counseled the patient about her diagnoses, treatment options, and management of plan. Referral to emergency room by ambulance for pain control of severe low back pain. The progress note lacked follow-up appointment recommendation. MR reviewed R121's EHR and was unable to locate an infectious disease appointment on the calendar in PCC. During subsequent interview on 7/11/24 at 2:54 p.m., the IP stated they would defer to the facility's in-house provider for R121's ongoing antibiotic use and would re-evaluate her every month. During subsequent interview on 7/11/24 at 3:06 p.m., the MR and IP stated R121 was seen most recently by the in-house provider on 6/25/24. They stated they located a faxed order from the in-house provider dated 7/2/24 for R121 to follow-up with infectious disease. The IP showed a calendar view on PCC for R121 that showed an appointment for R121 at Park Nicollet Specialty Center Infectious Disease Appointment on 8/20/24 at 1:30 PM with Dr. [NAME]. The IP was unsure if the calendar view could be printed. The MR stated there was not a way to see when the appointment was made. The MR stated the unit coordinators would not have touched R121's infectious disease note from 6/11/24 because they only handle appointments and new orders. The MR stated someone on the clinical team would have been responsible for reviewing the note and following up on any other recommendations. The MR stated at the time of interview, the note from infectious disease dated 6/11/24 had not been uploaded into R121's EHR. The MR stated it was due to technical trouble and that's the problem with just one of me here to upload everything. The MR verified there was no way for the clinical team to review the infectious disease note from 6/11/24 because there was no way for them to view the note. During interview on 7/11/24 at 3:47 p.m., the scheduler at Park Nicollet Specialty Center, Infectious Disease stated the appointment for R121 was made on 7/11/24 around 11 a.m. The scheduler stated no other appointments for R121 were previously scheduled or cancelled. During interview on 711/24 at 3:59 p.m., the director of nursing (DON) stated the expectation after an appointment if there was any paperwork received, it should go to the unit coordinator to review for future appointments and to be uploaded into the resident's chart. However, the DON stated the facility had some difficulties with outside providers and not receiving progress notes and after-visit summaries. The DON stated in those instances, staff could either access the portal or call the provider's office and request the paperwork. The DON stated a recent process change to how follow-up appointments were handle was being implemented but verified the time between R121's last infectious disease appointment and when it was followed up on by staff was lengthy and expected it to be made sooner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R121's infectious disease provider progress notes were requested and not received. A facility appointment policy was requested and not received. 49035 R73: R73's quarterly minimum data set (MDS) dated [DATE], included R73 had severe cognitive impairment. R73 required partial to moderate assistance with eating and had diagnoses of heart failure, dementia, and depression. R73's medication administration record (MAR) for June and July 2024, included an order to weigh Monday, Wednesday, and Friday and notify the provider of a 2-pound weight gain in 1 day or a 5 pound weight gain in a week for a diagnosis of heart failure. R73's weight was completed and recorded as follows: 7/3/24: 138.3 lbs 6/24/24: 134.5 lbs 6/21/24: 136.1 lbs 6/19/24: 136.4 lbs 6/12/24: 137.5 lbs 6/1/24: 140.1 lbs R73's record lacked evidence of documentation of weight on the following Mondays, Wednesdays and Fridays: 6/3/24 6/5/24 6/7/24 6/10/24 6/14/24 6/17/24 6/26/24 6/28/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/1/24 7/5/24 7/8/24 R73's temperature and respiration rate were recorded on 7/7/24, 6/30/24, 6/23/24, 6/16/24, 6/9/24, and 6/2/24. R138: R138's quarterly MDS dated [DATE], indicated moderate cognitive impairment. R138 had diagnoses of heart failure, hypertension, dementia, and malnutrition and required moderate assistance with eating. R138's order summary report dated 7/10/24, included to check vital signs daily and assess lung sounds, peripheral edema and measure saturations every morning for heart failure. R138's Nutritional Quarterly Evaluation dated 4/23/24, included the resident had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. The resident was not on a prescribed weight-loss regimen. R138's weight was last recorded on 6/10/24 at 128.7 lbs. Previous recorded weight was 128.7 lbs on 5/30/24. During interview on 7/11/24 at 10:51 a.m., registered nurse (RN)-F stated weights were taken once a month for everyone on the unit and document in the electronic medical chart. Some residents would have specific orders for daily or weekly weights from a provider and the dietitian. RN-F confirmed daily vital signs would include more than a blood pressure reading. RN-F confirmed monitoring for fluid overload was part of monitoring for heart failure. During interview on 7/11/24 at 11:25 a.m., RN-E stated a full set of vitals would include weight, respiration rate, blood pressure, temperature, pulse rate, oxygen saturation and pain. RN-E confirmed R73's last weight was 7/3/24 and R138's last weight was 6/10/24. RN-E had staff obtain weights for both residents. R73's weight on 7/11/24 was 138.0 lbs (down 0.3 lbs since 7/3/24) and R138's weight was 140.7 lbs. (up 12.0 lbs since 6/10/24). During interview on 7/11/24 at 11:52 a.m., registered dietitian (RD) stated she would want to check weights every two weeks for someone with a significant weight loss who continued to lose weight or had recently stabilized. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/11/24 at 12:44, director of nursing (DON) stated every resident was to be weighed monthly. The DON confirmed a full set of vitals should include temp, blood pressure, oxygen saturation, respiration rate, pulse. Weights should be included for a resident who had heart failure because monitoring weights is important for monitoring change in condition. DON confirmed there was not an order for weight frequency for R138, but she did have an order for a set of daily vitals. DON confirmed a set of vitals was not completed daily as ordered. DON confirmed R73's last weight was recorded 7/3/24 and was ordered to be completed Monday, Wednesday and Friday, which had not been completed. She stated it was important to monitor for change in condition and worsening heart failure conditions. 47263 R190: Both R190's quarterly Minimum Data Sets (MDS) dated [DATE], and 6/18/24, identified R190 was cognitively intact. Section I active diagnosis included Z93.2 ileostomy status [surgical procedure for a colostomy] [colostomy: surgical opening that connects the lower end of the small intestine to the abdominal wall to allow for intestinal waste to be collected in a pouch outside of the body]. R190's Admission Record face sheet dated 7/11/24 included the following diagnoses: malignant neoplasm of the bladder and ileostomy status. R190's electronic medical record (EMR) included an order entered on 12/13/23: Colostomy care every shift and PRN. R190's Electronic Treatment Records (TAR) included: Colostomy care every shift and PRN. During the period of 12/14/23, to 7/10/24, nursing staff consistently signed off colostomy care had occurred each shift. R190/s Urology provider notes dated 12/13/23, indicated R190 had had a surgical procedure for a urostomy. Note indicated R190 was passing gas and having BMs. Provider notes lacked evidence of an ileostomy or colostomy. R190's facility provider visit notes between 1/4/24, and 6/26/24, indicated R190 had a urostomy and lacked evidence of a colostomy. R190's EMR included a nurse note entered on 7/6/24, that documented R190 had a colostomy and indicated the nurse had given R190 supplies to collect a stool sample from their colostomy bag. During an observation/interview on 7/8/24 at 4:53 p.m., R190 had the outline of a pouch under their shirt on the right side of their torso. R190 touched the area and stated they had to have their bladder removed because of cancer so they had a pouch for urine now. During a follow-up interview on 7/10/24 at 10:48 a.m., R190 confirmed they did not have a colostomy. R190 stated they used the toilet to have a bowel movement and had a bag to collect urine [urostomy]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 1:22 p.m., registered nurse (RN)-B stated they provided urostomy care to R190 and documented that on the TAR. During an interview on 7/10/24 at 1:33 p.m., RN-A opened R190's EMR for review and stated R190 had both a colostomy and a urostomy. RN-A navigated to the TAR and indicated R190 had orders for the care of both the urostomy and the colostomy. RN-A reviewed the TAR and confirmed colostomy care had been signed off as provided each shift to R190 for several months. When informed R190 had indicated they did not have a colostomy, RN-A stated they would have to investigate that and report back. During a follow-up interview on 7/11/24 at 11:01 a.m., RN-A stated they had reviewed R190's medical record and discussed situation with the director of nursing (DON). RN-A indicated they believed the order for colostomy care was a typo because R190 did not have a colostomy but did have a urostomy. The colostomy order should have been discontinued instead of documented on as completed because R190 did not have a colostomy. RN-A stated it was their expectation that staff would only document on actions and care they had done or provided. During an interview on 7/11/24 at 2:22 p.m., the DON confirmed R190 did not have a colostomy and indicated the nurse who had entered the order for colostomy care had entered the order in error. The DON stated they had a double nurse sign off incorporated into their order process and they expected this process and or nurse manager review to catch routing and order entry errors before they were released in the EMR. In this case, nurses should have caught and discontinued the order error right away when it was discovered R190 didn't have a colostomy. The DON stated they did not have an explanation as to why staff had continued to sign off on colostomy care for 7 months when R190 did not have a colostomy.

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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** 49035 Based on observation, interview and document review, the facility failed to provide timely assistance in repositioning and toileting for 1 of 1 resident (R138) reviewed for pressure ulcers. Findings include: R138's quarterly Minimum Data Set (MDS), dated [DATE] included diagnoses of dementia, hemiplegia (weakness on one side of the body), and malnutrition. R138 was dependent for toileting hygiene and dependent for chair to bed transfer. R138's MDS indicated she had moderate cognitive impairment. R138's care plan dated 5/2/24, identified R138 was incontinent of bladder and required assistance every 2-3 hours for incontinent care to remain free from skin breakdown. R138 had the potential for pressure ulcer development. During continuous observation on 7/10/24 from 7:35 a.m. to 11:16 a.m., R138 was observed in her wheelchair in the dining room. At 7:35 a.m., R138 was observed at the dining room table waiting for breakfast. At 9:54 a.m., R138 attended an activity in the dining room. At 11:08 a.m., resident remained in the dining room following the activity and had not been approached by staff. During interview on 7/10/24 at 11:16 a.m., nursing assistant (NA)-C stated she could not remember if she had brought R138 to the bathroom. NA-C did approach R138 to offer toileting, however R138 refused. During interview on 7/10/24 at 11:21 a.m., registered nurse (RN)-F stated R138 was incontinent and did have a history of pressure ulcers. During interview on 7/10/24 at 11:29 a.m., RN-E stated residents were assessed to determine how frequently they were to be toileted. RN-E confirmed R138 had a healed pressure injury. RN-E expected R138 to be toileted every 2-3 hours and if she refused, R138 should be reapproached. During observation on 7/10/24 at 11:42, RN-E approached R138 to offer toileting and repositioning prior to lunch. R138 agreed and was toileted and repositioned by staff. During interview at 7/10/24 at 1:48 p.m., director of nursing (DON) confirmed R138 should have been toileted every 2-3 hours. DON stated it was the resident's right to refuse, however residents with memory impairment should have been encouraged and reapproached with refusal. DON stated repositioning and toileting was important to keep skin intact. Pressure ulcer prevention policy request and not provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on observation, interview and document review the facility failed to ensure a post hospitalization assessment was completed for 1 of 1 residents (R45) who had their arteriovenous (AV) access site and hemodialysis treatment discontinued and also failed to ensure post-dialysis monitoring assessments were consistently completed and accurately documented to provide continuity of care and reduce the risk of complications for 3 of 3 residents (R45, R166 and R143) reviewed for dialysis care and services. Findings include: R45: R45's quarterly Minimum Data Set (MDS) dated [DATE], indicated R45 was cognitively intact, and demonstrated no rejection of care behavior. The MDS indicated R45 was diagnosed with chronic kidney disease with dialysis. R45's order summary report dated 7/9/24, included the following current orders: -Hemodialysis (3) times per week on Tuesday, Thursday, and Saturday. Venous access site: care and dressing change during dialysis days and as needed (per dialysis). The order start date was 2/22/24. -Assess for thrill (a powerful pulse felt at the top of the fistula) and bruit (whooshing sound) each shift. The order start date was 2/22/24. -Monitor for signs and symptoms of infection at AV shunt, vascular catheter and/or Permacath (a special catheter used for short-term dialysis) every shift. The order start date was 2/23/24. -Hemodialysis: Permacath Dressing: Do not change unless soiled: change using aseptic technique and place transparent dressing over site (no gauze); keep site dry, sponge baths only (no showers). The order start date was 2/22/24. R45's care plan dated 6/18/24, identified R45 needed hemodialysis related to renal failure, was at risk for altered nutritional/hydration status related to stage 3 chronic kidney disease and received hemodialysis three times per week. The care plan directed staff to provide interventions which included check and change dressing daily at access site and document. Do not draw blood or take blood pressure in arm with graft. Monitor/document shunt site for abnormal bleeding, bruit and thrill or signs/symptoms of infection. Apply pressure to graft site if bleeding. Monitor/document/report to MD [physician] as needed for signs/symptoms of renal insufficiency, changes in level of consciousness, changes in skin turgor, changes in heart and lung sounds. Monitor/document/report to MD for signs/symptoms of bleeding, hemorrhage, bacteremia, septic shock, fatigue, seizure. Obtain vital sings and weight per protocol. (continued on next page)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of R45's medical record from 5/23/24 through 6/22/24 revealed R45 received dialysis on 5/23, 5/25, 5/28, 6/1, 6/6, 6/8, 6/11, 6/13, 6/15, 6/18, 6/20, and 6/22. The medical record lacked post dialysis assessments for 5/23, 5/28, 6/1, 6/6, 6/8, 6/11, 6/13, 6/15. The post dialysis assessments dated 5/25/24, 6/18/24, 6/20/24 and 6/22/24 lacked a current weight.

R45's hospital discharge summary dated 7/1/24, indicated R45 was hospitalized on [DATE] and discharged on [DATE]. Further, the discharge summary indicated R45 had been treated for an infection of her dialysis access device and it was subsequently surgically removed on 6/25/24. At time of hospital discharge R45 no longer required dialysis treatments. R45's medical record lacked an assessment of R45 upon readmission the facility and although R45 had her dialysis access device removed and no longer required dialysis treatment, the care plan lacked evidence of being updated with R45's new status or care needs.

Review of R45's Treatment Administration Record (TAR) dated 7/1/24 -7/31/24, indicated R45 had scheduled treatments including assess for thrill and bruit each shift, every shift; Hemodialysis (3) times per week on Tuesday, Thursday and Saturday: venous access site care and dressing change during dialysis days and as needed every shift for dialysis care; Hemodialysis Permacath dressing-do not change unless soiled, change using aseptic technique and place transparent dressing over site (no gauze). Keep site dry, sponge baths only (no showers); Monitor for signs and symptoms of infection at AV shunt, vascular cath and/or perm cath every shift. Site: Right arm every shift for monitoring if bleeding noted from shunt site apply pressure, call 911, notify the MD. Do not remove the dressing from the shunt site; No blood pressure taking and venipuncture on right arm every shift for blood pressure monitoring. Although R45 no longer had a dialysis access device and no longer received dialysis, the TAR identified staff had documented completion of the dialysis related services every shift from 7/1/24 thru 7/9/24. The orders were not discontinued until 7/10/24.

During observation and interview 7/8/24, at 5:57 p.m., R45 was alert and oriented, resting in bed wearing a long-sleeved pink shirt and was covered with a blanket up to her chin. R45 stated she had been hospitalized from 6/24-7/1 with an infection in her dialysis access site.

During interview on 7/10/24 at 8:22 a.m., registered nurse (RN)-N stated when residents returned to the facility after a hospital admission a full head to toe assessment was completed. During the assessment vitals were taken, skin was assessed for changes, and any noted changes were documented in the resident's medical record. RN-N described how to assess a dialysis site for bruit and thrill by listening with a stethoscope and putting fingers over the site to feel the fistula. When reviewing the medical record documentation RN-N confirmed he had documented completing a check for bruit and thrill of R45's fistula on 7/5. He went on to say while taking care of R45 on 7/5, R45 reported she had her access device removed. RN-N could not provide a reason why he documented checking for bruit and thrill and stated, I don't remember why I checked that off.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/10/24, at 9:08 a.m., kidney unit manager RN-H stated if a resident was hospitalized for 24 hours or more, a full head to toe assessment would be completed by an admission nurse or a floor nurse depending on the time and day of the week. The process included reviewing all discharge documents from the hospital, updating any new orders in the medical record, as well as updating care plans. RN-H stated she routinely reviewed all new and readmission documents for accuracy and to stay on top of everyone. When reviewing R45's discharge summary RN-H confirmed the documents indicated R45 had a surgical removal of her dialysis access device on 6/25 and verified R45's orders pertaining to dialysis care had not been discontinued nor had a readmission assessment been completed, nor the care plan revised after removal of the access and discontinuation of dialysis. When reviewing R45's TAR documentation for 7/1 thru 7/8 RN-H stated a check mark in the chart would indicate staff completed the task. RN-H confirmed from 7/1 thru 7/8, staff on every shift had documented completion of dialysis related tasks. RN-H stated, staff can't check an access device if it's not there. Additionally, RN-H stated the floor nurses were responsible for reviewing the dialysis communication binder before and after residents had dialysis. If a resident went to dialysis on a day shift, the day shift nurse would document the pre-dialysis vitals and the nurse working when the resident returned would be responsible for the post dialysis assessment and documentation. Upon reviewing R45's medical record RN-H confirmed staff had not completed post dialysis assessments on 5/23, 5/28, 6/1, 6/6, 6/8, 6/11, 6/13, and 6/15. R166: R166's admission MDS dated [DATE], indicated R166 was cognitively intact, demonstrated no rejection of care behaviors and had a diagnosis of end stage renal failure dependent on renal dialysis treatment. R166's order summary report dated 7/9/24, included the following current orders: -Dialysis (3) time per week. Weigh resident and check vitals before and upon return from dialysis. Fill out dialysis form and send to dialysis and review it upon return. Complete post dialysis user defined assessment (UDA). The order start date was 4/9/24. -Complete post dialysis UDA from assessment drop down manually initiate and complete UDA. The order start date was 4/10/24. R166's care plan dated 5/9/24, identified R166 needed hemodialysis related to renal failure, was a risk for altered nutrition/hydration status related to end stage renal disease and received hemodialysis three times per week. The care plan directed staff to provide interventions which included check and change dressing daily at access site and document. Monitor shunt site for abnormal bleeding, bruit and thrill or signs and symptoms of infection (redness, swelling, warmth or drainage). Apply pressure to graft site if bleeding. Monitor/document/report to MD as needed for signs and symptoms of renal insufficiency, changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds, peripheral edema. Monitor/document/report to MD as needed for signs/symptoms of bleeding, hemorrhage, bacteremia, septic shock, fatigue, seizures, nausea, pulmonary edema, fever headache, dizziness, diarrhea, hyper/hypotension, flushing, or itching. Obtain vital signs and weight per protocol. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R166's medical record from 6/1/24 through 6/22/24, ok revealed R11 received dialysis on 6/1, 6/4, 6/8, 6/11, 6/13, 6/15, 6/18, 6/20, 6/22, 6/25, 6/29, 7/2, 7/4, 7/6, and 7/9. The medical record lacked post dialysis assessments for 6/1, 6/11, 6/13, 6/18, and 6/20. The post dialysis assessment dated [DATE] lacked current weight and vital signs information. During interview on 7/10/24, at 9:08 a.m., RN-H stated the floor nurses were responsible for reviewing the dialysis communication binder before and after residents had dialysis. If a resident went to dialysis on a day shift, the day shift nurse would document the pre-dialysis vitals and the nurse working when the resident returned would be responsible for the post dialysis assessment and documentation. Upon reviewing R45's medical record RN-H confirmed staff had not completed post dialysis assessments for 6/1, 6/11, 6/13, 6/18, and 6/20. R143: R143's quarterly MDS dated [DATE] identified R143 was cognitively intact, demonstrated no rejection of care behaviors and had a diagnosis of end stage renal failure dependent on hemodialysis. R143's care plan dated 5/28/24, identified R143 needed renal dialysis related to renal failure, was at risk for altered skin integrity, nutrition and hydration related to end stage renal disease and received dialysis three days per week. Interventions included encouraging R143 attend all scheduled dialysis treatments, monitor/document shunt site for abnormal bleeding, bruit and thrill or signs/symptoms of infection. Apply pressure to graft site if bleeding; update MD as needed with changes. Monitor/document/report to MD as needed for signs/symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds, peripheral edema. Monitor/document/report to MD as needed for signs/symptoms of the following: Bleeding, hemorrhage, bacteremia, septic shock, fatigue, seizures, nausea, pulmonary edema, fever, headache, dizziness, diarrhea, hyper/hypotension, flushing itching. Obtain vital signs and weight per protocol. Review of R143's Medication Administration Record (MAR) dated 7/1/24-7/31/24 include the following orders: -Weigh resident and check vitals before and upon return from dialysis two times a day every Tuesday, Thursday, and Saturday. -Dialysis three days a week (Tuesday, Thursday, Saturday) Weigh resident and check vitals before and upon return from dialysis. Fill out dialysis form and send to dialysis and review it upon return. Complete post dialysis UDA two times a day every Tuesday, Thursday, and Saturday for hemodialysis. Night staff to get ready for dialysis. All entries were recorded as complete. Review of R143's TAR dated 7/1/24-7/31/24 identified R143 had scheduled treatments including Complete post dialysis UDA one time a day every Tuesday, Thursday, and Saturday for post dialysis assessment. All entries were recorded as complete. Review of R143's medical record indicated R143 received dialysis treatments on 6/1, 6/4, 6/8, 6/11, 6/13, 6/15, 6/18, 6/20, 6/22, 6/25, 6/29, 7/2, 7/4, 7/5, 7/6, and 7/9. The medical record indicated there was no post dialysis assessments completed on 6/1, 6/18, 6/22, 6/25, 7/4, and 7/5. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 7/8/24, at 06:23 p.m., R143 was lying in bed in pajama's covered with a fuzzy gray blanket. R143 stated she received dialysis three times a week on site. Additionally, R143 rubbed her left inner arm and state they never check me after dialysis. During interview on 7/10/24, at 09:08 a.m., kidney unit manager RN-H stated floor nurse are responsible for reviewing the dialysis communication binder before and after residents have dialysis. If a resident went to dialysis on a day shift, the day shift nurse would document the pre-dialysis vitals and the nurse working when the resident returned would be responsible for the post dialysis assessment and documentation. Upon reviewing R143's medical record RN-H confirmed staff had not completed post dialysis assessments on 6/1, 6/18, 6/22, 6/25, 7/4, and 7/5. During interview on 7/11/24, at 10:00 a.m., director of nursing (DON) stated the facility admission nurses were responsible for completing all admission and re-admissions of residents. If a resident returned on an evening or weekend, one of the floor nurses would be responsible for completing any necessary admission assessments, and a second nurse would review the admission documents and perform a second check to confirm accuracy of new or changed orders. DON stated this would include a full a head-to-toe assessment. DON confirmed R45's record lacked a readmission assessment. While reviewing R45's hospital discharge summary documents DON confirmed the summary indicated R45's dialysis shunt had been removed and R45 was no longer receiving dialysis treatments. She also confirmed R45's dialysis related orders had not been discontinued nor had her care plan been updated to reflect her changes in treatment. Additionally, DON confirmed staff had falsely documented completing dialysis related tasks from 7/1 thru 7/8, and stated she couldn't explain why staff had documented the tasks as completed. DON stated her expectation of staff was to complete assigned tasks and complete all documentation accurately. DON stated this is important for accuracy of the medical record and to prevent any potentially harmful outcomes to the residents. Upon review of the aforementioned post dialysis assessments for R45, R166 and R143 whose medical record either lacked documentation or the assessments lacked current weights and/or vital sign documentation, DON stated nursing staff were responsible for the accuracy and timeliness of assessments and documentation and she expected all floor nurses to complete assigned tasks and documentation on their shift as this was crucial for patient safety and continuity of care. The Dialysis, Care for a Resident with F698 policy dated 9/2023 directed resident with end-stage renal disease (ESRD) will be care for according to currently recognized standards of care. The policy also directed the resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care including provisions for the cognitively impaired that may impact the safe administration of dialysis including resistance to care, pulling on tubes/access sites, and informing of the practitioner of changes in condition. The policy further directed upon return from dialysis staff were to document post weight (recommended to come from the center), bleeding at site or other complications or if the resident unable to accept dialysis for any reason. The Using the Care Plan policy dated 9/2023, directed the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. The policy directed changes of condition would be reported to the MDS coordinator for applicable review of the care plan. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/11/24, at 10:00 a.m., director of nursing (DON) stated the facility admission nurses were responsible for completing all admission and re-admissions of residents. DON went on to say if a resident returned on an evening or weekend one of the floor nurses would be responsible for completing any necessary admission assessments, and a second nurse would review the admission documents and perform a second check to confirm accuracy of new or changed orders. DON stated this would include a full a head-to-toe assessment. While reviewing R45's hospital discharge summary documents DON confirmed the summary indicated R45's dialysis shunt had been removed and R45 was no longer receiving dialysis treatments. Additionally, DON confirmed staff had falsely documented completing dialysis related tasks from 7/1 thru 7/8, and stated she couldn't explain why staff had documented the tasks as completed. DON stated her expectation of staff was to complete assigned tasks and complete all documentation accurately. DON stated this is important for accuracy of the medical record and to prevent any potentially harmful outcomes to the residents.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview and record review the facility failed to develop and implement dementia care as part of the comprehensive care plan for 1 of 3 residents (R184) reviewed for dementia care. Finding include: R 184's quarterly Minimum Data Set (MDS) dated [DATE], quarterly indicated R184 had moderate cognitive impairment with the diagnoses of chronic obstructive disease, major depressive disorder recurrent, and dementia. R184's care plan listed as last reviewed on 4/17/24, lacked evidence of individualized interventions to support R184's dementia diagnosis. In addition, the care plan lacked evidence of interventions for mental health needs and management. During an interview on 7/11/24 at 1046 a.m., registered nurse (RN)-A confirmed R184 had a diagnosis of dementia. After review of the electronic medical record (EMR) and the paper chart, RN-A confirmed R184's care plan did not include interventions for dementia care or mental health needs. During an interview on 7/11/24 at 2:10 p.m., the director of nursing (DON) stated the care plan should have interventions that are developed specific to the resident to support dementia and mental health needs. The DON confirmed R184's care plan did not include interventions that addressed R184's dementia and behavior health needs.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on interview and record review, the facility failed to identify individualized approaches for care, including non-pharmacological interventions to aid in the management of mood and behavior, for 2 of 5 residents (R67, R184) reviewed for unnecessary medications. Findings include: R67: R67's significant change Minimum Data Set (MDS) dated [DATE], included R67 was cognitively intact, had diagnoses of Alzheimer's disease and depression, and took antipsychotic and antidepressant medications. The MDS indicated R67 did not exhibit any behaviors. R67's provider History and Physical dated [DATE], included R67 had severe major depressive disorder with psychotic features. R67's care plan dated [DATE], included R67 used psychotropic medications for behavior management and depression, and R67 had a behavior problem relating to sitting in a chair with a blanket over their head. The care plan lacked resident-specific interventions to address R67's mood and behaviors. R67's Psychotropic Drug Use Care Area assessment dated [DATE], included R67 took olanzapine for mood and Prozac for depression, and nursing staff monitored for side effects and effectiveness. R67's Medication Administration Record (MAR) dated [DATE], included R67 received fluoxetine HCl (Prozac - an antidepressant), 20 milligrams (mg) daily, and olanzapine (an antipsychotic) 5 mg daily at bedtime for mood disorder. R67's progress notes included the following: [DATE] - R67's spouse died recently and R67 did not have any children. [DATE] - R67's family member informed the facility R67 was grieving the loss of their spouse and was having a hard time adjusting. [DATE] - R67 was easily irritated with cares and medication administration. [DATE] - R67 was informed they would not be able to return to their assisted living facility. [DATE] at 7:32 a.m., - R67 often covered their head with a blanket while in their chair. [DATE] at 2:56 p.m., - R67 refused to get out of bed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 1:10 p.m., nursing assistant (NA)-B stated if a resident exhibited signs of anxiety or depression, or began having behaviors, they would speak calmly and offer water, and if that didn't work, they would inform the nurse. They stated they did not know what worked best to calm each individual resident, so they just used a soft approach. NA-B stated R67 had some repetitive behaviors such as rummaging through their closet, but they were unaware of any specific interventions in the care plan to help address R67's mood and behaviors. During interview on [DATE] at 1:18 p.m., licensed practical nurse (LPN)-D stated they referred to the care plan to get any helpful hints in addressing a resident's mood and/or behavior issues, and if there was nothing specific, they just tried different things, or talked to other staff who might know the resident better. LPN-D stated they thought R67 was in bed a lot when they first arrived at the facility but was unaware of other behaviors. They reviewed R67's care plan in the electronic record and confirmed it lacked resident-specific interventions. During interview on [DATE] at 1:38 p.m., social worker (SW)-A stated R67 went through a time where it was obvious they weren't doing well after losing their spouse and learning they could not return to their previous home, and indicated the clinical mangers were responsible for updating the care plan with mood and behavior interventions as needed. During interview on [DATE] at 2:21 p.m., registered nurse (RN)-D stated staff referred to the care plan to know what worked best to address residents' mood and behavior concerns. The interventions were based on the diagnosis at admission and were updated as the staff learned more about the resident over time. They indicated staff could not simply give a medication and expect a psychological condition to go away. RN-D confirmed R67 did not have resident-specific interventions in place and indicated and it was important to help support their mental well-being. During interview on [DATE] at 2:41 p.m., director of nursing (DON) stated it was important to get to know a resident and identify personalized interventions to help relieve symptoms because what works for one person may not work for another. These interventions should be added to the care plan so staff could reference it when needed. The Psychotropic Drug Use F757 F758 policy dated ,d+[DATE], included staff should complete an evaluation of the resident prior to starting a standing order of a psychotropic including non-pharmacological interventions attempted and address in care plan. 47263 R184: R 184's quarterly Minimum Data Set (MDS) dated [DATE], indicated R184 had moderate cognitive impairment with the diagnoses of chronic obstructive disease, major depressive disorder recurrent, and dementia. The medication section indicated R184 received antipsychotic, antidepressant, and a hypnotics on a regular basis. A gradual dose reduction was identified as contraindicated for R184. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R184's electronic medication administration (EMAR) record dated Jun 2024, had an order for the antipsychotic medication olanzapine 2.5 mg [milligrams] give every 24 hours as needed for mood disorder. R184 received a prn dose of Olanzapine 2.5 mg on [DATE] at 8:03 a.m. The chart lacked documentation of non-pharmacologic interventions prior to administration and did not identify why R184 had received olanzapine. R184' behavior documentation provied by the facility for the months of [DATE], through [DATE], had zero behaviors documented. During an interview on [DATE] at 1046 a.m., registered nurse (RN)-A confirmed R184's care plan and orders did not provide alternative non-pharmacological interventions to try prior to the administration of the as needed (PRN) antipsychotic medication olanzapine nor did the olanzapine order indicate what target behaviors/symptoms the prn medication should be administered for. During an interview on [DATE] at 2:10 p.m., the director of nursing (DON) confirmed R184's care plan did not include interventions for R184's behavior health needs. The DON also stated PRN antipsychotic medications should have the indication for use identified in the order on the MAR. The facility policy Psychotropic Drug Use dated ,d+[DATE], indicated orders for antipsychotic medication should include the target symptoms or condition the medication was ordered for, and the care plan should address non-pharmacological interventions. R184's current orders were requested, but not received.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R6, R45, R202) were offered or received pneumococcal vaccination in accordance to Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) Adults 19-[AGE] years old with specified immunocompromising conditions, staff were to offer and/or provide: a) the PCV-20 at least 1 year after prior PCV-13, b) the PPSV-23 (dose 1) at least 8 weeks after prior PCV-13 and PPSV-23 (dose 2) at least 5 years after first dose of PPSV-23. Staff were to review the pneumococcal vaccine recommendations again when the resident turns [AGE] years old. 2) Adults [AGE] years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE [AGE] years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age [AGE] years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. A review of 5 sampled residents for vaccinations identified 3 of 5 residents (R6, R45, R202) with the following pneumococcal immunization record: 1) R6 was [AGE] years old and was admitted to the facility in April of 2024. R6 previously had the PPSV-23 on 9/19/12, and the PCV-13 on 1/30/15. Based on shared clinical decision-making, decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose regardless of whether PCV20 was administered, her pneumococcal vaccinations were completed. 2) R45 was [AGE] years old and admitted to the facility in February of 2024. R45 previously had the PPSV-23 on 10/1/10, and the PCV-13 on 10/4/19. Based on shared clinical decision-making, decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose regardless of whether PCV20 was administered, her pneumococcal vaccinations were completed. 3) R202 was [AGE] years old and was admitted to the facility in January of 2024. A Department of Veterans Affairs immunization record dated 2/26/24, indicated R202 received pneumococcal, unspecified formul* on 5/11/2010. R 202 received the PCV-13 on 9/18/15. During interview on 7/11/24 at 11:44 a.m., the infection preventionist (IP) explained the facility's process for determining a resident's vaccination status and eligibility and stated prior to their admission, staff reviewed the immunization report if they were able to access them. When a resident admitted to the facility, the IP stated they were provided a vaccine information sheet (VIS) and educated on the risks and benefits and then asked if they consented or declined the vaccine. If the resident was able to do so, they could sign the form and if not, their representative could, or they could provide verbal consent or declination. The vaccine was administered and documented in the resident's electronic health record (EHR). The IP stated there was a spreadsheet record of every resident's vaccine status. The IP verbalized being aware of the recent changes to CDC guidelines for pneumococcal vaccinations, including the availability of PCV20 to some residents. The IP stated the shared clinical decision-making piece about the additional PCV20 dose was being left to the providers and stated, As of now, I am not having that discussion. The IP stated the facility's in-house providers had separate immunization visits and encounters. During subsequent interview on 7/11/24 at 1:42 p.m., the IP was unable to locate R6 or R45 in the spreadsheet tracking log. The IP verified both residents would be eligible for the additional dose when reviewing the CDC guidelines. Furthermore, the IP verified there were no progress notes indicating the provider had conversations about the PCV20 dose. The IP stated, we do not drive that, rather it was left up to the provider. Additionally, the IP stated R202's immunization records were difficult to obtain. The IP verified R202's PCV-13 was entered into the EHR and the other was unspecified. The IP stated the spreadsheed log listed him as not eligible and stated, the provider would be ultimately the decision maker, it would be up to them to know that about the residents. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/11/24 at 3:39 p.m., the director of nursing (DON) stated most of the immunization responsibility defaulted to the IP to determine a resident's immunization history, what a resident was eligible for and obtaining a consent. The DON stated she was not real familiar with the facility's process but believed the provider was the one driving the shared clinical decision-making process. The DON stated if a resident had an unknown vaccination status or unknown vaccine formula, staff could attempt to reach out to the records department to clarify but it ultimately may be the provider driving that conversation. A facility policy titled Pneumococcal Vaccine F883 last revised 9/23, indicated residents would be offered the pneumococcal vaccine to aid in preventing pneumococcal infections (e.g., pneumonia). Before admission, the policy directed staff to assess a resident's eligibility to receive the pneumococcal vaccine, and when indicated, offer the vaccination unless medical contraindicated or the resident has already been vaccinated. Furthermore, the policy indicated administration of pneumococcal vaccination or re0vaccinations will be made in accordance with current CDC recommendations at the time of the vaccination. A request for documentation of shared clinical decision making was requested but not provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation and interview, the facility failed to provide a safe, sanitary, comfortable environment for resident on the locked memory care unit. This had the potential to affect all 36 residents, staff and visitors. Findings Include: During interview on 7/8/24 at 1:42 p.m., family member (FM)-A stated the facility was always dirty and had an odor of urine in the hallways. FM-A stated she cleaned R169's room or it would be dirty also. On 7/8/24 at 3:07 p.m., the carpeted floor in the dining room on the unit was observed to have various crumbs and other debris. An approximately 2 x 2 inch piece of paper that was white and yellow was under one square table. Numerous small, light colored, powder-like spots around the whole room. On 7/8/24 at 6:30 p.m., R169 was standing in the hallway in the general area outside her room walking, occasionally touching objects such as the door, handrail, and wall. On 7/9/24 at 1:38 p.m., two light brown spots on the floor approximately 2 inches in diameter close to the wall outside of room [ROOM NUMBER]. Spots are smooth, slight shin in appearance. Wall in room [ROOM NUMBER] across from door was two different colors of paint. Both were a tan color; one is a few shades darker. Approximately half of the wall is painted in the darker brown color. Paint has an uneven edge which ends approximately 1 in to 3 inches from the ceiling, wall to the side and baseboard. On 7/9/24 at 1:42 p.m., a housekeeping staff member was vacuuming the dining room. Two residents were in the room during vacuuming. On 7/9/24 at 1:42 p.m., numerous off white and tan spots in various sizes of 1 to 2 inches were observed on the carpet scattered throughout the whole room, but more concentrated around the tables. An approximately 4-foot section of wallpaper was missing in the corner under a window. On wall where wallpaper was missing, multiple dried dark brown stains are present including opaque brown streaks running in a downward manor. On 7/9/24 at 2:29 p.m., an approximately 1/2 inch in diameter dark brown spot with a 2-inch lighter smeared spot was on the handrail by room [ROOM NUMBER]. Approximately 1 foot to the side of the dark brown spot were light brown drip like streaks coving approximately a 2-foot area. On 7/10/24 at 7:28 a.m., the brown darker spot with smear by room [ROOM NUMBER] was still on handrail. Light brown drip-like streaks also remain. Section of carpet between dining room doors to room [ROOM NUMBER] going out approximately 2.5 feet from wall feel tacky when walked on. No discoloration noted. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24 at 9:51 a.m., activity staff were starting to prepare for an activity in the dining room. Tables were not wiped down after breakfast before activity started. During interview on 7/11/24 at 8:04 a.m., registered nurse (RN)-F housekeeping is on the unit every day. It was everyone's job to help clean the unit. RN-F stated she made sure the tables were clean after meals. RN-F confirmed there were two light brown spots on the floor approximately 2 inches in diameter close to the wall outside of room [ROOM NUMBER]. RN-F stated the area could not be cleaned because it was like glue now. RN-F confirmed the brown smear on the handrail by room [ROOM NUMBER]. She stated it was a new mark and housekeeping would clean. RN-F stated it must have been chocolate pudding or a chocolate ice cream desert and described it as handprint in size, about two fingers. RN-F used wet soapy paper towels to clean area. RN-F stated it was important to have the handrail clean because residents often though that area. During interview on 7/11/24 at 8:12 a.m., RN-E confirmed the carpet outside of the dining room felt sticky and described the two light brown spots outside of room [ROOM NUMBER] at a spilled supplement from a medication pass. RN-E stated there is a carpet cleaner on site and she would get them up to clean it. During interview on 7/11/24 at 8:21 a.m., Direct of housekeeping stated she does spot checks on the units daily. She stated the staff are instructed to wipe down hand railings daily, flat mop the walls weekly and as needed, vacuum the floor in the dining room after breakfast, whip down tables daily after breakfast and lunch. Director of housekeeping confirmed there was crumbs and food particles on the floor after breakfast. Direct of housekeeping confirmed there was a 4-foot piece of wallpaper missing and the exposed wall had both liquid and solid spilled on the wall and stated the wallpaper is old and needs to be replaced. Director of housekeeping confirmed spots on carpet outside of room [ROOM NUMBER] and that the carpet felt sticky outside of the dining room. She stated staff should have been able to clean spots off the floor. Direct of nursing confirmed the handrails needed to be cleaned and should have been done daily. She stated it was important to clean and disinfect daily because this was their home, and the facility needed to make sure they have a safe clean area to live. During interview on 7/11/24 at 8:56 a.m., administrator stated the carpet on the unit needed to be replaced and that there had been discussion but no solid timeline. The administrator confirmed the wallpaper in room [ROOM NUMBER] was not satisfactory or homelike and confirmed the color was not a match. The administrator stated the facility was working on replacing a few non-functioning exhaust fans which was the cause of the odor on the unit. He stated the facility was still obtaining quotes for the exhaust fans. The administrator confirmed there were rips and missing pieces of wallpaper in the dining room and stated the wallpaper in the whole building needs to be replaced but that was a massive undertaking. He stated it was not a homelike or welcoming environment. The administrator confirmed a few handrailings were missing endcaps, which caused them to have a blunt edge and could lead to injury. He stated he would have expected a work order to be put in as critical and for the issue to be fixed.