STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. Building B. Wing	03/07/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure a call light that accommodated the resident's needs or an acceptable alternative, was provided or implemented to promote safety and allow for means of notification for 1 of 1 residents (R190) reviewed for the accommodation of needs. Findings include: R190's admission Minimum Data Set (MDS) dated [DATE], indicated R190 had a functional limitation in the range of motion of both upper extremities and was dependent on staff for almost all his activities of daily living (ADL) needs. R190's care plan dated 5/15/24, indicated R190 had a communication problem related to his tracheostomy (surgical hole in the windpipe), and his call light was to be within reach. The care plan did not discuss what type of call light R190 needed. R190's care plan dated 9/24/24 indicated R190 utilized mittens on his right hand to prevent pulling on his catheter and tracheostomy, and R190 had left-sided weakness. R190's census report dated 3/1/25, indicated R190 was readmitted to the facility on [DATE]. During an observation on 3/3/25 at 3:44 p.m., R190 was observed lying in bed with his left hand contracted with a palm protector in place and his right hand inside of a restraint mitt (observed as a netting-covered white pillow that the hand was inserted into that tightens around the wrist with the hand partially visible through the netting). A call light with a small red button was observed hanging off the right side of R190's bed. During an observation and interview on 3/4/25 at 2:41 p.m., R190 was observed lying in bed with his left hand contracted with a palm protector in place and his right hand inside of a restraint mitt. A call light with a small red button was observed clipped to R190's bedding. When R190 was asked if he could use the call light, he confirmed he could not. (continued on next page)

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 3/5/25 at 8:53 a.m., R190 was observed lying in bed with his left hand contracted with a palm protector in place and his right hand inside of a restraint mitt A call light with a small red button was observed clipped to the sheets of R190's bed. Registered nurse (RN)-J confirmed R190 had the mental capacity to use a call light to ask for staff assistance. RN-J stated she was going to get R190 a soft-touch call light. RN-J confirmed R190 was not able to use the call light with the button related to the mitt and the left-sided weakness. On 3/6/25 at 12:48 p.m., RN-J stated it had been an oversight not giving R190 a soft touch call light. RN-J stated R190 used to have a soft touch call light but then went to the hospital and was readmitted in 1/25/25 to a different room and did not remember to switch out the call light. The facility's Reasonable Accommodation of Needs policy dated 10/24, indicated the facility would assess the individual's resident's needs, including needed modifications to the physical environment, and those should be accommodated to the extent possible.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview and record review the facility failed to ensure family requested pretreatment of nausea occured prior to meals for 1 of 1 residents (R97) reviewed for self-determination. Findings include: R97 significant change Minimum Data Set (MDS) dated [DATE], indicated R97 was severely cognitively impaired. Section O. indicated R97 had been admitted to hospice care. R97's diagnoses included arthritis and non-Alzheimer dementia. R97's careplan last updated 2/25/25, indicated R97 had been admitted to hospice. Palliative care goals included optimize treatment and control of physical symptoms such as anorexia, nausea and vomiting. R97's Order Summary Report Active orders as of 3/6/25 included the following order: Ondansetron oral tablet disintegrating 4mg give one tablet sublingually two times a day for nausea vomiting. 1 tab under the tongue before meals and at bedtime. R97's Medication Administration Records (MAR) for February and March showed that R97's ondansetron had been scheduled to give at 4:00 p.m. and 8:00 p.m. R97's ondansetron was documented as given at 4:00 p.m. and 8:00 p.m. starting on 2/5/25, through 3/5/25. A progress note entered on 2/19/25, by the registered dietician recommend R97's ondansetron be switched from BID [two times a day] to 4x/day (prior to meals and bedtime). The note indicated the daughter and hospice dietician had been looped in. A progress note dated 3/1/25 at 2:47 p.m., indicated R97 had had an emesis x1 at 2:15 p.m. During an interview on 3/3/25 at 5:04 p.m., R97's family member (FM-Q) stated they wanted R97 to get nausea medication before eating but some of the nurses forgot to give R97's nausea medication before R97 ate dinner. Without it, R97 has been getting sick when they eat and or has thrown up after eating. FM-Q stated they were having to ask to make sure R97 got their nausea medication before they ate. FM-Q pointed to a note on the wall and stated the nurse manger posted that on the wall to remind staff to give R97's nausea medication before R97 ate. During an interview on 3/6/25 at10:09 a.m., registered nurse RN-C stated R97 was having episodes of nausea and vomiting associated with meals, so the provider was notified. RN-C reviewed R97's ondansetron orders and stated they were not sure how the order could be ordered two times a day with the instruction to give before meals and at bedtime. RN-C reviewed and confirmed R97 had been receiving ondansetron at the scheduled times of 4:00 p.m. and 8:00 p.m. and indicated they were not sure why someone had manually set those times for administration. RN-C stated they would need to review the orders with their supervisor to determine if R97 was getting the intended therapeutic benefits of ondansetron the way it was scheduled. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 3/6/25 at 12:07 p.m., RN-C stated they had reviewed the ondansetron order with the DON and determined the order had been entered incorrectly. RN-C stated the current order, and scheduled times were not giving R97 the desired therapeutic effects to address nausea and vomiting with meals. RN-C stated they were in the process of contacting the provider for a new ondansetron order so R97 could receive doses four times a day - before meals and at bedtime. During an interview on 3/7/25 at 10:18 a.m., the consulting pharmacist stated the current order could not be followed because R97 needed to get ondansetron 4 times a day, but it was only ordered for two times a day. A dose time of 4:00 p.m. and 8:00 p.m. would not cover the resident for breakfast and lunch meals the next day. The half-life of Zofran 4mg was 3 to 6 hours so it would be out of the system 6 to 12 hours after taking the medication. If should be given at least 30 minutes before each meal for the best effect of preventing nausea and vomiting if it is caused by the meal. During an interview on 3/7/25 11:19 a.m., the director of nursing (DON) stated R97's ondansetron order was a transcription error. The order would have had to be give 4 times a day to be able to give before meals and bedtime. In addition, the nurse should not have manually changed the times to be given at 4:00 p.m. and 8 p. m. Normally a mediation ordered two times a day would be scheduled for 8:00 a.m. and 8:00 p.m. This was discussed with RN-C and RN-C has been instructed to contact the provider and get a new order. The transcribing RN will receive education when they return to work. The facility policy Medication Orders dated 6/2024 indicated that medication orders must include the type, route, dosage, frequency and strength of medication ordered. The policy does not address taking verbal orders or order transcription.

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview and document review, the facility failed to ensure a resident's advance directives were accurately and consistently documented in the resident's paper chart, electronic medical record (EMR) banner, Provider Order for Life-Sustaining Treatment (POLST), and physician orders to ensure the resident's wishes would be followed in the event of a respiratory or cardiac arrest. This resulted in immediate jeopardy for 1 of 49 residents (R43) whose code status was not accurately documented and was reviewed for advanced directives. In addition the facility failed to ensure the power of attorney (POA) was identified and would be contacted for care decisions for 1 or 49 residents (R223) who was reviewed for resident rights regarding decisions about care. The immediate jeopardy began on [DATE], when R43 signed an updated POLST indicating wishes were cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest. In contrast, the physician's order and banner in R43's chart indicated R43 was DNR status. Upon interview several staff indicated they would look at the banner, therefore would not provide R43 CPR in the event R43 required resuscitation. The immediate jeopardy was identified on [DATE]. The director of nursing (DON) and administrator were notified of the immediate jeopardy on [DATE], at 12:54 p.m. The immediate jeopardy was removed on [DATE], however, non-compliance remained at a lower scope and severity, level 2, isolated scope, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R43's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R43 was cognitively intact. R43's diagnoses included: end stage renal disease with dialysis, Parkinson's disease, diabetes, and congestive heart failure. R43's face sheet, undated, indicated R4 did not have a power of attorney or designated decision maker other than themselves. On [DATE], the banner in R43's EMR read POLST: Do not attempt resuscitation/DNR. The Provider order in the EMR dated [DATE], read POLST: Do not attempt resuscitation/DNR. The POLST in R43's paper chart and the POLST scanned into the EMR on [DATE], both directed CPR. R43's EMR included a document named, Retired POLST [DATE], which was signed by the provider on [DATE], and directed DNR with selective treatment. A provider note entered by advanced practice nurse (APRN-A) in the EMR dated [DATE] at 8:20 a.m., indicated APRN-A had discussed code status with R43 who expressed they desired to change their status to FULL CODE. The note included Forms discussed/updated: See patient chart. A document named POLST.pdf with a scanned date of [DATE], was scanned into R43's EMR. The POLST directed CPR, and selective treatment. R43 signed the POLST, however the provider (APRN-A) listed as completing the POLST had not signed section D Provider Signature. The POLST was also not dated. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note entered in PCC by the DON on [DATE] at 8:55 p.m., indicated APRN-A had not returned to the facility to address R43's undated unsigned POLST so the medical director (MD) was contacted, and the MD gave a verbal order to change R43's code status to full code to align with R43's wishes. The order was processed and R43's code status was changed to CPR. During an interview on [DATE] at 2:34 p.m., R43 verified they were asked about code status and stated their wishes were to receive CPR. During an interview on [DATE] at 1:50 p.m., RN-F stated they would check code status in the EMR first if the computer was closest to them and they would go with the most recent order in the EMR (R43's banner indicated DNR at the time of the interview). RN-F explained every time there was a new POLST it got updated in the EMR, so it was current. During an interview on [DATE] at 1:53 p.m., registered nurse (RN) -D stated they would first look in the EMR banner for the code status (R43's banner indicated DNR at the time of the interview). During an interview on [DATE] at 1:57 p.m., RN-B stated they usually took the code status from the EMR banner and put it on a worksheet they use for the day so they would know what to do right away if a resident coded (R43's EMR banner indicated DNR at the time of the interview). During an interview on [DATE] at 2:04 p.m., RN-C stated if the EMR banner was different from the POLST before they started CPR, they would page the provider and call the resident's family to determine resident/family wishes for code status. It would be the family's choice for code status. RN-C reviewed R43's chart and confirmed R43's POSLT identified R43 wanted CPR. RN-C verified there was no date on the POLST which was in the front of R43's hard chart and scanned into R43's PCC record. RN-C reviewed R43's EMR and confirmed R43's EMR banner identified do not resuscitate (DNR). RN-C reviewed the orders and confirmed there was a current order for DNR. RN-C indicated a delay in CPR while determining R43's code status could have long term negative health consequences for R43. During an interview on [DATE] at 2:26 p.m., RN-I stated they would look at the EMR first. RN-I explained once there was a new POLST, the POLST would go to the HUC after the RN entered the order into PCC, and then the HUC scanned the new POLST into the electronic record and placed it into the paper chart. The old POLST would be sent to medical records. During an interview on [DATE] at 2:38 p.m., health unit coordinator (HUC)-B stated the process was for the POLST be given to the nurse, the social worker, or the HUC and then the HUC would scan the POSLT into the chart. HUC-B stated they would make sure they were signed, filled out completely, and stamped as scanned into the EMR. Normally they would have scanned the POLST in and entered a new order and that order would have updated point click care, but they missed entering R43's order. HUC-B stated they hadn't noticed that R43's POLST hadn't been signed or dated, but they would look for that from now on. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 6:11 p.m., the director of nursing (DON) stated they would not use R43's POLST scanned into PCC on [DATE], because it was not signed by the provider. At the time of the interview, the DON stated the facility would go off of the [DATE], POLST because it was dated and signed by a provider. Per facility policy, the ,d+[DATE] POLST was not current because it was not signed or dated, so R43's EMR banner and DNR order was/is correct. The unsigned and undated POLST scanned in on [DATE], was done so in error. It should not have been scanned in and placed in the paper chart. The ,d+[DATE] POLST should have been left as current in both the paper chart and PCC. If R43 coded today their status would be DNR. Clearly R43's wish was to be a full code based on the provider note, however facility policy was that a code status change did not go into effect until the provider signed the order. Until the provider signed the POLST to change R43's status to CPR, the current order of DNR status would be honored. Per policy residents would also remain DNR until they submitted a request in writing to have their code status changed from DNR to CPR. If a resident with a DNR code status wanted their status changed to CPR they would need to submit that request in writing and then have a provider order. The code status would not change until there was a new order and the provider completed and signed a new POLST. The provider should have signed and dated R43's POLST, discontinued the old DNR order, and entered a new order so R43's banner reflected the new CPR status. It was communicated to the DON that APRN-A had been notified of the errors in R43's POLST and APRN-A would be coming in to correct R43's POLST. The DON explained in an emergency staff would have to go off of what staff had available to them; they would check the status and respond. Staff would not know there was a code discussion documented in the chart. In an emergency they would not be reviewing notes, staff would be finding the code status and responding. The DON indicated if a resident coded and they were working on their laptop they would check the laptop in front of them and the EMR would show them R43 was/is a DNR, and they would act off of that. There was not a need to double check the paper chart or open the POLST in PCC, because the banner should be right. If the hard chart was closer, the DON stated they would look at the chart and follow the POLST in the front of the chart. The DON indicated if R43 had coded and they had checked the chart and followed the POLST in the chart, R43 would have received CPR, even though his current order, banner and signed POLST were for DNR. The DON confirmed there was not a need to check two sources for code status, the paper chart POLST, PCC order, banner status and scanned POLST should be correct and match in all places. The DON stated even though R43 had indicated they wanted to be a full code, if R43 coded now they should be treated as a DNR. During an interview on [DATE] at 10:24 a.m., APRN-A stated they completed the POLST on their second day working at the facility. Initially, they did not sign the POLST because before they signed, they needed to completely discuss status with the resident and make sure there was not a power of attorney they also needed to contact. Once it was confirmed they did not have to talk to anyone but the patient, the APRN-A indicated they must have forgot to sign the POLST before they put the chart with the new POLST into the order rack. APRN-A stated they did have a concern that if something happened to R43, R43 would have been treated as a DNR. APRN-A stated they did not know who had uploaded the POLST into PCC and confirmed they had not been contacted to sign or date the POLST until yesterday evening. This was concerning because not performing CPR in the event R43 coded would have gone against R43's wishes. If there was delayed CPR, R43 could have experienced worse outcomes like residual deficits or death. The more CPR is delayed the more residual disabilities and issues can/will occur. APRN-A stated they did understand the magnitude of not signing R43's POLST and stated since they had entered a note and documented their credentials on the most current POLST they wanted to believe the facility would follow and honor R43's wishes even though they (as the provider) had forgotten to sign the new POLST. In addition, the POLST was signed by R43 so APRN-A hoped the POLST would be followed based on R43's wishes. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:54 p.m., the medical director (MD) and the DON were present. The MD indicated they had been contacted about R43's POLST last evening and they had provided a verbal order for CPR last evening and then they had completed the POLST today ([DATE]). The DON indicated APRN-A was not available the previous evening, but had come in today ([DATE]) after the MD had corrected R43's POLST. The MD stated it was a very serious issue for a resident's code status to not be updated as soon as a resident expressed a desired change. Delays in starting CPR can result in permanent damage or death. A provider should discuss and then document in the medical record a resident's desire for a code change. Following discussion the POLST should be completed and signed immediately, and an order should be entered so that the residents new code status is in place right away. In R43's situation when the APRN did not sign and date R43's POLST, it put R43 at risk for not receiving CPR when that was what R43 wanted. The immediate jeopardy that began on [DATE], was removed on [DATE] when the facility developed and implemented a systematic removal plan. The removal plan was verified through interview and document review as the facility had corrected R43's code status on the EMR banner/provider order to CPR, completed a facility-wide audit to ensure there were no other code status discrepancies, reviewed related policies and procedures, and provided education for all staff involved in ensuring advance directives were honored, and education on CPR and POLST policies/procedures and their respective roles in the process. Facility Policy F 678 Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS)North Ridge Health & Rehab, dated ,d+[DATE], indicated Change of code status by the resident or representative should be witnessed by two staff members or per state directives to become effective immediately, The provider shall be notified of the changes via telephone or electronic communication, the provider will review the changes on subsequent visit. 49034 R223's quarterly Minimum Data Set (MDS) dated [DATE], indicated R223 had severely impaired cognition. R223's care plan dated [DATE], indicated R223 had impaired cognition related to dementia and a stroke. The care plan indicated the resident had advanced directives in place with a goal of honoring and respecting those wishes. R223's Health Care Directive dated [DATE], indicated R223's POA was family member (FM-B). R223's electronic health record (HER) contact list, indicated FM-C was listed as Emergency Contact # 1 and not FM-B. During an interview and observation on [DATE] at 12:15 p.m., RN-L confirmed he was R223's nurse. When asked who would be called if decisions needed to be made regarding R223's care, RN-L was observed to check the EHR contact list and state he would FM-C as she was listed as R223's emergency contact. During an interview on [DATE] at 12:15 p.m., FM-B stated she was R223's POA as FM-A doesn't know what's up and she would have a problem with the facility contacting FM-C instead of her if decisions needed to be made regarding R223's care. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure ongoing monitoring and assessments of the resident ' s condition during restraint use were completed to decrease the likelihood of adverse outcomes of restraint use (skin breakdown, injury from attempts to free self, decline in physical functioning, etc.) and failed to complete a comprehensive assessment and/or re-assessment to determine if the least restrictive device (restraint mitt) was used or determine if the restraint was effective when 1 of 2 residents (R190) reviewed for restraint use, was found to be able to self-decannulate his tracheostomy tube while the restraint was in place. Findings include: R190's admission Minimum Data Set (MDS) dated [DATE], indicated R190 had a functional limitation in the range of motion of both upper extremities and was dependent on staff for almost all his activities of daily living (ADL) needs. The MDS indicated that physical restraints were not used on R190. R190's care plan dated 5/15/24, indicated R190 had a communication problem related to his tracheostomy (surgical hole in the windpipe), and his call light was to be within reach. R190's care plan dated 9/24/24 indicated R190 had a potential for injury or harm related to pulling on the catheter and tracheostomy tubing. The care plan indicated staff were to anticipate R190's needs such as food, thirst, resident comfort, and pain levels. The care plan indicated R190 utilized mittens on his right hand to prevent pulling on his catheter and tracheostomy. R190's Informed Consent for Use of Restraints dated 9/9/24, indicated the facility had recommended a restraint mitt for R190 related to pulling of his tracheostomy tube and catheter for 24 hours and with a release and reposition schedule of every two hours. The form indicated the family member (FM)-D had consented to the use of restraints. The document included possible negative outcomes of physical restraints such as a decline in physical functioning, muscle condition, contractures, skin breakdown, delirium, agitation, anxiety, withdrawal, depression, or reduced social contact. The form indicated it was best practice to attempt less restrictive alternatives, complete appropriate assessments, re-assessments, care planning, and ongoing monitoring that documents if the restraint was effective at treating the medical symptom and when reduction of the use of the restraint would be warranted. R190's progress note dated: -9/9/24 at 2:44 p.m., indicated FM-D had consented to mitt use. -10/7/24 at 10:33 a.m., indicated R190 had pulled his tracheostomy tube out, staff were unable to reinsert it, and no respiratory distress was noted. The note indicated the resident was sent to the hospital for evaluation. The note did not indicate if the mitt was in place at the time of tracheostomy tube removal. (continued on next page)

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	245183	A. Building B. Wing	03/07/2025

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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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/14/24 at 9:24 p.m., R190 had pulled his tracheostomy tube out, staff were unable to reinsert it, no respiratory distress was noted but the resident was sent to the hospital for evaluation. The progress note indicated that R190's restraint mitt was in place when R190 had pulled the tracheostomy tube out. -10/29/24 at 3:05 p.m., indicated R190 was admitted to the hospital related to chest congestion and shortness of breath. -1/22/25 at 5:15 p.m., indicated R190 was readmitted from the hospital and was alert and orientated to both person and place. The note did not indicate whether mitts were applied at the time of admission. R190's provider note dated 1/25/25 at 11:00 p.m., indicated that staff had reported R190 had a history of digging in his depends and lines and a right hand mitt was used to prevent line and tube removal. The provider then indicated R190 used to use right hand mitt and a plan that it could be reordered as needed for safety and should be removed intermittently for skin checks and offloading of the skin. R190's Nursing: Physical Restraint Admission Evaluation dated 1/25/25, included a section titled Considerations, that indicated R190 had a current diagnosis of a stroke, with subsection titled, 2. Define Acute Medical Condition that was left blank and 3. Emergency Use, with the options: prevention of injury to self, prevention of injury to others, and for life-sustaining treatment that were all left unchecked. The next section was titled Alternatives Attempted with options such as family companion, 1:1 activities, other, etc., and a section to list other alternatives tried not listed above, with the only intervention listed as attempted being the bed in the low position. The next section was the Restraint Decision which indicated no physical restraints were to be applied. The next section was restraint type which indicated a wrist restraint, or hand glove was used. The next section was Notifications/Follow-Up with the questions, notification of physician and order obtained, notification of responsible party, consent obtained, care plan updated, Kardex updated, and point of care task update, all of which were left blank. R190's Administration Record dated 1/28/25 to 3/1/25, indicated R190 had an order dated 1/28/25, Okay to use right hand mitten gloves as needed for safety with the frequency of three times a day, with the additional instruction to use intermittently. The order was checked as completed three times a day during the period. The written provider order for mitt use was requested and not received. The administration record did not include how often staff were removing the restraint and what assessments of R190 were completed related to the restraint use. R190's provider note dated 1/30/25, indicated R190's right hand mitt restraint was in place on the exam and had R190 had no motor function to his left upper extremity, which was in a splint. The resident was alert, calm, and cooperative with no acute distress, and was able to answer simple yes/no questions and would attempt to mouth answers as he had aphonia (a loss of voice or inability to speak above a whisper). R190's provider notes on 2/4/25 and 2/12/25 indicated R190's right-hand mitt restraint was in place on exam. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R190's provider note dated 2/13/25, indicated R190 had deliberately pulled out his tracheostomy tube on this day and was calm and without respiratory distress during the assessment. The note indicated R190's right upper extremity was in the restraint mitt on the exam. The note did not indicate if the restraint mitt had been in place at the time of tracheostomy removal. R190's provider note dated 2/21/25, indicated R190 had deliberately pulled out his tracheostomy tube on 2/13/25 and was calm and without respiratory distress during that time. The note indicated that R190 had told ACP that it was a suicide attempt. The note indicated ACP, social work, and the nurse manager had met with the resident who indicated he did not wish to die but wanted to work towards decannulation. The note indicated R190 understood he could not pull out his tracheostomy tube, but they would work towards decannulation. The note indicated that R190 was able to understand the risk of decannulation and the potential for decompensation. The note indicated a restraint mitt was in place to prevent him from pulling at his medical devices. R190's order summary dated 3/4/25, indicated R190's hand mittens were to be removed intermittently to assess for skin breakdown and be reapplied as ordered with a frequency of every two hours. During an observation on 3/3/25 at 3:44 p.m., R190 was observed lying in bed with his left hand contracted with a palm protector in place and his right hand inside of a restraint mitt (observed as a netting-covered white pillow that the hand was inserted into that tightens around the wrist with the hand partially visible through the netting). During an observation and interview on 3/4/25 at 2:41 p.m., R190 was observed lying in bed with his left hand contracted with a palm protector in place and his right hand inside of a restraint mitt. R190 was asked if he was able to take the mitt off himself, R190 placed the top of the mitt in his mouth and used his teeth to attempt to pull the mitt off, but was unsuccessful and then shook his head no. When asked if staff were removing the mitt, R190 shook his head no and mouthed that staff were not taking it off very often. During an interview on 3/5/25 at 8:46 a.m., RN-L stated that R190 was his own responsible party and was able to understand and make his own decisions. RN-L stated he had to be asked yes or no questions related to his speech difficulties. RN-L stated R190 had the mitt restraint as he grabs things and had a history of pulling out his tracheostomy tube. RN-L confirmed that R190 could not remove the restraint mitt himself and did feel it restricted R190's use of his hand. RN-L stated he followed the orders to know when to remove the restraint and to assess the skin so he would remove the restraint every two hours, assess the skin, and reapply it but otherwise, the mitt was used continuously. RN-L acknowledged this assessment was ordered yesterday and was unsure what was being completed or where to find this documented on how often the restraints were taken off or when skin was assessed before this order. RN-L was unsure what other interventions were being attempted to address the medical symptoms leading to the need for restraint use. On 3/5/25 at 8:57 a.m., RN-J, the nurse manager stated she thought R190 came from the hospital with the mitt restraint and would need to find the written order from the prescriber to continue the restraints. RN-J stated the restraint mitt was ordered for intermittent use, but it had been missed to indicate when staff should remove the restraints and assess for possible adverse effects such as skin breakdown, so she added the order last night. RN-J stated the expectation was for staff to remove the restraint every two hours but after reviewing the medical record could not find that this was occurring. RN-J stated that R190 had the restraint as he had previously removed his tracheotomy tube. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 9:30 a.m., RN-J stated she thought R190 could still use his hand while the mitt was applied as he had continued to pull the tracheostomy tube out while the restraint was applied. RN-J stated although the mitt did not stop him from removing the tracheostomy she felt it was a good way to deter him from/acted as a reminder for not pulling the tracheostomy tube out. RN-J stated she still felt the restraint was effective so did not think that the restraint mitt had been reassessed to see if less restrictive interventions could be used but acknowledged it had been ineffective at stopping him from self-decannulating. RN-J stated they had educated the resident on the importance of not removing his tracheostomy tube but after removing the medical record was unable to find if any other less restrictive interventions had been attempted to deter or remind the resident not to pull the tracheostomy tube out. During an interview on 3/7/25 at 11:03 a.m., the director of nursing (DON) stated when restraints were needed related to a resident's behaviors possibly compromising their airway, this was treated differently than other possible restraint use. The DON stated that sometimes residents were admitted from the hospital with these restraints in place and interventions may not be attempted before application related to the airway issue and possible adverse outcomes. The DON stated it would be up to the nurse manager to get orders from the provider to determine how often restraints should be removed and the resident should be monitored for adverse outcomes related to restraint use. The DON stated she would then expect this order to be placed on documented on the administration record and a progress note added as needed if adverse outcomes were noted. The DON stated she would expect staff to reassess residents for the necessity for restraint use every month and if a restraint was noted to be ineffective at treating the symptom it was ordered for, she would expect the resident to be reassessed for the need for continued restraint use or if another intervention should be attempted. The facility's Physical Restraint Application policy dated 10/24, indicated a physical restraint is any manual method or physical device, material, or equipment attached to the resident's body that cannot be easily removed which restricts freedom of movement or normal access to one's body. The policy indicated staff should document the date/time the restraint was applied, the type of physical restraint, the specific reason the restraint was applied, the length of time the restraint will be used, and each time the restraint is released.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to initiate and complete a Significate Change in Status Assessment (SCSA) for 1 of 1 resident (R42) after a physical and cognitive decline following a stroke. Findings include: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI manual) indicates the SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines. A significant change is a major decline in resident status that will not normally resolve itself without intervention by staff, impacts more than one area of the resident's health status and requires interdisciplinary review and/or revision of the care plan. R42's quarterly Minimum Data Set (MDS), dated [DATE], indicated R42 had severe cognitive impairment, significant weight loss, a mechanically altered diet, upper and lower extremity impairment on one side and 2 or more falls since readmission to the facility. R42's past MDS (annual in November 2025) indicated R42 was cognitively intact, was not on a mechanically altered diet, did not have weight loss and did not have any impairments of her extremities. R42's Progress Notes, dated 11/1/24 - 3/7/25, indicated R42 was hospitalized on [DATE] - 1/10/25 for a stroke with right sided weakness. On 2/4/25 it was documented 2/4/25 R42 was found on the floor by staff at 215 pm on this date. Stated she was trying to walk. Resident has a recent change of condition related to stroke and does not understand that she cannot walk or transfer without assist. During observation on and interview on 3/3/25 at 6:01 p.m., R42 was laying in bed, able to respond only yes or no to basic questions but was unable to form full sentences. During observation on 3/5/25 at 12:33 p.m., R42 was sitting in her wheelchair out at the dining room table. An unnamed staff member was assisting R42 with drinking a sip of juice. R42 had pureed food on a plate in front of her and intermittently throughout the meal required staff assistance with getting the utensils to her mouth. During an interview on 3/6/25 at 10:36 a.m., nursing assistant (NA)-J stated since R42 came back from the hospital she needed assistance with eating and could only communicate with yes, no or pointing to what she needed. NA-J stated prior to having a stroke, R42 was transferring on her own and now required a mechanical lift for transfers. NA-J also confirmed R42 had lost weight since returning from the hospital. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 10:50 a.m., licensed practical nurse (LPN)-H stated prior to her stroke, R42 would spend time outside, smoking and socializing with other residents and she now spent a lot more time in her room. LPN-H stated R42 had a complete change since returning from the hospital as she was no longer able to communicate with other residents and move around the facility on her own. During an interview on 3/6/25 at 12:10 p.m., nurse manager and registered nurse (RN)-F stated prior to hospitalization for a stroke R42 was able to bear weight and transfer on her own. R42 was able to self-propel in her wheelchair to go outside independently which was now unsafe for her to do due to an increase in falls. RN-F stated R42 was able to communicate with yes or no responses. During an interview on 3/6/25 at 11:24 a.m., R42's family member (FM)-E stated R42 had become mostly non-verbal since having a stroke, stating R42 used to be a social butterfly. FM-E stated prior to her stroke, R42 would socialize with other residents outside while smoking and could move around the care facility on her own. During an interview on 3/7/25 at 8:31 a.m., the MDS nurse stated an SCSA should be completed if there were two changes in activities of daily living needs or significant weight loss. The MDS nurse stated for R42 they wanted to give her a few weeks in therapy to see if she was progressing. The MDS stated R42 started physical and occupational therapy on 1/29/25 and discharged on [DATE]. The MDS nurse confirmed that R42 had a change in her wheelchair mobility, transfer status and eating assistance stating, this would be a good time to initiate a SCSA for R42. During an interview on 3/7/25 at 10:49 a.m., the director of nursing (DON) confirmed an SCSA should have been completed for R42 when she returned from the hospital, stating it would have triggered other comprehensive assessments to be completed as well. The DON stated, I think we could have done better by her. A facility policy on MDS was requested and not received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on inteview, obsersavation and document review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 resident (R86) reviewed for care needs (i.e. interventions and identfication of pressure ulcer/laundry/preference of care giver/communication ability/ambulation ability). R86's quarterly Minimum Data Set (MDS) assessment, dated 2/15/25, indicated R86 had severely impaired cognition with no hallucinations or delusions present, no behaviors and no rejection of care. R86 required moderate staff assistance with showering, lower body dressing, footwear, transfers from bed/chair/toilet/shower and personal hygiene. R86 required set up assistance from staff for oral hygiene and supervision for toileting hygiene. Furthermore, Section M skin conditions indicated R86 was at risk for developing pressure ulcers and indicated R86 had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also be present as an intact or open/ruptured serum-filled blister). The most recent annual MDS assessment, dated 10/24/25, Section F Preferences for Customary Routine and Activities indicated it was very important to choose what clothes to wear for R86. R86's medical diagnosis report, printed 3/7/25, included the following pertinent diagnosis vascular dementia (a brain disorder that affects memory, thinking and behavior), type 1 diabetes (condition where the pancreas makes little or no insulin which leads to high blood sugar levels), chronic kidney disease (kidneys not filtering waste and excess fluid from the blood properly) and hypertension (high blood pressure). R86's care plan, printed 3/6/25, indicated the following: -(R86) has communication problem r/t (related to) language barrier (speaks Somalia language) and Dementia with the following interventions: - encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense or responds to the feeling resident is trying to express. - Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. - Provide translator as necessary to communicate with the resident. Translator is: Somali language. -Res at risk for pressure ulcer development r/t occasional incontinence with the following interventions: -Pressure relieving/reducing mattress in bed. -Weekly skin checks on bath days by the nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident has an ADL (activities of daily living) self-care performance deficit r/t confusion, dementia with the following interventions: -grooming: set up -resident likes to wear jacket inside -BATHING: limited staff assist to provide a bath weekly and as necessary. -PERSONAL HYGIENCE ROUTINE: independent assist as needed (washing, shaving, trimming nails etc), -DRESSING: set up/limited staff assist prn (as needed) -AMBULATION: set up -Resident has a history of declining assistance with ADL's with the following interventions: -call resident's SON to encourage cooperation. -Approach resident alone -Explain each step involved in completing task -Reapproach -Try another caregiver -Bath in another location, such as in own room -Offer reward for completion of task -Check room temperature before bringing person for bathing; heck water temperature frequently -Allow resident to disrobe independently R86's care plan lacked evidence of identified pressure ulcer, additional interventions for prevention of worsening of pressure ulcer, preference of laundry being done by daughter, preference of men providing care assistance with care, and daughter providing showers at least weekly. Furthermore, lacked evidence of interventions of ways to communicate with R86 such as picture cards, or need to use of walker when ambulating or wheelchair when weak. During observation on 3/03/25 at 3:37 p.m., R86 was observed walking with staff with a walker. R86 had a compression sock on his left leg and R86 was wearing a hospital gown. During interview and observation on 3/04/25 at 9:06 a.m., R86 stated he was observed wearing two hospital gowns (one normally and one backwards). R86 stated he didn't know about his clothes and pointed to the closet. R86 had one pair of underwear in the closet and no other clothes were observed. R86 indicated he did not have any clothes at the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 3/04/25 at 2:03 p.m., R86 was observed in the community dining room. R86 was observed to be wearing 2 hospital gowns and was observed to have a compression sock on left leg with gripper socks on. During observation on 3/06/25 at 10:39 a.m., R86 was observed lying in bed with a hospital gown on. R86 smiled when asked a question. During an observation on 3/06/25 at 12:57 p.m., R86 was observed to have regular clothes on and sitting in the community dining room. During an interview on 3/05/25 at 3:05 p.m., family member (FM)-A stated they were concerned that staff are not able to understand (R86) due to the language barrier. FM-A stated they have told the facility numerous times to call them to help interpret and they have never called. FM-A stated they have never seen them use communication cards or a communication board to help to communicate. FM-A stated R86 would not be ok with wearing a hospital gown all the time and this would not be preference. FM-A stated the facility has notified them in the past of R86 needing clothes but have not notified them anytime recently of needing clothes. FM-A stated they were unaware of R86 not having clothes at the facility. FM-A stated they visit R86 numerous times a week and were familiar with his needs. During an interview on 3/06/25 at 10:10 a.m., registered nurse (RN)-O stated R86's primary language was not English but felt R86's English was ok. RN-O stated they felt they could communicate ok with R86. RN-O stated R86 can become aggressive with cares but does do better with men. RN-O stated, he doesn't care about wearing a gown, but did not answer the question directly when asked if R86 was asked directly if this was a preference. RN-O stated they were unsure if R86 had clothes at the facility. RN-O stated R86 was not really verbal all the time. RN-O stated, (R86) took a jacket from a kitchen worker before and didn't give it back. RN-O stated the nurse manager updates the care plans. During an interview on 3/06/25 at 10:58 a.m., RN-O stated if a resident doesn't have clothes, the social worker would reach out to family to bring in clothes for the resident. RN-O stated the expectation was all residents have AM (morning) cares completed which would include being dressed in street clothes. RN-O stated R86 was recently in the hospital, hasn't fully recovered and was not sure of current ability. RN-O stated R86 was not always accepting of assistance and was a private person. RN-O stated his daughter does his laundry. RN-O stated R86 had a blister on his left heal that had popped and stated, it is not a pressure ulcer. RN-O stated she was responsible for updating the care plans. RN-O was going to review the care plan and follow up with surveyor. During an interview on 3/06/25 at 10:44 a.m., nursing assistant (NA)-F stated they were familiar with R86. NA-F stated R86 needed limited assistance prior to hospitalization but now required assist of 1 staff but needs assist of 2 due to behaviors as R86 had been refusing cares. NA-F stated R86 does ok with changing the hospital gown but does refuse to get his underwear changed. NA-F stated does not have any clothes at the facility and verified R86 currently does not have any clothes at the facility. NA-F stated they were unsure if the social worker had been notified regarding R86 not having clothes but knows that the nurse had been notified R86 did not have clothes at the facility. NA-F stated R86 was not proficient in English but proficient in Somalian. NA-F stated they feel they can communicate effectively with R86 but stated they do not use hand gestures, do not routinely show items to R86, have never tried a communication board, communication cards or an interpreter with R86. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 3/06/25 at 12:19 p.m., FM-A stated they give R86 a shower every 2-3 days. FM-A stated they do R86's laundry as the facility has continually lost R86's clothes. FM-A again, expressed that they do not communicate effectively with R86. FM-A stated R86 does much better with male staff than female staff as he was a private person. FM-A stated they brought clothes in today for R86 and got R86 ready for the day and assist R86 with [NAME] dressed. During a follow up interview on 3/06/25 on 2:08 p.m., RN-O stated they were unaware that R86 was diagnosed with a pressure ulcer. RN-O verified the care plan lacked evidence of R86 having a pressure ulcer and interventions placed since development. RN-O stated R86's family does his laundry and provides showers/care which are not on R86's care plan. RN-O stated the care plan does mention some resistance with care but lacks identification that R86 does better with male caregivers. RN-O verified there was no documented preference of R86 preferring to wear a hospital gown and the expectation would be R86 would be wearing street clothes daily. RN-O stated all the above should be on R86's comprehensive care plan. RN-O stated residents should have comprehensive care plans as it ensures residents are treated with a holistic approach. During an interview on 3/7/25 at 10:49 the director of nursing stated it was expected for care plans to be reviewed, and updated if needed, at least quarterly and more frequently if a resident had a change in condition. The DON stated it was important for residents to always have up to date and accurate care plans to ensure all staff know how to take care of the residents. A facility policy titled Comprehensive Care Plans, reviewed 8/24, indicates an individualized comprehensive person-centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident.

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North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review, the facility failed to provide timely and quarterly care conferences for 3 of 4 residents (R184, R224, R146) reviewed for care planning. Findings include: R184: R184's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R184 was cognitively intact. Diagnoses included cancer, gastroesophageal reflux disease and post-traumatic stress disorder Review of R184's progress notes indicated a staff member with Anoka County requested a care conference on 11/18/24. Review of R184's care conference forms and progress notes identified care conferences were held on 1/24/25, 5/6/24 and 1/30/24. The care conference forms, and progress notes lacked a documented care conference around 11/24 as requested by Anoka County. During an interview on 3/3/25 at 6:29 p.m., R17 stated there is never an invite sent for care conferences and was not sure when the last care conference occurred. During an interview on 3/5/25 at 10:42 a.m., registered nurse (RN)-R stated care conferences were set up by the social worker about 14-21 days after admission and then quarterly and annually after that, RN-A stated nursing attended the care conferences to discuss the resident's medical care and how the resident wanted their medical care to proceed. During an interview on 3/5/25 at 10:48 a.m. licensed social worker (LSW)-C stated care conferences would be 21 days after admission, quarterly and annually. Social services department was responsible to set up the care conferences each time and to send out the invites. LSW-C stated R184 was always invited to the care conferences but did not sign the forms. LSW-C reviewed the care conference forms in the electronic medical record (EMR), the progress notes in the EMR and the handwritten notes from R184's care conference file and stated nothing was found related to a care conference around 11/24. During an interview on 3/7/25 at 10:27 a.m., the director of nursing stated care conferences should be held after admission, quarterly and annually based on the MDS dates. The Care conference was important because the resident had the ability to let staff know what their expectations were related to care and their stay at the facility. R224: R224's admission record indicated an initial admitted [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R224's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R224 was cognitively intact. Diagnoses included diabetes mellitus and respiratory failure. Review of R224's care plan undated, lacked information related to discharge planning and discharge goals. Review of R224's care conference forms and progress notes identified care conferences were held on 1/31/25. The documentation lacked any other care conference information prior to 1/31/25. During an interview on 3/5/25 at 10:42 a.m., registered nurse (RN)-R stated care conferences were set up by the social worker about 14-21 days after admission and then quarterly and annually after that, RN-A stated nursing attended the care conferences to discuss the resident's medical care and how the resident wanted their medical care to proceed. During an interview on 3/5/25 at 10:48 a.m. social services designee (SSD)-A stated care conferences would be 21 days after admission, quarterly and annually. Social services department was responsible to set up the care conferences each time and to send out the invites. Items discussed as part of the admission care conference included resident goals and discharge plans. Those conversations were important so the facility could start looking at discharge plans right away. All information obtained during the admission care conference would then be utilized to build the social services part of the comprehensive assessment, which included discharge planing. SSD-A stated she had not worked with R224 until around 12/24. Prior to 12/24, a different social worker worked with R224 and would have been responsible for the admission care conference and first comprehensive care plan. During an interview on 3/6/25 at 11:18 a.m. licensed social worker (LSW)-C stated she had worked with R224 for the first 2 months of stay at the facility but did not do a care conference. LSW-C confirmed the admission care conference should be done within the first 21 days of stay at the facilty. During an interview on 3/7/25 at 10:27 a.m., the director of nursing stated care conferences should be held after admission, quarterly and annually based on the MDS dates. The admission care conference was important because the resident had the ability to let staff know what their expectations were related to care and their stay at the facility. The resident could also vocalize to the staff their discharge goals and plans. Facility policy Resident/Family Participation-Assessment/Care Plans last reviewed 10/24 indicated each resident/family member was encouraged to participate in the development of the resident's comprehensive assessment and person-centered care plan. The resident and/or family members are invited to each care conference. The policy lacked information related to how often the care conferences should occur. 47263 R146: R146's Minimum Data Set (MDS) indicated R 146 was mildly cognitively impaired. R146's diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting left dominate side, cognitive communication deficit, and diabetes type 2. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R146's careplan was last reviewed 12/20/24. R146's most recent care conference was documented on 8/23/24, in the electronic medical record (EMR) Care Plan Conference Summary flow sheet. The social worker and nurse manager were in attendance. R146 had been invited but chose not to attend. A Social Services Quarterly Review was completed on 2/25/25, however there was no documentation to support a care conference had been held in conjunction with completion of the Social Services Quarterly Review. During an interview on 3/3/25 at 6:35 p.m., R146 stated that nobody was really talking to them about their careplan or their plan of care. They stated they were not sure if they had ever been to a care conference meeting or been invited. During an interview on 3/7/25 at 10:19 a.m., registered nurse RN-C stated it was the social worker's (SW) responsibility to schedule and invite the resident, family and staff to the care conference. Care conferences are expected to occur at least quarterly and then as needed. I would expect quarterly. Care conferences are needed because conferences give family and residents an opportunity to hear and give input into care and express needs or concerns. During a follow-up interview on 3/7/25 at 12:30 p.m., R146 confirmed that they had not attended or been invited to a care conference in a long time. Facility policy Resident/Family Participation-Assessment/Care Plans last reviewed 10/24 indicated each resident/family member was encouraged to participate in the development of the resident's comprehensive assessment and person-centered care plan. The resident and/or family members are invited to each care conference. The policy lacked information related to how often the care conferences should occur.

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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** 48109 Based on observation, interview and document review, the facility failed to ensure 2 of 9 residents (R21, R28) reviewed for activities of daily living (ADLs) and who were dependent on staff for their ADLs, routinely had their fingernails cleaned and trimmed. Findings include: R21's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure, diabetes mellitus and chronic kidney disease (CKD). R21's MDS identified the need for moderate assistance with bathing, dressing, and toileting. R21's provider orders dated 1/30/25, identified an order for a weekly bath on Fridays including nail care and shaving. R21's care plan dated 2/6/25, identified the need for extensive assistance with bathing but didn't specifically address nail care. During an observation on 3/4/25 at 8:56 a.m., R21's fingernails were noted to be about one-eighth of an inch long with dark matter underneath all of them. During an interview on 3/5/25 at 3:11 p.m., nursing assistant (NA)-E stated the NAs knew what to do for each resident by looking at their Kardex (a task-driven portion of the EMR) and pulled up R21's Kardex which contained instructions to ensure fingernails and toenails were trimmed. NA-E also stated R21 was diabetic so the nurses would have to trim his nails. During an interview on 3/5/25 at 3:26 p.m., registered nurse (RN)-M confirmed he had looked at R21's nails today and they were dirty and long. RN-M stated R21's shower was charted as being done last Friday and he didn't find a refusal charted. RN-M stated the expectation was to chart if a resident refused care. During an interview on 3/7/25 at 11:53 a.m., the director of nursing (DON) would expect nail care to be done as it was planned or that a refusal of care would be documented. 49034 R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 had intact cognition and was diagnosed with multiple sclerosis (breakdown of the protective covering of the nerves that can cause weakness, lack of coordination, fatigue, etc.) and respiratory failure. The MDS did not indicate that R28 was diagnosed with diabetes. The MDS indicated R28 was dependent on staff for toileting and personal hygiene and required extensive assistance with bathing. R28's care plan dated 12/9/24, indicated that R28 needed staff assistance with his ADLs including bathing, oral hygiene, and dressing. The care plan did not indicate R28 had a history of refusing nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's Task list dated 3/3/25, included a task for a shower/ bed bath in the morning on Mondays and staff were to ensure nails were trimmed and the resident was shaved. The task indicated R28 received his bath on 3/3/25 and did not indicate a refusal. R28's medical record was reviewed and did not indicate R28 had refused to have his nails trimmed. During an observation and interview on 3/3/25 at 2:44 p.m., R28 was observed in bed with his fingernails over 1/4 of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. R28 stated he could not cut his fingernails by himself, and staff were not good at assisting him with trimming them and he never refused to let them cut them. R28 stated he thought his fingernails were too long and wished staff would cut them for him and he did not like the way they looked. During an observation on 3/4/25 at 9:40 a.m., R28 was observed in bed with his fingernails over 1/4 of an inch beyond the end of his fingertip with a brown substance underneath the tips of his fingernails. During an interview on 3/4/25 at 2:24 p.m., nursing assistant (NA)-D stated she was the aide for R28 yesterday and stated R28 had refused to let her cut his nails. NA-D stated they were supposed to document when a resident refused cares and did not recall if she had done that but thought R28's nails were not that long anyway. During an observation and interview on 3/4/25 at 2:31 p.m., on entering the room, NA-D was observed standing at R28's bedside and cutting R28's fingernails. Registered nurse (RN)-J stated she did not think R28 had refused to get his nails cut yesterday but his nails grow underneath so she did not feel it was necessary to have them cut yesterday. NA-D then again stated that R28 refused to have his fingernails cut, and when R28 was asked by RN-J if he refused to get his nails cut, he stated no. RN-J stated if R28 had refused, she would expect the NA to notify the nurse who should have put in a progress note about the refusal. A policy, Care of Fingernails/Toenails dated 10/2024, identified the purpose of the procedure was to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy described the steps to clean and trim nails including cleaning underneath and around them with an orange stick and trimming them with a clipper. For documentation, the policy indicated any refusals of care would be documented.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review, the facility failed to compressively reassess a resident for activity interest and socialization needs after hospitalization for a stroke for 1 of 2 residents (R42) reviewed for activities who was no longer able to communicate verbally with other residents and move around the facility independently. Findings include: R42's quarterly Minimum Data Set (MDS) dated [DATE], indicated R42 had severe cognitive impairment, significant weight loss, lower and upper extremity impairment to one side and required substantial to maximum assistance with toileting and bathing. The MDS further indicated R42 had been admitted to the care facility on 4/1/15. R42's progress notes dated 11/1/24 - 3/7/25, indicated R42 was hospitalized on [DATE] - 1/10/25 for a stroke with right sided weakness. R42's care plan revised 7/25/24, indicated R42 preferred to be to be in room engaging in independent activities or going outside or fresh air rather than going to group programs offered. The care plan lacked any updated interventions post hospitalization for a stroke with right sided weakness. R42's care conference note dated 1/30/25, indicated R42 preferred independent leisure activities to group programs. She [R42] enjoys resting in bed, watching tv and going outside. She [R42] also has magazines that she likes to look at. The resident [R42] is not able to go outside as often since returning from hospital due to health issues. R42's most recent therapeutic recreation review, dated 2/26/25, indicated R42 continued to prefer independent leisure activities to group programs. She [R42] enjoys resting in bed, watching tv and going outside. She [R42] also has magazines that she likes to look at. The resident [R42] is not able to go outside as often since returning from hospital due to health issues. The resident [R42] has family who are involved and visit. TR will continue to monitor. R42's electronic medical record (EMR) indicated R42's last comprehensive activities assessment was dated 11/17/24, prior to R42's hospitalization and change in physical and cognitive condition. During observation on 3/3/25 at 3:18 p.m., R42 was laying in her bed, awake. R42's room was dark and quiet, no television or music for stimulation. R42 had the television remote in her hand but appeared unable to use it and was fidgeting with it. During observation on 3/3/25 at 6:01 p.m., an unnamed staff member brought R42 her dinner tray, elevated the head of R42's bed and left R42 alone in her room for dinner. The television was left off. During observation on 3/5/25 at 2:53 p.m., R42 was laying in her bed, the room was dark and quiet, without television or music on. R42 appeared restless in bed with her eyes open. During observation on 3/06/25 at 9:45 a.m., R42 was in bed, awake. Her room was dark and quiet. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 8:32 a.m., the activities director (AD) stated residents would be compressively assessed for activity needs and interest at least annually and with any change in condition, stating a hospitalization could indicate a change in resident condition but generally would correlate with a significant change MDS. During an interview on 3/6/25 at 9:01 a.m., the activities aide (AA)-A stated the last time R42 was comprehensively assessed for activities was last November, stating R42 was very active at that time and was going outside by herself. AA-A confirmed since R42 was hospitalized , she was unable to go outside on her own anymore and her routine had changed however R42 was not compressively reassessed to address how her socialization needs would be met without her able to communicate or move around the facility independently anymore. AA stated she completed an isolation assessment of R42 but not a comprehensive assessment which would have assessed what specific activities R42 would potentially be interest in or able to participate in. AA-A stated she had not initiated any one-to-one visits with R42 but she checked in with R42 once a week to make sure her TV [television] was working. During an interview on 3/6/25 at 10:36 a.m., nursing assistant (NA)-J stated prior to R42's hospitalization she was able to transfer on her own and spent a lot of time outside, smoking with other residents. NA-J stated since her stroke, R42 required a mechanical lift for transfers and NA-J had been instructed to lay R42 back in bed after meals, stating if R42 was left up in her wheelchair she would try to go outside and was not safe to go outside alone anymore. During an interview on 3/6/25 at 10:50 a.m., licensed practical nurse (LPN)-H stated R42 spent a lot more time in her room since her hospitalization , stating she had a complete change since her hospitalization and was no longer able to go outside and smoke anymore. During an interview on 3/6/25 at 12:10 p.m., nurse manager and registered nurse (RN)-F stated staff at times would offer to bring R42 to a group activity, but she was never really into group activities. RN-F stated R42 liked to watch television and could hold her own remote. During an interview on 3/6/25 at 11:24 a.m., R42's family member (FM)-E stated R42 was never a frequent participant in group activities but that she was a social butterfly and got her socializing in through smoking outside with other residents. FM-E stated when R42 first returned from the hospital she had a family friend staying with her as she lived out of town but now there was not anyone available to frequently visit her. R42 voiced concerns that R42 was just lying in bed with nobody there to help her. During an interview on 3/7/25 at 10:49 a.m., the director of nursing (DON) stated she would have expected a comprehensive activities assessment to be completed after R42 had a stroke to determine how her socialization needs could be met. The DON stated, I think we could have done better by her [R42] and that if a significant change MDS was initiated it would have triggered staff to comprehensively assess R42. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Activities and Social Events, revised 9/2012, indicated, staff will evaluate a resident's physical and mental capacity to participate in various levels of activities. They will note any significant physical and cognitive limitations or behavior issues that would influence the level of a resident's participation or type of activities that are relevant to that individual. They will also note in the medical record any restrictions or needs that might be relevant to participation in activities (e.g., the need for toileting during the activity or limitations on the type, consistency, or amount of food that can be eaten while participating in an activity involving food).

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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** 42587 Based on observation, interview, and document review the facility failed to ensure orders were current and accurate for 1 of 1 resident (R90) reviewed for orders. In addition, facility failed to ensure site care was performed for 1 of 2 residents (R4) reviewed for tube feeding Findings include: R90's quarterly Minimum Data Set (MDS) dated [DATE], identified R90 had diagnoses which included intestinal malabsorption (a condition that prevents absorption of nutrients through the small intestine), gastrostomy tube status (a flexible, hollow tub inserted through the abdominal wall and into the stomach), malnutrition, diabetes mellitus, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), anxiety, and depression. R90 was cognitively intact and independent with activities of daily living. R90's Order Summary Report dated 3/7/25, identified R90 had orders that included the following: Two liter fluid restriction every shift start date 11/13/24, order status active Antibiotic monitoring order date 12/20/24, order status active R90's care plan dated 8/10/23, did not address a fluid restriction or antibiotic monitoring. R90's treatment record identified staff were completing antibiotic monitoring December through March. Antibiotic monitoring: Document effectiveness of antibiotic therapy, potential side effects and vital signs daily and for 3 days post completion to ensure resolution of infection. December 2024 revealed the antibiotic monitoring started on 12/20/24, and was documented daily with the exception of three days (24, 25, 26). January 2025 revealed the antibiotic monitoring was documented daily with the exception of four days (1, 2, 3, 22). February 2025 revealed the antibiotic monitoring was documented daily. March 2025 revealed the antibiotic monitoring was documented daily day until the order was discontinued on 3/6/25. R90's medication administration record identified staff were documenting R90's fluid restriction on the day and evening shift for all of December 2024, January 2025, February 2025, and March day and evening shift through 3/6/25, and on the day shift 3/7/25. During an interview on 3/5/25 at 2:30 p.m., registered nurse (RN)-B stated she was unsure if R90 was currently on a fluid restriction, she was also unsure if they were doing antibiotic monitoring for R90. (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 3/5/25 at 2:37 p.m., nursing assistant (NA)-I stated R90 was not on any fluid or diet restriction. During an interview on 3/5/25 at 2:46 p.m., R90 stated she was not on any fluid restriction. During an interview on 3/5/25 at 3:20 p.m., RN-C reviewed R90's orders and stated she was no longer on an antibiotic and stated the order for antibiotic monitoring should have been discontinued after the antibiotic was completed. RN-C verified R90's order for a two liter fluid restriction was not a current order. During an interview on 3/6/25 at 10:40 a.m., RN-R reviewed R90's orders and stated the antibiotic monitoring order should have ended on 12/8/24. RN-R verified staff should be reading the orders and they should understand what they are signing when documenting they completed a task in the medication administration and treatment records. During an interview on 3/7/25 at 8:41 a.m., the director of nursing stated staff should understand what they are documenting when they sign they completed a task in the medication and treatment record. The facility policy Medication Orders dated 6/2024, identified a current list of orders must be maintained in the clinical record of each resident. In addition, treatment orders specified When recording treatment orders, specify: The specific treatment, frequency and duration of the treatment. 47263 R4's admission MDS dated [DATE], indicated R4 was moderately cognitively impaired. Diagnoses included epilepsy, traumatic brain injury, quadriplegia, diabetes, and sepsis. The MDS indicated R4 had a catheter and received greater than 51% of their nutrition by tube feeding. R4's care plan, undated, indicated R4 was receiving nutrition via tube feeding. The focus area tube feeding goals last updated 1/16/25, included R4 will be free of aspiration, insertion site will be free of signs and symptoms of infection. Interventions included monitor/document/report to MD any signs or symptoms of complications. The careplan identified R4 had a suprapubic catheter with the goal R4 will show no signs or symptoms of infection. Interventions did not include dressing changes or assessment of the catheter insertion site. R4's Order Summary Report Active Orders as of 3/6/25 included the following: -Monitor for complications of tube feeding such as aspiration, dislodgement, fluid overload, fecal impaction, diarrhea, nausea or vomiting, leaking around insertion site, intestinal perforation, abdominal wall abscess or erosion at the insertion site. every shift -Feeding Tube Site Care: clean site Q Day and apply gauze one time a day -Flush catheter twice a day -Ensure weekly bath, skin assessments and UDA are completed (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's orders lacked instruction for care of R4's suprapubic catheter site. Notes from R4's visit to the emergency department on 3/4/25, documented a suprapubic catheter change, diagnosis of UTI and a prescription for the antibiotic Cefdinir. A progress note dated 3/4/25, indicated R4 had noticeable suprapubic catheter bypass, a change in level of consciousness, and low BP. Order received to send resident to ER for eval. Family (Wife) was notified through voice mail. R4's weekly skin assessments were documented as follows: -1/27/25 Skin condition: open areas not skin tears, site: coccyx, description: MASD -2/3/25, 2/10/25, 2/25/25 and 3/5/25 skin assessments read: Skin condition: other not listed above, note: no change noted. -3/7/25 at 8:20 a.m., R4's Skin and Wound Assessment documentation identified a new moisture associated skin damage (MASD) location: left lower quadrant abdomen - stoma, in-house acquired. Measurements: area: 21.1 cm, length: 7.3 cm, width: 4.1 cm, depth: 0.1 cm. No evidence of infection. Exudate: none. Treatment: wound cleanser, antimicrobial dressing. Provider notified. -3/7/25 at 8:16 a.m., R4's Skin and Wound Assessment documentation identified a new rash. Location: left lower quadrant midline, middle. Measurements: area: 3.9, length 2.6 cm, width 2.1 cm, depth 2.1 cm. No exudate. No odor. No evidence of infection. Erythema. Wound treatment: cleanse, antimicrobial dressing, apply bacitracin. Provider notified. R4's skin and wound assessment documentation did not include documentation of R4's suprapubic catheter site. During an observation on 3/5/25 at 11:38 a.m., registered nurse (RN-B) stated R4 had gone to the hospital yesterday because their tube feeding access site was looking bad. RN-B pulled back R4's covers to expose R4's site which was not covered with a dressing. RN-B left the room and returned with a dressing. RN-B estimated R4 had a 2 inch by 1-inch reddened area around the tube feeding insertion site. The site appeared moist with yellow crust around the skin boarder and there appeared to be a scab in the reddened area. RN-B confirmed R4 also had a second red area on the left abdomen that was about 2 inches in diameter. There were also scratch marks above R4's lower left groin area. RN-B cleansed, applied bacitracin, and a new dressing around R4's tube feeding site. During an observation on 3/6/25 at 12:38 p.m., RN-G removed R4's suprapubic dressing. RN-G described the skin around R4's suprapubic site as red, moist, with crusting on the skin around the area where the tube entered R4's body. RN-G cleansed the site with wound spray. Both R4's old dressing and the 4x4 used to clean the site had visible red and yellow drainage on them. RN-G removed the dressing around R4's tube feeding tube site. RN-G described the skin around the tube as red and moist with red and yellow drainage with some crusting at the insertion site. RN-G stated both the suprapubic site and the tube feeding site dressing had had some bloody drainage on them and stated neither site looked good. (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 3/6/25 at 1:35 p.m., RN-C stated part of their rounding routine was to do skin checks on residents. On 3/4/25, they had been in to assess R4 and found that he had had a change from baseline. RN-C had stated R4 had blood and discharge at the suprapubic catheter site, low blood pressure, and urine was bypassing. They discussed this with the nurse practitioner and R4 was sent to the ED for evaluation. During a follow-up interview on 3/7/25 at 9:42 a.m., RN-C stated on 3/4/25, they had noticed excoriation around the stoma area of R4's suprapubic catheter and had also been concerned about the state of R4's tube feeding site. RN-C stated they had communicated those concerns to the provider before R4 was sent to the ED. RN-C pulled up R4's weekly skin assessments and noted neither the 2/25/25, or the 3/5/25, assessments included identification and documentation of a new skin occurrence. Once a new wound/skin issue was identified they expect the identifying nurse to document and do appropriate follow-up. RN-C stated they had photographed and entered R4's tube feeding site and rash area into the wound assessment flowsheets and the provider had also entered wound care orders for both sites. RN-C reviewed the flowsheets and stated the suprapubic site should also be photographed and entered into the Wound Assessment flow sheet so the provider could view and enter orders. During an interview on 3/7/25 at 10:36 a.m., RN-B stated they had not been the only nurse that had performed dressing changes on R4. RN-B was not sure if anyone else has documented on R4's skin, but they had not because R4's sites had been red for a few days leading up to R4's ED visit so it was not a new skin change. RN-B stated the nurse manager was also aware of R4's skin on 3/4/25. If they were going to document on a skin issue they would go in and make a progress note. During an interview on 3/7/25 at 11:23 a.m., advanced practice registered nurse APRN-O stated they had looked at R4's tube feeding site the day R4 went to the ED. R4's tube feeding site and R4's supra pubic sites had been red and gunky. Because R4 was considered high acuity/high risk, R4 was sent to the ED to have those sites checked their suprapubic catheter as well. When NAs are changing R4 and they notice urine or drainage from the tube feeding or catheter site, they should be immediately reporting that. Nurses should be documenting and reporting those changes to the provider immediately. APRN-O stated they expected nurses to follow facility policies for catheter/tube feeding care and management. During an interview on 3/7/25 at11:23 a.m., the director of nursing (DON) stated NAs should be looking at skin and bringing forward changes/concerns. When a dressing change is completed and there is a change in skin condition that nurse is responsible for documentation and proper notifications. A full skin assessment should be completed each week, and any changes should be documented and brought forward to the nurse manger/provider. Wound assessments should be done as they are found and weekly. When a new concern is brought forward or a wound has changed, it should be documented and communicated to the provider so care can be updated as needed. This process would include tube feeding, catheter sites, and any other noted skin change or wound. The facility policy Suprapubic Catheter Care F 690 dated 10/2024, included staff instruction to remove the drainage sponge from around the stoma site and wash around the site and along the tubing. Inspect the stoma site and skin around the stoma for redness or skin break down. Document the results of the skin assessment around the stoma. Notify physician of any abnormality in the skin assessment or characteristics of the urine. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policies Enteral Nutrition F693 dated 10/2024, and Gastric Tube Feeding Via Continuous Pump dated 5/2024, were received and reviewed however neither policy addressed tube feeding site skin assessment.

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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** 47263 Based on observation, interview, and record review the facility failed to follow identifed pressure relieving interventions, to timely identify a wound as a pressure ulcer and failed to follow care plan interventions to promote healing and prevent worsening of a pressure ulcer for 1 of 4 residents (R4) reviewed for pressure ulcer care. Findings include: R4's re-admission Minimum Data Set (MDS) dated [DATE], indicated R4 was moderately cognitively impaired and was at risk of developing pressure ulcers but did not have any unhealed pressure ulcers at the time of admission and advised pressure reducing devices for R4's chair and bed. Hospital provider notes dated 12/30/24, identified R4 as having a stage 3 pressure ulcer [defined as full-thickness loss of skin in which adipose (fat) tissue is visible. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, and cartilage are not viewable. If slough or eschar obscures the extent of tissue loss this is an unstageable pressure injury] Nursing progress notes included a skin assessment when R4 was admitted and readmitted to the facility however there was a lack of documentation regarding nurse identification of a pressure ulcer. R4's face sheet dated 3/6/25, included the diagnoses of epilepsy, traumatic brain injury, quadriplegia, diabetes, and sepsis. Diagnoses did not include a pressure ulcer. The North Ridge Nursing Admission Evaluation -V2 completed on 12/19/24, indicated R4 was brought to the facility by EMS and had a foley catheter and a g-tube. The skin section identified yes to one or more pressure ulcers at a stage 1 [blanchable erythema] however the location was not documented. The following was described under other: an abrasion upper buttock, blister right foot lateral, scab second right toe, redness groin, redness both right and left heel, dry skin lower extremities. R4's Re-Admit Skin Care Area: Pressure Ulcer/Injury dated 1/8/25, indicated R4's trigger areas for pressure ulcers were frequently incontinent of bowel, at risk for developing pressure ulcers, ADL (daily activities of living) assistance required to move in bed. R4's status was potential for development of pressure ulcers and identified the following measures for preventative skin care: redistribution mattress on bed, cushion to wheelchair, routine skin monitoring, a.m./h.s. [bedtime] cares, and weekly skin monitoring. No current pressure ulcer was identified on the assessment. (Note: the redistribution matress was not implemented for R4) R4's care plan focus area potential for skin impairment interventions last updated 1/17/25, instructed staff to follow facility protocols for treatment of pressure injuries, use a pressure relieving device in bed, turn reposition every 2 hours, use pressure relieving device in chair, and to keep skin dry and clean. R4's electronic medical record (EMR) order history included: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ordered 12/18/24: Calmoseptine external ointment apply to affected area topically as needed tid [three times] prn [as needed]. -Ordered 1/22/25: Wound order: clean wound bed with cleaner, apply zinc paste daily, dc when resolved. One time a day wound care. Wound Care - Coccyx: Clean wound and apply sulfamylon cream (Mafenide Acetate) to coccyx wound area until resolved. one time a day start 1/30/25. (order active on 2/6/25, Order Summary) Provider Notes identified the following: -1/13/25, identified R4 had a stage one wound on the left buttock. -1/13/25, indicated R4 had been hospitalized from 12/22/24 to 12/30/24 for respiratory failure, COVID, and septic shock secondary to UTI. The note identified a level 1 buttock pressure wound. An addendum to the note indicated R4 returned to the hospital 1/6/25, for catheter and respiratory issues. -1/30/25, identified R4 had an open wound described as stable measuring 43.8 cm with evidence of epithelial granulation, slough and eschar. Treatment changed from zinc cream to sulfamylon cream daily until healed. -2/11/25, skin section exam findings listed negative: erythema, wounds, bruising -2/17/25, skin section exam findings listed negative: erythema, wounds, bruising. -2/21/25, noted skin exam findings Negative: warm dry. R4's Weekly Skin Assessments were documented as follows: -1/27/25: Skin condition: open areas not skin tears, site: coccyx, description: MASD [moisture associated skin damage] -Weekly Skin Assessment documentation on 2/3/25, 2/10/25, 2/25/25, and 3/5/25, skin assessments read: Skin condition: other not listed above, the entered note for each entry was: no change noted. R4's weekly Skin and Wound Evaluation flowsheets were documented as follows: -2/5/25, Skin & Wound Evaluation identified moisture associated skin damage (MASD), type: incontinence associated dermatitis, location: intergluteal cleft, in-house acquired, status: new. Wound measurement area: 7.8 cm, length 4 cm, width 2.8 cm, depth not applicable. -Wound care - Coccyx: clean wound and apply sulfamy, no secondary dressing. Provider notified. -2/12/25, assessment identified MASD with measurements: area: 7.8 cm, Length 4.4 cm, Width 2.4 cm, depth 0.1 cm. Wound care - Coccyx: clean wound and apply sulfamy, no secondary dressing -2/19/25, assessment identified MASD present for 2 weeks with measurements: area: 8.7 cm, Length 3.7 cm, Width 3.3 cm, depth 0.1 cm. Wound care - Coccyx: clean wound and apply sulfamy, enzymatic debridement, calcium alginate dressing/foam. Practitioner notified. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/26/25, assessment identified MASD present for two weeks with measurements: area: 6.2 cm, Length 3.6 cm, Width 2.4 cm, depth 2 cm. Wound bed slough 20%. Macerated wet white tissue. Wound care - Coccyx: clean wound and apply sulfamy, mechanical debridement, dressing other with secondary dressing foam. Practitioner notified. Progress stalled. -3/5/25, assessment identified MASD present for two weeks with measurements: area: 4.6 cm, Length 3.1 cm, Width 2.2 cm, depth 3 cm. Wound bed slough 40%. Moderate serous exudate with faint odor. Edge appears as a cliff. Dressing saturated. Wound care - Coccyx: clean wound and apply sulfamy, enzymatic debridement, dressing other with secondary dressing foam. Practitioner notified. Progress deteriorating. Provider sent new orders and active to wound. Air mattress applied to bed. Nurse documentation of assessment and treatment of R4's pressure ulcer prior to 12/30/24, and documentation of nurse's first identification of pressure ulcer were requested however not received. During an observation on 3/3/25 at 3:18 p.m., R4 was positioned on their back with the head of the bed elevated. During an observation 3/3/25 at 5:30 p.m., R4 was positioned on their back with the head of the bed elevated. During an observation on 3/3/25 at 6:50 p.m., R4 was positioned on their back with the head of the bed elevated. During an observation on 3/4/25 at 8:26 a.m., R4 was positioned on their back with the head of the bed elevated. During an observation on 3/5/25 at 11:38 a.m., R4 was positioned on their back with the head of bed elevated. During an observation on 3/5/25 at 12:05 p.m., R4 was positioned on their back with head of bed elevated. During an observation on 3/5/25 at 2:32 p.m., R4 was positioned on their back with head of bed elevated. At the start of a continuous observation on 3/6/25 from 12:01 p.m. to 1:23 p.m., R4 was positioned in bed on their back with the head of the bed elevated. Registered nurse (RN-G) stated they were going into R4's room because R4 was due for every two-hour repositioning and cares at that time. Nursing assistant (NA-A) was already in the room. RN-G and NA-G performed a check and change, and RN-G changed R4's dressings. When cares were completed, R4 was repositioned in the same position, back on his back. During an interview on 3/6/25 at 1:23 p.m., RN-G stated they were not sure what position R4 was in before they did the repositioning because NA-A was in R4's room already. RN-G stated R4 should not have been put back in the same position he was in before. R4 needed to be repositioned into a different position every 2 hours to get pressure off of R4's wound to help it heal and prevent it from getting worse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 1:26 p.m., NA-A stated R4 always ended up in the same position. NA-A confirmed R4 was put back in the same position R4 was in before the check and change, with two pillows on R4's left side. NA-A stated R4 should have been put in a different position and identified this was important because R4's sores could get worse from being in the same position. During an interview on 3/6/25 at 1:35 p.m., RN-C stated R4 was care planned for pressure reducing device in bed and explained they had been using pillows as pressure reducing devices. RN-C stated the plan also called for repositioning every two hours. Returning R4 to the same position was not an acceptable repositioning. They had just acquired a broda chair for R4, and RN-C expected staff to use the Broda chair as part of R4's repositioning as well as different positions in bed. Repositioning was important to reduce pressure and promote good blood flow. Remaining in the same position can cause skin break down and can worsen wounds. During an observation on 3/7/25 at 8:34 a.m., R4 was seated in a broda chair in the dayroom. During a request to review R4's coccyx wound with RN-C on 3/7/25 at 10:33 a.m., RN-C stated they would transfer R4 from the broda chair back to bed and do a dressing change once R4's new air mattress arrived. RN-C anticipated it would arrive sometime before noon. During an observation on 3/7/25 at 10:36 a.m., R4 was seated in a broda chair in the group activity area. During an observation on 3/7/25 at 12:25 p.m., R4 was back in bed positioned on their back with the head of the bed elevated. During an interview on 3/7/25 at 9:42 a.m., RN-C stated initially R4's coccyx was first identified as MASD and the treatment had been wound cleaner. Once the skin integrity became compromised and worsened the provider switched treatment to seflamylin. RN-C reviewed R4's EMR and confirmed R4's wound measurements and classification was still MASD. RN-C stated R4's coccyx wound had worsened, and they believed it was a stage 3 pressure ulcer because it didn't involve bone yet. RN-C confirmed the pressure ulcer was not documented in R4's record and indicated the providers usually did, but had not staged R4's wound yet. RN-C stated R4's care plan and wound documentation should have been updated when it was identified R4 had a pressure ulcer. RN-C confirmed R4's hospital note from 12/2024, identified R4 had had a coccyx stage 3 pressure injury however the facility had not photographed and entered data on the Skin and Wound Evaluation flow sheet until 1/22/25. That entry identified R4's coccyx as MASD only and had not identify a pressure ulcer in addition to MASD. RN-C stated it was important for wounds to be identified and documented as soon as they were found so the correct treatment could be put into place and/or updated. RN-C stated they would expect all nursing staff including NAs to report skin changes and licensed staff should be documenting and reporting significant changes to the prover. RN-C stated a pressure relieving mattress had been ordered for R4 yesterday and the provider was also notifed the wound had taken a turn and the current wound care was not working. The provider is now reviewing additional treatment options. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 10:42 a.m., advanced practice registered nurse APRN-O stated they had been treating R4's coccyx wound with sulfadimidine, but they were now changing the treatment to santyl. APRN-O stated they had seen, but not staged R4's wound and indicated the wound was more of a moisture associated injury that was now definitely a pressure injury. Due to the worsening state of the wound APRN-O indicated they had put in orders for a wound consult yesterday. R4 should be repositioned on their right or left side as much as possible. The expectation would be to keep R4 off their coccyx as much as possible to keep R4's wound from getting worse, and to help it heal. APRN-O reviewed R4's record and indicated it did not appear R4 had had a wound consult. When a wound worsens additional interventions such as an air mattress should be implemented, and the wound nurse should be consulted and involved with wound care. APRN-O indicated they thought these measures should have been implemented sooner for R4. During an interview on 3/7/25 at 11:23 a.m., the director of nursing (DON) pulled up R4's Skin and wound evaluation flow sheets and confirmed the first documentation on R4's coccyx was documented as MASD on 1/22/25. The DON reviewed R4's hospital note from 12/30/24, and confirmed it identified R4 had a coccyx stage 3 pressure ulcer. The DON had not been directly involved in R4's care but did articulate expectations. All staff including NA's should be looking at skin and bringing forward changes/concerns. A full skin assessment should be completed each week, and any changes should be documented and brought forward to the nurse manger. Wound assessments should be done as they are found and weekly. When a new concern is brought forward or a wound has changed, it should be documented and communicated to the provider so care can be updated as needed. R4's coccyx should have been identified and treated as a pressure ulcer. Both the nurse mangers and providers can stage a wound. R4's pressure wound should have been added to the flow sheet and the careplan. R4 should have had a pressure reducing mattress and likely a wound nurse consult implemented much earlier in R4's wound progression. R4 should not be returned to the same position after care, R4 should be repositioned into a new position every two hours. This was an expectation because off-loading took pressure off of R4's wound and helped it heal whereas pressure on the wound could worsen the wound and or prevent healing. The facility policy Pressure Injury treatment Guidelines dated 4/2024, heading Stage 3 and Stage 4 Protocol provided instruction to staff to protect, fill dead space including tunnels and undermining, manage drainage, and to promote moist wound healing and management of pressure ulcer pain. The header Debride slough/eschar directed staff to follow provider order for debridement most appropriate to resident's condition and goals. The policy Documentation and Reporting sections instructed daily monitoring of pressure ulcers indicated if a pressure ulcer showed no progression after 2 to 4 weeks, the provider should be contacted for new treatment. The facility prortocols for pressure injury were resquested and not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure a nursing functional maintenance program was implemented to prevent a possible decline in range of motion (ROM) for 1 of 6 residents (R190) reviewed for range of motion. Findings include: R190's admission Minimum Data Set (MDS) dated [DATE], indicated R190 had a functional limitation in the range of motion of both upper extremities and was dependent on staff for almost all his activities of daily living (ADL) needs. R190's care plan dated 2/25/25, indicated R190 had a functional maintenance program to prevent furthering of his contractures and to prevent skin breakdown. The care plan indicated the nursing assistants (NA)s were to complete bilateral lower extremity ankle and knee ROM with R190. R190's Functional Maintenance Program (FMP) dated 2/18/25, indicated nursing staff were to complete bilateral lower extremity ankle and knee ROM with R190 daily, and the program was signed by physical therapist (PT)-A. R190's medical record was reviewed and did not indicate bilateral lower extremity ankle and knee ROM was completed daily since the start of the FMP on 2/18/25. During an interview and observation on 3/5/25 at 11:51 a.m., NA-D confirmed she worked with R190 frequently and she would look at the tasks assigned to her on the electronic health record (EHR) to see what or if ROM needed to be completed. NA-D was observed checking the tasks for R190 and stated there was nothing related to ROM, so this did not need to be completed for him. During an interview on 3/5/25 at 12:05 p.m., NA-C stated that she worked with R190 frequently, but therapy did most of his ROM right now. NA-C stated she would do exercises with him sometimes but not anything specific. When asked to further describe what range of motion she completed with R190, she stated she would complete ROM with R190's upper extremities while assisting with dressing in the morning but did not complete ROM for the lower extremities. NA-C stated she knew what ROM exercises needed to be completed by checking with the nurse. During an interview on 3/5/35 at 12:09 p.m., registered nurse (RN)-L confirmed he was R190's nurse for the day and stated some range of motion should be done with cares but was unsure of the specifics and would need to check with therapy. During an interview on 3/5/25 at 12:14 p.m., the director of rehabilitation, occupational therapy assistant (OTA)-A confirmed R190 was not seeing physical therapy right now but was seeing occupation therapy, who was working with his upper extremities. OTA-A stated if the physical therapist had recommendations upon discharge, they would write an FMP and give this to nursing staff to follow. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:58 p.m., registered nurse (RN)-J, the nurse manager, stated that R190 was supposed to be on an FMP related to contracture management. RN-J stated she had added it to his care plan but had missed adding it as a task for the NAs to see and document, as was the normal procedure, so she could not confirm that it was being done. The facility's Range of Motion Exercises policy dated 10/24, indicated residents with limited range of motion would receive appropriate treatment and services to prevent further decrease in ROM. The policy indicated staff should record in the medical record when ROM was performed.

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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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R90) who was observed using an electric heating pad, was free of potential injury. Findings include: R90's quarterly Minimum Data Set (MDS) dated [DATE], identified R90 had diagnoses which included intestinal malabsorption (a condition that prevents absorption of nutrients through the small intestine), gastrostomy tube status (a flexible, hollow tub inserted through the abdominal wall and into the stomach), diabetes mellitus, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), anxiety, depression, hypothyroidism, and insomnia. R90 was cognitively intact and independent with activities of daily living. R90's Order Summary Report dated 3/7/25, did not identify any orders for a heating pad or heat therapy. A review of R90's care plan dated 10/25/24, identified R90 had a potential for pressure ulcer development related to disease process. Interventions included the following: -pressure redistribution mattress to bed and cushion to wheel chair -moisturizer applied to skin -do not massage over bony prominences A review of R90's weekly skin assessments for past five weeks, identified no change in skin condition or skin intact. On 3/5/25 at 12:45 p.m., R90 was observed lying in bed with a heating pad under her which was plugged directly into the wall. On 3/5/25 at 3:05 p.m., R90 was lying in bed with the heating pad under her back and plugged into the wall. On 3/7/25 at 8:37 a.m., R90 was lying in bed her breakfast tray was in her room, she was lying on her back with the heating pad underneath her and plugged into the wall. On 3/5/25 at 12:09 p.m., maintenance (M)-A stated their department didn't have anything to do with heating pads or other equipment brought in from outside of the facility. On 3/7/25 at 8:24 a.m., nursing assistant (NA)-H stated if a resident brought in a heating pad from home he would tell the nurse. NA-H stated there were no residents on the unit who were using a heating pad. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/7/25 at 8:26 a.m., NA-A stated if a resident brought in a heating pad she would tell the nurse. NA-A also stated there were no residents on the unit with heating pads. On 3/7/25 at 8:28 a.m., registered nurse (RN)-B stated she did not know if there was a policy regarding heating pads brought in from home. RN-B stated she did not know what she would do if a resident brought a heating pad in from the outside. However, RN-B verified R90 had a heating pad that she was currently using. On 3/7/25 at 8:30 a.m., RN-C stated he was unsure what the policy was for heating pads brought in from the resident's home. RN-C verified R90 was using an electrical heating pad and believed it was not a facility heating pad. On 3/7/25 at 8:41 a.m., the director of nursing (DON) stated electrical heating pads should not be brought in from home, there should be a provider order and staff should be doing skin checks. The DON verified the maintenance department never inspected the heating pad and identified the heating pad as Intertek #5023264. The Electrical Safety for Residents dated 10/2024, identified residents would be protected from injury associated with the use of electrical devices, including electrocution, burns and fire. Residents were supposed to be oriented to basic electrical safety precautions as part of the admission process and reinforced as indicated or appropriate. The policy identified electrical devices were supposed to be inspected as part of routine fire safety and maintenance inspections. The policy identified the use of electrical heating pads was discouraged. If used follow manufacturer's instructions, do not allow residents to sleep with heating pads turned on, do not allow the heating pad to be constricted, encourage residents to report redness, pain, burning sensation and inspect resident's skin often for signs of thermal injury.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on observation, interview, and document review, the facility failed to ensure appropriate interventions were taken to reduce the risk of aspiration for 2 of 2 residents (R4, R129) reviewed who used a tube feeding and was observed to be positioned flat in bed while their feeding was running. In addition, the facility failed to ensure infection prevention practices were followed and tube feeding was administered at the ordered flow rate for 1 of 2 residents (R4) reviewed for tube feeding administration. Findings include: R4's re-admission Minimum Data Set (MDS) dated [DATE], indicated R4 was moderately cognitively impaired and received 51% or greater of their nutrition by tube feeding. R4's diagnoses included the diagnoses of epilepsy, traumatic brain injury, quadriplegia, diabetes, and sepsis. R4's care plan tube feeding focus area udpated 1/16/15, indicated R4 was receiving nutrition via tube feeding and listed Osmolite 1.5 at 50 ml [milliliters]/hour. Goals included free of aspiration, insertion site will be free of signs and symptoms of infection. Interventions included monitor/document/report to MD any signs or symptoms of complications. R4's Summary Report Active Orders as of 3/6/25, included the follow orders: -Enteral Feed: Change spike set when new bottle is hung every shift -Tube feeding: Change and date graduate cylinder daily one time -Tube feeding: Change and date syringe daily, rinse with hot water after use every shift. -Feeding Tube Site Care: clean site Q Day and apply gauze one time a day -Monitor for complications of tube feeding such as aspiration, dislodgement, fluid overload, fecal impaction, diarrhea, nausea or vomiting, leaking around insertion site, intestinal perforation, abdominal wall abscess or erosion at the insertion site. every shift -Osmolite 1.5, 60ml/hour times 22 hours to provide 1980 kcals, 83 grams protein, and 1006 ml fluid. Continue same flush and prostate orders. Start:1200, end at 1000 daily. Start: 2/18/25. The treatment record and medication administration record for January, February, and March were reviewed and staff had been signing off on orders to date the graduated cylinder & syringe, dressing changes, tubing changes and administration of tube feeding at ordered rate. A progress note on 2/11/25, entered by the registered dietician identified R4 had experienced a 7.5% weight loss in one month and calculated R4 needed their tube feeding rate increased to 60ML/hour to meet nutritional needs. The documented goal was for R4 not to experience unintentional significant weight loss. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/3/25 at 3:18 p.m., R4's tube feeding was running at a rate of 50 ML an hour. The tube feeding solution container was not dated or documented with a start time. The syringe and tubing set with attached water bag was not dated. The graduated cylinder was dated 3/3 and was partially full of water. An undated syringe was in the cylinder of water. During an observation on 3/3/25 at 6:50 p.m., R4's tube feeding was running at 50ml an hour. Solution, tubing and syringes remained updated. During an observation on 3/4/25 at 8:26 a.m., R4's tube feeding was running at a rate of 50 ml an hour. The tube feeding solution container was not dated or documented with a start time. The tubing set with attached water bag was not dated, the syringes were not dated. The graduated cylinder was dated 3/4 and was partially full of water. An undated syringe was in the cylinder of water. During an observation on 3/5/25 at 12:05 pm., registered nurse (RN-B) connected R4's tube feeding and stated R4's pump which was programmed to give R4 water every hour and deliver Osmolite at a rate of 50 ml an hour. The syringe in R4's room was not dated. The graduated cylinder was dated 3/5, the solution was dated 3/5 with a start time of 9:45 a.m. During a follow-up interview on 3/5/25 at 2:32 p.m., RN-B pulled up R4's orders and stated R4 had orders for 100 ml of water every 2 hours by tube feeding pump, the Osmolite 1.5 was ordered at the rate 60 ml per hour. RN-B went down to R4's room and confirmed R4's tube feeding was not set at the correct rate. RN-B changed R4's pump rate from 50ml/hour to 60 ml/hour. RN-B also updated the administration rate and start time on the bottle of Osmolite hanging on the pump. RN-C explained the water bag was part of the tubing system and dated the water bag 3/5 to show they had changed the tubing when they set up R4's tube feeding that a.m. RN-B stated it was important to date and change supplies and tubing every day to prevent contamination and infection. RN-C stated it was important for the rate to be correct so that R4 got the nutrition they needed. At the start of a continuous observation on 3/6/25 from 12:01 p.m. to 1:23 p.m., R4 was positioned in bed on their back with the head of the bed elevated. Registered nurse (RN-G) stated they were going into R4's room because R4 was due for every two-hour repositioning and cares. Nursing assistant (NA-A) was already in the room. R4's head of the bed was lowered flat with the tube feeding attached and infusing. RN-G and NA-G performed a check and change, and RN-G changed R4's dressings. When cares were completed, R4's head of the bed was elevated greater than 30 degrees. During an interview on 3/6/25 at 12:53 p.m., RN-G stated when we reposition or provide care to a resident with a tube feeding the tube feeding should be stopped and discontinued from the resident. RN-G stated they should have put R4's Tube feeding on hold and disconnected it from R4 before they put him flat and moved him around for cares. This was important because it prevented the resident from aspirating and getting sick. During an interview on 3/6/25 at 1:26 p.m., NA-A stated they knew the tube feeding should be stopped before cares, but they were not allowed to stop a tube feeding, the RN needed to do it. NA-A had thought RN-G had stopped R4's tube feeding before they started R4's cares. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/7/25 at 8:34 a.m., R4 was not in their room. R4's graduated cylinder was dated 3/7, however the syringe on the bedside table was not dated. R4 was out on the unit in a broda chair in day room with the tube feeding pump running at 60 ml an hour. The Osmolyte and the water bag were dated 3/7. During an observation on 3/7/25 at 10:36 a.m., R4 was not in the day room, however R4's tube feeding pole was in the day room capped and unattended. During an observation on 3/7/25 at 1225 p.m. R4 was back in bed positioned on their back with the head of the bed elevated and the tube feeding infusing at 60 ml/hour. During an interview on 3/7/25 at 10:13 a.m., RN-C stated tube feeding bottles and tubing should be dated and timed when changed and or hung. Syringes and graduated cylinders should also be changed each day and dated. The graduated cylinder should be empty and left to air dry. Staff should not leave water in it with syringes in it. The syringes should be rinsed after use and left to dry. This was important for contamination and infection prevention. Tube feedings should be administered as ordered. Nurses are responsible to check the ordered rate against the pump setting to make sure the ordered rate is being delivered to the resident. Nurses are expected to stop and disconnect a resident's tube feeding before transferring, providing care, or lowering the head of the bed below 30 degrees. This should be done to prevent pulling on the tubing and to prevent the resident from aspirating the tube feeding solution into their lungs. During an interview on 3/7/25 at 10:42 a.m., advanced practice registered nurse APRN-O stated They would expect nurses to follow facility policies for tube feeding care and management. Nurses are to document dates and times when tubing, solutions, and supplies are put into use to help prevent infection. When a tube feeding is running the bed should be elevated to 45 degrees to prevent aspiration. If a resident is lowered below or flat, then there is a concern the resident may aspirate and develop aspiration pneumonia. Tube feeding rates are set to ensure adequate nutrition is being received, so ordered rates should be followed. During an interview on 3/7/25 at 11:41a.m., the director of nursing (DON) stated they expected staff to be dating tubing, formula bottles, syringes and other supplies for tube feedings each day as this was a prevention infection measure for resident safety. Stopping and disconnecting a resident from their tube feeding before lowering the head of the bed or providing cares was also a safety measure to prevent aspiration of the tube feeding. When a resident is on a continuous tube feeding it cannot be stopped for groups unless there is a provider order to do so. If a resident is disconnected from their tube feeding, the pole should be kept in the resident's room instead of a common area where other residents could inadvertently contaminate it. 49034 R129's quarterly Minimum Data Set (MDS) dated [DATE], indicated R129 had severely impaired cognition, was dependent on staff for their activities of daily living (ADLs), and received 51% or more of their nutrition through a tube feeding. R129's Administration Record dated 1/1/25, indicated R129 was to have nothing by mouth (NPO) and received continuous (24 hours a day) feedings through his gastric tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R129's care plan dated 11/19/24, indicated the head of R129's bed should be elevated at least 30 to 45 degrees during and for one hour after feedings. During an observation and interview on 3/6/25 at 7:51 a.m., R129 was observed lying in bed with the head of the bed flat, not elevated. R129's tube feeding was running with a visible tube connected to his abdomen. Nursing assistant (NA)-G was observed assisting the resident with ADLs. NA-G stated that R129 had a bowel movement, and his nurse was busy, so she had not asked for the tube feed to be paused before she lowered the head of the bed. NA-G confirmed the tube feeding was still running. During an interview and observation on 3/6/25 at 7:35 a.m., registered nurse (RN)-Q stated she was the nurse in charge of R129's care and she would have expected the NA to find her or another nurse to pause the tube feeding when they needed to lower the head of the bed. RN-Q stated she would be worried about the resident aspirating if the feeding was not paused. RN-Q was observed to enter R129's room and confirmed the tube feeding was actively being administered to R129 and had not been paused. During an interview on 3/6/25 at 12:52 p.m., RN-J, the nurse manager stated she would expect the NAs to find a nurse, including herself, if they needed to lower the head of the bed to complete cares. RN-J stated she would be worried about aspiration if the tube feed was not turned off when the head of the bed was lowered. The facility policies Gastric Tube Feeding Via Continuous Pump dated 5/2024, and the policy Enteral Nutrition F693 dated 10/2024 were received and reviewed however neither policy addressed aspiration prevention or the labeling and dating of supplies and solutions for infection prevention purposes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and record review, the facility failed to ensure oxygen order parameters were followed for 1 of 4 residents (R21) and that provider orders for as needed (PRN) oxygen administration were in place for 1 of 4 residents (R204) reviewed for respiratory care. Findings include: R21's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. R21's MDS also identified continuous oxygen therapy. R21's provider orders dated 1/30/25, identified an order for oxygen at 3.5 liters per minute via nasal cannula to keep oxygen saturation levels greater than or equal to 90%. Review of R21's care plan dated 1/31/25, identified altered respiratory status related to chronic respiratory failure and COPD with an intervention to provide oxygen as ordered. Review of R21's electronic medical record (EMR) identified oxygen saturation readings from 3/1/25 to 3/6/25 ranging from 92-100%. The oxygen liter flow was not identified at each reading. During an observation on 3/4/25 at 8:57 a.m., R21 was wearing a nasal cannula which was connected to the oxygen tank, and the dial on the tank was set to five liters. During an observation on 3/5/25 at 11:43 a.m., R21 was sleeping in his bed wearing an oxygen cannula connected to an oxygen tank with the dial set to five liters. During an interview on 3/5/25 at 2:52 p.m., registered nurse (RN)-M stated they check oxygen saturation levels every shift for R21, and at that time they should be checking the liter flow and taking a look at the person to see how they are doing. RN-M confirmed the oxygen liter flow for R21 was 3.5 liters, and then went to R21's room and confirmed the dial on the oxygen tank was set to five. RN-M adjusted the oxygen from five down to 3.5, R21's oxygen saturation level was 96%. RN-M explained the risk for R21 having his oxygen too high could be retaining too much carbon dioxide. During an interview on 3/7/25 at 11:53 a.m., the director of nursing (DON) would expect the liter flow for oxygen was correct when nurses were checking the oxygen saturation level of a resident. The DON stated for R21 this would be important because he had COPD and he could become over-oxygenated. 49878 R204's quarterly Minimum Data Set (MDS) identified resident as being cognitively intact with diagnoses that included acute respiratory failure with hypoxia (low levels of oxygen in the body), history of throat cancer, chronic obstructive pulmonary disease (lung condition caused by damage to the airways and alveoli of the lungs), moderate protein-calorie malnutrition, emphysema, muscle weakness, and anxiety. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/4/25 at 8:28 a.m., R204's room had an oxygen concentrator with connected tubing and a portable oxygen container. Tubing connected to the oxygen concentrator had a date of 12/30 taped onto it. R204 reported he does need oxygen at times but not very often. Upon record review, R204's orders did not contain any current orders for oxygen administration. R204's discontinued orders identified an order started on 10/21/24 and discontinued on 1/22/25 for resident to be given oxygen at 2-3 liters per minute (LPM) via T-piece (section of tubing in the shape of a T). During interview on 3/6/24 at 2:24 p.m., licensed practical nurse (LPN)-C verified R204 had oxygen concentrator and portable oxygen in his room. LPN-C indicated R204 does use oxygen but not everyday. LPN-C confirmed there was no active order for oxygen administration in R204's chart. During interview on 3/6/24 at 2:37 p.m., registered nurse (RN)-H verified R204 had an oxygen concentrator and portable oxygen in his room. RN-H confirmed R204 would use oxygen as needed. RN-H verified R204's medical record did not contain an active order for oxygen administration. During joint interview on 3/7/24 at 9:51 a.m., director of nursing (DON) and assistant administrator (AA) identified expectation for staff to follow provider orders. DON explained provider orders should be followed in order for the provider and the staff to properly monitor administration and effectiveness of medication or treatment. Oxygen Administration policy dated 10/2024, identified the purpose was to provide guidelines for safe oxygen administration. Policy indicated the first step was to verify that there is a physicians's order, and ensure the proper flow of oxygen is being administered.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based in observation, interview and document review the facility failed to assess a resident for potential trauma, who was found to have vulvar lesions and under went a Sexual Assault Nurse Examiner exam, in order to implement any potential interventions to ensure R42 was safe and did not have lasting negative effects for 1 of 1 resident (R42) reviewed for trauma informed care. Findings include: R42's quarterly Minimum Data Set (MDS) dated [DATE], indicated R42 had severe cognitive impairment, significant weight loss, lower and upper extremity impairment to one side and required substantial to maximum assistance with toileting and bathing. The MDS further indicated R42 had been admitted to the care facility on 4/1/15. R42's progress note dated 12/25/24, indicated R42 was found unresponsive in her room and was transferred to the hospital. R42's progress note dated 1/10/25, indicated R42 arrived back to the facility via stretcher. R42's hospital discharge summary, dated 1/10/25, indicated R10 was hospitalized from 12/25/24 - 1/10/25 due to a stroke with right sided weakness. R42 was found to have urine retention when admitted to the hospital, when the hospital nurse was catheterizing R42, R42 was noted to have several vulvar lacerations. R42 was evaluated by the Hennepin Assault Response Team and a forensic SANE (sexual assault nurse examiner) exam was completed. The hospital note indicated R42's family member (FM)-E was understandably upset that R42 to return to the care facility but agreed after not being able to find another care facility as long as several safeguards were put in place. The hospital social worker spoke with the clinical director of business (CDB) at the facility regarding the situation who stated R42 was welcome back to the care facility and due to barriers of finding new placement R42 would return the care facility with safeguards in place. R42's orders list dated 1/30/25, indicated an order for cares in pairs. R42's electronic medical record (EMR), including the care plan, Kardex, care conference note, and assessments lacked any indicated of a trauma assessment and, if needed, any updated interventions other than cares in pairs to ensure R42 was safe and did not have any lasting negative effects of triggers from the potential sexual assault and sexual assault examination. The EMR further lacked any mention of R42's stroke, vulvar lesions, and potential trauma from the resulting examinations. During an interview on 3/6/25 at 11:24 a.m., FM-E stated she had checked in with the facility multiple times since R42 returned from the hospital and was discouraged that the staff didn't even know anything about R42's potential sexual assault and the exam she was subjected to, stating communication at the facility regarding the situation was just horrible. FM-E stated R42 was more responsive when she first returned from the hospital and seemed more isolated and nonverbal as time went on, stating she (FM-E) could tell it was traumatic for her (R42). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 10:50 a.m., licensed practical nurse (LPN)-H stated he was aware of the sexual assault allegation and that R42 was cares in pairs and generally he only interacted with R42 to give her medications. During an interview on 3/6/25 at 12:10 p.m., nurse manager and registered nurse (RN)-F confirmed there was nothing on R42's care plan regarding the potential for continued trauma due to the labial tears and SANE assessment R42 went through, stating R42 was offered a visit by the Associated Clinic of Psychology (ACP) but refused, and R42 was able to communicate with yes or no answers only since her stroke. RN-F stated she was not sure if R42 was ever assessed for residual trauma as that was something the social worker would have done but that with cares in pairs there was an extra set of eyes on her [R42]. During an interview on 3/6/24 at 12:29 p.m., the social worker (SW)-C stated she did not find out about the allegation of sexual assault and resulting SANE assessment until R42's care conference on 1/30/25. SW-C stated she had offered ACP to R42 however was unable to provide documentation and R42's care conference note lacked any documentation of a conversation with R42 and FM-E regarding the allegations and any resulting trauma. SW-C stated she did not do a trauma assessment with R42 because R42 did not acknowledge what had happened. SW-C stated generally if a resident had allegations of sexual assault resulting in a SANE assessment, it would trigger a trauma assessment, and she would be reaching out to the provider to have ACP go in for their own assessment. However, SW-C didn't want to cause more trauma as she did not believe R42 had been phased by what had happened. During an interview on 3/6/25 at 1:00 p.m., CDB stated she was aware of the allegation of sexual assault and that the allegation was unsubstantiated against the facility. The CDB stated she was aware that FM-E was apprehensive about R42 returning to the facility due to the potential sexual assault and that FM-E wanted safeguards put in place for R42 when she returned to the facility. The CDB stated the admission coordinator at that time would have been responsible for communicating that information to the floor staff. During an interview on 3/7/25 at 10:49 a.m., the director of nursing (DON) stated after the facility's own internal investigation they believed the vulvar lesions to perhaps be self-inflicted and not from a sexual assault, however stated she would believe the SANE assessment to be potentialy traumatizing for someone, along with any potential trauma from having a stroke and not being able to fully communicate. The DON stated she was aware FM-E did not want R42 to return to the care facility, stating the facility could have done better by her [R42] by completing a more comprehensive assessment for R42 upon her return from the hospital. A facility policy titled Clinical Protocol: Trauma-Informed Care, revised 10/22, indicated that residents would be assessed upon admission, quarterly and with a change in condition to determine if they may have new or existing trauma or post traumatic stress disorder.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42587 Based on observation, interview, and document review, the facility failed to ensure the emergency kits were tracked to prevent potential theft and diversion of medications. This had the potential to affect all residents residing on the nursing unit. Findings include: During a tour on 3/5/25 at 11:48 a.m., with registered nurse (RN)-E of the medication room for the 500 wing the refrigerator had an insulin kit with lorazepam (a benzodiazepine [controlled substance] medication used to treat anxiety) one bottle 2 milligrams per milliliter (mg/ml). RN-E verified the kit was not part of the narcotic count at the change of shift and the box was not secured in the refrigerator. On 3/7/25 at 8:41 a.m., the director of nursing (DON) stated the emergency kit with insulin and lorazepam did not need to be counted at the shift change because the kit was secured with a green tab that only pharmacy could replace. The DON did however, state when the narcotic count was done staff should have been laying eyes on the box because it wasn't secured in the refrigerator. The facility policy Controlled Substances dated 10/2024, identified Controlled substances must be stored in the medication cart in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. If permitted by law, and in accordance with state regulations, the community may store some controlled medications in an emergency medication supply. A reconciliation record will be maintained. In addition, Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the director of Nursing Services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on interview and document review the facility failed to ensure pharmacy consultant recommendations were followed up on in a timely manner for 2 of 5 residents (R183, R204) reviewed for medication management. Finding included: R183's quarterly Minimum Data Set (MDS) dated [DATE], identified R183 had intact cognition. R13's diagnoses included hypertension, renal failure, diabetes mellitus, and depression. R183's consultant pharmacist's medication review reports (CPMR) included the following: - 1/29/25, identified the same recommendation as the one on 9/26/24, because no action was taken. The CPMR was not addressed and signed off until 3/6/25. - 10/22/24, indicated R183 took Aripiprazole (mental health medication) and Reglan (medication for stomach) which could cause involuntary movements of various parts of the body and lacked an Abnormal Involuntary Movement Scale (AIMS) (assessment to monitor for involuntary movements of the body) had not been documented in the previous 6 months. This CPMR was not addressed until 3/6/25, when the surveyor brought attention to the facility R183's medical record lacked an AIMS assessment. - 9/26/24, indicated R183 received aspirin daily in the morning and was on dialysis. The clearance of aspirin low dose increased with hemodialysis to the point supplemental dosing or adjustment to the administration time may be necessary. Recommendations was to consider adjusting the of administration of aspirin to the evening/after dialysis. This CPMR was not addressed or signed off as addressed. During a telephone interview on 3/7/25 at 10:18 a.m., the consulting pharmacist (CP) stated the resident's medications are reviewed monthly and any irregularities or recommendations are to be sent to the facility to be addressed by the director of nursing (DON) or the medical director. The expectations were that it would be done within 30 to 60 days. During an interview on 3/7/25 at 10:27 a.m., the director of nursing (DON) stated all pharmacy reviews were sent to the assistant director of nursing. The reviews were then given to the unit nurse managers to either be addressed by nursing or given to the provider to be addressed. After being addressed, the completed CPMR would be signed off by the director of nursing. The expectation was all CPMR's would be addressed within a week of receiving or on the providers next rounding day. The DON did confirm R183's CPMR's had not been completed until 3/6/25. 49878 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R204's quarterly Minimum Data Set (MDS) identified resident as being cognitively intact with diagnoses that included acute respiratory failure with hypoxia (low levels of oxygen in the body), history of throat cancer, chronic obstructive pulmonary disease (lung condition caused by damage to the airways and alveoli of the lungs), moderate protein-calorie malnutrition, emphysema, muscle weakness, and anxiety. R204's medication orders included orders for aripiprazole (antipsychotic medication) to be given enterally (via tube into the digestive system) once a day for depression. This order began on 10/21/24, was discontinued on 2/18/25, and reordered on 2/19/25. R204's consultation report dated 1/23/25, identified R204's medication regimen had been reviewed by CP with irregularities found with the order for aripiprazole. CP recommendation included please make sure monitoring is in place: -specific target behaviors, - documentation of the frequency and impact of behaviors, -non-pharmalogical interventions and their outcomes, -potential adverse events and associated monitoring. There was no response from the provider noted. During interview on 3/7/25 at 10:09 a.m., CP explained she would look at medications for each resident every month. CP reported looking at medications, monitoring, lab work, medical notes, and vital signs from resident's medical record. CP further explained any recommendations would be emailed to the facility, with the DON and assistant director of nursing (ADON) get the report monthly. CP identified checking previous month's recommendations and would resend recommendations if no provider response within 60 days. CP identified the importance of monitoring any medication for side effects. During joint interview on 3/7/25 at 9:52 a.m., DON and assistant administrator (AA) stated expectation that pharmacy reviews were done monthly and they were important part of resident's care. DON explained pharmacy medication reviews were helpful to ensure residents were getting medications correctly and providers aware of potential problems from the medications. DON stated expectation for providers to review recommendations from pharmacy consultant and to respond with their acceptance or declination of the recommendation. The facility's Drug Regimen Review policy was not provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure a scheduled antifungal medication without an end date was evaluated for the appropriateness of its continued use for 1 of 6 residents (R129) reviewed for unnecessary medications. Findings include: R129's quarterly Minimum Data Set (MDS) dated [DATE], indicated R129 had severely impaired cognition and was dependent on staff for their activities of daily living (ADLs). R129's Order Summary Report dated 1/20/25, indicated R129 had an order starting on 4/2/24 with no end date for nystatin (an antifungal medication) powder application to the groin two times a day for a rash. R129's Medication Administration Report (MAR) dated 1/1/25-3/3/25, indicated R129 had received twice daily applications of nystatin powder during this period. R129's Weekly Skin Evaluation dated 2/14/25, included a section where staff could check any of the following skin conditions: skin intact, dry, rash, plaques, callouses, redness, skin tears, blisters, open areas, and other. The evaluation had skin intact checked and did not indicate a rash was present. R129's Weekly Skin Evaluation dated 2/18/25, included a section where staff could check any of the following skin conditions: skin intact, dry, rash, plaques, callouses, redness, skin tears, blisters, open areas, and other. The evaluation had skin intact checked and did not indicate a rash was present. R129's Weekly Skin Evaluation dated 2/25/25, included a section where staff could check any of the following skin conditions: skin intact, dry, rash, plaques, callouses, redness, skin tears, blisters, open areas, and other. The evaluation had skin intact checked, as well as redness. The evaluation did not indicate where this redness was located. The evaluation did not indicate a rash was present. R129's Weekly Skin Evaluation dated 3/4/25, included a section where staff could check any of the following skin conditions: skin intact, dry, rash, plaques, callouses, redness, skin tears, blisters, open areas, and other. The evaluation had skin intact checked with the comment, no skin issues at this time. The evaluation did not indicate a rash was present. During an interview on 3/4/25 at 2:47 p.m., registered nurse (RN)-V confirmed she was in charge of applying R129's nystatin powder and R129 did not have any redness or a rash currently. RN-V stated she was unsure about the last time R129 had a rash. RN-V stated she had still applied the Nystatin powder to R129's groin to keep the skin dry but acknowledged rash it was ordered for was now gone. During an interview and observation on 3/6/25 at 7:53 a.m., the nursing assistant (NA)-G was observed completing personal cares for R129 and confirmed he did not have any redness in his groin. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:47 a.m., RN-J, the nurse manager, stated she would expect the nursing staff to either let her know or notify the provider directly if the rash the nystatin powder was ordered for was gone, so the order could be discontinued. During an interview on 3/7/25 at 9:06 a.m., the infection preventionist (IP) stated if the condition an antifungal was written for had gone away, she would expect the nurse to notify the provider, so they do not give any unnecessary medications or cause the medication to become less effective for the resident. During an interview on 3/7/25 at 10:15 a.m., the consulting pharmacist (CP) stated if the rash had resolved, the facility could discontinue the medication as although the risk was low, there were risks of long-term use of antifungal use. The facility's Infection Prevention and Control Program policy dated 8/24, was received but did not include the process of antimicrobial monitoring.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review the facility failed to ensure insulin pens were dated when opened and dated with an expiration date for 13 residents (R4, R92, R166, R105, R114, R202, R85, R101, R196, R189, R206, R720, R462) and outdated medications were removed and disposed of properly in 8 of 10 medication carts. In addition, the facility failed to ensure supplies were not outdated, discharged resident medications were properly disposed of for (R721, R722), and medication temperatures were within safe temperature ranges for 8 residents (R2, R29, R71, R30, R91, R92, R109, R149), in 4 of 5 medication rooms. This deficient practice had the potential to affect residents receiving medications from these medication carts and medication rooms. Findings include: During a tour on [DATE] at 2:06 p.m., with registered nurse (RN)-G at the 3 North medication cart, an aspart insulin pen (rapid-acting insulin used to treat type 1 and type 2 diabetes) for R4 with an open date of [DATE], and no expiration date. Humalog insulin (rapid-acting insulin) pen for R92 with an open date of [DATE], and a Lantus insulin (long-acting insulin) pen for R166 with an open date of [DATE], and an aspart insulin pen with an open date of [DATE]. The insulin pens did not have an expiration date. RN-G pointed to the manufacturer's expiration date and stated the insulin pens would be okay to use until that date. During a tour on [DATE] at 2:29 p.m., with licensed practical nurse (LPN)-D at the medication cart on the memory care unit, R105 had a glargine insulin (long-acting insulin) pen dated as opened on [DATE], and no expiration date. R114 had a Humalog insulin pen with an open date of [DATE]. LPN-D pointed to the manufacturer's expiration date and stated the pens would be okay to use until that date. During a tour on [DATE] at 2:55 p.m., with LPN-E at the 2 South medication cart a glargine insulin pen for R202 with an open date of [DATE], and no expiration date. R202 also had a lispro insulin (rapid-acting insulin) pen with an open date of [DATE], and no expiration date. LPN-E stated all insulin pens were good for 27 days after opening. RN-I stated there should have been a list on top of the cart that identified how many days after opening an insulin pen could be used. RN-I looked for the reference, it was not on the cart. During a tour on [DATE] at 3:04 p.m., with RN-E at the 300 medication cart A an aspart insulin pen for R85 had an open date of [DATE], and for R101 a Lantus insulin pen opened on [DATE], neither pen was dated for expiration. During a tour on [DATE] at 3:16 p.m., with RN-K at the 100 medication cart A insulin pens aspart and Lantus for R196 had open dates of [DATE], and no dates for expiration. R189 glargine insulin pen was dated as opened on [DATE], and aspart insulin pen was dated as opened on [DATE]. RN-K stated all insulin pens were good for 30 days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a tour on [DATE] at 10:59 a.m., with RN-B at medication cart 2 North a stock bottle of famotidine (used to treat ulcers, gastroesophageal reflux and conditions that cause excess stomach acid) with an expiration date of ,d+[DATE]. RN-B stated the nurse managers were responsible for checking the medication carts for outdated medications and verified the medication was expired. During a tour on [DATE] at 11:39 a.m., with RN-E at the 500 medication cart a bottle of Novolin insulin (intermediate-acting insulin) for R206 was in the cart. The bottle was open and did not have open or expiration dates. During a tour on [DATE] at 11:57 a.m., with RN-D at the ,d+[DATE] medication cart aspart insulin, Novolog (rapid-acting insulin), and Lantus insulin pens were in the medication cart. RN-D verified the insulin pens were not dated with open and expiration dates. R720 (who was no longer a current resident) had a glargine insulin pen also with no open or expiration dates. In addition, the medication cart had two bottles of Geri-Dryl (stock medication [diphenhyrdramine] used to treat pain and itching) with an expiration date of ,d+[DATE]. RN-D verified the medication was expired and that insulin pens needed an open date and an expiration date. A review of Omnicare Storage Recommendations for Injectable Diabetes Medications dated 2023, revealed the following: Storage at room temperature after opening Insulin Aspart - 28 days Humalog pen - 28 days Lantus pen - 28 days Insulin Lispro pen - 28 days Novolin (R, N, ,d+[DATE]) - 42 days Novolog - 28 days During a tour on [DATE] at 10:59 a.m., with RN-J of the medication room covering rooms ,d+[DATE], RN-J stated all insulin pens should be dated with the open date and the expiration date as per the policy. RN-J stated the medication room had been in use for about one year. Five intravenous connectors for R721 were in bins and were dated as expired on [DATE], approximately 10 intravenous caps for R721 expired on [DATE], and one intravenous administration set expired on [DATE] was also in the medication room. R721 had been admitted on [DATE] and discharged on [DATE]. For R722, seven heparin flushes with an expiration date of [DATE], remained in the medication room. R722 had been admitted on [DATE] and discharged on [DATE]. During a tour on [DATE] at 12:50 a.m., with trained medication aide (TMA)-B in the 2 North medication room an open box of lubrication jelly packets had an expiration date of [DATE], an open box of cotton tip applicators had an expiration date of [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a tour on [DATE] at 2:32 p.m., with LPN-C in the 3 North medication room the refrigerator temperature was at 22 degrees Fahrenheit. LPN-C verified the temperature reading. A review of the past three months of temperatures revealed the following dates with temperatures outside of the ,d+[DATE] degree range on the temperature monitoring sheet: March- (1, 6) lowest temperature reading was 22 degrees F on [DATE] at 2:32 p.m., verified by LPN-C. February- (1, 2, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 24, 26, 27, 28, 29) lowest temperature reading was 30 degrees F. January - (1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 16, 17, 18, 20, 21, 22, 23, 26, 27, 28, 29, 30) lowest temperature reading was 30 degrees F. RN-H was present and stated the temperature in the refrigerator should be around 40 degrees F. RN-H verified temperatures that were too cold could to lead to the medication not being viable. The Refrigerator/Freezer Temperature Log identified the refrigerator temperature range was ,d+[DATE] degrees F. An inventory of the refrigerator revealed the following along with the Omnicare Medication Storage Guidance dated 2023: R2 one bottle of acetylcysteine inhalation solution 20% - no information R29 two bottles of lantanoprost ophthalmic solution 0.005% - store in the refrigerator at 36 - 46 degrees F until ready to use. R71 two bottles of lantanoprost ophthalmic solution 0.005% - store in the refrigerator at 36 - 46 degrees F until ready to use. R30 two bottles of lorazepam solutions 2 mg/ml - store in the refrigerator at 36 - 46 degrees F. Protect from light. R91 two Novolog insulin pens - store in the refrigerator at 36- 46 degrees F unopened. R92 one Lantus insulin pen and two Ozempic pens - store in the refrigerator at 36- 46 degrees F unopened. R109 one insulin aspart pen - store in the refrigerator at 36- 46 degrees F unopened. R149 one Dupixent pen - no information. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:41 a.m., the director of nursing (DON) stated insulin pens should be dated when opened and the expiration date should be on the pen as well. The DON stated some insulins expire at different number of days after opening. The DON stated checking medication carts and medication rooms for expired medication should be a collaborative effort with purchasing, the nurse manager and the night shift staff on the unit. The DON stated if staff find the medication refrigerator out of the temperature range she would expect them to fill out a slip for maintenance so the refrigerator could be fixed. The DON stated refrigerators needed to be kept in a certain range to keep medications viable. The DON stated when a resident is discharged their medications and supplies should have been sent with them, returned to pharmacy or destroyed depending on their payer source. On [DATE] at 10:23 a.m., the consultant pharmacist (CP)-E stated they did periodic spot checks of the medication rooms and the medication carts. CP-E stated it was her expectation as well, that the facility would also be checking for outdated medications and supplies. CP-E stated when staff open an insulin pen they could refer to the chart to see how many days after opening the insulin pen would expire. CP-E stated if a medication refrigerator was out of the safe temperature range she would expect them to follow their facility policy to correct the temperature. CP-E stated if after a few days the refrigerator remained out of the temperature range she would expect them to contact the pharmacy to see if the medications were still viable for use. CP-E stated medications left after a resident was discharged should have been sent home or destroyed properly based on the payer type. CP-E stated she would not expect to find medications from residents discharged several months ago or from 2021. The facility policy Storage of Medications dated ,d+[DATE], identified The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. The policy did not address labeling insulin pens for an open and expiration date. The policy identified Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. The policy did not address medication refrigerator temperatures. The facility policy Controlled Substances dated ,d+[DATE], identified the facility would comply with all laws, regulation, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) and/or standard precautions were followed to reduce the risk of infection to others for 2 of 3 residents (R611, R612) reviewed for EBP during tracheal care. In addition, the facility failed to ensure infection control practices were followed regarding tracheal suctioning for 1 of 3 (R612) reviewed for tracheal care. The facility also failed to ensure proper hand sanitization occured during cares for 1 of 3 residents (R97) standard precautions. Also, the facility failed to follow clean procedures when administering tube feedings for 1 of 2 residents (R90) reviewerd for tube feedings. The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during high contact resident care activities. The article indicated high-contact activities include changing linens, bathing, dressing, tracheostomy (surgical hole in the windpipe) care, etc. The article indicated EBP should be implemented (when contact precautions did not apply) for residents with indwelling medical devices (central lines, urinary catheter, tracheostomy) regardless of MDRO colonization status. The CDC article titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes dated 7/28/24, indicated that when residents require EBP, standard precautions still apply including utilizing face protection when splashes and sprays are likely (e.g., wound irrigation, tracheostomy care). R611: R611's admission MDS dated [DATE], indicated R611 had intact cognition and was diagnosed with respiratory failure. The MDS indicated that R611 received oxygen therapy, suctioning, and tracheostomy care. R611's Administration Record dated 3/1/25, indicated R611 had a tracheostomy, tracheal suctioning could be completed as needed, and R611 was on EBP related to an indwelling medical device. During observation and interview on 3/4/25 at 9:31 a.m., R611 was observed lying in bed as respiratory therapist (RT)-A inserted a suction catheter into R611's tracheostomy tube. RT-A was observed wearing a mask and gloves but no gown or eye protection. RT-A confirmed that she had suctioned R611's tracheostomy and when asked about any additional PPE needs, stated she was moving fast and didn't get to applying any additional PPE although she should have. R612: R612's entry tracking record indicated R612 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/5/25 at 2:56 p.m., nursing assistant (NA-I) and registered nurse (RN-C) donned PPE and informed R197 they were going to transfer R97 to bed for a brief change. R197 was moved to the bed. Both RN-C and NA-I removed their gloves and without sanitizing hands put on new gloves. NA-I proceeded to use wipes to clean R197's peri area and then NA-I removed R97's old brief. NA-I removed their gloves, brought a box of gloves to the bedside and without sanitizing hands, NA-I put on new gloves while RN-C held R97 on their side. NA-I then placed a clean brief under R97 and R97 was laid flat. RN-C removed their gloves and put on a new pair without sanitizing hands. R97's brief was secured, and a new pad was replaced on R97's bed. RN-C and NA-I removed their gloves and put on new gloves without sanitizing hands and proceeded to transfer R97 back to the chair with the mechanical lift. NA- I and RN-C removed their gown and gloves and left the room. RN-C returned with portable hand sanitizer and sanitized hands upon entering the room. NA-I returned to the room sanitized hands and moved R97's bedside table and water next to R97. Once out of the room NA-I wiped down the mechanical lift with sanitizing wipes. During a follow-up interview on 3/5/25 at 3:17 p.m., with NA-I and RN-C both identified they should have been sanitizing their hands every time they took off a set of gloves before they put a new pair on. NA-I stated they had been in the middle of cares when they noticed there wasn't any hand sanitizer in the room and had decided to finish the cares. RN-C stated in retrospect they should have stopped and got hand sanitizer so they could sanitize their hands between glove changes. For infection control it was very essential for hand sanitization between glove changes because there could be unseen organisms present that could cause contamination when going from dirty to clean. NA-I agreed it was important to sanitize hands before and after glove changes to prevent infections and contamination. The facility policy Infection Prevention and Control Program F 880 dated 8/2024, indicated the facility would follow accepted national standards and components of the program would include hand hygiene. 42587 R90: R90's quarterly Minimum Data Set (MDS) dated [DATE], identified R90 had diagnoses which included intestinal malabsorption (a condition that prevents absorption of nutrients through the small intestine), gastrostomy tube status (a flexible, hollow tub inserted through the abdominal wall and into the stomach), malnutrition, diabetes mellitus, anxiety, and depression. R90 was cognitively intact and independent with activities of daily living. R90's Order Summary Report dated 3/7/25, identified R90 had orders that included the following: ProStat SF Liquid one time a day for meeting protein needs for malnutrition. Provide via G-tube. Enteral Feed Orders: -every night shift change irrigation syringe/bottle, and feeding set up daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-every night shift site care: clean tube site with warm water and soap, pat dry, apply a dressing if drainage is present, observe for signs and symptoms of infection, for example redness, odor, drainage. Notify the primary care provider if needed. -every shift elevate head of bed at least 30-45 degrees (semi or high-Fowler's position, if tolerated by the residents physical or medical condition) during and for one hour after feeding/medications. -every shift verify patency and placement prior to feeding/medications. Aspirate small amount of stomach contents to check pH, reading must be less than five. -four times a day water flush via G-tube, 30 milliliters (ml) before and after each feed providing 240 ml daily. -one time a day check residual prior to feeding/med. If residual is more than 200 ml or other specifically ordered amount, hold for one hour and recheck. If it still remains high, hold feeding and notify practitioner. -Hold tube feeding (TF) before and after with Synthroid administration at 6:00 a.m., in the morning for diet. -Please monitor left lower quadrant feeding site every shift for leakage. Every shift. -Jevity 1.5 cal/fiber oral liquid (nutritional supplements) give 350 ml via G-tube four times a day for intestinal malabsorption. R90's care plan dated 8/10/23, identified resident required tube feeding related to malabsorption disorder, malnutrition, roux en Y gastric bypass surgery (a type of surgery that involves creating a small stomach pouch and rerouting part of the small intestine) and need for PEG J placement (a surgical procedure used to insert a feeding tube into the stomach). Interventions included the following: -elevate the head of bed at least 30-45 degrees (semi or high-Fowlers position, if tolerated by the resident's physical or medical condition) during and for one hour after feeding/medications -provide and serve diet as ordered -provide tube feeding and water flushes ordered. See medical doctor (MD) orders for current feeding orders A review of R90's nurses notes did not identify the provider had been notified of any redness around the tube feeding site. On 3/4/25 at 8:39 a.m., in R90's room there was an open bottle of Jevity 1.5 with no date or time. There was also an open bottle of Glucerna (nutritional supplement) with no date or time (R90 did not have TF orders for Glucerna). A used TF bag was hanging with no date on the bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 12:17 p.m., R90 was lying in her bed, her graduate which contained a syringe was dated 3/5. The tube feeding bag was hanging on an intravenous (IV) pole, the bag was undated. A bottle of Jevity 1.5 had been opened and was dated 3/4/25, no time. On 3/5/25 at 2:10 p.m., registered nurse (RN)-B was preparing to administer R90's noon TF. R90 lifted the corner of her shirt a dressing was in place around the G-tube site, it had a brownish substance on the dressing. RN-B filled the graduate with water from the bathroom, placed a few paper towels on R90's room mate's overbed table setting the graduate on the paper towels (room mates juice from lunch was on the tray, RN-B did not clean the overbed table). RN-B checked for residual and tested the pH, flushed the G-tube with 30 ml of water. RN-B used the open Jevity 1.5 dated 3/4/25, but with no time noted on the bottle and poured 350 ml into the TF bag and adjusted the clamp for gravity flow. RN-B removed R90's dressing the site was red in about a one inch circle around the tube. RN-B cleansed the site with skin integrity wound cleanser, R90 winced with the cleaning and said it hurt. RN-B stated she would let the nurse practitioner know. RN-B put supplies away clearing them off of the room mate's overbed table but did not clean the table, the juice remained on the overbed table. RN-B removed her gloves, gown and washed her hands with soap and water. During an interview on 3/5/25 at 2:25 p.m., RN-B verified the Jevity 1.5 bottle was dated with 3/4/25, and had no time indicating when it had been opened. RN-B verified the Jevity 1.5 was good for 24 hours only. RN-B verified the overbed table she used was R90's room mate's and that she did not clean it before or after using it for the TF supplies. RN-B could not say how long R90's tube site had been red but thought it had only been a couple of days . On 3/5/25 at 2:39 p.m., R90 was not in her bed, the TF had been stopped and the end of the TF was hanging free. On 3/5/25 at 2:45 p.m., R90 was observed re-connecting her TF. During an interview on 3/5/25 at 2:49 p.m., R90's room mate stated they always used her table and never cleaned it. During an interview on 3/5/25 at 3:05 p.m., R90 stated the staff didn't typically throw the TF bag away after each use. R90 stated it usually hung for the day. During an interview on 3/5/25 at 3:20 p.m., RN- C verified R90 was not on Glucerna and was not sure why it would have been in her room. RN-C also verified TF bottles should have both the date and the time they were opened because they could only be used for 24 hours. RN-C verified staff should not be using the room mates overbed table for TF's for R90, and stated it was an infection control issue. RN-C verified the TF bag should be changed with each tube feeding. During an interview on 3/6/25 at 12:20 p.m., RN-G verified she had done a TF in the morning but did not change the graduate which was dated 3/5, stated nights should have done that. During an interview on 3/7/25 at 8:41 a.m., the director of nursing (DON) verified site care should be monitored at each TF and concerns reported to the provider. The DON verified staff should not be using the room mate's overbed table and the TF bottle should have a date and time it was opened to prevent use beyond 24 hours. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Gastric Feeding via Continuous Pump dated 5/2024, identified as part of preparation the physician order should be reviewed. In addition, the policy identified the overbed table should be cleaned after use and disposable equipment should be discarded. The policy identified any assessments or complications should be documented. The policy did not address dating and placing a time after opening tube feeding bottles.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 48109 Based on observation and interview, the facility failed to ensure a complete wireless call system in which staff were provided with functioning devices alerting them to call light activation in their possession. This had the potential to affect all 250 residents at the facility. Findings include: During an observation on 3/5/25 at 2:35 p.m., it was noted there were no call light indicators above the resident rooms on the East side in hallways 500, 600, or 700. At about the middle of each hall there were two scrolling kiosks of about two feet in length and five inches tall, suspended from the ceiling in facing opposite ways. The kiosk displayed the resident room and bed number of the resident who had activated their call light. During an interview on 3/5/25 at 2:45 p.m., nursing assistant (NA)-E stated she knew when a resident call light went off by the kiosk in the hallway. NA-E stated the NAs didn't carry a pager or anything that alerted her a call light had gone off. NA-E also stated they didn't carry any type of communication, if they were in a room with a resident and needed help, they either had to yell out the door or turn on the call light. NA-E provided the kiosk for this hall also showed the call lights on the 600 hallway, but they didn't show how long the light had been on. During an interview on 3/6/25 at 10:09 a.m., RN-F state there was no audible tone for the call lights, they had to watch the board (kiosk). There was a kiosk in the corner of the hall by the nurse's station, so they made sure someone was always at the station to watch for call lights. During an observation on 3/6/25 at 3:39 p.m., it was noted the second and third floors of the [NAME] building had scrolling kiosks at the ends and middle of the hallways, which displayed the room and bed number of the activated call light. During an interview on 3/6/25 at 3:51 p.m., registered nurse (RN)-R explained the marque alerts staff to the call lights, but there was no audible tone when activated. RN-R stated the managers carry a pager which will alert when a call light has gone on more than ten minutes, but the other staff didn't have pagers. RN-R added there used to be pagers with the call lights, but after their system crashed the pagers didn't work and the maintenance person who knew how to reprogram them no longer worked there. RN-R stated staff in a resident room wouldn't necessarily know another call light had gone on without being able to see the kiosk, they don't carry walkies or other way to communicate, so if staff in a room needed help with a resident, they could either open the door or put the call light on. If they were in a position where they couldn't leave the resident side, they would have to yell. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/7/25 at 8:42 a.m., the acting administrator (AA) stated the staff knew a call light had been activated by looking at the kiosk in the hallway. AA confirmed there was no audible tone when a call light activated. The AA also stated they did have pagers for the system but only the nurse managers carried those during the day and with the nurse supervisor in the afternoon and overnight. The AA explained there were enough staff on all shifts to see the kiosks, or to have the manager or supervisor alert staff to call lights going off, to have timely responses to call lights. During an interview on 3/7/25 at 10:07 a.m., the director of campus plant operations (DPO) stated his understanding of the call light system was when a button gets pushed it triggers to the kiosk. The kiosk displayed the room and bed with the call light activation, but there wasn't an audible tone when it activated. They had pagers at one point, but was not sure what happened to the pagers. The nurse managers have pagers but wasn't aware of how the pagers get programmed. They have some additional pagers, but has handed them off to an administrator previously. During an interview on 3/7/25 at 10:42 a.m., RN-N confirmed there was one nurse supervisor on afternoons and overnights and that person carried a call light pager which would alert when a call light had gone on longer than ten minutes. A call light policy and procedure were requested but not received.