STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R6, R49) who were observed to have medications in their rooms, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R6's facesheet printed on 1/28/25, included diagnoses of rheumatoid arthritis and dementia. R6's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R6 had moderately impaired cognition, clear speech, could understand and be understood. R6 required assistance of staff for most activities of daily living (ADL). R6 did not ambulate. R6's physician orders dated 10/28/24, included Voltaren (treats joint and muscle pain) external gel 1%. Apply 2 g (grams) to knees topically as needed for pain four times a day. Orders did not include authorization for self-administration of medication. R6's care plan dated 12/5/23, indicated R6 had pain in her knees related to arthritis and to administer pain medications per physician orders. The care plan did not include self-administration of medication. No assessment for safe self-administration of medication was noted in the electronic medical record (EMR). During an observation and interview on 1/27/25 at 3:39 p.m., observed a large tube of Voltaren, 3.53 ounces on bedside dresser on the vacant side of the room. R6 stated she did not put it on herself, adding They do sometimes. R49 R49's facesheet printed on 1/28/25, included diagnoses of stroke, type 1 diabetes and dementia. R49's quarterly MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R49 was independent with ADL's and ambulatory with a walker. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R49 physician orders dated 6/17/24, included glucose oral tablet chewable, give 4 gram by mouth as needed for low blood sugar. Give if blood sugar less than 70 mg (milligrams) wait 15 minutes, recheck blood sugar level. If still less than 70 take an additional 4 gm tablet. Repeat until blood sugar above 70. R49's orders did not include aspirin, iron or an order for self-administration of medications. R49's care plan dated 6/18/24, did not include self- administration of medication. No assessment for safe self-administration of medication was noted in the EMR. During an observation and interview on 1/27/25 at 1:52 p.m., observed the following medications in R49's room: --Chewable glucose tablets, three large bottles, 50 tablets in each bottle, observed on a bookcase --Aspirin 325 mg, one bottle of 500 tablets observed on the bedside dresser --Iron 65 mg, one bottle of 365 tablets observed on a tall dresser R49 stated he brought the medications from home, but didn't use them anymore. During an interview and observation on 1/28/25 at 11:30 a.m., along with the director of nursing (DON) went to R6 and R49's rooms. In R6's room, the Voltaren had been moved to the bedside table next to R6's bed. The DON removed it, stating it could not be left in R6's room unless she had a self-administration order and didn't think she did. In R49's room, and with R49's permission observed the aspirin and iron bottles had been moved to the top drawer of his bedside dresser. The glucose tablets remained on the bookcase. The DON stated R49 did not have a self- administration order and the medications should not be in his room. The DON did not know why staff had not observed the medications that were in plain sight -- adding they should have caught that. During an interview on 1/29/25 at 7:43 a.m., licensed practical nurse (LPN)-A stated a resident couldn't have medications in their room without a self- administration order and it also needed to be care planned. LPN-A stated she was not aware R6 had a tube of Voltaren in her room -- she had not seen that. LPN-A stated R49 did have an order for self-administration of glucose tablets - she had personally sent a message to the provider to request it. LPN-A looked in the EMR and acknowledged there was no order, nor was it care planned. The facility Medication Self-Administration policy dated 6/1/17, indicated residents were not permitted to administer or retain any medication in his or her room unless their attending physician wrote an order for self-administration of the medication and resident was assessed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to notify resident representatives following falls with subsequent transfer to the hospital for 2 of 2 residents (R20, R164) reviewed for falls. Findings include: R20's facesheet printed on 1/29/25, included diagnoses of chronic kidney disease with heart failure, dependence on renal dialysis, recent femur fracture, morbid obesity and diabetes. R20's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 was independent with some activities of daily living (ADL) including eating, toileting, and self-propelling in her wheelchair. R20 was dependent upon staff for dressing, showering and transferring in and out of bed. R20's care plan dated 3/25/18, indicated a history of falls. Care plan dated 12/28/24, indicated R20 had pain and impaired mobility related to recent femur fracture with surgical repair. During an interview on 1/27/25 at 5:12 p.m., R20 stated on 12/28/24, she was standing in the bathroom when her knees gave out, causing her to fall and fracture her left femur. Incident report dated 12/28/24 at 7:07 p.m., for R20's unwitnessed fall, under a heading titled: Agencies / People Notified -- indicated a statement: No notifications found. A progress note dated 12/28/24 at 9:52 p.m., indicated R20 was found on the floor in her room with left knee and calf shifted laterally. Paramedics were called; R20 was inconsolable. R20 left the facility around 7:30 p.m. , and the director of nursing and nurse manager were notified. A progress note dated 12/28/2024, at 10:48 p.m., indicated family member (FM)-A called the facility to inform them R20 would be admitted to the hospital and taken to surgery the next morning to reduce a fracture of her left femur. FM-A expressed dissatisfaction and was upset no staff had called to notify her of the fall and transfer to the emergency department (ED). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/28/25 at 3:11 p.m., FM-A stated she found out about R20's fall and subsequent transfer to the ED when R20 called her from the ED. FM-A stated she was R20's emergency contact and the facility had been informed previously to notify FM-A if R20 was sent to the ED --- which R20 had requested too. FM-A stated the fall happened around 6:30 p.m. on 12/28/24, and R20 was not able to contact her until between 8:30 p.m., and 9:00 p.m. FM-A stated she worried for R20 being alone because R20 liked her to be present to ask questions and give her opinion. FM-A stated she talked to the administrator about it and voiced her concerns. FM-A stated the administrator informed her that R20 was her own person and FM-A didn't need to be notified. FM-A stated she informed the administrator that she was listed as R20's emergency contact and the administrator told her she didn't see that listed in R20's care plan. FM-A then spoke to the business office manager (BOM)-D who was very apologetic and found right away that FM-A was listed as R20's emergency contact on R20's facesheet. During an interview on 1/29/25 at 10:57 a.m., the administrator stated she went to see R20 in the hospital and R20 told her FM-A was upset she wasn't notified when R20 was transferred to the hospital on 12/28/24. The administrator then called FM-A and told her R20 was her own person, and therefore it would have been up to R20 to notify FM-A. The administrator acknowledged FM-A was listed as R20's emergency contact on R20's facesheet in the electronic medical record (EMR). Administrator was aware facility policy indicated to notify the resident representative when there was an accident involving injury to a resident. During an interview on 1/29/25 at 11:22 a.m., R20 stated before she left the facility to go to the hospital on 12/28/24, she told staff to call FM-A, but they did not. R20 stated she contacted FM-A from the hospital, who then came right away. R20 stated she looked to FM-A when she went to the hospital to help speak on her behalf. During an interview on 1/29/25 at 11:34 a.m. the director of nursing (DON) stated she was aware FM-A had not been notified of R20's fall and subsequent transfer to the hospital on 12/28/24. The DON stated R20 was her own person so R20 would need to contact FM-A herself. The DON admitted R20 was not likely in a position to contact FM-A herself as she had fractured her femur and according to the staff was in considerable pain. R164's facesheet printed on 1/29/25, included diagnoses of post-op orthopedic after care for neck surgery, mild cognitive impairment, and lack of coordination. R164's admission MDS assessment dated [DATE], indicated R164 had moderately impaired cognition, clear speech, usually understood and could usually understand. R164 needed assistance with ADLs and did not walk. He had two or more falls since admission. R164's care plan dated 1/22/25, indicated risk of falls due to impaired mobility. During an interview on 1/27/25 at 4:31 p.m., FM-B stated R164 had two falls that she was aware of since admission on 1/21/25. FM-B stated after the second fall (she wasn't sure of the date), R164 had been sent to the ED. FM-B stated no one from the facility contacted her to inform her he had fallen and was being sent to the ED. FM-B stated the first she knew about it was when the ED called her and by that time he had already been returned to the facility. FM-B was worried about R164 being by himself at the hospital because he is not able to communicate well and had been experiencing confusion. FM-B stated she lived close by and could have gone to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes in the EMR and/or indecent reports indicated R164 had three falls since admission: 1. 1/22/25 2. 1/24/25, and R164 was sent to the ED. A progress note at the time of the transfer indicated: notified the situation to resident's family. 3. 1/26/25, and R164 was sent to the ED. A progress note at the time of the transfer did not indicate FM-B was notified. The incident report for this fall indicated: emergency contact was called; not currently answering; nurse will attempt to contact them again. During an interview on 1/29/25 at 11:52 a.m., the DON was informed of FM-B's concern about not being informed of R164's fall with transfer to the ED on 1/26/25. The DON was informed the incident report indicated there was an attempt to contact FM-B, but there was no answer. The DON stated, it's not one and done -- staff need to attempt again and/or ask the next shift to try. The facility Change in Condition policy with revised date of 10/10/24, indicated a facility would immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Notify resident's family/responsible party as applicable and in accordance with resident's wishes. Documentation should include notification of responsible party - include date, time, what was conveyed, any comments (each time notified).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview and document review, the facility failed to complete a baseline care plan for 1 of 2 residents (R164) reviewed who was newly admitted to the facility. Findings include: R164's facesheet printed on 1/29/25, indicated R164 had been admitted on [DATE]; diagnoses included post-op orthopedic after-care for neck surgery. R164's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R164 had moderate impaired cognition, clear speech, was usually understood and could usually understand. R164 needed assistance with ADLs and did not walk independently. During an interview on 1/27/25 at 4:29 p.m., family member (FM)-B stated neither she nor R164 had received a copy of a care plan after he was admitted on [DATE]. FM-B looked through a folder of all the paperwork she had received from the facility and a baseline care plan was not among them. During review of R164's electronic medical record (EMR), a baseline care plan was not found. During review of R164's paper chart, observed a two-page, carbonless form (a white and yellow copy) titled Baseline Care Plan Summary. R164's name and room number had been filled in by hand, but the rest of the form was blank. During an interview on 1/28/25 at 12:33 p.m., the director of nursing (DON) was provided with the carbonless form from R164's paper chart. The DON stated it was the correct form for documentation of a baseline care plan. The DON acknowledged it had R164's name and room number on it, that it was blank and therefore had not been completed. The DON stated she would have expected it to have been completed and a copy given to the resident and/or resident representative. The facility Comprehensive Care Plan policy with revised date of 9/23/22, did not include language about a baseline care plan to be developed and summary given to a residents and/or resident representative.

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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** 42073 Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan for 1 of 2 residents (R163) reviewed for urinary catheter. Findings include: R163's facesheet printed on 1/29/25, included a diagnoses of urinary retention. R163's discharge assessment/return anticipated Minimum Data Set (MDS) assessment dated [DATE], indicated R163 was dependent upon staff for most activities of daily living (ADL) and had an indwelling urinary catheter. R163's physician orders dated 1/27/25, indicated indwelling Foley catheter (drains urine from bladder). R163's care plan dated 1/27/25, did not include R163's urinary retention, use of an indwelling Foley catheter, leg bag, or urinary drainage bag. During an interview on 1/29/25 at 9:02 a.m., registered nurse (RN)-C who was also the MDS nurse stated she added focus areas to resident care plans, as did the nurse manager and director of nursing (DON). RN-C was informed R163's care plan did not include urinary retention or urinary catheter. RN-C looked in R163's electronic medical record (EMR) and confirmed it did not. RN-C stated she had just been in R163's record yesterday to update it and missed the urinary catheter. RN-C stated it was a mistake and she would correct it right away. During an interview on 1/29/25 at 11:43 a.m., the DON was informed R163's urinary retention and urinary catheter had not been care planned. The DON stated she expected it to be care planned so staff would know what cares to provide pertaining to R163's catheter, leg bag and urinary drainage bag. The facility Comprehensive Care Plan policy with revised date of 9/23/22, indicated it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that were identified in the residents comprehensive assessment. The comprehensive care plan would describe, at a minimum, services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. Staff responsible for carrying out interventions specified in the care plan would be notified of their roles and responsibilities for carrying out the interventions, initially and when changes were made.

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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** 40614 Based on observation, interview and document review, the facility failed to comprehensively assess and provide ongoing treatment for edema for 1 of 2 residents (R5) who required leg wraps to prevent and treat edema. Findings include: R5's face sheet printed 1/29/25, included diagnoses of pneumonia, urinary tract infection, Alzheimer's disease, traumatic arthropathy (inflammation of joint) left ankle and foot, and patent foramen ovale (flap-valve opening in the heart from right to left of the top two heart chambers which generally closes at birth, causing abnormal flow of blood). R5's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R5 understands and is understood, has moderately impaired cognition, requires moderate to substantial and maximal assist with transfers and walking and has impaired range of motion in both lower extremities. R5 has had multiple falls without major injury and takes anticoagulant, diuretic and opioid medications. R5's provider orders dated 10/21/24, included Right leg: Low stretch compression wraps from toes to knee. Left Leg: Low stretch compression wraps from toes to thigh, both one time a day for edema and remove per schedule. R5's plan of care dated 8/23/21, with revision on 11/10/24, included R5 had impaired cardiovascular status related to high blood pressure with interventions including elevate lower extremities as indicated, and Right Leg: Low stretch compression wraps from toes to knee. Left Leg: Low stretch compression wraps from toes to thigh. Apply in a.m., and remove at bedtime. Review of the electronic medical record (EMR) for January 2025 included right and left legs compression wraps were not applied 6 times due to resident sleeping, 3 times for other reasons/see progress notes, which were reviewed and lacked documentation as to why. R5 refused 10 times to have ace wraps applied. No reattempts were documented. During observation and interview on 1/27/25 at 3:39 p.m., R5 was in his wheelchair roaming the hallways asking where his shoes were. R5 had gripper socks on both feet and no compression wraps present on bilateral legs. R5 was unsure were he was and repeatedly asked for his socks and shoes and roamed into other residents rooms. During interview on 1/27/25 at 4:55 p.m. family member (FM)-D stated R5 should have both his legs ace wrapped daily due to swelling but it doesn't happen. FM-D indicated his left knee and ankle have had a lot more swelling due to previous injury, so the left leg is wrapped from the thigh down. FM-D added they (staff) are supposed to massage legs, put lotion on before applying wraps but I can see how dry his legs are so I know that isn't happening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 1/28/25 at 11:27 a.m., FM-D was at bedside. R5 was sitting in his wheelchair in his room with legs down and no ace wraps present. Swelling was present per FM-D and stated its getting worse. FM-D opened the bedside drawer and pointed at the ace wraps present and stated a request was made for one of the nursing assistants (NA) this morning to put them on and she indicated the nurse has to do that but not one has come to wrap his legs yet. During observation and interview on 1/28/25 at 1:49 p.m., R5 was lying in bed. No ace wraps were present on either leg. NA-C and NA-D stated they were unsure if R5 was supposed to have ace wraps on his legs as R5 just moved to floor yesterday. NA-C further added the NA role can put compression stockings on, but it is the nurses responsibility to do compression wraps or ace wraps. During interview on 1/28/25 at 2:28 p.m., registered nurse (RN)-D indicated R5 should have leg wraps applied in the morning and taken off at bedtime. RN-D indicated per charting, R5 refused them at 6:00 a.m. this morning. RN-D indicated especially on the memory care unit, staff should reproach a minimum of 3 times to attempt to provide cares like compression stockings that are ordered. RN-D was not aware R5 did not have his legs wrapped and indicated she just started her shift at 2:00 p.m. During interview on 1/28/25 at 2:30 p.m., licensed practical nurse (LPN)-B indicated she was not sure if R5 required ace wraps as he was new to the floor. LPN-B indicated NA's can apply ace wraps. During observation 1/28/25 at 3:45 p.m. R5 had his feet out of the bed, attempting to stand up at bedside. No ace wraps were present on lower legs. During observation 1/29/25 at 8:00 a.m., R5 was lying in his bed, awake attempting to get out of bed. No ace wraps were present on lower legs. During observation and interview on 1/29/25 at 8:28 a.m., NA- E and NA-C transferred R5 from bed to wheelchair using stand assist device and brought R5 to the dining room. NA-E and NA-C stated the wraps are put on by the nursing staff. NA-C added only the nurses can do, but NA's can apply compression stockings. During interview 1/29/25 at 8:01 a.m., trained medication aide (TMA)-A stated she hasn't worked with R5 before and is unsure if he should have wraps on his legs. TMA-A indicated the nurse on 1st floor is covering for treatments on this floor and she would be the one to put them on. During interview 1/29/25 at 9:28 a.m., registered nurse (RN)-E, covering nurse for R5's floor indicated R5 is supposed to wear wraps up to thigh on left leg and right leg is compression socks. RN-E was unaware the wraps were not present on R5 and stated they should be put on by night shift. Documentation review 1/29/25 at 9:40 a.m., of the medication administration record for January 2025 indicated compression wraps were applied 1/29/25. During interview 1/29/25 at 9:53 a.m., the director of nursing (DON) confirmed there was an order present for bilateral leg wraps for R5. The DON stated I would expect staff to put them on daily and take them off at bedtime. The DON indicated if residents refused, they should be reproached a minimum of three times. The DON added only one TMA is trained to apply wraps, otherwise it is the nurses responsibility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy on edema prevention and treatment was requested but not received.

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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** 40614 Based on observation, interview and document review, the facility failed to assess and evaluate causal factors for a fall and failed to ensure interventions were implemented to reduce the risk of falls for 2 of 2 (R5, R164) who were reviewed for accidents. Findings include: R5's facesheet printed 1/29/25, included diagnoses of pneumonia, urinary tract infection, Alzheimer's disease, traumatic arthropathy (inflammation of joint) left ankle and foot, and patent foramen ovale (flap-valve opening in the heart from right to left of the top two heart chambers which generally closes at birth, causing abnormal flow of blood). R5's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R5 understands and is understood, has moderately impaired cognition, requires moderate to substantial and maximal assist with transfers and walking and has impaired range of motion in both lower extremities. R5 had more than 2 falls without major injury and takes anticoagulant, diuretic and opioid medications. A Care Area Assessment (CAA) dated 1/15/25, included assist as needed with activities of daily living. R5 able to make needs known. Has had several falls, with no injury. Has use of wheelchair and walker. No pressure ulcers. Is assisted with toileting and skin care needs. Is reminded to call and wait for assist. Care plan reviewed and up to date. Continue with plan of care. R5's plan of care last revised 11/10/24, included R5 is at risk for falls related to history of falls and chronic knee pain. Interventions included call do not fall sign in room, commonly used items to be placed within resident's reach, education for resident on fall prevention measures, ensure all daily necessitates are within reach, ensure proper footwear, ensure wheelchair is close to bed with brakes locked while resident is in bed and follow therapy recommendations for transfers, mobility and ambulation. An admission Fall Risk assessment dated [DATE], indicated R5 was a low risk for falls. A Fall Risk Assessment completed 1/19/25, indicated R5 remained a low risk for falls. R5 had 7 falls between 10/30/24 and 1/25/25. Falls included: -An Event report dated 10/30/24 at 3:45 p.m. indicated R5 was sitting up on floor head facing the bathroom door. Resident then laid flat on floor, short of breath and confused. Resident indicated he needed to use the toilet. R5 was sent to the hospital. No injury was identified. Interdisciplinary team (IDT) meeting 10/31/24, indicated root cause as self-transfer with confusion. Intervention included: call do not fall sign in room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Event report dated 11/14/24 at 6:45 p.m., indicated R5 was found in between bed and nightstand. Resident was confused and sitting up right. R5 stated he slipped out of bed and the television was on and was trying to turn that off. No injuries observed. An added note on 11/15/24 at 9:40 a.m., indicated confusion was root cause and fall mat placed next to the bed. - Event report dated 11/19/24 at 5:30 p.m., indicated resident was found on the floor with no injury. Resident was unable to relay preceding events that led to fall. No injuries observed. IDT meeting 11/20/24, indicated root cause as attempting to self-transfer to go to bed. Intervention included to toilet him after meals. -Event report dated 12/6/24 at 2:45 a.m., indicated R5 was found sitting on the floor next to his bed. Stated he was trying to stand up to grab a brief from his closet and slipped and fell . IDT team review 12/6/24 9:59 a.m., indicated fall was related to resident needing incontinent brief with intervention to move incontinent briefs to a drawer in his night stand for easier access. -Event report dated 12/14/24 at 9:04 a.m., indicated call light was on and found R5 sitting on the floor next to resident's bed. R5 stated he slid down on the floor while he was trying to get to the wheelchair. IDT team review 12/15/24 at 1:16 p.m., indicated root case of self-transferring from bed to wheelchair. Intervention included ensure wheelchair is close to bed with wheels locked while resident is in bed. -Event report dated 12/21/24 at 3:30 p.m., indicated resident was found sitting on the floor next to his wheelchair and leaning against the bed. He stated he was trying to reach for the bed remote and slid off the bed. The resident had on grip socks and call light was within reach but not on. Two hour safety checks initiated. The record lacked root cause analysis and review by IDT team or any new interventions. -Event report 1/19/25 at 3:30 p.m., R5 was found on the floor. R5 stated he was trying to sit on the wheelchair after coming from the bathroom and the chair slid away and he fell . No injuries noted at time of incident. Frequent 15 minutes checks initiated. Provider notified with request to check for urinary tract infection. IDT met 1/20/25 at 10:06 a.m., with confusion and self-transferring as root cause. Intervention is to have him evaluated by the provider. During observation on 1/27/25 at 3:39 p.m., R5 was seated in his wheelchair with grippy socks on both feet. R5 was in the hallway entering other resident's rooms looking for his shoes and socks. R5 came out of another resident's room with one slipper, 2 pairs of socks and a blue incontinent pad in his lap. At 3:54 p.m., nursing assistant (NA)-F approached R5 in the hallway and began to take him back to his room when she noted names on the items in R5's lap. NA-F then took items from R5, placed back in the correct residents room and took R5 back to his room. R5 self-propelled himself back out of room and continued to wheel self up and down the hallway in his wheelchair. No call don't fall sign was present in R5's room. During interview on 1/27/25 at 5:07 p.m., family member (FM)-D stated R5 has had multiple falls since he was hospitalized in October 2024 but none with injury. FM-D indicated R5 hasn't worn shoes since last April 2024 due to swelling issues in his feet. FM-D stated she doesn't know if the facility is doing anything to prevent falls or injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation 1/28/25 at 11:27 a.m., FM-D was present at the bedside with R5 sitting in his wheelchair in his room. There was no call don't fall sign present in his room. Call light way lying on the bed. FM-D indicated R5 is less confused than the previous 4 or 5 days and is much calmer today. During observation on 1/28/25 at 3:45 p.m., R5 was sitting on the edge of bed attempting to get feet on the floor. R5's wheelchair was parked out of reach of resident, call light was on the floor under the bed. Upon request for assistance, staff came and transferred R5 to his wheelchair. During observation and interview 1/29/25 8:08 a.m., R5 was lying with feet over the side of the bed, attempting to pull his shirt off. There was no call don't fall sign present in the room. The call light was on the floor, wheelchair was out of reach and no bedside table was present next to the bed. R5's bedside table was located towards the foot of R5's bed which had personal items present on top but not within R5's reach. R5 requested assistance and staff were notified. NA-G entered the room and stated she can't assist with cares as she is currently on light duty but will get others to assist. NA-G indicated R5 was previously on 1st floor and was not a fall risk at that time so doesn't believe R5 is a high fall risk. NA-G is unsure if R5 has had previous falls. NA-C and NA-E arrived into room at 8:28 a.m. and assisted R5 with morning cares. Incontinent pads were in bottom drawer of bedside stand. A stand lift was used to transfer R5 to his wheelchair. NA-E indicated staff informed her in report this morning to use the stand as R5 has been very unsteady on his feet since moving to this floor 2 days ago. NA-E and NA-C were unsure if R5 was a high fall risk or not and confirmed there was no call don't fall sign in the room. During interview on 1/29/25 at 8:01 a.m., trained medication aide (TMA)-A indicated she hasn't worked with R5 in the past and is unsure if he is a fall risk or not and confirmed there is no call don't fall sign in his room. During interview on 1/29/25 at 9:28 a.m., registered nurse (RN)-E indicated R5 has been declining lately and got moved from 1st floor to 3rd floor 2 days ago. RN-E stated R5 is a high fall risk and had fallen when he was on 1st floor. RN-E indicated communication from the IDT meetings and of new interventions implemented aren't always communicated to the staff after a fall event. RN-E indicated they should be alerted to any changes right away. During interview 1/29/25 at 9:53 a.m., the director of nursing (DON) confirmed R5 is a high fall risk and has been since he was hospitalized in October 2024 for pneumonia. The DON stated she would expect staff to follow the plan of care with all interventions. The DON indicated staff might have forgotten to take the call don't fall sign when he moved to another floor 2 days ago. 42073 R164's facesheet printed on 1/29/25, included diagnoses of post-op orthopedic after care for cervical myelopathy (compression of the spinal cord in the neck) and laminectomy (removal of bony arch that protects the spinal cord) repair on 1/14/2025, mild cognitive impairment, and lack of coordination. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R164's admission MDS assessment dated [DATE], indicated R164 had moderately impaired cognition, clear speech, was usually understood and could usually understand. R164 needed assistance with ADLs (activities of daily living) and did not walk independently. R164 had two or more falls since admission. R164's physician orders dated 1/21/25, included physical therapy (PT) and occupational therapy (OT) evaluate and treat. R164's nursing admission evaluation dated 1/22/25, indicated R164 was at risk for falls. R164's care plan dated 1/22/25, indicated risk of falls due to impaired mobility. The following interventions were entered by registered nurse (RN)-G who was also the nurse manager: --Bed in low position - 1/22/25 --Encourage to transfer and change positions slowly - 1/22/25 --Have commonly used articles within easy reach - 1/22/25 --Reinforce need to call for assistance -1/22/25 --Reinforce wheelchair safety as needed such as locking brakes -1/22/25 --Report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status post fall - 1/22/25 On 1/23/25, the DON added the following to R164's care plan: have evaluated by therapy. However, this was already an admission order dated 1/21/24. R164's CAA for falls dated 1/27/25, indicated R164 had periods of confusion, several falls, no injuries. May be linked to Roxicodone (narcotic pain medication) use for pain management. Monitoring closely and trying Tylenol for pain when able. Is assisted with cares as needed. Is working with therapy and goal is to return home. Incontinent at times, use of disposable undergarments as needed. Taking Effexor for mood/behavior which put at greater fall risk. During an interview on 1/27/25 at 4:31 p.m., FM-B stated R164 had two falls that she was aware of since his admission on 1/21/25. FM-B stated R164 was at the facility for short-term rehabilitation following neck surgery. FM-B stated R164 has been confused and had been impulsive, trying to stand without assistance. Progress notes in the EMR and/or incident reports indicated R164 had three falls since admission: 1. 1/22/25 - witnessed fall, R164 was using the toilet and once done attempted to get off toilet independently. R164 lowered himself to the floor. No injury sustained. 2. 1/24/25 -- unwitnessed fall. R164 was found on the floor in supine position and told staff he got up from the wheelchair and fell to the floor. R164 was sent to the ED. No injury sustained. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. 1/26/25 -- unwitnessed fall. R164 was found on the floor next to his bed. R164 was sent to the ED. No injury sustained. Two of three incident reports requested were received for falls on 1/22/25, and 1/26/25, but not for the fall on 1/24/25. Incident reports did not identify causal factors for falls nor did they identify new interventions to prevent future falls. During an interview on 1/29/25 at 11:52 a.m., with RN-J who was also corporate vice president of success, and the DON, RN-J stated she was not able to locate an incident report for R164's fall on 1/24/25. The DON stated she was usually notified when a resident sustained a fall but was not notified of the fall on 1/24/25. The DON stated IDT (interdisciplinary team) met every weekday morning and discussed residents who sustained a fall to determine root cause and potential interventions. With RN-J and the DON, reviewed each of R164's three falls: --1/22/25: IDT note indicated the root cause of the fall appeared to be difficulty with transfers and intervention was evaluation by therapy. Therapy evaluation was completed on 1/23/25. --1/24/25: No incident report. This fall was not discussed at IDT as the DON was unaware of the fall until R164 returned to the facility. The DON stated that should have prompted her to look for an incident report, but she stated she missed it. Consequently, this fall was not discussed at IDT, no root cause analysis was done and no new interventions were put into place. RN-J stated she would have expected an IDT review and new intervention(s) initiated. --1/26/35: Not discussed at IDT; no root cause analysis was done and no new intervention(s) were initiated. The DON described the process that should be following after a resident falls: nurses address the physical needs of the resident, and once addressed, expected staff to initiate an incident report, inform the provider, the DON and resident representative and enter a note in the electronic medical record (EMR). Each weekday, the DON reviewed risk management notes in the EMR and if there was a fall, looked for an incident report. The fall was then discussed at IDT. The IDT discussed the nature of the fall and potential interventions. RN-J stated the nurse would also complete a post-fall assessment which was used to determine last fall, reasons for the fall, patterns of falls and interventions currently in place and what new interventions to consider. RN-J stated a fall risk assessment was to be completed upon admission and following each fall. The DON and RN-J verified R164 had been admitted on [DATE], and sustained three falls within seven days. Further verified an incident report was completed for only two of three falls, IDT reviewed only one of three falls. No causal factors were identified and no new interventions were identified for two of the three falls, and a post-fall assessment was completed for only one of the three falls. The DON admitted in regard to R164's falls, the facility did poorly. The facility Fall Prevention and Management policy dated 7/18/24 included: -Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls or reduce the possibility/severity of injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Suggested standard interventions may include: Implement universal environmental interventions that decrease the risk of falling including a clear pathway to the bathroom and bedroom doors, bed is locked and lowered to a a level that allows the resident's feet to be flat on the floor when resident is sitting on edge of bed, call light and frequently used items within reach, wheelchairs and assistive devices in good repair. Implement routine rounding schedules, monitor changes in resident's cognition, gait, ability to rise/sit and balance, encourage residents to wear shoes or slippers with non-slip roles, complete a fall risk assessment quarterly, post-fall and as with a significant change of condition. -Review of each fall/fall investigation during the next morning meeting/clinical meeting with the IDT team. Actions of the IDT may include: Review of investigation and determination of potential root cause of fall; review of fall risk care plan and any updates to plan of care completed post-fall; additional revisions to the plan of care including any physical adaptation to room, furniture, wheelchair and or assistive devices; education of staff as to any care plan revisions.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview, and document review, the facility failed to ensure appropriate management of an indwelling catheter was provided for 1 of 1 residents (R163) reviewed for urinary catheter, when his leg bag had not been changed to a urinary drainage bag at night. Findings include: R163's facesheet printed on 1/29/25, included a diagnoses of urinary retention. R163's discharge assessment/return anticipated Minimum Data Set (MDS) assessment dated [DATE], indicated R163 was dependent upon staff for most activities of daily living (ADL) and had an indwelling urinary catheter. R163's physician orders dated 1/27/25, indicated indwelling Foley catheter (drains urine from bladder). R163's care plan dated 1/27/25, did not include R163's urinary retention, use of an indwelling Foley catheter, leg bag, or urinary drainage bag. During an observation on 1/27/25 at 2:21 p.m., R163 was resting in bed; urinary drainage bag visible. During an observation on 1/28/25 at 10:19 a.m., R163 was sitting on top of his bed with a urinary leg bag in place on his left leg. During an observation on 1/29/25 at 7:17 a.m., R163 was in bed sleeping. No urinary drainage bag was visible. During an interview and observation on 1/29/25 at 7:53 a.m., licensed practical nurse (LPN)-A stated residents who had a urinary catheter with leg bag should have the catheter hooked up to a urinary drainage bag at night so the urine drained properly. Together went into R163's room. LPN-A pulled the sheet back and observed R163's urinary catheter was still hooked up to his leg bag and was about three-quarters full of yellow urine. Observed two urinary drainage bags hanging in R163's bathroom. LPN-C didn't know why the catheter had not been hooked up to the drainage bag last night. During an interview and observation on 1/29/25 at 8:01 a.m., nursing assistant (NA)-B stated residents were not supposed to sleep with their leg bag on -- should be switched to a urinary drainage bag so the urine drained properly. NA-B stated it would be the responsibility of the evening shift to switch from leg bag to urinary drainage bag, then in the morning the day shift switched back to the leg bag. NA-B was informed R163 had his leg bag on. Together with NA-B, went into R163's room. NA-A helped R163 to sit on the side of the bed. NA-A emptied the urine from the leg bag into a urinal. NA-A observed straps from the leg bag had made R163's skin red, so removed the leg bag and attached the urinary drainage bag to relive R163's skin and stated she would inform the nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 11:43 a.m., the DON was informed R163's urinary catheter had not been switched from a leg bag to a urinary drainage bag last night. The DON stated typically a resident who used a leg bag would have a urinary drainage bag hooked up at bedtime in order for gravity to pull urine away from bladder. The DON states it was important to prevent urine backflow into the bladder in order to prevent a urinary tract infection. The facility Catheter Care policy with revised date of 3/15/23, indicated it was the policy of this facility to ensure that residents with indwelling catheters received appropriate catheter care when indwelling catheters are in use. Legs bags may be worn during the day but need to be removed and a bedside drainage bag replaced on the catheter at night.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation and interview, the facility failed to ensure meals were served at a warm and palatable temperature to promote quality of life and nutritional intake for 3 of 3 residents (R6, R9, R35) reviewed for dining. This had the potential to affect all 30 residents who resided on second floor. Findings include: R6's facesheet printed on 1/28/25, included diagnoses of congestive heart failure (when the heart doesn't pump as it should) and diabetes. R6's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R6 had moderate cognitive impairment and ate independently after set up help. R6 was on a consistent carbohydrate, cardiac diet. R6's care plan dated 11/27/23, indicated her food preferences would be honored. R9's facesheet printed on 1/29/25, included diagnoses of stroke and diabetes. R9's admission MDS assessment dated [DATE], indicated moderate cognitive impairment and ate independently after set-up help. R9 was on a consistent carbohydrate, cardiac diet. R9's care plan dated 1/8/25, indicated her food preferences would be honored. R35's facesheet printed on 1/29/25, included diagnoses of multiple sclerosis and diabetes. R25's quarterly MDS assessment dated [DATE], indicated intact cognition and ate independently. R35 was on a regular diet. During an interview on 1/27/25 at 3:28 p.m., R6 who ate meals either in her room or the dining room, stated most of the time her food was cold. R6 stated she poured coffee in her oatmeal to warm it up and her eggs this morning were cold -- food was cold for every meal. During an observation on 1/28/25 at 12:35 p.m., carts with meal trays were observed parked on second floor. One cart was a metal, enclosed thermal cart and one was a tall open sided cart with plastic over it. Residents were seated at tables in the dining room waiting for their meals. No staff were delivering the trays. During an observation on 1/28/25 at 12:41 p.m., the first meal tray was delivered; several staff had begun passing trays. Per a menu posted on a bulletin board, the menu was burgundy beef tenderloin tips, waxed beans, roasted potatoes, roll, and apple crisp. During an observation on 1/28/25 at 12:55 p.m., staff starting to deliver room trays. During an observation on 1/28/25 at 1:02 p.m., four room trays left to be passed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/28/25 at 1:07 p.m., room meal trays on the open sided cart had been standing in the hallway for at least 32 minutes. Staff scheduler (SS)-J was asked to remove the last meal tray and take it to the dining off the kitchen to have the temperature of the food checked. SS-J was accompanied to the dining room. During an interview and observation on 1/28/25 at 1:09 p.m., in the dining room with dietary manager (DM)-F, the director of nursing (DON), DM-F temped the food with an instant read dial thermometer. Readings were as follows: Beef tips: 120 degrees Fahrenheit (F) Potatoes - 110 degrees F Waxed beans - 115 degrees F The DON and surveyor tasted the food for purposes of temperature palatability. The DON stated she thought it was fine -- she didn't like her food too hot. Surveyor felt food was lukewarm. DM-F stated the temperature of the food should be closer to 135 degrees F. DM-F stated their plate warmer broke down about two weeks ago and maintenance was looking for someone to service it. The DON stated she would expect resident food to taste good and be hot. The DON stated nursing assistants (NA) and nurses were expected to deliver meal trays on second floor, and that most days a manager or two assisted with passing trays. The DON stated no managers were assigned to pass trays, nor were they required to help. During an interview on 1/28/25 at 1:18 p.m., registered dietician (RD)-E stated food served to residents should be 130 degrees or higher for hot food. RD-E was informed of meal trays sitting on second floor for over 30 minutes before being delivered to residents, and of the temperatures obtained by DM-F. RD-E stated when hot food temps were below 130-135 degrees, there was a concern for food being in the temperature danger zone, resulting in formation of bacteria causing foodborne illness. RD-E stated and if food wasn't hot, it may be a palatability issue for residents. RD-E stated she would help look into how they could improve the process. During an interview on 1/28/25 at 1:32 p.m., R9 who received a room tray on second floor stated her lunch today was okay but it wasn't very warm. R9 stated her food was usually not warm - especially the dinner meal, and asked if surveyor could do something about that. Resident Council Meeting: During an interview on 1/29/25 at 10:31 a.m., R35 stated she had voiced her concern to management last week (could not recall to whom) about cold food. R35 stated breakfast, lunch and supper were cold on second floor. R35 stated there were not enough staff to pass meal trays, so trays sat for a long time and food got cold. R35 stated the kitchen staff delivered the trays to second floor in carts, and if nursing staff were not in the immediate vicinity, they don't know trays were there. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Food Quality and Palatability policy with revised date of 2/2023, indicated food would be prepared by methods that conserved nutritive value, flavor and appearance. Food would be palatable, attractive and served at a safe and appetizing temperature. The cook(s) prepared food using temperature guidelines as outlined in the Federal Food Code. Food was prepared in a manner, form and texture that meets each residents needs.

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	245184	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview, and document review the facility failed to ensure dishwashing sanitization at the correct level and was appropriately monitored during dishwashing. Further, staff failed to ensure expired food was identified and removed from a unit refrigerator that stored resident personal food. Findings include: Dishwashing On [DATE] at 3:00 p.m., during the kitchen tour dietary aide (DA)-A placed dishes through the dish machine. DA-A stated the wash dial needed to indicate a temperature of 120 degrees Fahrenheit (F) and rinse dial at 140 degrees F. During the observation DA-A placed dishes through the dish machine and the wash dial indicated a temperature of at 130 degrees F and rinse dial at 140 degrees F. A vial of Ecolab chlorine test paper strips was on top of the dish machine. DA-A stated the dish machine sanitized dishes with hot water. DA-A stated the bottle with the test strips were used to test the chemicals of the water after dishwashing was completed. DA-A confirmed she had not checked the chemicals of the water and had already washed dishes. DA-A removed a test strip from the bottle and dipped the test strip in the water reservoir of the dish machine and the paper did not change color, DA-A was observed to check the chemicals six times with six different strips, and the strip did not change color. DA-A stated the strip was expected to change color to know the dishes were sanitized. DA-A stated the strip was to change to a purple or darker color. A box above the machine dish machine had a light flashing red and dietary manager (DM)-A stated, we have been battling the dish machine. The DM-A confirmed the dish machine used the sanitization of chemicals not temperature of water. DM-A viewed the Ecolab chlorine test paper strips on top of the dish machine and DM-A verified the strips were not expired. DM-A stated she would immediately contact Ecolab to troubleshoot the problem. DA-A and DM-A provided a clipboard with a form titled Dish Machine Log dated [DATE]. The log had 13 columns for date, wash and rinse temperatures, ppm (parts per million) and staff initials for each meal service of breakfast, lunch and dinner. DM-A stated chemicals was used in the dish machine to sanitize dishes. When asked how the ppm of the chemical sanitizing solution was determined, DM-A stated with strips. The log was reviewed, and documentation indicated all the readings documented were the same (and were within range noted below). DA-A stated she had not documented the readings on the log for the day. DM-A pointed to the bottom of the log which indicated temperature and ppm standards of: Chemical sanitizing (low temp): Wash ,d+[DATE] F. Rinse ,d+[DATE] F. Manufacturer recommended PPM: ,d+[DATE] ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 7:10 p.m., DA-A and DM-A stated an Ecolab representative had been to the facility and fixed the sanitization on the dish machine. DM-A stated the sanitization line was clogged. The box above the dish machine was no longer blinking red. DA-A was currently using the dish machine and DA-A stated the test strips were used prior to check the level and the test strip now changed color and was measured at 50ppm. DA-A was observed and removed a test strip from Ecolab vial and checked the water in the dish machine reservoir and the strip changed a purplish color and was observed at 50ppm. DA-A and DM-A stated the expectation going forward is to check the level of sanitization prior to all the dishes washed. On [DATE] 11:24 a.m., DM-G, known as the district dietary manager, stated the dish machine chemicals were expected checked prior to the first load of dishes washed to ensure the test strip the chemicals were at the proper level to sanitize the dishes. On [DATE] at 11:26 a.m., registered dietician (RD)-E stated she came to the facility weekly. RD-E stated the level of chemicals with the test strips was expected checked during the dish washing process to ensure the dishes were properly sanitized. Food Storage On [DATE] at 11:00 a.m., a refrigerator on second floor was observed with a sign posted on the door and indicated please note this refrigerator is cleaned every Tuesday night after 10 p.m., all items must be labeled with the resident's name and the date its placed in the refrigerator. On [DATE] at 11:04 a.m., the second-floor refrigerator was observed with registered nurse (RN)-B. RN-B stated the refrigerator was used for residents' personal food items brought in from outside the facility. The refrigerator was observed with a freezer section located without a built-in door. The inside freezer section was not able to be observed due the ice built up and enclosed the freezer section. RN-B confirmed the following items located in the refrigerator were expired and were not expected in the refrigerator: clear plastic container dated [DATE], with resident name with red sauce and pasta. An ice-cream sandwich with no date or name, miracle whip expired [DATE] with resident name, yogurt expired [DATE] with resident name , cantaloupe expired [DATE], Styrofoam container with ,d+[DATE] piece of lemon pie dated [DATE] with resident name , cardboard pizza box with 3 pieces of pizza dated [DATE], cardboard box with cheese breads dated [DATE] with resident name 5. RN-B removed the food from the refrigerator and stated the food was expired food removed from the refrigerator and would discard them. On [DATE] at 11:15 a.m., the DON stated the second-floor unit refrigerator was for resident's personal food and the overnight night NA's were expected to clean and discard of expired food. The DON observed the fridge and confirmed the fridge was not clean. The DON stated expired food was not expected in the refrigerator, and staff were expected to discard the expired food, and confirmed the fridge and freezer were not clean. On [DATE] at 11:33 a.m., DM-F stated nursing was expected to clean and discard of expired food of the resident unit refrigerator on second floor. DM-F stated she had mentioned to the DON during meeting the refrigerator was not cleaned and expired food had not been removed as expected. DM-F stated the food was expected removed after three days or based off the expiration label on the product. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] 11:36 a.m. RD-E stated staff were expected to ensure expired food was not located in the unit refrigerators. The facility Ware Washing policy with revised dated of ,d+[DATE], indicated all dishware would be cleaned and sanitized after each use. The dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. All dish machine water temperatures would be maintained in accordance with the manufacturer recommendations for high or low temperature machines. Temperature and/or sanitization concentration logs would be completed as appropriate, and that all dishware would be air dried and properly stored. The facility Food Brought in from Outside Sources and Personal Food Storage policy dated ,d+[DATE], indicated . will be handled according to safe food handling guidelines. Designated staff will monitor foods and beverages brought in from outside sources for storage refrigeration units for food or beverage disposal, units the tips in the Resource: food Safety for Your Loved One.

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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** 44630 Based on observation, interview and document review the facility failed to ensure personal protective equipment (PPE) was utilized for 2 of 2 residents (R54, R23) reviewed for medication administration and performed cares on these residents that were on enhanced barrier precautions (EBP). Finding include: R54's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, dependent on staff for activities of daily living (ADL's), feeding tube, diagnoses included Parkinson's disease, gastrostomy (g-tube, surgical procedure used to insert a tube through the abdomen and into the stomach, and dysphagia (condition that makes it difficult to swallow). R54's care plan revised 1/27/25, indicated at risk for infection r/t (related to) indwelling medical device tube-feeding and interventions included enhanced barrier precautions when performing high-contact care activities. On 1/27/25 at 3:38 p.m., registered nurse (RN)-A entered R54's room and failed to don PPE, R54 was lying in bed. RN-A used gloved hands lifted up R54's shirt and exposed the g-tube with gloved hands, then removed the covering of the g-tube, connected a syringe to the tube and pulled back the syringe. RN-A stated she was checking for residual prior to administering the medication. RN-A was observed to use a syringe and administered medication in the g-tube, and then flushed the g-tube with water. After the medication administration, RN-A changed gloves, disinfected hands, applied new gloves, pulled R54's shirt down over upper body, and then placed blankets on R54's upper body. RN-A confirmed R54 was expected placed on EBP due to the g-tube, with a sign indicating EBP and PPE cart outside R54's door. RN-A confirmed sign was not posted on R54's door as expected to indicate EBP precautions and a gown was not worn as expected. On 1/27/25 at 3:40 p.m., trained medication aide (TMA)-A stated she was not aware R54 was on EBP precautions and confirmed PPE was not worn during the care of R54 during transfers or cares. TMA-A stated a gown and gloves were expected to be worn during transfers for residents placed on EBP. TMA-A stated a sign on the door was expected for resident on EBP. On 1/27/25 at 4:52 p.m., RN-B, known as the infection preventionist, stated R54 was recently on isolation precautions for COVID and stated the EBP sign had been removed mistakenly and not replaced. RN-B stated residents on EBP had signage posted on the resident doors that indicated the resident was on EBP, PPE cart outside the room, and EBP placed on the resident's care plan. RN-B stated R54 did not have a sign on the door as expected or PPE outside of the room. On 1/28/25 at 11:15 a.m., the director of nursing (DON) stated residents with a g-tube were expected on EBP and a EBP sign was expected on resident doors for staff to know the residents on EBP. The DON stated during g-tube medication administration staff were expected to wear gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 8:58 a.m., RN-B, confirmed R54 was on EBP due to a g-tube, and stated staff were expected to wear a gown and gloves during high contact care including medication administration, transfers, brief changes, and dressing changes. RN-B stated a sign on R54's door indicating she was on EBP was expected to ensure staff were aware. RN-B stated the EBP was not on the care plan as expected until 1/27/25. 51578 R23's facesheet printed on 1/30/25, included diagnoses of unspecified dementia, anxiety, osteoarthritis, atrial fibrillation (abnormal heartbeat). R23's quarterly MDS assessment dated [DATE], indicated R23 had no cognitive impairment, clear speech, could understand and be understood. R23 required substantial to maximum staff assistance with some ADL's including dressing and toileting hygiene, incontinent of bowel and bladder. R23 was dependent upon staff for transferring in and out of bed. R23 did not walk. MDS further identified R23 had stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister). R23's care plan dated 1/13/25, indicated at risk for infection r/t (related to) wound (coccyx wound) and interventions included enhanced barrier precautions when performing high-contact care activities. During an observation on 1/28/25 at 12:17 p.m., R23 was calling for help to go to the bathroom. RN-E entered room, placed gloves on and assisted R23 while in bed, including performing peri cares for R23 with no gown in place. RN-E then repositioned R23 and proceeded to leave room after performing cares and completing hand hygiene. Sign on outside of R23's door directed EBP precautions, and PPE cart outside of room. During an interview on 1/28/25 at 12:26 p.m., RN-E stated she works full time and was familiar with R23. RN-E stated was aware that R23 did have pressure ulcers on bottom. RN-E explained that she forgot to put on a gown when doing cares with R23. When prompted RN-E explained that she remembered after she came out of R23's room that R23 was on EBP precautions. On 1/28/25 at 2:19 p.m., RN-B, known as the infection preventionist, stated R23 was placed on EBP precautions due to her increase in skin alteration (pressure sore). RN-B stated residents on EBP were expected to have signage posted on resident doors with EBP precautions, PPE cart outside the room, and EBP placed on the resident's care plan. On 1/28/25 at 11:15 a.m., DON stated residents with pressure sores were expected on EBP and a EBP sign was expected on resident doors for staff to know the residents on EBP. The DON stated while performing cares staff were expected to wear gown and gloves. The facility Enhanced Barrier Precautions policy dated 8/8/24, indicated The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Initiation of Enhanced Barrier Precautions: An order for enhanced barrier precautions (in accordance with physician-approved standing orders) will be initiated for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices(e.g., central lines, peripherally inserted central catheters (PICCs), hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions. infection or colonization with a CDC-targeted or novel MDRO when Contact Precautions do not otherwise apply. Implementation of Enhanced Barrier Precautions: Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42073 Based on observation and interview, the facility failed to ensure 1 of 1 tub/shower room on second floor was maintained in good repair and in sanitary conditions for the 30 residents on second floor who could potentially use the area. Findings include: During an observation on 1/28/25 at 2:26 p.m., the second floor tub/shower room had a wall partially enclosing the shower area. The wall was covered with yellow tiles, approximately 4 inches x 4 inches in size. On the lower portion of a wall adjacent to the floor, six tiles were missing creating an opening in which wood and plaster were visible. During an interview and observation on 1/28/25 at 3:52 p.m., along with the corporate maintenance director (CMD), looked at the wall in the tub room. CMD was not aware of the missing tiles and stated maintenance relied on staff to inform them of this sort of thing so it could be repaired. CMD acknowledged this was not sanitary nor a homelike environment for residents. During an interview on 1/29/25 at 8:24 a.m., housekeeper (H)-A stated he was aware of the missing tile and stated he had told someone about it but couldn't recall who or when. During an interview on 1/29/25 at 8:58 a.m., facility maintenance director (MD)-A stated he had only been in this position for two months and had not been aware of the missing tiles and didn't recall if he had a received a maintenance requisition informing him of it. MD-A stated he had been trying to catch up on the backlog of repairs. A policy on building maintenance, upkeep and repairs was requested and not received.