| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245187 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villas at the Cedars | 7900 West 28th Street<br>Saint Louis Park, MN 55426 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on observation, interview, and record review, the facility failed to maintain resident privacy and dignity 2 of 3 residents (R46, R11) reviewed for dignity.<br><br>R46<br><br>R46's admission (MDS) dated [DATE], indicated R46 had moderate cognitive impairment and required substantial and/or maximal assistance with most activities of daily living (ADLs), such as hygiene, dressing, and transfers.<br><br>During observation on 9/18/24 at 7:30 a.m., R46 had their call light on. At 7:32 a.m., the social services designee (SS)-A knocked on R46's door and stated they would let them [the staff] know as they walked out of R46's room. At 7:34 a.m., SS-A stated loudly down the hall to nursing assistant (NA)-A R46 needed a check and change.<br><br>During interview on 9/18/24 at 8:48 a.m., NA-A stated SS-A always does that when questioned about SS-A's statement in the hall. NA-A stated SS-A should come to staff and tell them what residents' need with a quieter voice. NA-A stated residents needed privacy and did not want other residents to think what is going on by hearing voices in the hallway.<br><br>During interview on 9/19/24 at 11:52 a.m., SS-A stated nursing staff spoke with them afterwards and speaking more privately about residents' needs was important for residents' dignity and HIPPA (Health Insurance Portability and Accountability Act; law to protect the privacy and security of health information).<br><br>During interview on 9/19/24 at 11:58 a.m., R46 stated that's part of being here when asked how they would feel about a staff member stating they needed a check and change by name in the hallway, then asked his family member (FM)-B if such an incident would bother her. FM-B stated the incident would bother her, and R46 agreed he would be bothered too.<br><br>During interview on 9/19/24 at 3:10 p.m., DON expected staff to pull a staff member aside or talk in a different room to share information about other residents to provide resident privacy and maintain dignity.<br><br>R11<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/19/2024 |
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| NAME OF PROVIDER OR SUPPLIER The Villas at the Cedars | | STREET ADDRESS, CITY, STATE, ZIP CODE 7900 West 28th Street Saint Louis Park, MN 55426 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R11's annual Minimum Data Set (MDS) dated [DATE], indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness).<br><br>During observation and interview on 9/18/24 at 9:32 a.m., nursing assistant (NA)-C and NA-E assisted R11 with morning cares, which included a bed bath, oral and toileting hygiene, and dressed R11 with a clean gown. Throughout all cares, including when R11 was exposed during incontinence cares, the privacy curtain was partially closed, and there was a clear view from R11 to R30's side of the room. R30 sat facing away from R11 in his electric wheelchair which he used independently and was awake or with eyes closed throughout R11's cares. NA-C left the room after cares were completed and stated R11 wore a gown all the time and thought he preferred to be in a gown. NA-C stated some care plans indicated resident or family preferences for dressing. NA-C stated they always pulled the privacy curtain when assisting residents and verified they did not pull the privacy curtain for R11.<br><br>R11's care plan dated 9/7/24, indicated R11 was dependent on staff for dressing and did not specify if R11 wanted to dress in a gown or personal clothes during the day time.<br><br>During interview on 9/18/24 at 10:33 a.m., NA-E verified R11's privacy curtain was not pulled during cares and stated the room was tight for transferring R11 when pulled, and R30 went through R11's side of the room to get out the bedroom door regardless of the privacy curtain being pulled during cares. NA-E stated the curtains were important to provide resident privacy.<br><br>During interview on 9/18/24 at 4:38 p.m., family member (FM)-A stated R11 would want privacy and not to be cleaned where another resident could see. FM-A stated R11 was a smart and clean person who took care of himself and not normal for him to be in a gown throughout the day.<br><br>During observation on 9/19/24 at 10:50 a.m., R11 had a gown on and laid in bed.<br><br>During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated family preferences were in the care plan or the nurse manager communicated preferences to staff after care conferences.<br><br>During observation on 9/19/24 at 11:45 a.m., R11 still had a gown on and laid in bed.<br><br>During interview on 9/19/24 at 12:01 p.m., NA-C stated R11 was repositioned, but his morning cares were not completed. NA-C stated they were going to assist R11 with another staff member next.<br><br>During interview on 9/19/24 at 12:13 p.m., NA-D stated residents' care plan, assistance needs, and functional maintenance programs were on their computer and a sheet in a binder, and staff documented cares completed in POC (Point of Care). NA-D stated R11 wore a gown all day and was not sure of family preferences.<br><br>During observation on 9/19/24 at 2:29 p.m., R11 was in a gown and sat in wheelchair in room.<br><br>(continued on next page) |

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| The Villas at the Cedars | 7900 West 28th Street<br>Saint Louis Park, MN 55426 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected privacy curtain use when staff completed resident cares and was important to maintain the dignity of R11. DON stated family preferences were verbalized and care planned. DON reviewed R11's care plan, NA sheet, and NA tasks and did not see an intervention specific to whether to dress R11 in a gown or personal clothes. DON expected residents to be dressed in day clothes, unless care planned, to maintain resident dignity.<br><br>The facility was asked for a policy related to resident dignity and stated they did not have a policy on dignity. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on observation, interview, and document review, the facility failed to ensure a self-administration of medications (SAM) assessment was completed to allow 1 of 1 resident (R30) to safely administer their own non-oral medications.<br><br>Findings include:<br><br>R30's annual Minimum Data Set (MDS) dated [DATE], indicated R30 was cognitively intact and had diagnoses of paraplegia (loss of muscle function in lower half of the body), cataracts (clouding of the lens of the eye), diabetes mellitus (condition which affects how body uses blood sugar), hypertension (high blood pressure), and renal failure (chronic kidney disease; loss of kidney function). R30 required substantial and/or maximal to dependent assistance with activities of daily living (ADLs) such as dressing, toileting hygiene, and rolling left and right and was independent with ADLs such as eating and use of motorized wheelchair.<br><br>R30's care plan dated 9/12/24, indicated R30 desired to self-administer TUMs (chewable antacid which treats symptoms cause by too much stomach acid) and 650 milligrams (mg) of acetaminophen and keep at bedside and all other oral medications after nurse setup. The care plan directed staff to perform a self-administration assessment to evaluate ability to self-administer.<br><br>R30's physician orders included:<br><br>-Fluticasone propionate nasal suspension 50 mcg/act (micrograms per actuation) one spray in both nostrils one time a day related to other seasonal allergic rhinitis with start date of 9/23/23.<br><br>-Biofreeze external gel 4% apply to right upper extremity and/or hand topically every day and evening shift for arthritic pain with further directions which indicated unsupervised self-administration okay to use home supply and leave at bedside with start date of 2/29/24.<br><br>-May self-administer TUMs and Tylenol (acetaminophen) and keep at bedside and all other oral medications after nurse set-up with start date of 5/17/24.<br><br>R49's most recent Self-Administration (SAM) assessment dated [DATE], indicated R30 was able to self-administer oral medications after nurse setup and keep TUMs and Tylenol at bedside per order. Opthalmic, nasal and/or aural and topical medication/treatment were not selected as medications R30 was capable of self-administering.<br><br>R49's SAM assessement dated 2/27/24, indicated R30 was able to self-administer oral medications after nurse setup and opthalmic and nasal medications and keep TUMs at bedside. Topical medication and/or treatment was not included.<br><br>R49's SAM assessment dated [DATE], indicated R30 was able to self-administer oral medications, nasal spray, and eye drops after nurse set up and keep TUMs at bedside. Topical medication and/or treatment was not included.<br><br>(continued on next page) |

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| The Villas at the Cedars | 7900 West 28th Street Saint Louis Park, MN 55426 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R49's SAM assessment dated [DATE], indicated R30 was able to self-administer oral medications, topical medication and/or treatment, opthalmic, nasal, and inhalation medication after nurse setup and keep TUMs at bedside.<br><br>During observation and interview on 9/16/24 at 1:10 p.m., R30 sat in his motorized wheelchair in his room and had a fluticasone nose spray with a prescription label, Clear Eyes Triple Relief eye drops, and Biofreeze on his rolling bedside table. R30 stated he kept the medications in his room and used the Flonase once a day to unplug his right nostril and the eye drops three to four times a day for his dry eyes.<br><br>During interview on 9/16/24 at 1:21 p.m., licensed practical nurse (LPN)-B, stated a self-administration assessment and doctor's order were required before residents administered their own medications and/or kept medications in their room. LPN-B reviewed R30's physician orders and medication administration record (MAR). LPN-B verified R30 did not have an order for self-administration of the nasal spray and no order for the eye drops. LPN-B stated R30 ordered some medications himself, such as eye drops.<br><br>During observation and interview on 9/16/24 at 1:42 p.m., registered nurse (RN)-A verified the fluticasone, eye drops, and Biofreeze were in R30's room, and R30 stated to leave the medications in his room where they were kept for years.<br><br>During interview on 9/19/24 at 3:10 p.m., DON expected nursing to compete self-administration assessment upon admission or when residents had a change in cognition. DON reviewed R30's Self-Administration assessment dated [DATE] and verified the assessment did not include non-oral medications, such as eye drops, Biofreeze, or Flonase. DON stated R30 was at risk of using the non-oral medications improperly without having an assessment for the non-oral medications.<br><br>A facility policy titled Self-Administration of Medications dated 2/24, directed staff to assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident and document in the medical record and care plan if a resident was deemed safe and appropriate to self-administer medications. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on observation, interview, and document review, the facility failed to ensure resident use of shared toilet for 1 of 1 resident (R62) reviewed for accommodation of needs.<br><br>Findings include:<br><br>R62's quarterly Minimum Data Set (MDS) dated [DATE], indicated R62 had intact cognition and no behaviors or rejection of cares. R62 had limb prosthesis and used a wheelchair. R62 required partial and/or moderate assistance for toileting hygiene and toilet transfers and supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. The MDS indicated R62 was frequently incontinent of bowel and bladder.<br><br>R62's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) Worksheet dated 6/14/24, was triggered due to assist needed with activities of daily living (ADLs), such as dressing, hygiene, sitting to standing, and transfers.<br><br>R62's care plan dated 9/10/24, directed staff to provide R62 with supervision for non-weight bearing transfers, and R62 washed hands and held grab bars but needed assistance with adjusting clothes and wiping during toilet use.<br><br>During interview on 9/16/24 at 2:08 p.m., R62 stated he used a bathroom and toilet down the hall because his shared bathroom smelled and had a tube which drained into the toilet. R62 stated he had spoken with staff previously, but they stated it was only body fluids.<br><br>During observation and interview on 9/16/24 at 7:18 p.m., RN-A set up overnight peritoneal dialysis for a resident who shared the bathroom with R62 and lined the drain to the shared toilet. RN-A stated other residents did not use the bathroom, since they used urinals and bed pans. The bathroom and toilet was shared between two rooms with two males in each room.<br><br>During observation on 9/18/24 at 7:13 a.m., R62 sat in his wheelchair with prosthetics on in the television area of the floor and was already dressed.<br><br>During observation on 9/18/24 at 7:22 a.m., the peritoneal dialysis tube was still lined to the toilet.<br><br>During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated R62 used the bathroom down the hallway and not in his room and was not sure why.<br><br>During interview on 9/19/24 at 12:25 p.m., licensed practical nurse (LPN)-A stated peritoneal dialysis drain tubes were usually attached to a drain bag and not to the toilet. LPN-A stated the residents of the shared bathroom usually used urinals and had not heard concerns about residents using the shared bathroom.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 9/19/24 at 2:31 p.m., NA-D stated they tried to clean the bathroom whenever R62 told them the bathroom was soiled, knew R62 used a bathroom down the hall, and had not told anyone about R62's concerns.<br><br>During interview on 9/19/24 at 3:10 p.m., DON stated dialysis contents may be drained into the toilet or into drain bags when multiple residents used the bathroom. DON was not aware R62 used the bathroom down the hall instead of the shared bathroom connected to his room. DON stated R62 had a bedside urinal but used a bathroom for bowel movements, and they would get a drain bag for the resident with peritoneal dialysis, so R62 could use the shared bathroom.<br><br>No policy provided. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on observation, interview, and document review, the facility failed to ensure an enteral feeding pump, tube feeding pole, and supporting legs were cleaned and in sanitary condition for 1 of 2 residents (R11) reviewed for tube feeding. Furthermore, the facility failed to keep the building clean for 1 of 1 bathroom with an unclean exhaust fan and 1 of 1 room with an unclean wall vent and ceiling tiles. Also, the facility failed to keep furniture in good condition for 1 of 2 residents (R30) who had an extended table from a dresser in their room.<br><br>Findings include:<br><br>TUBE FEEDING EQUIPEMENT<br><br>R11's annual Minimum Data Set (MDS) dated [DATE], indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). The MDS indicated R11 had a feeding tube through which they received more than 50% of their nutrition.<br><br>R11's medication and treatment administration record July 2024, directed the night shift to clean the tube feeding pole with a start date of 4/4/24. The tube feeding pole was recorded as cleaned every night shift until a discontinued date of 7/12/24. The rest of July 2024 lacked documentation of tube feeding pole cleaning, as well as the MAR and TAR for August and September of 2024.<br><br>During observation on 9/16/24 at 1:15 p.m., R11's enteral feeding pump had splatters of tan splotches, tube feeding pole had dusky, cloudy appearance throughout, and supporting legs had grayish splatters.<br><br>During observation on 9/17/24 at 3:26 p.m., the enteral feeding pump, tube feeding pole, and supporting leg conditions were unchanged.<br><br>During observation on 9/18/24 at 7:53 a.m., the enteral feeding pump, tube feeding pole, and supporting leg conditions were unchanged.<br><br>During observation and interview on 9/18/24 at 9:14 a.m., licensed practical nurse (LPN)-B stated they cleaned tube feeding equipment when they saw a spill and housekeeping also cleaned regularly or when nursing notified them. LPN-B did not know if there was a schedule to clean the tube feeding equipment or where the cleaning was documented. LPN-B stated tube feeding equipment were kept clean for R11's dignity and infection control purposes. LPN-B wiped the enteral feeding pump and pole with a disinfectant wipe and stated they would let housekeeping know to clean the supporting legs. The splatters came off the enteral feeding pump, and the pole had a shiny appearance.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 9/19/24 at 3:10 p.m., DON expected tube feeding poles to be cleaned and documented regularly and when visibly soiled. DON reviewed R11's orders and did not see an active order or documentation for cleaning R11's tube feeding pole. DON stated a clean tube feeding pole was important for infection control.<br><br>A facility policy Maintaining Patency of a Feeding Tube (Flushing) dated 3/23/23, directed staff to clean reusable equipment used for opening a clogged feeding tube according to manufacturer's instructions but did not include enteral feed pump, tube feeding pole, and supporting legs.<br><br>Facility policies Isolation Room Cleaning Procedures, Daily Cleaning Procedures, and Deep Clean Procedures undated, did not include cleaning of enteral feeding pump, tube feeding pole, or supporting legs.<br><br>EXHAUST FANS, WALL VENTS, AND LINING OF FLAT SURFACE<br><br>Findings include:<br><br>R11's annual Minimum Data Set (MDS) dated [DATE], indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living (ADLs), such as oral and toileting hygiene, dressing, mobility, and transfers.<br><br>R30's annual MDS dated [DATE], indicated R30 was cognitively intact and required substantial and/or maximal to dependent assistance with ADLs such as dressing, toileting hygiene, and rolling left and right and was independent with ADLs such as eating and use of motorized wheelchair.<br><br>R49's quarterly MDS dated [DATE], indicated was cognitively intact and independent with most ADLs, such as walking, hygiene, and transfers.<br><br>R62's quarterly MDS dated [DATE], indicated R62 had intact cognition and required partial and/or moderate assistance for toileting hygiene, and putting on and/or taking off footwear, supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking.<br><br>R69's quarterly MDS dated [DATE], indicated R69 had intact cognition and required assistance for most ADLs.<br><br>R70's quarterly MDS dated [DATE], indicated R70 was cognitively intact and required assistance for most ADLs.<br><br>The facility's Closed Work Orders report dated 4/18/24 through 9/17/24, lacked requests to clean exhaust fan for the shard bathroom and the wall vent and ceiling tile in R11 and R30's room. The report also lacked request to fix the lining of the furniture item in R11 and R30's room.<br><br>A TELS (platform to track maintenance tasks) Report Builder dated 9/17/24, indicated exhaust fans, including those in the bathroom, had been marked done on-time twice a month March 2024 through August 2024, and the last task completion was 9/9/24. Exhaust fan checks included ensuring air flow was sufficient enough to hold a piece of paper to the vent when operating and cleaning vents with a vacuum and air compressor, when needed to remove all dust.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 9/16/24 at 1:15 p.m., a wall vent near the ceiling in R11 and R30's room had grayish particles and ceiling tile had brownish colored streaks which started narrower near the wall vent then expanded out.<br><br>During observation on 9/16/24 at 2:08 p.m., a shared bathroom between R49, R62, R69, and R70 had a square shaped ceiling exhaust fan with gray particles plugging every other row of smaller squares.<br><br>During interview on 9/18/24 at 8:21 a.m., trained medication assistant (TMA)-A stated they put requests for maintenance into TELS.<br><br>During observation on 9/18/24 at 9:14 a.m., licensed practical nurse (LPN)-B cleaned a tube feeding pole of R11 who shared a room with R30. LPN-B went to bathroom to doff personal protective equipment and washed hands and upon exiting the bathroom brushed against the side lining of an extended table of a dresser. R30 stated he had told someone to fix that, and LPN-B did not reply.<br><br>During observation and interview on 9/19/24 at 2:35 p.m., the maintenance director (DOM), corporate maintenance (CM), and regional maintenance director (RM) stated fans and vents were checked daily by housekeeping. DOM, CM, and RM observed the exhaust fan in the shared bathroom and stated the exhaust fan looked pretty plugged and needed to be vacuumed out. DOM, CM, and RM observed the wall vent near the ceiling by R11's bed and verified needed cleaning. DOM verified the loose lining of the extended dresser in R11 and R30's room and was not aware it needed fixing and expected staff to place in a TELS (platform to track maintenance tasks) request when maintenance needed to fix an item.<br><br>During interview on 9/19/24 at 4:57 p.m., the administrator expected housekeeping to clean vents and exhaust fans during general daily and deep cleaning, and the exhaust fans and vents should be free of dust.<br><br>The facility was asked for a policy related to maintenance and fixing resident room items and/or furniture and stated they did not have such policy.<br><br>A facility policy Daily Cleaning Procedures undated, directed staff to work clockwise around the room and dust all high surfaces, which included vents. The policy also directed staff to dust vents in the restroom.<br><br>A facility policy Deep Clean Procedures undated, directed staff to use a high duster to clean vents. |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Villas at the Cedars | 7900 West 28th Street<br>Saint Louis Park, MN 55426 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on interview and observation, the facility failed to ensure a comprehensive and individualized care plan was developed for 1 of 1 resident (R49) reviewed for constipation.<br><br>Findings include:<br><br>R49's quarterly Minimum Data Set (MDS) dated [DATE], indicated was cognitively intact, had verbal behaviors and rejection of care, used a walker, and was independent with most activities of daily living (ADLs), such as walking, hygiene, and transfers. R49 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS indicated R49 had end stage renal disease (medical condition in which a person's kidneys stop functioning on a permanent basis) and diabetes mellitus (condition which affects how body uses blood sugar).<br><br>R49's care plan dated 9/16/24, lacked information about bowel and bladder incontinence, toileting, or constipation.<br><br>R49's nursing progress notes indicated the following:<br><br>-On 8/26/24 at 00:20 [12:20 a.m.], R49 called ambulance for stomach pain and constipation.<br><br>-On 8/26/24 at 03:09 [3:09 a.m.], R49 returned to the facility and senna-docusate sodium was ordered as needed.<br><br>-On 8/27/24 at 23:23 [11:23 p.m.], R49 called ambulance for discomfort and constipation and went to the University of Minnesota Fairview.<br><br>During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated staff looked at residents' care plans to know what kind of assistance residents required for eating, toileting, and other activities of daily living (ADLs). NA-B stated staff asked R49 whether he had bowel movements or not, and R49 spoke with the nurses when he had concerns about bowel movements.<br><br>During interview on 9/19/24 at 11:14 a.m., licensed practical nurse (LPN)-A stated staff referred to physician orders, medication and treatment administration records, and resident care plan to know how to care for a resident.<br><br>During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) stated R49 had history of constipation, refusing suppositories, and hospitalization related to abdominal pain. DON expected staff to monitor and follow facility protocol for constipation. DON reviewed R49's care plan and verified R49's care plan did not have information about bowel or bladder continence, constipation, or toileting needs. DON expected resident care plans to be resident-specific so staff knew how to assist them.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A facility policy Care Planning- Interdisciplinary Team dated 7/21/23, indicated care plans were based on resident's comprehensive assessment and developed by a care planning and/or interdisciplinary team.<br><br>A facility policy Care Planning dated 1/6/22, indicated would be developed based on resident's daily care routines and utilized by staff personnel for the purposes of providing care or services, and the care plan was modified and updated as the condition and care needs of the resident changed. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor non-pressure related skin conditions for 1 of 1 resident (R49) reviewed for skin concerns.<br><br>Findings include:<br><br>R49's quarterly Minimum Data Set (MDS) dated [DATE], indicated was cognitively intact, had verbal behaviors and rejection of care, used a walker, and was independent with most activities of daily living (ADLs), such as walking, hygiene, and transfers. R49 was occasionally incontinent of bladder and frequently incontinent of bowel. The MDS indicated R49 had end stage renal disease (medical condition in which a person's kidneys stop functioning on a permanent basis) and diabetes mellitus (condition which affects how body uses blood sugar). The MDS did not indicate any behavioral symptoms not directed towards others, such as scratching self. R49 had diabetic foot ulcer, dressings to feet, and nonsurgical dressings to areas other than to feet.<br><br>R49's care plan dated 9/16/24, direct staff to monitor R49's skin integrity daily during cares and weekly inspection by nurse, monitor skin breakdown for signs and/or symptoms of infection and report to provider, document on skin condition and keep provider informed of changes. These interventions were initiated 5/9/24. The care plan lacked information about papular eczema, rashes, and itching and/or scratching.<br><br>R49's Medication Administration Record (MAR) dated 8/1/24 through 8/31/24, indicated an order for triamcinolone acetonide external cream 0.1% topical to affected areas on arms and neck twice a day for papular eczema (type of eczema which causes red bumps that look similar to acne to appear on your skin). The MAR indicated R49 received 22 applications, refused twice, and was hospitalized three times when cream was supposed to be applied before the order was discontinued on 8/29/24. Four times at the beginning of the treatment staff indicated to see notes but the progress notes lacked text to further describe whether the cream was applied or not.<br><br>R49's Weekly Skin Inspection indicated the following:<br><br>-On 8/3/24 at 15:43 [3:43 p.m.], R49 had no visible bruising, swelling, redness or open areas to facial region, arms and declined for staff to assess other body parts.<br><br>-On 8/10/24 at 14:51 [2:51 p.m.], R49 refused shower and skin check.<br><br>-On 8/17/24 at 15:26 [3:26 p.m.], R49 had a wound to right foot and no visible bruising, swelling, redness or open areas to facial region, arms and declined for staff to assess other body parts.<br><br>-On 8/24/24 at 13:42 [1:42 p.m.], R49 refused skin assessment and had wound to right foot.<br><br>-On 9/7/24 at 14:45 [2:45 p.m.], R49 had no new skin issues.<br><br>(continued on next page) |

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| | 245187 | A. Building<br>B. Wing | 09/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Villas at the Cedars | 7900 West 28th Street<br>Saint Louis Park, MN 55426 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 9/14/24 at 15:37 [3:37 p.m.], R49 had a wound to right foot and no visible bruising, swelling, redness or open areas to facial region, arms and declined for staff to assess other body parts.<br><br>An Acute encounter note [provider progress note] dated 8/13/24 at 00:00 [midnight], indicated R49 had bumps on bilateral arms, nape of neck and hairline. Many papular, red bumps at varying stages .No drainage. No pain. Arms are generally itchy, skin is dry and flakey. Will trial topical corticosteroid, if no improvement I recommend referral to dermatology. The note directed for an order for triamcinolone cream 0.1% for arms, neck, and upper back for papular eczema twice daily for 14 days. The note indicated R49 believed the papular eczema was slowly worsening over one week and had the raised areas previously.<br><br>A History and Physical encounter note [provider progress note] dated 8/15/24 and 8/27/24 at 00:00 [midnight], indicated no new information about R49's papular eczema.<br><br>R49's nursing progress notes dated 8/5/24 at 11:16 [11:16 a.m.], indicated R49 had an order for dry itchy area twice daily but did not specify what was applied or where. R49's nursing progress notes dated 8/3/24 to 9/18/24, identified R49's skin was warm/dry but no further description related to bumps on arms.<br><br>During observation and interview on 9/16/24 at 6:23 p.m., R49 had multiple raised, circular areas on both upper extremities. R49 stated he had the raised areas on his arms for a while and discussed with his provider about seeing a dermatologist (medical doctor who specializes in conditions which affect the skin, hair, and nails). R49 stated he had an itching problem, used ointment, was not sure what helped his skin, and thought the raised areas were improving.<br><br>During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated they report skin concerns to the nurse right away and the nurse documented about residents' skin.<br><br>During interview on 9/19/24 at 11:14 a.m., licensed practical nurse (LPN)-A stated they notified the nurse manager, provider, and responsible party when a resident had a new skin concern, and the provider would let them know of any recommendations. LPN-A stated staff monitored skin conditions during daily treatments and weekly skin assessments and documented in progress notes or skin assessments. LPN-A stated they would update the provider if they were not seeing an improvement in skin condition or if a concern persisted after treatment completed. LPN-A stated they worked with R49 previously and knew about the raised areas on R49's upper extremities but would have to look in R49's chart to know if the raised areas were improving or not. LPN-A stated R49 was alert and oriented and would let staff know if he had concerns.<br><br>During interview on 9/19/24 at 11:27 a.m., registered nurse (RN)-B stated they noticed the raised areas on R49's arms and thought the raised areas were present the last time they worked with R49. RN-B stated they did not apply any treatment to R49's arms during the morning and would have to look at R49's chart to know if the raised areas were improving or not. RN-B did not see any current treatments or progress notes about the raised areas on R49's arms. RN-B reviewed the four most recent skin assessments. RN-B stated there were no specific notes about R49's arms, and R49's arms were visible to staff even when R49 refused skin assessments.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected new skin concerns to be monitored every shift until healed and/or noted in weekly skin assessments. DON reviewed R49's skin assessment, progress notes, and MAR and verified no documentation on if R49's skin was improving or not and so no dermatology appointment had been set up. DON stated resident was hospitalized when the 14 days of triamcinolone cream application ended. DON stated documentation was important for following up on skin conditions.<br><br>A facility policy Skin Assessment and Wound Management dated 3/24, expected staff to notify provider and treatment ordered, notify resident representative, complete education with resident/representative, initiate skin and wound evaluation, notify nurse manager, referral to dietary or therapy if appropriate, review and update care plan including interventions and risks for skin breakdown, and update resident care lists for new skin concerns. The policy directed staff to update provider and resident and/or representative as needed and update care plan as needed. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299<br><br>Based on observation, interview, and document review, the facility failed to provide routine range of motion for 1 of 2 residents (R11) reviewed for range of motion (ROM). Further, the facility failed to implement a walking program for 1 of 1 resident (R62) reviewed for walking program.<br><br>Findings include:<br><br>R11<br><br>R11's annual Minimum Data Set (MDS) dated [DATE], indicated R11 was in a persistent vegetative state and/or had no discernible consciousness. R11 was dependent on staff for activities of daily living, such as oral and toileting hygiene, dressing, mobility, and transfers, and had impairment on both sides of upper and lower extremities. R11 had diagnoses of quadriplegia (severe or complete loss of motor function in all four limbs) and epilepsy (brain condition which causes recurring burst of uncontrolled electrical activity and changes in behavior, movements, feelings, and levels of consciousness). The MDS indicated R11 had a feeding tube and no range of motion (for at least 15 minutes a day) in the last seven calendar days of the MDS period.<br><br>R11's face sheet dated 9/20/24, indicated R11 had additional diagnoses of contractures (permanent tightening of the muscles, tendons, skin, and nearby tissues which causes the joints to shorten and become stiff) to both ankles, right wrist, elbow, and shoulder.<br><br>R11's care plan dated 9/7/24, directed staff to perform passive range of motion with am/pm (before noon or midday/after noon or midday) cares daily.<br><br>R11's Functional Maintenance Program dated 4/18/21, directed staff to perform daily passive range of motion to bilateral lower extremities.<br><br>R11's Occupational Therapy Evaluation and Plan of Treatment revised 6/11/24, indicated nursing was managing R11's contracture impairment.<br><br>R11's Occupational Therapy Progress Report signed 6/25/24, indicated R11 was seen five days during the 6/7/24 to 6/24/24 progress period. The report indicated R11 had significant tone and contracture. The report included short and long-term goals related to developing a range of motion program for staff to continue after therapy discharge.<br><br>R11's Physical Therapy Evaluation and Plan of Treatment signed 6/14/24, the report indicated R11 had impaired left and right lower extremity range of motion and a caregiver goal to establish a range of motion program to prevent worsening of contractures and skin breakdown.<br><br>R11's Physical Therapy Treatment Encounter Notes signed 6/25/24, indicated passive range of motion to bilateral lower extremities completed to increase mobility and prevent the risk of contractures and education to nursing assistant on bed and body positioning to prevent contractures.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R11's medication and treatment administration record dated 7/1/24 through 9/19/24, lacked documentation on range of motion.<br><br>R11's progress notes dated 6/28/24 to 9/19/24, lacked documentation on range of motion.<br><br>R11's Documentation Survey Report (nursing assistant charting on tasks) dated 7/1/24 to 9/19/24, lacked documentation on range of motion.<br><br>During observation and interview on 9/18/24 at 9:32 a.m., nursing assistant (NA)-C and NA-E assisted R11 with morning cares, which included a bed bath, oral and toileting hygiene, and dressed R11 with a clean gown. R11's right wrist and elbow and left fingers were curled. NA-C and NA-E used a mechanical lift to assist R11 into his wheelchair and applied pillow boots to both feet. NA-C and NA-E left R11's room, and NA-C returned and covered R11 with a sheet and started remaking R11's bed with clean linen. NA-C left R11's room and stated they were going to get more linen. NA-C stated R11's morning cares were completed, and R11 would be repositioned throughout the shift. NA-C completed ROM on residents to assist with stiffness, pain, and circulation of blood. NA-C stated they looked at residents' schedule or charting to know who needed ROM. NA-C stated they did not perform ROM with R11 during morning cares but was going to later.<br><br>During interview on 9/18/24 at 10:33 a.m., NA-E stated they looked at residents' care plans to know who needed ROM and charted ROM when completed. NA-E stated they did not assist R11 with ROM, and therapy had not told tell them R11 needed ROM.<br><br>During interview on 9/19/24 at 12:34 p.m., the director of rehab (DOR) stated nursing received a form after therapy which described residents' functional maintenance program. DOR stated R11 had a stretching program, and R11's range of motion was difficult to maintain due to hospitalization s and chronic contractures.<br><br>During interview on 9/19/24 at 2:51 p.m., RN-B stated some walking programs or other functional maintenance programs, like ROM and/or stretching, were in the MAR or TAR (medication or treatment administration record), and NAs assisted the residents with the programs.<br><br>During interview on 9/19/24 at 3:10 p.m., the director of nursing (DON) expected ROM and strengthening exercises to be in care plans and documented in tasks or nursing notes. DON reviewed R11's ROM intervention in care plan and did not see ROM in the NA tasks or other areas of R11's chart. DON stated ROM exercises were important to improve R11's pain and positioning and prevent further contractures.<br><br>R62<br><br>R62's quarterly Minimum Data Set (MDS) dated [DATE], indicated R62 had intact cognition and no behaviors or rejection of cares. R62 had no impairment to upper or lower extremities, limb prosthesis, and wheelchair, and lacked identification of use of walker. R62 required partial and/or moderate assistance for toileting hygiene, toilet transfers, and putting on and/or taking off footwear, and supervision and/or touching assistance for chair and/or bed-to-chair transfers and walking. The MDS indicated R62 had zero days of training and skill practice in walking in the last seven days of the MDS look back period.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R62's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) Worksheet dated 6/14/24, was triggered due to assist needed with activities of daily living (ADLs), such as dressing, hygiene, sitting to standing, and transfers.<br><br>R62's care plan dated 9/10/24, directed staff to provide R62 with supervision for non-weight bearing transfers. The care plan lacked information on walking or ambulation.<br><br>R62's physician order with start date of 6/5/24, directed staff to provide R62 with non-pharmacological interventions, such as ambulation, if target behavior observed.<br><br>R62's therapy communication form dated 8/1/24, indicated R62 should be ambulated to and/or from all meals and to the bathroom with staff supervision and/or stand-by assistance with FWW (four wheeled walker).<br><br>R62's Associated Clinic of Psychology (ACP) Progress Note dated 8/12/24, directed staff to help R62 focus on interventions to help him feel he was making progress, such as working on walking.<br><br>R62's treatment administration record (TAR) dated 7/1/24 to 7/31/24, indicated R62 ambulated twice on 7/4/24 in response to target behavior but no other days. R62's TAR dated 8/1/24 to 8/31/24, indicated R62 had target behaviors and non-pharmacological interventions were completed other than ambulation. R62's TAR dated 9/1/24 to 9/19/24, indicated R62 did not have a target behavior which required a non-pharmacological intervention.<br><br>R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified walking in corridor (hallway) occurred at the following frequency:<br><br>6/1/24 through 6/30/24: 11 out of 30 mornings, and six out of 30 evenings.<br><br>7/1/24 through 7/31/24: three out of 31 mornings, and seven out of 31 evenings.<br><br>8/1/24 through 8/31/24: 14 out of 31 mornings, and nine out of 31 evenings.<br><br>9/1/24 through 9/19/24: five out of 19 mornings, and seven out of 19 mornings.<br><br>R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified NA (Not Applicable) or lacked documentation at the following frequency for walking in corridor:<br><br>6/1/24 through 6/30/24: 19 out of 30 mornings, and 24 out of 30 evenings.<br><br>7/1/24 through 7/31/24: 28 out of 31 mornings, and 24 out of 31 evenings.<br><br>8/1/24 through 8/31/24: 17 out of 31 mornings, and 22 out of 31 evenings.<br><br>9/1/24 through 9/19/24: 14 out of 19 mornings, and 12 out of 19 evenings.<br><br>R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified walking in the room occurred at the following frequency:<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 6/1/24 through 6/30/24: 10 out of 30 mornings, and four out of 30 evenings. One morning out of 30 was marked as RX (Resident not available).<br><br>7/1/24 through 7/31/24: three out of 31 mornings, and six out of 31 evenings.<br><br>8/1/24 through 8/31/24: 16 out of 31 mornings, and eight out of 31 evenings.<br><br>9/1/24 through 9/19/24: six out of 19 mornings, and five out of 19 evenings.<br><br>R62's Documentation Survey Report (nursing assistant charting on tasks) dated 6/1/24 through 9/19/24, identified NA (Not Applicable) or lacked documentation at the following frequency for walking in room:<br><br>6/1/24 through 6/30/24: 19 out of 30 mornings, and 26 out of 30 evenings.<br><br>7/1/24 through 7/31/24: 28 out of 31 mornings, and 25 out of 31 evenings.<br><br>8/1/24 through 8/31/24: 15 out of 31 mornings, 23 out of 31 evenings.<br><br>9/1/24 through 9/19/24: 13 out of 19 mornings, and 14 out of 19 evenings.<br><br>During interview on 9/16/24 at 1:56 p.m., R62 sat in a wheelchair with bilateral leg prosthetics. R62 stated he was supposed to walk every day but could not get assistance. R62 stated staff were aware and spoke with staff about walking but getting walking assistance was still a hit or miss. Unknown staff person approached resident with a walker and gait belt, but R62 stated he wanted to continue interview and assistance afterwards.<br><br>During observation on 9/18/24 at 7:13 a.m., R62 sat in his wheelchair with prosthetics on in the television area of the floor.<br><br>During observation on 9/18/24 at 8:46 a.m., R62 wheeled himself down the hallway.<br><br>During interview on 9/18/24 at 12:28 p.m., R62 sat in his wheelchair in his room and stated the staff did not return to walk with him on 9/16/24 and today (9/18/24) was the first time he walked with staff in a long time.<br><br>During interview on 9/19/24 at 10:58 a.m., nursing assistant (NA)-B stated staff looked at residents' care plans to know which residents have range of motion exercises, walking programs, and what assistance was required for eating, toileting, and other activities of daily living (ADLs). NA-B stated R62 ambulated, and R62 should have a walking program although NA-B was not as familiar with the hallway R62 was on.<br><br>During interview on 9/19/24 at 12:13 p.m., NA-D stated residents' care plan, assistance needs, and functional maintenance programs were on their computer and a sheet in a binder, and staff documented cares completed in POC (Point of Care). NA-D was not sure if R62 had a walking program and stated R62 was in his wheelchair most of the time.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245187 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/19/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villas at the Cedars | 7900 West 28th Street Saint Louis Park, MN 55426 |

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

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 9/19/24 at 12:34 p.m., the director of rehab (DOR) stated nursing received a form after therapy which described residents' functional maintenance program. DOR stated R62 had a double amputation and prosthetics. R62 walked 300 feet with a walker and supervision assistance. DOR stated R62 had a walking program but preferred to walk with certain NAs over others. DOR expected NAs to ask R62 to walk once or twice a week and document refusals, even if they were not R62's preferred NA.<br><br>During interview on 9/19/24 at 2:51 p.m., RN-B stated some walking programs or other functional maintenance programs, like ROM and/or stretching, were in the MAR or TAR (medication or treatment administration record), and NAs assisted the residents with the programs. RN-B stated they had seen a staff walking with R62 during their morning shift.<br><br>R62's Documentation Survey Report dated 9/19/24, indicated NA (Not Applicable) for walking in room and corridor for the morning shift.<br><br>During interview on 9/19/24 at 3:10 p.m., DON stated nursing received a sheet from therapy for walking programs and then entered the program into the care plan and/or into the NA tasks. DON reviewed R62's care plan and tasks and did not find a walking program description for R62. DON reviewed therapy communication form and ACP note. DON stated R62's walking program was important to give R62 a feeling of independence and control, strengthen R62, and get used to his prosthetic legs.<br><br>A facility policy Activities of Daily Living (ADLs)/Maintain Abilities Policy dated 3/31/23, directed staff to provide care and services for ADLs, such as ambulation, to ensure a resident's ability with ADLs maintained or improved unless resident had an unavoidable clinical condition. The policy did not address resident range of motion. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>22580<br><br>Based on observation, interview, and record review the facility failed to ensure personal protection equipment (PPE) was used when sorting dirty laundry. This had the potential to impact all 82 residents who reside in the facility.<br><br>Findings include:<br><br>During observation and interview on 9/19/24 at 10.24 a.m., Environmental Service Director (ESD) indicated the laundry aide would take the dirty laundry from the red chute in the laundry room and sort it. He indicated the staff was to wear a gown and gloves when handling dirty laundry. He indicated the gowns are to be hung on the wall in the dirty laundry room. He verified there were no gowns on the wall. Interview with laundry aide (LA) -A and LA- B at 10:35 a.m. they indicated there were no gowns, and there had not been for around a month. LA-B indicated she wears gloves when sorting dirty laundry, but no gowns have been available.<br><br>Review of undated Contaminated Laundry policy indicated:<br><br>Employers must ensure that employees who have contact with contaminated laundry wear appropriate PPE as discussed in the Bloodborne Pathogen Standard 29 CFR 1910.1030(d)(4)(iv)(B) when handling and/or sorting contaminated laundry.<br><br>Employers must ensure employee wear appropriate PPE such as gloves, gowns, face shields, and masks when sorting contaminated laundry. |

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

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22580<br><br>Based on interview and record review the facility failed to ensure the current pneumococcal vaccination was offered for 1 of 5 residents (R47) reviewed for immunizations.<br><br>Findings include:<br><br>Review of R47 record indicated R47 was admitted on [DATE], with diagnosis including metabolic encephalopathy(brain dysfunction caused by a chemical imbalance in the blood that affect the brain) , and dementia<br><br>Review of R47 record indicated R47's family gave written consent on 3/4/24, for R47 to receive the pneumococcal vaccine per PCP (Primary care provider) order and CDC (Center for Disease Control) guideline. R47's medical record lacked evidence R47 was offered or received the current pneumococcal vaccination.<br><br>Interview on 9/19/24 at 4:40 p.m., the Director of Nursing (DON) indicated if the consent was signed by the family, the physician would be notified, orders received, and the vaccination would be added to the medical record. The DON verified no orders were received from the physician. The DON indicated she would verify with R47's son and get an order from the physician. |