STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview and document review, the facility failed to provide and maintain personal dignity for 1 of 1 residents (R16) reviewed for dignity with personal care. Findings include: R16's quarterly Minimum Data Set (MDS) assessment, dated 8/16/24, documented an admitted to the facility on [DATE] and indicated R16 had intact cognition. R16 required maximal staff assistance for toileting, showering, lower body dressing and putting on/taking off footwear along with transfers. R16's diagnoses included: bilateral primary osteoarthritis of knee (a degenerative joint disease), heart failure (heart cannot pump or fill adequately), diabetes (chronic disease where body doesn't produce enough insulin or can't use insulin properly), and chronic pain. R16's care plan (CP), printed 8/14/24, indicated self-care deficit related to physical impairment: assist of 1 with dressing. In addition, a revision was made 8/13/24 (after survey entrance), alteration in psychosocial well-being .resident wears hospital gowns and does not wear clothes due to his catheter. Resident understands that he wears hospital gowns due to his catheter and he is agreeable to this with an intervention, resident understands that he wears hospital gown due to the use of catheter. R16's CP lacked evidence that it was R16's preference to wear a hospital gown versus personal clothing. Furthermore, CP lacked evidence of facility working with R16 to obtain personal clothing items. R16's progress notes reviewed from 5/29/24 to 8/13/24 included the following: -5/30/24: Res is very resistive to therapy always stating things like I can only do therapy if I am wearing shorts. -5/29/24: Res requested that writer call his [family] and have her bring 4XL short. Writer called [family] and [family] states she will bring them for res.R16's progress notes lacked evidence of follow-up to ensure R16 had received clothing. Furthermore, R16's progress notes lacked evidence R16 preferred to wear a hospital gown versus personal clothing. R16's Care Conference Form, dated 6/27/24, identified R16, R16's spouse, nurse manager, director of rehab and social worker were present for R16's quarterly care conference. The document lacked evidence the facility was assisting R16 with obtaining clothing. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing assistant care guides, printed 8/13/24, identified R16 needed assist of 1 staff in the ADLs (activities of daily living) column. The column titled, Behaviors and interventions safety/Miscellaneous, was left blank. The document lacked evidence that it was R16's preference to be dressed in a hospital gown daily. During observation and interview on 8/12/24 at 1:04 p.m., R16 was observed to have a blue hospital gown on with a t-shirt on underneath. R16's foley catheter (urinary catheter that drains urine from the bladder into a collection bag outside the body) tubing was observed laying over the top of his right leg with the covered urine collection bag hanging from the right side of the wheelchair. R16 stated that he prefers to wear shorts and a shirt but I don't have any here. R16 stated the staff are aware that he doesn't have any clothing. R16 stated that he asked his wife a while ago to bring him clothing but, she lives in another facility and has not had the time or strength to bring them to me, ya know she is sick. R16 stated again, I would feel a lot better if I was able to wear clothes when I go out instead of this gown. R16 stated, the staff have not offered to assist me to get my own clothing. During follow-up interview with R16 on 8/13/2024 at 9:41 a.m., R16 was observed sitting in his wheelchair with a t-shirt on with a hospital gown over the top. R16 stated surveyor could look in his closet and surveyor verified R16 had no clothes present in his closet or drawers. R16 stated he would feel more comfortable being dressed in shorts and a shirt when going out of his room instead of a hospital gown. R16's foley catheter tubing was visible from the bottom of the gown (which stopped at mid-thigh), crossing over his right thigh to the collection bag which was hanging on the right side of the wheelchair. On 8/13/2024 at 9:56 a.m., nursing assistant (NA)-B stated they are familiar with R16 and work with him frequently. NA-B verified that R16 does not have any personal clothing at the facility. NA-B verified they assist him with morning cares. NA-B stated, he would prefer to wear shorts, but we don't always have his size in the lost and found, when we do then I grab them for him to wear as that is what he prefers. NA-B stated R16 has not had any personal clothing since moving to the facility as far as I am aware as I have never seen clothes in his room. NA-B stated R16 seems more comfortable in shorts and a shirt and that is what he prefers. On 8/14/24 at 10:15 a.m., assistant director of nursing (ADON) stated that if a resident is not able to get clothing themselves, the facility would help them. ADON stated, we don't see a lot of folks without clothing. ADON stated the facility would work with the resident and the family to obtain clothing and when needed, we provide this [clothing]. ADON stated that nursing, social services and therapeutic recreation collaborate to ensure resident needs for clothing are met. On 8/14/24 at 10:27 a.m., social worker (SW)-B verified that she is familiar with R16. SW-B verified the facility will work with residents and their family to obtain clothing and will provide clothing to residents who need clothing. SW-B stated they are aware that R16 wears a hospital gown and stated, I think he is comfortable with it .he has a catheter so he has to wear a gown. SW-B verified they have not talked to R16 about his preferences about what he prefers to wear. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 10:33 a.m., administrator verified she is familiar with R16. Administrator stated she had talked to R16 in the past about clothing as he previously refused in the past to get dressed. Administrator verified R16 did not have clothing and reached out to R16's wife to bring in clothing. Administrator stated R16's clothing was discussed at R16's last care conference and after review of notes, verified this was not documented in the note. Administrator verified she was unsure if clothing had been brought in for R16. Administrator stated she was going to follow up on this issue and get clothing for R16 if he didn't have any. A policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 5/9/24, indicates the facility will honor and support each resident' preference, choices, values, and beliefs and during the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts.

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F 0584 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure necessary maintenance services were performed to provide a home-like environment for 1 of 1 residents (R41) with a broken overhead light. Findings include: R41's significant change Minimum Data Set (MDS) dated [DATE], indicated R41 had intact cognition, required supervision for oral hygiene and personal hygiene, and was independent with transfers. The facility's Closed Work Order report dated 7/1/24 through 7/30/24, included a request for R41 to get a mattress that fit correctly on the bed and indicated the light over the bed did not work. The facility order delivery report dated 8/6/24, included a picture of what appeared to be light bulbs and indicated the package was delivered on 8/6/24 and signed for by the maintenance director (MAD). During an interview on 8/12/24 at 1:05 p.m., R41 stated her overhead light had not worked since she had moved into her room, at least a few works ago, and the maintenance staff told her they would fix it but that never happened. During an interview and observation on 8/14/24 at 8:32 a.m., nursing assistant (NA)-A stated R41's light had been broken for a while and R41 had asked them to get it fixed more than once. NA-A stated they had requested maintenance to fix it but that never happened. NA-A was observed attempting to turn the light on with no result. R41's bed was observed pushed up against the farthest wall from the door, with a privacy curtain pulled between R41's bed and her roommate's bed which was against the right-side wall closer to the entrance. R41's room had a working light on the wall by the bathroom, close to the room's entrance. The entrance light was turned on but R41's side of the room, behind the privacy curtain continued to appear dimly lit. During an interview and observation on 8/14/24 at 9:05 a.m., the MAD stated he was not aware the light was broken. The MAD was observed entering R41's room and confirmed that even with the entrance light on, the room appeared dimly lit. The MAD stated the facility was switching over to LED lights and they had run out but had gotten an order last week that could be used to fix R41's overhead light. During an interview on 8/14/24 at 9:50 a.m., the MAD said he was the one who reviewed the maintenance requests, and he must have accidentally closed the request for R41's overhead light to be fixed. The MAD stated he must have missed the request for R41's light to be fixed because it was under the same request as the mattress. A policy regarding maintenance requests was made and a TELS Masters procedure dated 2019 was received. The procedure did not address an expected timeline for completing maintenance requests.

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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** 33925 Based on interview and document review, the facility failed to ensure care-planned interventions for substance use were implemented and documented to provide continuity of care for 2 of 2 residents (R44, R1); and failed to individualize the care plan to include target behaviors for psychotropic medication use for 1 of 5 (R48) residents reviewed for unnecessary medication use. Findings include: R44 R44's quarterly Minimum Data Set (MDS), dated [DATE], identified R44 had intact cognition and multiple medical conditions including heart failure, high blood pressure, and kidney disease. Further, the MDS outlined R44 consumed diuretic and opioid medications. R44's care plan, printed 8/13/24, identified R44's assessed problems or concerns along with corresponding interventions for each. The care plan outlined R44 was a current, independent smoker and had a history of substance abuse including, . has diagnosis of alcohol dependence with withdrawal unspecified. Reports drinking a fifth of alcohol every other day . offered CD [chemical dependency] and declined . has been sober in the facility. A goal was listed which read, Resident will be supported in compliance with current substance use policy, along with multiple interventions including encouraging him to attend activities to reduce boredom, monitoring for signs of intoxication, and, Staff to monitor and check vitals of resident if under the influence of a substance. R44's progress note, dated 7/1/24 at 10:08 p.m., identified R44 was intoxicated with dictation, . no medication was given at bedtime. However, R44's entire medical record, including treatment history and vital signs documentation, was reviewed and lacked evidence any vital signs were checked or monitored as directed by the care plan. R44's progress note, dated 8/6/24 at 6:02 p.m., identified R44 was found sitting on the smoking patio. The note outlined, [R44] . drinking and crying to writer . states 'he [expletive] up but needed a drink' . stated that he was just feeling down. Writer empathized . educated [resident] that smoking weedand [sic] drinking is not a proper way to deal with his emotions. However, again, the medical record was reviewed and lacked evidence any vital signs were checked or monitored as directed by the care plan. When interviewed on 8/13/24 at 2:01 p.m., registered nurse (RN)-B stated they had worked with R44 multiple times adding he, of late, seemed to have been sleeping a lot during the day. RN-B stated R44 often left the campus and did, at times, demonstrate verbal behaviors to the staff adding, [R44] will cuss ya out. RN-B stated they were aware R44 consumed alcohol but since they usually worked on the morning shift, they feel like I miss a lot of the intoxicated [issues], adding they last knew or heard of R44 using alcohol or substances like two months ago. RN-B stated if R44 was intoxicated, then the nurses should be checking his vital signs, updating the medical provider, and recording the vital signs in the vital tab on the medical record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 at 11:41 a.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed R44's medical record. ADON acknowledged the lack of recorded vital signs and stated staff were sometimes putting them in and sometimes not. ADON verified R44 actively consumed alcohol and explained staff should be checking his vital signs and updating the medical provider if found to be drinking or intoxicated adding, They need to at least look at them. ADON verified those actions, including vital sign monitoring, should be recorded in the medical record but expressed they suspected staff members took them and wrote them down, however, just never entered them. ADON added, If you take a set of vitals, I want them in [the record]. Further, ADON verified the campus' used agency staffing and they stated it was important to ensure nursing actions in response to alcohol and substance use, like monitoring vital signs, was important to record in the medical record to allow continuity of care as following nurses or shifts wouldn't always know R44's condition prior if not recorded. 48065 R1 R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, did not reject cares and occasionally had verbal behaviors toward others without display of hallucinations or delusions. R1's Clinical Diagnosis Report printed 8/13/24, indicated chronic obstructive pulmonary disease (lung disease that blocks the airflow and makes it difficult to breath), restless leg syndrome (a condition that causes a strong urge to move the legs), schizoaffective disorder (mental health condition that includes features of both schizophrenia and mood disorder), bipolar disorder (a mental condition that causes mood swings), essential hypertension (abnormally high blood pressure that's not the result of a medical condition), tobacco use, cocaine abuse and alcohol abuse. R1's care plan printed 8/13/24, indicated R1 had a history and diagnosis of cocaine and alcohol abuse. R1 attended a CD (chemical dependence) treatment program for a short time then declined. R1 used crack cocaine and alcohol. Care plan goal read: Staff will make every reasonable attempt to keep resident safe in the event of an opioid-related overdose. R1's care plan outlined the following interventions: - Notifi doctor of substance use while at the facility. - Encourage resident to stay in her room if she has signs of alcohol intoxication or substance abuse. - Monitor for intoxication/impairment. - Observe for signs of intoxication and follow orders if observed. - Staff to monitor and check vital signs if under the influence of a substance. - When resident is noted to have been smoking illegal substances like marijuana, cocaine, or meth, etc. OR is intoxicated (unsteady gait, slurred speech, pinpoint pupils, etc.) DO NOT ADMINISTER ANY medications. Updated the provider for more directions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Medication Administration Records (MAR) included an order to monitor for signs of intoxication, unsteady gait, slurred speech, odor of alcohol/illicit substance, check pupils, sclera for constricted or blood shot . R1's MAR review for the months of 6/2024, 7/2024 and 8/2024, the nursing staff identified and documented on the MAR, several episodes in which R1 displayed signs of intoxication. Documentation as follows: - On June - 6/7, 6/10, 6/24 and 6/30. - On July - 7/8, 7/14, 7/17 and 7/18. - On August - 8/3 and 8/6. Review of R1's MARs for the months of June, July, and August 2024, lacked indication R1's medications were held any of the days the staff documented during which R1 showed signs of intoxication. Review of R1's clinical progress notes from June 1st, 2024, through August 12th, 2024, lacked documentation related to R1's signs of intoxication, vital signs, calling the provider, and obtaining instructions to administer or hold scheduled medications. During interview on 8/13/24 at 10:40 a.m., licensed practical nurse (LPN)-B stated, she [R1] drank last night; she does this very often. LPN-B said, R1 woke up this morning, took her medications and went back to sleep. LPN-B stated she could tell R1 was intoxicated because it took R1 five minutes to slightly raise herself on her elbow while lying in bed. LPN-B stated R1's speech was slurred, couldn't articulate her words, and there was an empty bottle of alcohol on her bed side table. During interview on 8/13/24 at 2:10 p.m., LPN-B stated she did not check R1's vital signs this morning. LPN-B stated the nurse practitioner (NP)-B was at the facility this morning and she authorized to administer all medications to R1. LPN-B stated she will complete today's documentation before the end of her shift. During interview on 8/14/24 at 10:38 a.m., pharmacist (PH) reviewed R1's medication regimen. PH stated if resident was intoxicated or was under the influence of narcotics or an illegal substance, her medications would cause more sedation. PH stated her medication, Belbuca, (opioid pain control medication) posed a potential for respiratory distress. During interview on 8/14/24 at 11:16 a.m. NP-B stated, at base line R1's speech is not clear, she is not chatty, did she go to the hospital? NP-B stated she was not aware how often R1 was using alcohol or other substances. NP-B stated if a nurse suspects a resident is intoxicated or under the influence of a substance, NP-B expected the nurses to check vital signs and neurological status. NP-B added it's basic nursing. Regarding the administration of medication to a resident showing signs of intoxication or under the influence of a substance, NP-B stated, if the residents' vital signs are stable, I'm not opposed for the nurses to administer their medications. If a resident takes pain medications the nurses need to clarify the orders with the pain clinic. NP-B added, the nurses will know to hold the medications if R1's vital signs are off. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/15/24 at 10:10 a.m., interim director of nursing (DON), stated the nurses needed to keep residents safe, check vital signs, and call the providers. The provider might want to hold the resident's medications if the resident was intoxicated. Additionally stating the expectation was, the nurses need to follow the guidelines to assure the safety of the resident. 49336 R48 R48's printed medical diagnosis list dated 8/14/24 identified she had depression, encephalopathy (a group of conditions that cause brain dysfunction), alcohol abuse, and cocaine abuse. R48's admission Minimum Data Set (MDS), dated [DATE], identified an admitted [DATE]. The MDS indicated R48 was cognitively intact and had no behaviors, R48 had little interest or pleasure in doing things and felt down, depressed, or hopeless never to 1 day. In addition the MDS documented R48 had taken antipsychotics, antianxiety and antidepressant medication on a routine basis. R48's Medication Administration Record (MAR) dated 8/2024, identified R48 had taken olanzapine (an antipsychotic medication to treat schizophrenia and bipolar disorders) 5 milligrams (mg) twice a day for anxiety with a start date of 7/03/24. R48's 8/2024, Treatment Administration Record (TAR) identified R48 was monitored for behaviors or reactions to lorazepam (anti-anxiety medication), venlafaxine (medication to treat depression/anxiety), and buspar (medication to treat depression/anxiety) every Wednesday. There was no mention of target behaviors it was prescribed to treat or alleviate for olanzapine medication use. R48's undated care plan identified the goal was for R48 not to experience any acute drug reaction to current psychotropic regimen. Interventions were for staff to administer medication as ordered, report suspected acute drug reactions to the provider and to update the provider of the effeicency of psychotropic medications. The care plan lacked individualized documentation of pharmacological and non-pharmalogical interventions for R48, as well as side effects and/or adverse effects of olazanpine medication use. During interview on 8/14/24 at 1:21 p.m., interim director of nursing (DON) stated the facility did not include specific behavior charting for R48's olanzapine medication and the care plan lacked target symptoms and/or reactions to determine if the medication was effective. During interview on 8/14/24 at 2:38 p.m., administrator stated each resident's care plan should reflect pharmacological interventions, including drug specific side effects for use of antipsychotic medications. Review of July 2015 Care Planning policy identified the facility would place individualized goals and interventions that target resident's problem areas and from analyzed information gathered from the resident's comprehensive assessments. The facility would modify and update the condition and care needs of resident changes, as indicated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Care Planning, dated 1/6/22, indicated each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. Facility's policy titled Substance Use dated 7/2024, indicated licensed nurse will observe for positive signs of intoxication including unsteady gait, slurred speech, odor of alcohol, cannabis, or illicit substance, check pupils and sclera for constriction or blood shot. Policy also indicated, provider needed to be notified to discuss medications orders; documentation of residents' condition needed to be completed in progress notes and MAR. Furthermore, policy indicated notification to providers needed to be documented.

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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. 49339 Based on observation, interview and document review, the facility failed to accurately and comprehensively assess for smoking practices for 1 of 1 residents (R35) reviewed for smoking. Findings include: R35's admission Minimum Data Set (MDS) assessment, 7/19/24, indicated R35 had intact cognition. Diagnoses included: paraplegia (chronic condition that causes loss of function and sensation in the lower half of the body), and diabetes (chronic disease that occurs when body doesn't produce enough insulin or can't use insulin properly). In section GG Functional Abilities and Goals: under section GG0130 self-care: indicated R35 needed partial/moderate assistance from staff with eating. Other areas of activities of daily living (ADLs), R35's level of assistance range from partial/moderate assistance to dependent on staff assistance. Furthermore, in section J Health Conditions: under section J1300 current tobacco use: indicated R35 uses tobacco by a check mark in the yes box. R35's Smoking Evaluation, dated 7/13/24, indicated R35 does not identify as a smoker. The remaining questions of the assessment remained unanswered. The assessment would have assessed areas including: cognitive loss, visual deficits, dexterity problems, frequency of smoking, ability to light own cigarette, if R35 had been deemed safe to store/handle their own cigarette and lighter, oxygen use, need for adaptive equipment such as smoking apron, cigarette extension/holder, supervision and/or individualized plan of care along with a summary and intervention in place. The Smoking Evaluation lacked evidence that a comprehensive assessment was completed for R35. During interview on 8/12/24 at 1:02 p.m., R35 stated that he smokes cigarettes and has smoked since being moving into facility. R35 stated that he must smoke in the designated smoking area, and smoking is not allowed inside the facility. R35 stated he keeps his cigarettes and lighter with him. R35 stated, the place I stayed at before did a smoking assessment with me to make sure I was safe to smoke but they [facility] haven't done that here .no one has watched me smoke or talked to me about it. R35 stated staff are not outside in the designated smoking area when he is outside smoking, and he does not use any adaptive equipment for smoking or wear a smoking apron. R35 did not have any burn marks on his clothes or his fingers. R35 indicated staff are aware that he smokes as he tells them he is going outside to smoke. R35's care plan, printed 8/13/24, indicated, R35 admitted was 7/12/24. On 7/22/24, Resident currently smokes at this facility; resident can smoke safety and independently, was added to the care plan with the following interventions: - education for potential danger of Butane lighter, - Independent with smoking per evaluation - Smoking evaluation per facility policy and PRN. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's progress notes, dated 7/16/24 to 8/16/24, were reviewed. The progress notes lacked evidence further assessments or observations of R35 smoking. During interview on 8/13/24 at 10:47 a.m., licensed practical nurse (LPN)-B indicated that they are familiar with R35 and work with him often. LPN-B verified that all residents have a smoking assessment completed to ensure they are safe to smoke. LPN-B stated, we want to make sure they can light it .can hold it .monitor for burn holes reassess residents as needed when we see changes. LPN-B verified R35 is a smoker, he smokes Newport's. LPN-B stated that R35 has smoked since arriving at the facility. LPN-B stated they have never seen any burn holes in R35's clothes, his hands or anywhere on his body. After reviewing electronic medical record (EMR), LPN-B verified the Smoking Evaluation, dated 7/13/24, indicated R35 was not a smoker and stated, he does smoke and needs a full assessment completed. During an interview on 8/13/24 at 11:10 a.m., LPN-A verified they are familiar with R35. LPN-A stated smoking assessments are completed to ensure residents are safe to smoke as they determine if a resident needs any assistive devices, if they need supervision, understand where they have to smoke, an if they are able to hold their cigarettes. LPN-A stated they are unsure if R35 smokes. After review of the EMR, LPN-A stated, the assessment indicates he does not smoke. LPN-A verified smoking assessments are done quarterly and as needed. LPN-A stated they were going to complete another assessment with R35. During interview with assistant director of nursing (ADON) on 8/13/24 at 12:56 p.m., ADON indicated smoking assessments are completed when a resident first admits to the facility, quarterly and as needed. ADON stated smoking assessments are completed to help ensure residents are safe when smoking. ADON verified during a smoking assessment, residents are observed smoking. After reviewing EMR, ADON verified R35's smoking assessment completed indicated he was a non-smoker. ADON further verified R35's care plan indicated R35 had been assessed and can smoke safely and independently. ADON indicated he was going to follow-up and determine whether a smoking assessment needed to be completed or the care plan needed to be updated. During an observation on 8/13/24 at 1:20 p.m., R35 went outside the front of the building in his power wheelchair independently. R35 was observed with a small pouch that hung from around his neck which contained a pack of cigarettes and lighter inside. R35 was noted to interact with other residents outside. During observation, R35 used both hands to pick up the small pouch, bring it up to his mouth and bite a cigarette out of the pack. R35 took the cigarette (unlit) out of his mouth and laid it on his stomach. R35 used both hands to pick up the pouch, brought it to his mouth, shook it and grabed the lighter out with his mouth. R35 laid the pouch down, took the lighter out his mouth, put the cigarette in his mouth and lit his cigarette. R35 was observed smoking his entire cigarette. R35 ashed his cigarette away from his body during the entire observation, held the cigarette over the side of his wheelchair when not actively smoking and extinguished it properly when done. On 8/14/24 at 10:15 a.m., ADON verified the smoking assessment that had been completed with R35 was incorrect as R35 is a smoker. ADON stated a new smoking assessment had been completed and R35 was deemed to be a safe to smoke. On 8/14/24 at 10:39 a.m., administrator stated the importance of smoking assessment is it helps ensure residents are safe to smoke. Administrator stated smoking assessments are completed upon admission, quarterly and as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Resident Smoking Policy, dated 1/26/24, indicated the intent of the policy is to outline the procedure for safe resident smoking including evaluation of residents to determine those who are capable of smoking independently, and to provide a designated smoking area for those residents who choose to smoke.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to comprehensively assess and, if needed, develop or implement interventions with newly developed back pain for 1 of 2 residents (R11) reviewed for pain management. Findings include: R11's quarterly Minimum Data Set (MDS), dated [DATE], identified R11 had moderate cognitive impairment and required, at least, partial/moderate assistance with sitting up or transferring. Further, under Section J - Health Conditions, the MDS identified R11 consumed no scheduled or as-needed (i.e., PRN) pain medication; but reported pain on a frequent basis which interfered with day-to-day activities. The MDS recorded a pain rating level, 02. R11's most recent MHM (Monarch Healthcare Management) Pain Evaluations V3, dated 6/25/24, identified R11 did not consume scheduled or PRN pain medication, however, received non-pharmacological interventions for pain. The evaluation outlined R11 had reported pain which occurred, Frequently, and did interfere with day-to-day activities adding R11 had rated it, 02, on the 0-10 pain scale with additional checkmarks placed next to the options, Vocal complaints of pain ., and, Facial expressions . The evaluation concluded with a section to record what, if any, medications or non-pharmacological interventions were taken along with a box labeled, Comments. This identified R11 used warm towels for pain control and had dictation reading, . has left sided weakness and contractures [related to] a hx [history] of stroke . frequently refuses range or [sic] motion and their brace to keep their hand open . reports warmed towels are effective for loosening the tension . easing the pain in their hand. However, the completed evaluation lacked any further information on exact locations (i.e., back, limbs) or other characteristics of R11's pain including what, if any, input R11 had to his pain management and treatment plan. R11's care plan, printed 8/13/24, identified R11 current identified problem or focus statements along with various interventions to help R11 meet outlined goals of care. The care plan outlined R11 was at risk for an alteration in comfort and listed a goal which read, . will have adequate relief from pain as evidenced by verbalization, and freedom from signs/symptoms of non-verbal indicators of pain. The interventions listed to help R11 meet this goal included providing non-medicinal forms of pain relief such as warmed towels, medications as ordered by the physician, and monitoring for pain medication side effects. However, the care plan lacked any further information on what, if any, current or actual pain issues R11 had (i.e., characteristics of his pain, location of pain, his goals for pain management). On 8/12/24 at 3:27 p.m., R11 was observed laying in bed while in his room with his knees towards his chest and his body nearly in a fetal position. R11 was interviewed and stated he had a lot of pain which was in his arms and lower back but added, [It's] everywhere. R11 was unsure what, if any, pain medication he took to help it and stated he was unsure what, if any, actions staff took to help him with it such as ice packs or heat adding, Maybe Tylenol. R11 stated his pain was not being managed and expressed aloud, I need something different. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 8/2024, identified R11's current medications and treatments with their respective administrations or refusals. These identified an order which read, Monitor for pain. Offer resident Bio Freeze [topical pain gel] every 4 hours for monitoring, with a start date, 05/06/2024. The order had a recorded, Pain Level, with each time-threshold and the recorded levels ranged from 0 to 4 including six episodes of 4 rated over the past week. The MAR outlined two recorded doses of PRN Bio Freeze were applied on 8/3/24 and 8/13/24, respectively, with each administration being effective. R11's corresponding progress note, dated 8/2/24, identified the medication was administered but lacked any recorded characteristics of the pain (i.e., location, sensation, etc.). When interviewed on 8/13/24 at 9:22 a.m., nursing assistant (NA)-C stated they had worked with R11 multiple times and described him as not the easiest to care for at times due to behaviors. NA-C stated R11 needed help with most cares and he, of late, had been complaining more about pain adding, He complains of back pain a lot. NA-C stated R11 spent a majority of time in his bed and the back pain complaints of late were fairly new happening for maybe like a week now. NA-C stated R11 had actually asked for a back rub the day prior due to the pain which was new. NA-C expressed the nurses were aware of it, to their knowledge, adding aloud, I'm pretty sure they're doing things about it. When interviewed on 8/13/24 at 10:39 a.m., registered nurse (RN)-B stated they had worked with R11 multiple times prior and the care provided to him depends on the day or if he'd allow it adding, The new thing is back pain. RN-B explained R11 used to spend more time up in his wheelchair but, of late, staff had heard more of an increase in back pain complaints which had been happening the past month-ish. RN-B stated the pain evaluations (i.e., MHM Pain Evaluation) were done upon admission and by the nurse managers, but if new pain was reported then the floor nurses could also do it and update the physician. However, R11's medical record was reviewed and lacked evidence the newly developed back pain had been comprehensively assessed to determine what, if any, interventions were needed to promote comfort for R11. On 8/13/24 at 1:07 p.m., the assistant director of nursing (ADON) was interviewed and verified they were the nurse manager for R11's unit. ADON reviewed R11's medical record and explained R11's recorded pain levels were not a big jump over previously recorded ones but verified if staff are hearing reports of pain, including new locations of pain, then it should be evaluated and recorded in the medical record notes. ADON stated nobody had reported the back pain to them so, as a result, it was not evaluated using the MHM Pain Evaluation which is the tool used to evaluate pain and interventions needed. ADON stated, had they been told of it, then it would have been assessed adding, People should not be sitting in pain. A facility' provided Pain Management Protocol, dated 3/2023, identified a purpose of ensuring residents with pain or at risk of such, would have an effective pain management program in place. The policy directed, The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The policy continued, Resident's plan of care will reflect pain management needs.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49034 Based on observation, interview, and document review, the facility failed to ensure the accuracy of the posted nurse staffing information with the potential to affect all 65 residents residing in the facility and/or visitors who may wish to view the information. Findings include: The facility staff postings dated 8/5/24- 8/14/24, each of the days indicated on the day and evening shifts the facility had six nursing assistants (NA) and on the night shifts they had three NAs. The staffing report dated 8/5/24, indicated on the day shift the facility had three NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/6/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had five NAs, and on the night shift they had two NAs. The staffing report dated 8/7/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/8/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/9/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/10/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/11/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/12/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/13/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. The staffing report dated 8/14/24, indicated on the day shift the facility had four NAs, on the evening shift the facility had four NAs, and on the night shift they had two NAs. During an interview on 8/15/24 at 8:37 a.m., the staffing coordinator (SC) stated the facility used a computer program to pull in the staffing information for the staff postings. The SC stated after comparing the staffing data to the staff posting, it looked like the computer was pulling the unfilled NA slots every day as if they were filled, so the staff postings were inaccurate. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility's Nursing Hours Posting policy dated 10/22, indicated the facility must post the total number of NAs directly responsible for resident care during each shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and reduce the risk of complication for 1 of 6 residents (R34) observed to receive medication during the survey. Findings include: R34's annual Minimum Data Set (MDS) dated [DATE], indicated R34 had intact cognition and was diagnosed with asthma. R34 required maximal assistance with eating and oral hygiene. R34's Order Summary Report dated 8/15/24, indicated R34 had an order for two puffs of 50 micrograms (mcg)/five mcg of Dulera (an inhaler used to control symptoms of asthma) two times a day. R34's Medication Administration Record (MAR) dated 8/1/24 through 8/14/24, indicated R34 had received two puffs of 50 mcg/five mcg of Dulera two times a day except for on 8/13/24 where a 9 was coded meaning other/ see nurse notes for the morning administration. During an observation and interview on 8/13/24 at 8:50 a.m., licensed practical nurse (LPN)-B stated R34 was due for his Dulera but the medication was out so she would have to order another inhaler. LPN-B stated it should have been ordered when about 15 doses were left but it looked like that had not happened. LPN-B stated she always reorders the medication when they are low but had noticed a problem with other nurses not re-ordering timely. LPN-B stated the medication would not arrive at the facility until about 3 p.m., so R34 would not get the medication on time and would likely not receive the medication until the evening dose. R34's progress note dated 8/13/24 at 12:00 p.m., indicated the Dulera was not available. During an interview on 8/15/24 at 8:16 a.m., the interim director of nursing (DON) stated nursing staff should reorder medications when they are noticed to be running low to avoid residents missing doses. The facility Medication Ordering and Receiving from Pharmacy policy dated 4/18, indicated nursing staff should reorder medications three to five days in advance to ensure an adequate supply.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure adequate blood sugar monitoring was completed and documented to reduce the risk for potential unnecessary administration or associated complications related to insulin (medication used to lower blood sugar levels) use for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8's annual Minimum Data Set (MDS) dated [DATE], indicated R8 had intact cognition and had no rejection of care behaviors during the look-back period (LBP). The MDS indicated R8 was diagnosed with diabetes, depression, and schizophrenia (a severe mental illness that affects how people perceive and interact with reality, often causing hallucinations and delusions). R8's Medication Administration Record (MAR) dated 8/1/24 through 8/12/24, included an order dated 7/23/24 for 18 units of subcutaneous insulin glargine (long-acting insulin) for diabetes that was received every morning during the period. The MAR did not include corresponding blood sugar level tests. The MAR included an order dated 7/23/24 for eight units of subcutaneous insulin aspart (fast-acting insulin) that was received three times a day before meals (with occasional missed doses due to R8 being absent from home or hold) during the period for diabetes. The MAR did not include corresponding blood sugar level tests. R8's Order Summary report dated 8/13/24, was reviewed and did not include an order for daily blood sugar checks until 8/13/24 with an order for three times a day blood sugar checks. R8's Blood Sugar Summary dated 7/22/24 through 8/12/24, indicated R8's blood sugar results were recorded twice during the period with a result of 371 on 8/3/24 and a result of 352 on 7/28/24. R8's progress note dated 8/6/24 at 11:48 a.m., indicated R8 had a blood sugar level of 68 and as a result, his insulin was held. R8's progress notes dated 7/22/24 through 8/12/24 were reviewed and included no further blood sugar checks. R8's care plan dated 5/3/24, indicated R8 had a potential for an alteration in blood sugar levels related to a diagnosis of diabetes. The care plan indicated staff were to administer medications and obtain labs as ordered and to report abnormal results per the physician's parameters or guidelines. R8's provider note dated 7/18/24, indicated R8's blood sugars were higher than desired and his insulin dose would be increased. During an interview on 8/13/24 at 9:37 a.m., nurse practitioner (NP)-A stated R8's blood sugar levels were higher than desired when he last saw R8 on 7/18/24 so he had increased his insulin dosage and he expected nursing staff to monitor R8's blood sugar levels especially with this adjustment. NP-A stated after now reviewing R8's chart, he did not see an order for blood sugar checks, and it must have accidently been discontinued when he changed R8's insulin orders in July. NP-A stated he would add an order now for blood sugar checks as it was important that this was being completed to avoid possible complications from insulin use. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/24 at 9:47 a.m., registered nurse (RN)-B stated blood sugar levels should be taken with every meal and documented in the resident chart but was unsure if this was being completed for R8. During an interview on 8/13/24 at 9:54 a.m., the assistant director of nursing (ADON) stated he had reviewed R8's medical record and did not see that blood sugar levels were being consistently monitored for R8. The ADON stated it looked like when R8's insulin orders were updated, the order for blood sugar checks must have fallen off. During an interview dated 8/15/24 at 8:16 a.m., regional nurse consultant (RNC)-A stated the facility had reviewed R8's medical record and did not find a record of consistent blood monitoring consistently since R8's insulin orders were adjusted. The RNC-A stated it looked like when the insulin order had been discontinued, the order to check R8's blood sugar level had also been so now they would add the orders separately. The undated facility Blood Glucose Monitoring Procedure, indicated after blood sugar levels were taken the procedure should be documented.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336 Based on interview and record review the facility failed to have a qualifying diagnosis for routine use of an antipsychotic medication and failed to complete an abnormal involuntary movement scale (AIMS) for 1 of 1 resident (R48) reviewed for unnecessary medications. Findings include: R48's printed medical diagnosis list identified she had depression, encephalopathy, alcohol abuse, and cocaine abuse. R48's 7/18/24, Minimum Data Set (MDS) identified an admitted [DATE]. R48 was cognitively intact and had no behaviors. R48 had little interest or pleasure in doing things and felt down, depressed, or hopeless never to 1 day. R48 had taken antipsychotics, antianxiety and antidepressant on a routine basis. R48's 8/2024, Medication Administration Record (MAR) identified R48 had taken olanzapine (an antipsychotic medication to treat schizophrenia and bipolar disorders) 5 milligrams (mg) twice a day for anxiety with a start date of 7/03/24. R48 had received 58 doses of olanzapine medication from 7/3/24 to 7/31/24 and 27 doses from 8/01/24 to 8/14/24. R48's medical record lacked a baseline AIMS assessment (a clinical outcome scale used to assess abnormal movements in people with tardive dyskinesia. Tardive dyskinesia is a movement disorder characterized by irregular, involuntary movements most commonly in areas of the face, around the eyes, and of the mouth, including the jaw, tongue, and lips.) before initiation of her olanzapine medication. R48's undated care plan identified the goal was for R48 not to experience any acute drug reaction to current R48's psychotropic medication regimen. Interventions were for staff to administer medication as ordered, report suspected acute drug reactions to the provider and to update the provider of the efficiency of psychotropic medications. The care plan lacked individualized documentation of pharmacological and non-pharmalogical interventions for R48, as well as side effects and/or adverse effects of olanzapine medication use. R48's 8/09/24, Consultant Pharmacist Recommendation to Physician identified R48 had taken olanzapine medication with a diagnosis of anxiety and was not considered an appropriate indication for antipsychotic use and would require a gradual dose reduction if clinically appropriate. The provider indicated R48 would need a referral to the Associated Clinic of Psychology. There was no mention of a timeline when R48 should be seen and/or a gradual dose reduction had been implemented. During interview on 8/14/24 at 1:22 p.m., with interim director of nursing (DON), DON stated the facility had received a pharmacy recommendation of R48 antipsychotic medication use last month and was unaware if the facility had followed through for the referral to the Associated Clinic of Psychology. Lastly, she agreed an AIMS assessment should have been completed for R48 as stated in the facility's policy and admitted R48's initial AIMS assessment had been completed on 8/14/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 8/14/24 at 2:38 p.m., administrator the expectation would be the facility would perform an AIMS assessment on residents who were prescribed antipsychotic medications. A call was placed out to the Clinical Pharmacist and was unable to complete an interview during the survey visit. Review of 7/8/21 Psychotropic Medication Use policy identified the facility residents would receive psychotropic medications when necessary to treat specific conditions. The facility would evaluate appropriateness and indications for use of psychotropic medication, as well as, individualized pharmacological interventions, non-pharmalogical interventions, movement disorders, cognitive and/or behavioral changes would be initiated in the resident's care plan. In addition, the facility would perform an AIMS assessment to screen for tardive dyskinesia (is repetitive, involuntary movements, such as grimacing and eye blinking) at baseline, semi-annually, and after discontinuation every month for 3 months.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 3 of 3 residents (R16, R35, R44) reviewed for dining. This had the the potential to affect 24 residents identified to reside on the unit where the meal was served. Findings include: R16's quarterly Minimum Data Set (MDS), dated [DATE], identified R16 had intact cognition and demonstrated no delusional thinking. When interviewed on 8/12/24 at 1:04 p.m., R16 stated the meals served were always cold and they didn't like it. R35's admission MDS, dated [DATE], identified R35 had intact cognition and demonstrated no delusional thinking. When interviewed on 8/12/24 at 12:58 p.m., R35 stated the meals served were not good and always seemed to be cold, especially the breakfast meal. R44's quarterly MDS, dated [DATE], identified R44 had intact cognition and demonstrated no delusional thinking. When interviewed on 8/12/24 at 12:47 p.m., R44 stated they were upset by the care center's meal service adding, It's always cold [when served]. R44 stated they mostly consumed meals in their room, and they had never been, never served food warm or palatable. During an observation on 8/13/24 at 11:51 a.m., a non-enclosed cart containing multiple food trays was observed to leave the main kitchen on a dumbwaiter with resident menu cards for the third floor. During an observation and interview on 8/13/24 at 11:56 p.m., one cart containing multiple food trays was observed by the nursing station on the third floor. The trays were observed to have a plate covered with an insulated dome but did not appear to be on an insulated plate base. Nursing assistant (NA)-D stated a second cart of trays should be coming soon and they would wait until those arrived to start passing trays. During an observation on 8/13/24 at 12:00 p.m., NA-D and NA-B were observed removing another cart of trays from the dumbwaiter, also in an uncovered cart. The trays were observed to have a plate covered with an insulated dome but did not appear to be on an insulated plate base. NA-D and NA-B were observed to leave both carts of trays in the middle of the hallway and started pouring beverages for both carts. NA-D and NA-B each took a tray from a cart in the middle of the hallway and brought it to its respective room and then returned to the middle of the hallway to repeat the process. During an observation on 8/13/24 at 12:16 p.m., NA-D and NA-B were observed continuing to pass trays for the third floor. During an observation on 8/13/24 at 12:22 p.m., NA-D and NA-B were observed continuing to pass trays for the third floor with trays left to be passed to residents. (continued on next page)

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	245222	A. Building B. Wing	08/15/2024

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The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/13/24 at 12:29 p.m., the last resident tray was observed to be passed. A tray was sampled with the dietary manager who confirmed the food was approximately room temperature and food could be hotter. The DM stated she would have expected the aides to pass the trays within approximately 15 minutes and was unsure why it took them so long which could have led to the low temperature of the food. During an interview on 8/15/24 at 9:40 a.m., the administrator stated the facility had a heated plate system that used both an insulated plate lid and bottom that she expected staff to utilize. The administrator stated she expected management and additional staff, such as the nurses, to help with the tray pass so it would be completed in a timely manner. The facility Meal Tray Service policy dated 9/12, was received but did not include an expected time frame for meal tray passes or methods to ensure meal trays stayed at a palatable temperature. 33925

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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. 49034 Based on observation, interview and document review, the facility failed to ensure monitoring and timely removal of facility food stored in refrigerators and freezers was completed. In addition, the facility failed to ensure facility food was stored in a manner to reduce the risk of physical cross-contamination and potential foodborne illness. In addition, the facility failed to ensure all food items were properly covered when served to residents to reduce and/or prevent the risk of foodborne illness. These facility failures had the potential to affect all 65 residents who consumed food from the facility kitchen. In addition, the facility failed to ensure the third-floor unit refrigerator temperatures were properly monitored and maintained to reduce the risk of foodborne illness. This had the potential to affect all third-floor residents receiving meal service beverages and/or storing personal food items in the unit refrigerator. Findings include: UNLABELED FOOD During the initial kitchen observation with the dietary manager (DM) on 8/12/24 at 11:37 a.m., the following foods were found in a double-door cooler in the first-floor kitchen: -Undated corn in a clear plastic bag. -Undated peas in a clear plastic bag. -Undated carrots in an opened clear plastic bag. -Two bags of carrots, one dated 7/16/24 and one dated 6/21/24. -A plastic container of opened apple sauce dated 7/28/24. -A bag of pre-diced eggs dated 8/2/24. -A plastic container with no lid with undated turkey lunch meat, open to the air. -Undated, opened plastic container of caramel sauce. The following foods were observed in a freezer in the first-floor kitchen: -12 containers of frozen spinach dated 2/9/23. -Three bags of undated chicken, two of these open. -Three containers of undated sausage. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/12/24 at 11:46 a.m., the DM stated the undated food items listed above should have been dated when they were removed from the box that had the delivery date on it. The DM stated she was unaware of how long these undated food items had been in the refrigerator/freezer and that they would need to be discarded. The DM stated all the dated food listed above was no longer safe for consumption and should have been previously discarded. The DM stated it was the job of the cooks and herself to ensure food was dated and discarded in a timely manner. FOOD STORAGE During the initial kitchen observation and interview on 8/12/24 at 11:57 a.m., a large plastic container of flour was observed in the dry storage room. A Styrofoam cup was observed half buried in the flour and small kernels of rice were observed sporadically throughout the top layer of flour. A box of sweet potatoes was observed on the floor of the dry storage room. The DM stated food should not be stored on the floor and that this practice was unacceptable. The DM stated they used the cup to scoop the flour, but the cup should not be stored in the container. During a follow-up observation on 8/14/24 at 10:36 a.m., a box of sweet potatoes, a bag of onions, and an opened bag of pasta was observed on the floor of the dry storage room. REFRIGERATOR TEMPERATURE The third floor Refrigerator/Freezer Temp Log dated 8/1/24 through 8/12/24, indicated the refrigerator temperatures were taken daily and were measured at 30 degrees one time, 45 degrees twice, 46 degrees once, 47 degrees five times, and 48 degrees three times (8/10/24 through 8/12/24). The instructions at the top of the log indicated refrigerator temperatures needed to be at 48 degrees (38 appeared to be crossed out and replaced with 48). During an observation and interview on 8/12/24 at 3:26 p.m., the temperature of the third-floor kitchenette refrigerator was noted to be at 48 degrees Fahrenheit. Registered nurse (RN)-C stated she was unsure who oversaw measuring the refrigerator temperatures but thought it was the nursing assistants (NA) on the night shifts. RN-C stated the refrigerator was mostly for food brought in by residents, but beverages used for meal service were also stored there. RN-C stated she was unsure what a safe refrigerator temperature was. The refrigerator was observed with every shelf very full. The items consisted of various tied plastic bags appearing to have food items inside, Styrofoam food containers, a gallon of milk, a container of orange juice, a container of goat milk kefir, a container of low-fat cottage cheese, pudding, yogurt, and various other food items. During an interview on 8/12/24 at 4:06 p.m., licensed practical nurse (LPN)-C stated she had reviewed the temperature log for the third-floor kitchenette refrigerator. LPN-C stated she was unsure if the temperatures were appropriate as she did not know what safe refrigerator temperatures were. During an interview on 8/12/24 at 4:55 p.m., the DM stated the kitchenette refrigerator temperatures were monitored by nursing staff and should be 40 degrees or less. After the DM reviewed the temperature log for the third-floor refrigerator, she stated the temperatures were horrible and all the food in that refrigerator was spoiled and needed to be disposed of. The DM stated occasionally the refrigerators would be overfilled with food items and then would not work correctly. The DM stated this would lead to elevated temperatures as happened in this case. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	UNCOVERED FOOD During an observation on 8/14/24 at 12:34 p.m., two uncovered carts with food trays were observed in the third-floor hallway. The trays were observed to have a white cake with pink frosting served on an uncovered plate. A fly was observed around the serving area and landing on various kitchen items. The trays were passed from the middle of the hallway down to each end with the cakes uncovered, by five to six unknown staff members including nursing assistant (NA)-E. During an interview on 8/14/24 at 1:28 p.m., NA-E stated kitchen staff would sometimes send the dessert covered and sometimes they would not. NA-E acknowledged the facility staff had not covered the cake as it was passed to resident rooms during the lunch service and stated she would be concerned about infection control or things such as flies contaminating the food. During an interview on 8/14/24 at 1:41 p.m., the DM stated all food should be covered during tray pass to avoid food contamination. The DM stated the facility had domed plastic food containers, so she was unsure why they were not used. The facility Refrigerators and Freezers policy dated 12/14, indicated acceptable temperatures for a refrigerator were 35-40 F. These temperatures should be tracked on monthly sheets that include an action taken column for unacceptable temperatures. The designated employee should check the refrigerator and freezer with the first opening and at closing in the evening and immediate action should be taken for temperature out of range. This policy indicated all food should be properly dated including dating individual items removed from the box or case. The facility Food Receiving and Storage policy dated 10/17, indicated food in designated dry storage areas should be kept at least 18 inches off the floor.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure the Quality Assurance and Assessment (QAA) program identified and implemented ongoing, effective actions or monitoring to promote proper food storage (i.e., labeling, dating) and handling in 1 of 1 main production kitchen and various unit-based refrigerators despite known quality issues in this area and similar, repeated non-compliance with Federal regulations being identified for multiple years in a row during the recertification survey process. This had potential to affect all 65 residents, staff and visitors who consumed food at the care center. Findings include: A provided QAPI (Quality Assessment and Performance Improvement) Plan, reviewed last ,d+[DATE], identified the principles of QA would be integrated across all the care and services areas of the care center, with each area having a QAPI representative on the committee. The plan outlined the facility' would review data from areas the organization believed it needed to monitor on a routine basis; and it outlined a process for how Performance Improvement Projects (PIP) would be completed adding, The facility will utilize subcommittees for performance improvement projects or short-term action plans to be of scope and durations as determined by the QAPI committee. The facility will meet on an ad hoc basis as adverse events occur, or as needed based on issues or opportunities which may require more immediate correction. A Centers for Medicare and Medicaid (CMS) CASPER Report, dated [DATE], identified the dates of the most recent survey cycles along with findings of non-compliance. This report identified, F0812-Food Procurement, Store/Prepare/Serve Sanitary, was cited for the previous three survey cycles (,d+[DATE], ,d+[DATE], and , d+[DATE]), with a last listed date of correction, [DATE]. The CMS Statement of Deficiencies Form CMS-2567, dated [DATE], identified the last recertification survey was exited on [DATE], along with various findings of non-compliance which included F812 adding, . the facility failed to ensure food stored in the kitchen freezers and refrigerators were labeled and dated to ensure expired food was not served [and] . failed to ensure the food stored in the floor kitchenettes refrigerators was properly stored. The outlined non-compliance listed several food items were not dated, and the unit' refrigerators were not being tracked for temperature monitoring or consistently having items placed inside labeled/dated. On [DATE] at 11:37 a.m., an initial kitchen tour was completed and multiple, undated food items were discovered in the main production kitchen refrigerators and freezer. In addition, on [DATE] at 3:26 p.m., the third floor unit' refrigerator was inspected and found to be potentially over-packed with multiple undated, opened food items causing it to not hold appropriate temperature. The recorded temperature monitoring verified this had been ongoing for multiple days. See F812 for additional information. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on [DATE] at 8:31 a.m., the dietary manager (DM) explained they had been in the current role for coming up on one year now and verified they were present for the last onsite recertification survey (exited 2022); however, since being new to the role had some oversight and help from a regional person who was no longer present on campus. DM acknowledged the current survey had identified multiple issues with kitchen safety and serving, and expressed having so many staff turnover was definitely something that is hard to keep everyone in a team and ensure all [people] are doing the same thing. DM stated not labeling and dating food products in the main production kitchen had been an issue more recently again; however, the unit-based refrigerators were handed off to nursing to address from the last survey. DM verified they attended the routine QA meetings where they had those discussions on the kitchen and refrigerators but no formal audits or ongoing monitoring of them was being done outside of themselves (DM) just trying to manually check the labeling and dating of items as able. DM stated the care center just had a corporate mock survey a month prior and identified many of the same concerns the survey team was now locating; however, only some partial education had been done with the staff on a couple things with more scheduled for later on. DM stated there was no PIP in place for the kitchen, or it's respective identified concerns, adding aloud, Not that I can think of. On [DATE] at 9:11 a.m., the administrator was interviewed and stated the QA team met on a monthly basis. The administrator explained the current facility' PIPs included various projects on pressure ulcers, long-stay pain management, and falls with all current goals for them being met; and verified they were aware of concerns in the kitchen and expressed the staff needed a lot of coaching in that department with DM needing to more hold staff accountable. The administrator stated the QA team had discussed the kitchen and it's respective issues prior adding it had been on-radar since I've been here which was now several months. The administrator stated the care center recently got a new plating system to help with food temperatures which stemmed from a prior PIP, and expressed a mock survey was conducted a month prior which identified food storage with lack of labeling or dating and the overstuffed fridges [unit] as a concern. However, the administrator stated there was no PIP or documented audits being done of it despite to their knowledge adding, Probably not, honestly. The administrator stated the kitchen, and it's respective concerns, were identified as an issue but not an active PIP at the time. A request was made for the most recent QAPI meeting' minutes (,d+[DATE]). However, these were not provided or received.