STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245227	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER Bayshore Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 St Louis Avenue Duluth, MN 55802	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49878 Based on interview, observation, and document review, the facility failed to ensure the 56 residents with personal funds accounts (including R11, R14, R17, R20 and R44) deposited with the facility had access to the personal funds after hours and on weekends. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was cognitively intact. On 5/20/24 at 2:06 p.m., R11 stated she can only take money out or put money in between 1:30 p.m. and 3:30 p.m during the week. R11 further stated nobody is here on the weekend so we do money stuff during the week. R14's quarterly MDS dated [DATE], indicated R14 was cognitively intact. On 5/20/24 at 5:10 p.m., R14 stated he can access his money during the week and has to plan ahead to have the money he needs. R17's significant change MDS dated [DATE], indicated R17 was cognitively intact. On 5/20/24 at 5:11 p.m., R17 stated she can only get money from her account between 1:30 p.m. and 3:30 p.m. R17 further stated this is very inconvenient, used to be able to get money anytime. R20's quarterly MDS dated [DATE], indicated R20 was cognitively intact. On 5/20/24 at 7:04 p.m., R20 stated he cannot get money on the weekend. R44 quarterly MDS dated [DATE], indicated R44 was cognitively intact. On 5/20/24 at 12:29 p.m., R44 stated he cannot get money on the weekend. On 5/24/24 at 9:47 a.m., observation of sign at the front desk of facility: Banking Hours 1:30pm - 3:30pm During interview on 5/23/24 at 10:13 a.m., registered nurse (RN)-F stated residents can request money from their accounts during certain times in the afternoon. RN-F also stated there was no petty cash for residents. During interview on 5/23/24 at 12:51 p.m., trained medication aide (TMA)-B stated residents go to the business office to request money from their accounts. TMA-B also stated she doesn't think anything is setup on the weekend. (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: 245227	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 5/23/24 at 1:16 p.m., RN-G stated residents can request money from their account by talking to the business office. RN-G further stated if resident wanted money on the weekend, staff would call administrator. RN-G stated she has never had to call the administrator for a resident requesting money. RN-G also stated there is no petty cash available. During interview on 5/24/24 at 10:15 a.m., health unit coordinator (HUC) stated residents can request money from their accounts by going downstairs to the business office. HUC also stated she was not sure of the banking hours. During interview on 5/24/24 at 10:20 a.m., licensed practical nurse (LPN)-A stated residents can request money from their account by going downstairs to the business office during certain hours in the afternoon. LPN-A also stated being unsure of what hours residents can request money. During interview on 5/28/24 at 9:01 a.m., LPN-B stated residents can request money from their accounts by going downstairs to the business office. LPN-B further stated she did not know the exact hours for banking. During interview on 5/22/24 at 3:04 p.m., business office manager (BOM) stated residents can request to get money anytime by coming to the front desk during open banking hours or by talking with staff. BO stated open banking hours are from 1:30 p.m. to 3:30 p.m. on weekdays. Staff should be at the front desk during those hours and can help residents access their funds. Residents can access their personal funds at other times of day or on the weekend by talking to staff, and staff will relay the request to BOM or administrator. BOM or administrator would come to facility and fulfill request. BOM identified there is no petty cash in the facility. Facility policy Deposit of Resident Funds updated 8/15/23, indicated resident requests for access to their funds should be honored by facility staff as soon as possible but no later than: the same day for amounts less than $100 ($50 for Medicaid residents) and three banking days for amounts of $100 ($50 for Medicaid residents) or more. Interpretive guidance as laid out at S483.10(f)(10) (i)-(ii): Residents should have access to petty cash on an ongoing basis and be able to arrange for access to larger funds. Although the facility need not maintain $100.00 ($50.00 for Medicaid residents) per resident on its premises, it is expected to maintain petty cash on hand to honor resident requests.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to ensure a resident's advance directives were accurately and consistently documented in the resident's electronic health record (EHR) banner, Provider Order for Life Sustaining Treatment (POLST) and physician orders to ensure the residents wishes would be followed in the event of a cardiac arrest. This resulted in an immediate jeopardy for 1 of 34 residents (R86) who's code status was not accurately documented and was reviewed for advanced directives. The immediate jeopardy (IJ) began on [DATE], at R86's first care conference. The care conference identified R86 and family member (FM)-A as being in attendance. Section C Nursing included the following: Resident continues to be a full code. Section E Social Services identified R86's code status as Full Code. R86's POLST located in the EHR scanned documents dated [DATE], identified R86 as Do Not Resuscitate. In addition, when the facility became aware of the discrepancy they changed the banner in the EHR to DNR to match the POLST, which was against the resident's wishes to be resuscitated. The administrator was notified of the immediate jeopardy on [DATE] at 5:44 p.m. The immediate jeopardy was removed on [DATE], but noncompliance remained at the lower scope and severity level D, which indicated no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Findings include: On [DATE] at 7:56 a.m., R86's EHR banner in point click care (PCC) identified R86 as a full code. R86's Order Summary report dated [DATE], indicated full code status. R86's most current Physician's Orders for Life Sustaining Treatment (POLST) located in the scanned EHR, signed via telephone by R86's family member (FM)-A and medical doctor (MD)-A on [DATE] and [DATE], identified R86's wishes were do not resuscitate (DNR). On [DATE] at 8:54 a.m., licensed practical nurse (LPN)-A reviewed the POLST book at the nurses station for R86. The book revealed R86's POLST dated [DATE], as DNR. LPN-A verified the computer and the book did not match and she said she thought R86 was a full code. On [DATE] at 9:01 a.m. LPN-B stated he would check a resident's code status by looking in the computer or in the POLST book. LPN-B stated the POLST book would be the most up to date, but if it didn't match the computer staff would need to do CPR. On [DATE] at 9:07 a.m., the assistant director of nursing (ADON) stated she would expect staff to verify the code status by checking the POLST book located on each nursing unit. The ADON reviewed the POLST book and the EHR and verified they did not match. The ADON stated code status should be reviewed at each care conference. On [DATE] at 9:20 a.m., R86's Order Summary identified R86's code status as DNR. This DNR order was recently created by the assistant director of nursing (ADON), following the facility becoming aware of the discrepancy. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:38 a.m., registered nurse (RN)-A stated staff could check a resident's code status in the computer or in the POLST book, and said the POLST book should be the most up to date. RN-A stated she would go by the POLST book if they did not match, which indicated DNR. On [DATE] at 1:55 p.m., FM-A said she recalled September of 2023 as very busy but thought originally R86's code status was DNR. FM-A stated she recalled a meeting over the telephone (she was unsure of the date) and said R86 wanted to be full code so his status was changed to full code. FM-A stated R86's current wishes were to be resuscitated. On [DATE] at 2:26 p.m., the ADON stated they changed R86's order to DNR to match the POLST but they had not talked with FM-A. The ADON stated they had a phone call out to her but had not heard back. A review of R86's care conferences notes dated [DATE], [DATE], and [DATE], identified the code status was listed as full code. The care conferences attendees included FM-A, LSW(s), and nursing services. On [DATE] at 3:12 p.m., licensed social worker (LSW)-A and the ADON verified at each care conference the code status is reviewed by stating the status aloud. This would give anyone present to agree or disagree. They would not review the actual POLST unless there was a concern. On [DATE] at 4:22 p.m., RN-B stated she recalled the care conference on [DATE], and stated it was the initial care conference. RN-B stated she reviewed code status and explained in detail what CPR entails. She recalled the code status as full code and no objections were made by R86 or FM-A. RN-B stated the process was to review the code status by looking at the EHR banner and not by reviewing the actual POLST. LSW-B stated her recollection of the care conference was the same as RN-B's. On [DATE] at 5:03 p.m., the EHR banner in PCC identified resident code status as DNR. The POLST in the EHR was the POLST dated [DATE] and continued to indicate DNR A chart review of R86's care conference notes identified the following: -[DATE], R86 and FM-A were in attendance, section E identified Full Code -[DATE], R86 and FM-A were in attendance, section E identified Full Code Social Service progress note dated [DATE] at 1:47 p.m., identified they spoke to FM-A who verified originally the POLST was DNR, but was shortly after changed to CPR per R86's wishes. FM-A stated the current code status should be CPR. The immediate jeopardy that began on [DATE]. was removed when the facility developed and implemented a systematic removal plan. The removal plan was verified on [DATE], through interview and document review. The facility had corrected the code status for R86 to full code. R86's POLST in the EHR was listed as full code dated [DATE], per R86's wishes. In addition, the facility completed a facility wide audit to ensure there were no other code status discrepancies, reviewed polices and procedures, and provided education for staff involved with care conferences.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on interview and record review, the facility failed to update the provider for a resident with significant weight loss for 1 of 6 residents (R56) reviewed for nutrition and weight loss. Findings include: R56's quarterly Minimum Data Set (MDS) dated [DATE], identified a cognitive assessment was not successful and diagnoses of dementia without behavior and gastroesophageal reflux disease (GERD). R56 needed partial assist with eating, had no chewing or swallowing issues and had non-prescribed weight loss. R56's provider orders dated 4/15/24, identified an order for a regular diet with ground meat and regular liquids. On 5/22/24 R56 received an order for a house supplement three times per day. R56's care plan dated 9/13/22, identified a problem statement for nutrition with a goal to maintain 163 within five percent with no signs or symptoms of malnutrition and consuming at least 50 percent of meals. Interventions included getting weight per policy, adaptive equipment as needed, provide bowls with each food item, serve diet as ordered, and monitor intake and record at every meal. R56's medical record reflected the following weights recorded in pounds: -5/19/24 - 147.1 -4/21/24 - 147.5 -3/24/24 - 153 -2/25/24 - 158.6 -1/28/24 - 163.9 A Nursing Home Report, 60-day medical doctor (MD) visit dated 4/10/24, included a review of bodily systems but did not address weight loss. The registered dietician (RD)'s note from 5/9/24 identified R56 had significant unplanned weight loss at 30 days at 8.8 percent, at 90 days at 21.3 percent, and at 180 days at 17.6 percent. The note identified R56 was not on a supplement and needed adaptive equipment for eating. RD recommended offering house nutritional supplements three times daily between meals due to weight loss. No complaints of chewing or swallowing difficulties noted. Resident exhibits inadequate nutrition as evidenced by current weight loss in the presence of fair to good intake records. During an interview on 5/24/24 at 10:38 a.m., RN-B stated when a provider was updated a progress note went into the chart. RN-B verified there wasn't a notification to the provider regarding R56's weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/24 at 11:45 a.m., the director of nursing (DON) stated her expectation would be that the provider was notified when a resident had significant weight loss. A policy, Interdepartmental Notification of Diet (Including Changes and Reports) dated 12/9/21, identified nursing services shall notify the physician and dietician when a nutritional problem (e.g., weight loss, pressure ulcer, eating problem, etc.) has been identified and shall collaborate with the dietician and physician to initiate an appropriate process of clinical review for causes of the nutritional problem.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47263 Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 3 residents (R3) reviewed who remained in the facility after their Medicare part A covered services ended. Findings include: R3's Centers for Medicare and Medicaid Services (CMS)-10123 form dated 3/4/24, identified R3's Medicare last covered day (LCD) as 3/7/24. R3's medical record lacked evidence a SNFABN was provided to R3 to explain the estimated cost per day or provide rationale of the extended care services or items to be furnished, reduced, or terminated. During an interview on 5/22/24 at 12:47 p.m., the business manager (BM) stated R3 did not receive an SNFABN. During a follow-up interview on 5/23/24 at 11:07 a.m., the BM confirmed R3 had remaining Medicare part A days, and indicated when R3's Medicare Part A covered services were no longer required, R3 should have been issued a SNFABN. During an interview on 5/28/24 at 12:40 p.m., the administrator stated when a resident is discharged from a Medicare part A service and no longer needs that skilled service, the resident should receive a notice of what it will cost to remain in the facility once Medicare stops payment. A facility beneficiary policy was requested, but not received. However the facility provided a Centers for Medicare and Medcaid Services form: Instructions Skilled Nursing Facility Advanced Notice of Non-Coverage (SNFABN) Form CMS 10055 dated 2018 which contained instructions for SNFABN completion. The form indicated a SNFABN must be issued to beneficiaries (residents) prior to providing Medicare services that Medicare may not pay for when services are no longer medically reasonable and necessary or may be considered custodial.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on interview and document review, the facility failed to correctly code section B of the Minimum Data Set (MDS) for 1 of 1 resident (R67) reviewed for MDS accuracy. Findings include: R67's significant change MDS dated [DATE], identified diagnoses which included type 2 diabetes mellitus with stable proliferative diabetic retinopathy (a serious complication of diabetic retinopathy which can lead to total vision loss), bilateral posterior synechiae (abnormal adhesions between the iris and the lens or cornea), bilateral iridocyclitis (an inflammation of the vascular layer of the eye and ciliary body), and cataract (clouding of the normally clear lens of the eye) with neovascularization of right eye (new blood vessels grow in a cataract which can sometimes lead to vitreous hemorrhage (blood leaks into the vitreous humor which can cause vision problems). R67's significant change MDS dated [DATE], section B identified R67's vision as adequate. R67's care plan dated 4/12/23, identified R67 had a vision impairment. Interventions included telling the resident where items were placed and being consistent. R67's Order Summary Report dated 5/28/24, identified R67 had orders for timolol maleate ophthalmic solution 0.5% (used to treat glaucoma and high pressure inside the eye. Increased pressure inside the eye can cause damage to the optic nerve which can lead to vision loss or blindness) instill one drop in right eye two times a day. On 5/24/24 at 1:25 p.m., assistant director of nursing (ADON) reviewed R67's significant change MDS dated [DATE], and verified section B vision was marked as adequate. The ADON stated R67's vision was impaired and not adequate. The ADON stated it was important to have the MDS coded correctly because it drives care and reimbursement. On 5/28/24 at 10:36 a.m., the director of nursing (DON) stated the MDS needed to be accurate because it drives care and affects reimbursement. Resident Assessments dated 11/30/21, indicated the following: The results of the assessments are used to develop, review and revise the resident's comprehensive care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on observation, interview, and document review, the facility failed to ensure standard practices for safe medication administration were utilized for 1 out of 4 residents (R61) who were observed for medication pass. Findings include: R61's quarterly Minimum Data Set (MDS) dated [DATE], indicated R61 had severe cognitive impairment with the diagnoses of major depression, cognitive impairment, anxiety, osteoarthritis, and diabetes. R61's Order Summary Report dated 5/28/24, included the active order: -Nystatin external powder 100000 Unit/GM [gram] [antifungal medication used to treat fungal infections of the skin] apply to groin and abdomen two times a day until healed. During a medication observation on 5/22/24 at 3:39 p.m., registered nurse (RN)-D had two medication cups, one with powder and one with cream. RN-D entered R61's room, sanitized hands, and applied gloves. R61 lowered their pants and RN-D cleansed and dried R61's groin area. RN-D removed their gloves, applied new gloves, and applied Nystatin powder from the med cup to R61's groin area. During a follow-up interview on 5/22/24 at 3:46 p.m., RN-D stated they were not able to find R61's Nystatin powder so they had used another resident's powder. RN-D stated they were not sure who's nystatin powder they had used, but that they should not have administered another resident's powder to R61 even though it was the same dose. During an interview on 5/23/24 12:47 at p.m., the director of nursing (DON) stated it was not acceptable to take medication from one resident and administer it to another. Each resident should have their own nystatin powder designated for use by that resident. The Facility policy Administering medications dated 12/13/21, included the following instructions: medications are administered in accordance with prescriber orders, medications ordered for a particular resident may not be administered to another.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review, the facility failed to ensure orders were followed as written for 1 of 3 residents (R67) reviewed for heart failure and failed to administer medications as ordered for 1 of 4 residents (R81) reviewed for medication administration. The facility further failed to accurately document behaviors related to as needed medication administration for behaviors for 1 of 1 resident (R71) reviewed for behaviors. Findings include: R67: R67's significant change Minimum Data Set (MDS) dated [DATE], identified diagnoses which included type 2 diabetes mellitus, sequela of cerebral atherosclerosis (stroke), hypertension, and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should). In addition, R67's MDS identified him as cognitively intact. R67's care plan did not address his heart failure. R67's Order Summary Report dated 5/28/24, directed staff to report to the Essentia cardiology heart failure program any weight gains or losses of plus or minus three pounds per day or five pounds per week. The orders directed day shift to chart daily weights in a progress note and to notify medical doctor per parameters. The nurses's progress notes for May were reviewed, there were no daily progress notes on weights as per the order and no documentation indicating communication was made with the heart failure program. The weights for May were as follows: 5/17/24, no documented weight 5/12/24, 227.6 up 5.2 pounds 5/11/24, 222.4 up 3.2 pounds 5/10/24, 219.2 down 10 pounds from last recorded weight 5/9/24, no documented weight 5/8/24, no documented weight 5/7/24, 229 5/6/24, 228.1 up 5.1 pounds (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/5/24, 223 Faxed communications to heart failure clinic were done on 5/10/24 and 5/16/24. On 5/20/24 at 5:58 p.m., R67 stated staff were not getting accurate daily weights. On 5/24/24 at 1:36 p.m., the assistant director of nursing (ADON) stated she would expect to see a communication with the heart failure program and progress note as ordered for weight gains and losses. The ADON stated this was important because R67 had a recent heart surgery and it was important to monitor weights to make medication adjustments based on weights. On 5/28/24 at 10:31 a.m., the director of nursing verified she would expect to see progress notes and communications to the heart failure program as ordered because medications may have needed to be adjusted. R81: R81's significant change MDS dated [DATE], identified R81's diagnoses as malignant neoplasm of liver, hypertension and diabetes mellitus. In addition, R81's MDS identified he was cognitively intact and was receiving opioid medications. R81's care plan dated 6/13/23, identified chronic pain related to low back pain and malignant neoplasm of prostate. Interventions included, monitoring, recording, and reporting pain complaints to the nurse for treatment. R81's Pain assessment dated [DATE], identified R81's pain was a 7 on a 1-10 scale over the past five days. R81's Order Summary Report dated 5/28/24, identified an order for hydrocodone-acetaminophen (a combination medication [opioid and non-opioid] used to treat moderate to severe pain) 10-325 milligrams (mg) one tablet by mouth four times per day for moderate pain. The medication was ordered on 4/26/24. A review of R81's electronic medication record (eMAR) for May revealed the following missed doses: -5/15/24 at 5:00 a.m. (signed out in the controlled substance book) -5/15/24 at 10:00 p.m. -5/17/24 at 10:00 p.m. -5/19/22 at 10:00 p.m. -5/20/22 at 10:00 p.m. A review of the Park Breeze controlled substance book revealed on 5/15/24 at 4:30 a.m., one hydrocodone-acetaminophen 10-325 was signed out by registered nurse (RN)-C. There were no hydrocodone-acetaminophen 10-325 signed out on the rest of the days for the specified times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the nurse progress notes did not address the missed hydrocodone-acetaminophen doses. On 5/20/24 at 1:19 p.m., R81 stated some of the staff are lackadaisical when they are passing out medications. R81 stated he was supposed to receive a pain medication at 10:00 p.m., daily but would often not receive the medication depending on who was working. On 5/24/24 at 10:19 a.m., trained medication aide (TMA)-A was called with no answer, contact information was provided but there was no return call. TMA-A was the staff working on the days when the 10:00 p.m. medication was not given. On 5/24/24 at 10:20 a.m., RN-C verified she was working on 5/15/24, and stated R81 definitely received the medication but she must have forgotten to click the button to indicate the medication was given. On 5/28/24 at 10:34 a.m., the director of nursing (DON) stated she would expect all medications to be given as ordered and documented. Pain- Clinical Protocol dated 10/7/21, identified the following: 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing known diagnoses and conditions that commonly cause pain; for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology, and post-stroke syndromes. b. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary and non-pharmacologic treatments. 48109 R71: R71's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and a diagnosis of schizophrenia. R71's provider orders dated 4/26/24, identified the following: -hydroxyzine 25 milligrams (MG), one tablet daily three times daily PRN -olanzapine 5 MG, one tablet by mouth in the evening related to schizoaffective disorder. Target behaviors identified as crying out, agitation, exit seeking, and paranoia. Document in progress note and give one tablet by mouth every eight hours as needed for anxiety or agitation. -fluoxetine 40 MG, one capsule by mouth one time a day related to schizoaffective disorder. Target behaviors identified as crying out, agitation, exit seeking, and paranoia. Document in progress note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-olanzapine 5 MG, one tablet by mouth two times a day related to schizoaffective disorder. Target behaviors identified as crying out, agitation, exit seeking, and paranoia. Document in progress note. R71's care plan dated 5/2/24, identified a problem statement for care resistance, potential for verbal aggression and included interventions of reapproach, explaining what was going to happen, assess needs, analyze key times to look for patterns, documenting behavior problems of pacing, restlessness, paranoia, administering medications, anticipating needs, not arguing with her, validating and reminding this was safe place. Staff to intervene to protect resident, approach calmly, divert attention, remove from situation, observe and document. R71's medication administration record for 5/22/24 indicated the following: -8 a.m. olanzapine 5 mg scheduled, indicator box for behaviors marked no -8 a.m. hydroxyzine 25 mg PRN, indicator box for behaviors marked no -1 p.m. olanzapine 5 mg PRN, no indicator box by this medication -4 p.m. olanzapine 5 mg, indicator box for behaviors marked no -4 p.m. hydroxyzine 25 mg PRN, indicator box for behaviors marked yes -6 p.m. olanzapine 5 mg, indicator box for behaviors marked no R71's progress notes did not reflect behavior charting for 5/22/24. R71 was observed on 5/22/24 at the following times: -1:10 p.m., R71 yelled out in the dining room, can I go outside? You treat me as a child. There were no staff near to hear her. -1:13 p.m. nursing assistant (NA)-F came to the dining room and comforts R71, licensed practical nurse (LPN)-C came into the dining room with a pill in a medication cup. R71 asked what it was for, LPN-C said it was her PRN. R71 took the pill with some water. -1:24 p.m., R71 was yelling something about her life and NA-F comforts and reassures her. Registered nurse (RN)-B came to the dining room to talk with R71 and told her she would be moving tomorrow. RN-B asked R71 if she would like to go back to her room and talk. R71 declined and stayed in the dining room. -3:43 p.m., R71 was in her room sobbing, the director of nursing (DON) came to the unit and went into her room. -3:45 p.m., R71 came out to the hall sobbing, the DON brought her more water and walked with her to the common area. The DON left to get a nurse because R71 had a headache. 3:57 p.m., social services (SS)-B was in the common room with R71 and then lead her back to her room to get tissues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 1:44 p.m., LPN-B stated NA-F reported to him R71 was getting agitated and anxious, so he gave her a PRN olanzapine. LPN-B decided to use that medication because he gave the PRN hydroxyzine already at 8 a.m. and could only give it every 8 hours, so he used the olanzapine. LPN-B stated he would go back after an hour to see if it was effective. During an interview on 5/23/24 at 12:48 p.m., RN-B stated there were behavior interventions in place for R71, including not arguing with her as that was a primary trigger. RN-B stated the PRN medications were for the target behaviors and would expect there to be some charting if a PRN behavior medication was given. During an interview on 5/28/24 at 11:45 a.m., the DON stated she would expect for there to be charting to go along with the PRN behavior medication, and for the behavior indicator box on the MAR to be yes for behaviors. Facility document, Behavioral Assessment, Intervention and Observing dated 10/18/21, identified the facility will provide, and residents will receive, behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The new onset, or changes, in behavior will be documented regardless of the degree of risk to the resident or others. Non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms. When medications are prescribed for behavioral symptoms, documentation will include other approaches and interventions tried prior to the use of antipsychotic medications and observing for efficacy and adverse consequences.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and record review the facility failed to secure oxygen tanks in a resident room for 1 of 1 resident (R75) reviewed for accidents. Findings include: R75's significant change Minimum Data Set (MDS) dated [DATE], identified diagnoses which included morbid obesity, chronic respiratory failure, insomnia, and chronic fatigue. In addition, R75's MDS identified R75 as cognitively intact and on oxygen therapy. R75's Order Summary Report dated 5/28/24, identified oxygen via nasal cannula at four liters per minute every shift. On 5/20/24 at 1:40 p.m., in R75's room four oxygen tanks were observed behind her recliner, two were secured in stands and two were free standing. All four oxygen tanks were full. R75 stated the tanks were hers and were delivered to her room by the oxygen company. On 5/20/24 at 1:45 p.m., licensed practical nurse (LPN)-B and nursing assistant (NA)-B entered the room and verified the tanks were full and should not be free standing. NA-B went immediately to get stands to secure the two tanks. LPN-B stated the four tanks should not be stored in R75's room as she was using an oxygen concentrator to provide her oxygen. R75 said she thought the tanks had been delivered about a month ago and were for when she was discharged to home. On 5/23/24 at 8:24 a.m., the assistant director of nursing (ADON) and licensed social worker (LSW)-A were observed removing the four oxygen tanks from R75's room. On 5/23/24 at 2:40 p.m., a vehicle with Corner Home Medical was observed in the parking lot, the driver was observed bringing oxygen tanks to the vehicle. On 5/23/24 at 8:01 a.m. the ADON stated she was not aware oxygen was being stored in R75's room. On 5/23/24 at 8:07 a.m., LSW-A stated when R75 was ready to be discharged she would set up home oxygen at that time. On 5/28/24 at 10:29 a.m., the director of nursing (DON) stated oxygen tanks should not be stored in resident rooms, any tanks in use should be secured in a holder, and storing oxygen in a resident room is a potential fire hazard. Oxygen Administration dated 11/1/21, identified the following: 1. Portable oxygen cylinder (strapped to the stand) Medical Gas Cylinder Storage dated 1/2018, identified the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Compressed gas cylinders that sustain mechanical damage can also be a hazard. Gases inside cylinders are generally under high pressures, and the cylinders often have significant weight. The cylinders can cause injuries directly due to their weight and inertia. Damage to the regulators or valves attached to a cylinder can allow the escaping gas to propel the cylinder violently in a dangerous manner. The pin-index safety system and gas regulators can also suffer physical damage and cause hazards to patients if the wrong gas is delivered.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 48109 Based on interview and record review, the facility failed to monitor nurse aid registry for inactive nursing assistants (NA) during their employment and allowed them to continue to work directly with residents after their registry had become inactive for 1 of 6 NAs reviewed. This had the potential to affect all residents in the facility whom the NA may care for. Findings include: Review of NA-J's personnel file identified a hire date of 12/7/23. A search on the Minnesota Nurse Aid Registry revealed NA-J had an inactive status as of 5/16/24. Review of facility schedule revealed NA-J was on the schedule and actively worked day shifts during the survey on May 20th, 21st, 22nd, 23rd of 2024. During an interview on 5/28/24 at 11:04 a.m., the facility administrator stated the staffing agency and the facility both check the NA registry on hire and the agency was supposed to contact the facility with upcoming expirations. The administrator was not aware NA-J no longer had an active registration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview and document review the facility failed to ensure personal protective equipment (PPE) was used for 1 of 2 residents (R95) when providing care for residents in enhanced barrier precautions. In addition, staff failed to perform hand hygiene during medication administration for 1 of 4 residents (R61) observed during medication administration. Findings include: R95's admission Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and diagnoses of non-Alzheimer's dementia, constipation, and urinary retention. R95 was dependent on staff for toileting transferring and hygiene and was incontinent of bowel and bladder frequently. R95's care plan dated 4/4/24, identified an actual impairment to skin integrity as evidenced by a vascular wound to left lower extremity. A sign, Enhanced Barrier Precautions, was on the outside of R95's door and identified providers and staff must wear gloves and gown for the following High-Contact Resident Care Activities including transferring and changing briefs. During an observation on 5/22/24 at 10:27 a.m., NA-E and NA-F brought R95 to his room and donned gloves. The two NAs worked together to change his urine-soiled brief, provide perineal hygiene, assist with putting on a new brief and putting his shorts back on. NA-E and NA-F doffed their gloves and washed their hands with soap and water. During an interview on 5/22/24 at 10:40 a.m., NA-E stated they were supposed to wear gowns because of the sores on his legs. NA-F explained they don't keep a cart with PPE in the room because of this being a dementia unit. NA-E stated they have to try and hurry to do his cares because he normally tries to walk away, and they can't wear gowns in the hallway. Both NAs agreed they should be wearing a gown to give cares, but there weren't any down here. During an interview on 5/22/24 at 1:17 p.m., RN-B stated the PPE was stored in a cart at the end of the hall and the NAs would need to get their PPE before entering the room. RN-B stated her expectation would be that they wear PPE in a room with precautions when performing an activity such as changing a brief. This was important for protecting the resident. During an interview on 5/28/24 at 11:45 a.m., the DON stated her expectation would be for staff to wear appropriate PPE when providing personal care to a resident having EBP in place. 47263 R61's quarterly Minimum Data Set (MDS) dated [DATE], indicated R61 had severe cognitive impairment with the diagnoses of major depression, cognitive impairment, anxiety, osteoarthritis, and diabetes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication observation on 5/22/24 at 3:39 p.m., registered nurse (RN)-D had two medication cups, one with powder and one with cream. RN-D entered R61's room, sanitized hands, and applied gloves. R61 lowered their pants and RN-D cleansed R61's groin area and did not sanitize hands or change gloves before they dried R61's groin area with a clean cloth. RN-D removed their gloves, did not sanitize hands, applied new gloves, and applied Nystatin powder from the med cup to R61's groin area. When done, RN-D removed gloves, did not sanitize hands, applied new gloves, and proceeded to apply ointment to R61's left hip. RN-D removed gloves, sanitized hands and exited the room. During a follow-up interview on 5/22/24 at 3:46 p.m., to verify medication, RN-D stated they were not able to find R61's Nystatin powder so they had used another resident's powder. RN-D stated they were not sure who's nystatin powder they had used, but that they should not have administered another resident's powder to R61 because it created an infection prevention concern for possible cross contamination. RN-D confirmed they had not sanitized their hands after cleansing R61's groin area or between treatments, and new glove application. RN-D stated they felt their gloves had been clean, but they had changed them between treatments to prevent cross contamination. RN-D stated sanitizing hands after cleaning a resident and before doing a treatment, would be done to prevent cross contamination. During an interview on 5/23/24 at 12:47 at p.m., the director of nursing (DON) stated it was not acceptable to take medication from one resident and administer it to another. Sharing topical medications between residents created a concern for cross contamination between residents. For infection prevention reasons staff should perform hand sanitization every time they remove gloves and/or before they apply new gloves. Hand sanitization should also be done after performing cares and before moving onto another task. The Centers for Disease Control and Prevention Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPIC) Across Settings dated 11/15/22, included (but was not limited to) the following indications for hand hygiene: immediately before touching a patient, before moving from work on a soiled body part to a clean site on the same patient, and immediately after glove removal.