STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245235	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Health Care Center	7012 Lake Road Woodbury, MN 55125

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49034 Based on observation, interview, and document review, the facility failed to promote dignity for 6 of 6 residents (R1, R23, R28, R31, R47, R58) reviewed for resident rights when name labels were observed on the outside of clothing. Additionally, the facility failed to ensure a dignified home-like environment was provided during dining services in 1 of 2 dining rooms reviewed. Findings include: Clothing Labels R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had severely impaired cognition and required moderate assistance with lower body dressing. R23's quarterly MDS dated [DATE], indicated R23 had severely impaired cognition and was dependent on staff for dressing. R28's annual MDS dated [DATE], indicated R28 had severely impaired cognition and required maximal assistance with lower body dressing. R31's quarterly MDS dated [DATE], indicated R31 had severely impaired cognition and required maximal assistance with lower body dressing. R47's quarterly MDS dated [DATE], indicated R47 had severely impaired cognition and required maximal assistance with lower body dressing. R58's quarterly MDS dated [DATE], indicated R58 had severely impaired cognition and required maximal assistance with lower body dressing. During an observation on 6/24/24 at 1:00 p.m., R58 was observed sitting in a common area with no shoes on and socks that had a white name label that was visible from across the room. During an observation on 6/25/24 at 8:36 a.m., R47 was observed sitting in a common area wearing shoes and long socks that had a white name label that was visible from across the room. (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 - Some	During an observation on 6/25/24 at 11:18 a.m., R23 was observed sitting in a common area with no shoes on and socks that had a white name label that was visible from across the room. During an observation on 6/25/24 at 11:24 a.m., R1 was observed sitting in a common area wearing no shoes but socks that had a white name label that was visible from across the room. During an observation on 6/25/24 at 12:29 p.m., R28 and R31 were observed sitting in a common area wearing no shoes but socks that had a white name label that was visible from across the room. During an interview on 6/25/24 at 11:08 a.m., laundry aide (LA)-A stated he labeled resident clothing and normally labeled socks on the outside because it was hard to find the label while sorting when it was on the inside of the sock. During an interview on 6/25/24 at 1:20 p.m., the laundry supervisor (LS) confirmed that the laundry aides were instructed to put the clothing labeling on the outside of the sock because it was hard to find the label when it was on the inside. During an interview on 6/26/24 at 9:25 a.m., R58's family member (FM)-A stated R58 no longer had the cognitive ability to state her preferences but FM-A thought R58 would not have labeled her socks on the outside at home. FM-A thought it would bother R58 to have her name written on the outside of her socks in that manner. During an interview on 6/27/24 at 8:47 a.m., the assistant director of nursing (ADON) stated laundry staff should be applying name labels to the inside and not the outside of clothing. The ADON stated, that if it were her, she would not like her name written on the outside of her socks. The ADON stated she would guess it was being completed this way for convenience and that was not an appropriate reason. A policy regarding labeling clothing was requested and not received. 49339 Dining R79's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R79 had intact cognition with an admitted [DATE]. R24's quarterly MDS dated [DATE], indicated R24 had severely impaired cognition with no hallucinations or delusion with an admitted [DATE]. R59's quarterly MDS dated [DATE], indicated R59 had intact cognition with an admitted [DATE]. R35's quarterly MDS dated [DATE], indicated R35 had intact cognition with an admitted [DATE]. R346's entry MDS dated [DATE], indicated R346 admitted on [DATE]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 6/25/24 at 11:33 a.m., the lunch cart was brought to 3rd floor and delivered to the 3rd floor dining room by unknown dietary staff. The lunch cart was an uncovered metal cart on wheels with slots, that held hard plastic trays that contained resident meals. Each slot could hold two hard plastic trays which could be slid from the front or back of the approximately 6-foot metal cart. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with Saran wrap and the coffee cups were covered with plastic disposable lids. The silverware on the trays, were wrapped in napkins held together with a paper napkin band. R79 was observed sitting in the dining room at this time. At 11:37 a.m., two staff were observed to bring two residents (R59 and R24) downstairs to be seen by podiatry services. At 11:40 a.m., R79 came out of the dining room and asked unknown staff if lunch was going to be served which was responded with lunch hasn't come up yet. At 11:45 a.m., R79 removed his own tray from the dining cart and started to eat. No staff were present. At 11:49 a.m., unknown staff returned with R24 and brought him to the dining room. They sat R24 at the same table with R79. They told R24 the nursing assistant will get them their food and proceeded to leave the unit. During continued observation on 6/25/24 at 11:53 a.m., nursing assistant (NA)-C came out of a resident room stating, oh lunch is here. NA-C proceeded to wheel R346 to a table in the dining room. At 11:56 a.m., NA-C removed R24's tray from the lunch cart. NA-C set the hard plastic lunch tray which contained the separated food items on the table directly in front of resident. NA-C removed the warming lid off the plate and placed it on the table. NA-C uncovered the remaining plastic covered items on the tray and placed the plastic lids and Saran Wrap directly on the hard tray and walked away after asking R24 if they needed anything else. At 11:58 a.m., NA-C served R346 lunch. NA-C removed the hard plastic lunch tray from the lunch cart, placed the entire plastic tray on the table, removed the covering and left them on the tray. All food items are left on the serving tray. At 12:00 p.m., R59 returned to the floor and was served lunch. R59's hard plastic tray was placed in front of him, food items were uncovered, and plastic disposable coverings were left on the tray. At 12:22 p.m., R85 and R35's trays were placed on different dining room tables and remained covered. On 6/26/24 at 7:57 a.m., R59 was observed just finishing breakfast in the dining room. R59 stated the breakfast was pretty good. It was observed that R59's breakfast items were served on a hard plastic tray as the tray was placed on the table in front of him with the food items within the plastic tray. Additionally, there were plastic coverings sitting on the plastic tray. R59 was the only resident eating at the table at the time. There was one tray sitting on the table that appeared untouched. On 6/26/24 at 7:59 a.m., NA-D was observed bringing R85 to the dining room. NA-D moved the entire hard plastic tray that contained on it, a warming plate with a cover, bowl with a plastic cover along with covered drinks and left this at the table for R85. R85 proceeded to start to uncover her own items and start to eat. NA-D walked back over with an additional covered bowl of food which NA-D uncovered, placing the disposable plastic cover on the hard plastic tray. On 6/27/24 at 8:49 a.m., R35 was observed eating breakfast in the dining room which had just been served by NA-C. R35's breakfast was served on the hard plastic tray being set on the table. On 6/26/24 at 9:56 a.m., licensed practical nurse (LPN)-C stated, we always serve the food on the [plastic] trays. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 10:24 a.m., NA-D stated they are responsible along with the nurse to pass out meals during their shift. NA-D stated, the tray is left with resident adding there are items like brown sugar and it keeps everything together. On 6/27/24 at 8:43 a.m., R346 was observed eating breakfast in the 3rd floor dining room. R346 breakfast was served on the plastic tray. R346 was the only resident eating at the table. During follow up interview on 6/27/24 at 8:43 a.m., LPN-C stated, We always leave it on the tray keeps their food together in case there is an allergy their name is on there. LPN-C indicated they think they serve meals in the dining room on other floors on their trays. LPN-C verified that they help serve meals along with the nursing assistants. On 6/27/24 at 8:47 a.m., NA-C verified they do not take the food items off the tray prior to serving the food to the residents. NA-C verified this is the only floor that food is served on the trays except for sometimes on first floor and the lower level. NA-C stated, it is just easier to put the whole tray there. On 6/27/24 at 10:10 a.m., assistant director of nursing (ADON) stated the expectation is the meals should be removed from the trays. ADON stating by removing the meals from the tray it creates a more homelike environment for our residents which is what we want. A policy for homelike environment for dining relating to dignity was requested but not received.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was comprehensively assessed for 1 of 1 residents (R75) with medication found at the bedside. Findings include: R75's quarterly Minimum Data Set (MDS) dated [DATE], indicated R75 had intact cognition and was diagnosed with diabetes, a stroke, and hypertension. The MDS indicated R75 was dependent on staff for bed mobility, transferring, and toileting. R75's Order Summary Report dated 6/13/24, indicated R75 had an order for two tablets of 500 milligrams (mg) of chewable calcium carbonate (antacid), every six hours as needed. R75's care plan dated 2/7/24, indicated R75 was dependent on staff for all activities of daily living. The care plan indicated that R75 was to be fully upright and supervised while eating and given medications one at a time with sips of water. The care plan did not address the self-administration of medication. R75's Medication Administration Record (MAR) dated 6/1/24- 6/26/24, included no documented doses of calcium carbonate. R75's medication record was reviewed and did not include an assessment to ensure R75 could safely keep medications at the bedside and administer them independently. During an observation and interview on 6/24/24 at 4:56 p.m., R75 was observed lying in bed with a half-empty bottle of chewable Tums (calcium carbonate) smoothies 750mg tablets clearly visible on the bedside table. R75 stated he had the Tums bottle on his bedside table for the past month and the bottle was full when he first got it. R75 stated he used the medication for heartburn and kept it on his bedside table so he could take it whenever he wanted. R75 thought he took the medication every few days but couldn't remember for sure. During an observation on 6/25/24 at 8:46 a.m., a half-empty bottle of chewable Tums (calcium carbonate) smoothies 750 mg tablets was observed on R75's bedside table. During an observation and interview on 6/25/24 at 3:09 p.m., registered nurse (RN)-A stated she had been in R75's room earlier but hadn't noticed the Tums on his table. RN-A now noted the Tums bottle next to the cup of water she had set down after assisting R75 with taking his medications. RN-A stated the Tums R75 had in his room were not the type the facility provided residents so she thought the family must have brought the medication. RN-A stated she was the nurse in charge of R75's care during the day shift and no one had reported R75 had this medication at bedside. RN-A stated she was not sure if R75 had been assessed for self-administering medication. RN-A stated the assessment was important so the facility could ensure the medication was taken at a time that would not interact with other medications, track how often he was taking the medication, and ensure R75 could safely take the medication by himself. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 8:49 a.m., the assistant director of nursing (ADON) stated she reviewed R75's medical record and if he had a medication self-administration assessment completed, it would be found under the assessment tab but she did not see anything. The ADON stated she would have expected the nurse or one of the aides assisting with R75's care to remove the medication from R75's room until a self-administration assessment was completed to ensure R75 could safely take the medication. The facility's Medication Self Administration Safety Screen and/or Self Administration policy dated 9/23, indicated a medication self-administration assessment would be completed before the initiation of resident self-administration and at least quarterly.

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure quarterly statements of resident' trust fund balances were provided for 2 of 2 residents (R13, R75) who voiced they had not received one; and for an additional 32 of 32 residents identified to have trust accounts managed by the care center. Findings include: R13's annual Minimum Data Set (MDS), dated [DATE], identified R13 had intact cognition and demonstrated no delusional thinking. When interviewed on 6/24/24 at 1:34 p.m., R13 stated he had an active trust account which was managed by the care center. R13 stated he was unsure how much money he had in his account but added, They're [center] supposed to keep track of it. R13 stated he had not received a statement of the funds balance for many months and expressed aloud, I don't think they are [sending]. R13 stated he wanted to get a statement provided more routinely adding, I would like that. R75's quarterly MDS, dated [DATE], identified R75 had intact cognition and demonstrated no delusional thinking. When interviewed on 6/24/24 at 4:55 p.m., R75 stated he had an active trust account but was not getting any statements on the balance to his recall. R75 stated he would like to get a statement, if able. A provided Trial Balance print-out, dated 6/26/24, identified a total of 34 residents had an active trust account along with each corresponding balance. R13 and R75 were included on this list and had positive balances listed of $37.10 and $60.00, respectively. However, neither of their medical records had evidence a statement had been mailed or provided to them within the last quarter (i.e., 90 days). Further, during the recertification survey from 6/24/24 to 6/27/24, evidence was requested to demonstrate statements being provided on, at minimum, a quarterly basis to the residents with an account (or their representative, if applicable). However, no evidence was provided or received. On 6/26/24 at 10:52 a.m., the human resources director (HR)-A was interviewed. HR-A verified they helped manage the day to day withdrawals from the accounts but expressed they did not provide or send out any statements adding such would be done usually [by] the billing office. HR-A stated there was not a current business office manager (i.e., BOM) to speak with and directed the surveyor to speak with the administration. When interviewed on 6/26/24 at 2:40 p.m., the administrator stated they didn't think quarterly statements were being sent since the previous BOM resigned several months prior adding they could not locate any evidence or paperwork to demonstrate statements had been mailed or provided. The administrator stated there was currently nobody assigned to make or send these statements which was part of the issue. The administrator stated they had just developed a mitigation plan and would ensure statements were sent out moving forward. A facility' policy on personal funds management was requested, however, none was received.

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F 0569 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure resident' trust account balances above the state-required supplemental security income (SSI) threshold (i.e., $3,000) were identified and notice provided to the resident for 3 of 3 residents (R26, R5, R45) whose balance was over the amount. This had potential to affect a total of 6 of 6 residents with excessive balances with the potential to impact their medical assistance coverage. Findings include: A Minnesota Medical Assistance Treatment of Assets and Income, dated 9/2023, identified a person with medical assistance (i.e., Medicaid) living in a nursing home must contribute most of their income towards the cost of such care. The article outlined, The MA [medical assistance] asset limit is $3,000 for an individual and $6,000 for a couple, plus $200 for each dependent. A provided Trial Balance listing, printed 6/26/24, identified all resident' trust account balances for the care center. This identified a total of six residents (including R26, R5, R75) had a balance well over $3,000 at the time of survey. R26's quarterly Minimum Data Set (MDS), dated [DATE], identified R26 had intact cognition. Further, R26's Clinical Census listing, printed 6/27/24, identified R26's current payer source as, Medical Assistance - MN, with a last effective date, 3/1/2024. When interviewed on 6/26/24 at 10:42 a.m., R26 stated she managed her own finances and was unaware she had so much money in her trust account adding, I thought it was much less than that. R26 stated she could not recall ever being told or notified of the excessive balance. R26's medical record, including the scanned documents, was reviewed and lacked evidence R26 had ever been notified when the balance of their trust account had come within $200 of the SSI threshold ($3,000) and what, if any, impact on their current payer source such could mean. R5's quarterly MDS, dated [DATE], identified R5 had severe cognitive impairment. Further, R5's Clinical Census listing, printed 6/27/24, identified R5's current payer source as, Medical Assistance - MN, with a last effective date, 6/1/2024. When interviewed on 6/26/24 at 12:44 p.m., family member (FM)-B stated they helped R5 manage their finances and were aware of the excessive balance in R5's trust account as they had asked about it a month or so prior but added, I had to ask about it. FM-B stated they had not been approached or notified of the balance prior to them taking initiative and asking about it despite the excessive balance R5 had (i.e., over $20,000). R5's medical record, including the scanned documents, was reviewed and lacked evidence R5 or their representative had ever been notified when the balance of their trust account had come within $200 of the SSI threshold ($3,000) and what, if any, impact on their current payer source such could mean. (continued on next page)

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F 0569 Level of Harm - Potential for minimal harm Residents Affected - Some	R45's quarterly MDS, dated [DATE], identified R45 had moderate cognitive impairment. Further, R45's Clinical Census listing, printed 6/27/24, identified R45's current payer source as, Medical Assistance - MN, with a last effective date, 4/1/2024. When interviewed on 6/26/24 at 10:30 a.m., R45's family member (FM)-C verified they were R45's financial power-of-attorney (POA). FM-C stated they were unaware R45's trust account balance was so high expressing aloud, It's that high?! FM-C stated they had not been provided a statement (see F568) or told of the excessive balance adding the last statement they had received showed R45 with only a little over a thousand [dollars] in the account. FM-C verified they had not been notified when the balance reached or exceeded $3,000 to their recall. R45's medical record, including the scanned documents, was reviewed and lacked evidence R45 or their representative had ever been notified when the balance of their trust account had come within $200 of the SSI threshold ($3,000) and what, if any, impact on their current payer source such could mean. On 6/26/24 at 10:52 a.m., the human resources director (HR)-A was interviewed. HR-A verified they helped manage the day to day withdrawals from the accounts but expressed they did not provide or send out any statements adding such would be done usually [by] the billing office. HR-A stated they did not track the resident trust account balances for excessive amounts (i.e., over $3,000) adding, I don't. HR-A stated excessive amounts, including any need for a 'spend-down', would be tracked by the billing office, however, the person who managed it had resigned several months prior. When interviewed on 6/27/24 at 8:55 a.m., the administrator verified he had reviewed the trust account balances, and was unable to locate evidence to show the resident or their representative had been notified of the excessive balances. The administrator stated they had just developed and will mail a notice of it now. Further, the administrator stated the evidence should have been saved or scanned into the medical record and expressed it was important to ensure excessive balances were notified as residents' were entitled to the money, and then could spend it on themselves instead of the State taking it back. A facility' policy on personal trust account management was requested, however, none was received.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed and readily available to promote continuity of care for 2 of 3 residents (R61, R199) reviewed for care planning. Findings include: R61's admission Minimum Data Set (MDS), dated [DATE], identified R61 had intact cognition and was admitted to the care center on 6/3/24 from the acute care hospital. The MDS outlined R61 needed physical assistance for most activities of daily living (ADLs) and had multiple medical conditions including fractures, neurogenic bladder, and multiple sclerosis (MS). Further, the MDS outlined multiple Care Area Assessments (CAAs; items to have an in-depth review completed) were triggered for R61 including ADL Functional/Rehab, Urinary Incontinence and Indwelling Catheter, Falls, and Pressure Ulcer. On 6/24/24 at 1:07 p.m., R61 was interviewed. R61 explained they admitted to the care center several weeks prior after being hospitalized for a leg fracture. R61 stated she was working with therapy for rehab and, to her recall, had a care conference but it was earlier when I was doing better. R61 expressed multiple concerns about her care at the nursing home including a lack of bathing (see F677) and constipation not being addressed (see F684). R61's initial Comprehensive Nursing Data Collection - V7, dated 6/3/24, identified R61 was cognitively intact but orientated to person and place only. R61 was recorded as taking medications which could cause confusion and a section labeled, FUNCTIONAL STATUS, outlined R61 needed supervision or physical assistance to complete most ADLs. Further, the evaluation outlined R61 used a urinary catheter, had moderate pain, and several skin issues (i.e., bruising, redness) present upon admission. R61's care plan, printed 6/25/24, identified R61 admitted to the care center on 6/3/24 along with multiple areas to record a, Focus [i.e., problem], with a corresponding goal and interventions. The care plan identified several focus areas, however, these areas were left blank or not completed including but not limited to: (Preferred Name) has an ADL Self Care Performance Deficit r/t [blank, with a creation date listed, 06/04/2024. The focus statement lacked any written goals for the identified problem and multiple interventions were left un-edited to reflect R61's specific condition or presentation such as, TUB/SHOWER TRANSFER: dependent on assistance of # staff to complete. (Preferred Name) has Cognitive Loss/dementia or alteration in thought processes AEB [evidenced by] deficit's in memory/recall ability, judgement, decision making and thought process r/t [blank], with a creation date listed, 06/04/2024. A goal was written which read, Will be able to make basic needs known on a daily basis ., however, the space to record interventions for this identified concern was left blank with nothing written or completed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Preferred Name) has no cognitive impairments. Is alert and fully orientated to person, place, time and situation, with a creation date listed, 06/04/2024. The focus statement lacked any written goals for the identified problem and some interventions were left un-edited to reflect R61's specific condition or presentation such as, BIMS Score is (SPECIFY). (Preferred Name) has (specify type: indwelling, condom, supra pubic) Catheter. At increased risk for infection, with a creation date listed, 06/04/2024. The care plan lacked further information on which catheter type R61 had or used. On 6/26/24 at 12:11 p.m., the assistant director of nursing (ADON) was interviewed, and they verified they had reviewed R61's care plan. ADON stated the care plan had not been completed and added, There was like nothing done on there. ADON explained the MDS nurse typically updated them after the assessments were completed but stated anyone, such as floor nurses or staff, could edit or update it, when needed. ADON verified R61 should have their comprehensive care plan updated to reflect individualized needs and expressed aloud, It just didn't get done. Further, ADON stated the care plan, and some interventions placed within it, could be linked to the NA 'tasks' for documentation and care direction adding it should have been completed. ADON stated the care plan was a tool used to guide or direct staff and that tells you the picture [of them] and how best to care for them adding further, It's very important. 44656 R199's admission Minimum Data Set (MDS) dated [DATE] indicated R199 was admitted to facility on 6/10/24 and had intact cognition. R199's MDS identified the Care Plan Decision and Care Areas were completed on 6/21/24. R199's care plan (CP) dated 6/12/24 documented: (Preferred Name) has Renal Failure/Insufficiency r/t (Preferred Name) has altered cardiovascular status R/T (SPECIFY CARDIAC DX)(SPECIFY: With / without potential for bleeding/bruising R/T aspirin use, anticoagulant therapy, lovenox, heparin, Plavix) (PREFFERED NAME) has an infection of (SPECIFY) requiring antibiotic therapy (Preferred Name) uses Antidepressant Medication due to (SPECIFY: feelings of sadness, low self esteem, tearfulness, withdrawal from cares/activity, ineffective coping, feeling lonely/isolated) R/T (Preferred Name) is considered a vulnerable adult R/T (Preferred Name) wishes to return to the community (SPECIFY: goals for admission and desired outcome) [PREFERRED NAME] has potential/actual impairment to skin integrity r/t: (continued on next page)

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	245235	A. Building B. Wing	06/27/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with licensed practical nurse (LPN)-B on 6/27/24 at 8:30 a.m., LPN-B reviewed R199's electronic medical record (EMR) and care plan. LPN-B stated, Yes, I would expect the care plan to be more patient specific in the goals here (pointing to the care plan). It should always say his name and be more person centered. This looks like it was put in generically and no one edited it to reflect [R199's] name and goals. During interview with facility's assistant director of nursing (ADON) on 6/27/24 at 8:36 a.m., ADON reviewed R199's EMR and care plan. ADON stated, [R199's] care plan does not reflect being person-centered. The goals are generic and should at least mention his name. I expect this to be updated. Facility policy titled Person Centered Care Plan revised on 12/2022 state, Considerations for developing Person Centered Care Plan .should be individualized to the resident avoiding vague/non-specific information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure bathing care was consistently provided or recorded for 1 of 2 residents (R61) reviewed for activities of daily living (ADLs) and who was dependent on staff assistance for bathing. Findings include: R61's admission Minimum Data Set (MDS), dated [DATE], identified R61 had intact cognition and admitted to the care center on 6/3/24 from the acute care hospital. Further, the MDS recorded R61 demonstrated no delusional thinking and required substantial and/or maximum assistance with showering and/or bathing. R61's care plan, printed 6/25/24, identified R61 resided on the transitional care unit (TCU) and listed a focus, [Preferred Name] has an ADL Self Care Performance Deficit r/t [related to] [blank], with no goal statement associated. The care plan directed an intervention which read, SHOWER/BATHE SELF: requires partial/moderate assistance of # staff to complete, and, TUB/SHOWER TRANSFER: dependent on assistance of # staff to complete. The care plan lacked further information on bathing for R61 including frequency. On 6/24/24 at 1:17 p.m., R61 was observed seated in a wheelchair in her room. R61 was dressed in a hospital-type gown and stated they had been at the care center for a few weeks due to a fractured femur. R61 stated she had not really had a shower or good, in-depth bed bath since coming to the care center adding the lack of bathing had always been a bug-a-boo since [I've] been living here. R61 stated they would like help with bathing, including at least with a bed bath, and expressed she had told staff about the desire, too. R61's POC Response History, printed 6/26/24, identified a 21-day review period for R61's recorded assistance with bathing (i.e., independent, physical help). This outlined only a single recorded episode on 6/17/24, with the results being listed, Not Applicable. There were no other recorded baths on this form. R61's electronic medical record (EMR) outlined two completed Body Audit 11-15-V8 forms, dated 6/3/24 and 6/17/24, with each having a section labeled, Bath/Shower, along with spaces to record the type of bath received and a corresponding skin check. These identified R61 refused bathing on 6/3/24 (admitted) and received a bed bath on 6/17/24. There were no other recorded Body Audit 11-15-V8 identified despite R61 being admitted to the care center on 6/3/24. When interviewed on 6/26/24 at 8:43 a.m., nursing assistant (NA)-G verified they had worked with R61 since she admitted to the care center. NA-G stated R61 was more alert lately than when she first admitted and used a mechanical lift for transfers which was just implemented by therapy. NA-G reviewed the care sheet which had all residents on the unit, including R61, and their care needs listed. NA-G stated R61 was scheduled for a Monday evening shower which was not their typical shift, so they were unsure how often R61 was bathed or how much helped was needed to do so. However, NA-G stated all baths, including showers and bed baths, should be recorded in the POC charting when completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/26/24 at 8:58 a.m., registered nurse (RN)-B explained R61 was allowable to most cares but did, at times, complain about things such as cares and everything. RN-B stated bathing should be done on her scheduled bath day which was Monday evening and, when completed, the nurse on the floor should record it using the body audit [form]. RN-B verified the TCU had a shower available and added they had not had anyone report concerns with bathing not being completed stating, Nobody have ever said that to me. RN-B verified all bathing or attempts, including refusals when offered, should be recorded using the Body Audit form(s) in the EMR. However, R61's medical record was reviewed and lacked evidence R61 had been offered, provided or refused a shower or bathing between 6/3/24 to 6/17/24 (two weeks), or since 6/17/24 (over a week). There were no additional Body Audit 11-15-V8 forms identified nor further documentation within the POC charting to demonstrate bathing had been offered, completed or refused. On 6/26/24 at 12:11 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed R61's medical record. ADON explained the bath schedule was made with each room getting an assigned bath day which was listed on the NAR sheets for staff to be aware of and complete. ADON verified they were unable to locate documentation to demonstrate R61 had been offered or had bathing completed outside of the dates recorded (i.e., 6/3/24 and 6/17/24). ADON stated the nurses were recording on the Treatment Administration Record (TAR) they were doing a body audit, however, they were not filling out the corresponding form (i.e., Body Audit 11-15-V8). ADON stated they expected a bath or shower, along with the Body Audit 11-15-V8 form, to be done on a weekly basis or have documented rationale why it had not been done in the medical record. ADON stated R61 had a brief hospitalization (6/19/24 to 6/21/24), however, again, acknowledged the lack of documentation to support bathing had been done or offered adding, We have some work to do. ADON verified baths were usually recorded between the POC charting or Body Audit 11-15-V8 forms, and expressed bathing should be done to help reduce the risk of skin breakdown or other complications adding, Older peoples' skin is very thin. A facility' policy on ADL care, including bathing, was requested, however, none was received.

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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** 33925 Based on observation, interview and document review, the facility failed to comprehensively assess and, if needed, develope interventions to promote a proactive bowel management program to promote comfort and reduce the risk of complication (i.e., impaction, constipation) for 1 of 1 residents (R61); and failed to comprehensively assess and, if needed, develop or implement interventions to promote good posture and positioning while in bed for 1 of 1 resident (R26) observed who leaned significant to the side while in bed. Findings include: Bowel Management: R61's admission Minimum Data Set (MDS), dated [DATE], identified R61 had intact cognition and was dependent on staff for toilet hygiene and transfers. The MDS outlined a section labeled, H0600. Bowel Patterns, with spacing to record if constipation was present. This was answered, No. Further, the MDS identified R61 consumed multiple medications during the review period including opioids (i.e., narcotics). R61's initial Comprehensive Nursing Data Collection - V7, dated 6/3/24, identified R61's admission information along with a section labeled, BLADDER AND BOWEL, which outlined R61 had an indwelling Foley catheter and was continent of bowel adding, Continent - complete control. The evaluation outlined R61 used a toilet and bedpan for her elimination needs. However, the completed evaluation lacked evidence R61 had been evaluated for what, if any, risk factors for constipation were identified; if R61 had a history of or currently such condition; last bowel movement or normal patterns; and what, if any, personal preferences or input R61 had for her care with such. R61's care plan, printed 6/25/24, identified a section which read, (Preferred Name) is continent of bowel and bladder but requires (SPECIFY: cuing, assistance) to maintain continence, along with a single intervention which read, Notify nurse and medical practitioner of any increase in frequency, pain, discomfort or incontinence issues. The care plan lacked any specific interventions for R61's bowel continence or potential constipation risk, if applicable. On 6/24/24 at 12:58 p.m., R61 was observed seated in her wheelchair while in her room. R61 was interviewed and expressed concern she was having constipation. R61 explained the hospital had recently started her on Miralax (a laxative medication) which seemed to help but added she still felt constipated. R61 stated she was unsure how often it was scheduled but added, I do remind them [needing it]. R61 stated she was unsure what else could be done for her bowel management or what, if any, bowel management program was in place for her but added, I'm not regular yet. R61's M Health Fairview History and Physical, dated 6/19/24, identified R61 admitted to the hospital from the care center on 6/19/24, with several medical conditions including, 2/. Constipation secondary to neurogenic bowel . not a new situation at this time . did hesitantly acknowledge that she has ongoing constipation for the last 2 to 3 years and has been in the past taking prune juice but that seems to be somewhat of a challenge at the care facility . with her increased mobility it may be time to place her on scheduled MiraLAX and senna. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's subsequent Comprehensive Nursing Data Collection - V7, dated 6/21/24, identified R61 returned from the hospital. The evaluation again listed a section labeled, BLADDER AND BOWEL, along with various questions to be answered by the evaluator. This outlined R61 was continent of bowel, had a soft abdomen, and had bowel sounds present and active in all quadrants. The evaluation outlined R61 used a toilet, bedpan, and incontinent product (i.e., brief) for elimination; however, again, the completed evaluation lacked evidence R61 had been evaluated for what, if any, risk factors for constipation were identified; if R61 had a history of or currently such condition; last bowel movement or normal patterns; and what, if any, personal preferences or input R61 had for her care with such despite just being hospitalized with potential constipation issues identified. R61's POC (Point of Care) Response History, printed 6/25/24, identified the nursing assistant (NA) charting for R61's bowels including, Size of BM [bowel movement], from 6/5/24 to 6/25/24 with spacing to record the corresponding size (i.e., small, large). However, the completed charting showed only the following bowel movements recorded: On 6/12/24, R61 had a large BM. On 6/15/24, R61 had a large BM. On 6/17/24, R61 had a large BM. On 6/18/24, R61 had a large BM. On 6/19/24 to 6/20/24, R61 was recorded as, Resident Not Available [hospitalized]. There were no recorded BM(s) for R61 from 6/5/24 to 6/11/24 (seven days); nor were there any recorded BM(s) since R61 readmitted on [DATE] despite R61 being hospitalized and potential constipation being identified. R61's Medication Administration Record (MAR), dated 6/2024, identified R61's consumed medications and corresponding staff initials to demonstrate their administration while at the care center. This included: Miralax . 1 packet by mouth one time a day ., with a listed start date of 6/4/24 and discontinue date, 06/21/2024. The corresponding spaces to record staff initials had multiple spaces answered, 3 [drug refused], recorded. Polyethylene Glycol [Miralax] . 1 packet by mouth one time a day for CONSTIPATION, with a listed start date, 06/22/2024. However, the corresponding spaces to record administration again had multiple recorded, 3, answered. Senna-Docusate Sodium [stool softener medication] . 1 tablet by mouth one time a day ., written between two separate orders (due to hospitalization). These were all recorded as being administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/26/24 at 8:43 a.m., NA-G stated they had worked with R61 and described her as getting better now since when first admitted . NA-G stated R61 used a mechanical lift for transfers but, just recently, had started to use a standing-lift so using the toilet more would be possible moving forward. NA-G stated R61 was on a 'as requested' toileting program and verified R61 was able to ask for help when needing to have a bowel movement. NA-G stated resident' BM(s) were tracked and charted by the NA in the POC charting and expressed they were unaware R61 had any issues with constipation adding, I don't think so, no. NA-G stated R61 was not on any scheduled prune juice to their knowledge and expressed R61 had not had a BM for their shift (AM) during the past time they worked with her adding, I recorded no BM. R61's medical record was reviewed and lacked evidence R61 had been comprehensively assessed for what, if any, proactive bowel management needs were warranted or desired despite R61 being recorded as going multiple days between bowel movements (i.e., POC charting), R61 having periods of medication (i.e., laxative) refusals, and being recently hospitalized with constipation being outlined. There was no evidence what, if any, actions would be taken to help reduce the risk of complication for R61's bowels despite these identified risks. When interviewed on 6/26/24 at 8:58 a.m., registered nurse (RN)-B explained R61 was OK with her cares and usually allowing of them. RN-B stated they were aware R61 had constipation issues and explained R61 had, again, been refusing to always take her scheduled Miralax which lead to trouble having a BM due to R61 not being very mobile. RN-B reviewed R61's recorded BM(s) and stated the night nurse typically writes a listing of people on or over three days without a BM for the next shift to address with prune juice or medication. RN-B stated a more formal bowel evaluation, including with resident' preference and goals for their bowels, was typically discussed with them but was done more-so verbally and not recorded or documented anywhere. On 6/26/24 at 12:11 p.m., the assistant director of nursing (ADON) was interviewed. ADON verified they had reviewed R61's medical record, and they explained R61 did have scheduled prune juice in place but it had just been started on 6/25/24. ADON stated R61 was frequently refusing her scheduled laxative medication but verified R61 had a history of bowel-related issues. ADON verified they were unable to locate evidence in the medical record to demonstrate R61's bowels, including normal patterns and preferences, had been assessed adding aloud, as far as an actual assessment, no. ADON stated the care center used to have a different form to use to complete for such an evaluation which was more bowel focused but were no longer using it. ADON verified the NA charting in R61's POC and stated, She had a few days there she didn't go. A provided Bowel Management Program, undated, outlined the document was only a guide and for staff to follow physician orders for constipation prior to initiating. The document outlined, Constipation is if the resident has two or fewer bowel movements during the past 7-day period or for most bowel movements their stool is hard and difficult for them to pass . If resident has not had a BM for 2 days give 4 ounces of Prune Juice with breakfast. Encourage 2,000 ml [milliliters] daily fluid intake unless contraindicated. The document then listed several increasing steps to follow for multiple days without a stool. However, the provided document lacked information on how or when the care center would comprehensively reassess or what, if any, specific parameters would be evaluated to ensure a proactive bowel management program was in place in accordance with resident' wishes and goals. 47495 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bed Positioning: R26's quarterly Minimum Data Set (MDS), dated [DATE], indicated R26 was admitted to the facility on [DATE] and was cognitively intact. The MDS further indicated R26 required substantial to maximum assistance with most activities of daily living (ADLs) and was non- ambulatory. R26's diagnoses, printed 6/27/24, indicated R26 had several medical diagnoses which included cerebral ischemia (a condition in which there is insufficient blood flow to the brain to meet metabolic demand which leads to poor oxygen supply and thus leads to the death of brain tissue or stroke) and acquired absence of left leg below the knee. R26's care plan, revised 5/14/24, indicated R26 had a ADL self-care performance deficit related to cerebral vascular accident, left below knee amputation and weakness. Interventions including assistance of two staff members for repositioning in bed and ensuring R26 was upright for all oral intake. R26's care plan and care sheets (used to instruct nurses and nursing assistance on cares to provide residents) lacked instruction on how to position R26. R26's electronic medical record (EMR) lacked a comprehensive assessment of R38's positioning in bed along with interventions that have worked or not worked for R38's positioning. R26's EMR further lacked any evidence of refusing positioning interventions. During observation on 6/24/23 at 12:55 p.m., R26 was laying in her standard hospital bed with the head of the bed elevated approximately 45 degrees. R26's body was slouched down in bed and leaning over to the left side with her head resting directly on the affixed grab bar with her left shoulder and arm hanging off the side of the bed. R26's lunch was in front of her untouched. Further, above R26's bed was a sign posted which directed R26 should be boosted in bed and sitting upright when eating. R26 only shrugged her shoulders when asked if she was comfortable. During interview and observation on 6/26/24 at 12:32 p.m., R26 stated staff have tried to place a pillow under the mattress on her left side but that she does not like it because it hurts her shoulder. R26 was again in bed, with the head of the bed elevated approximately 45 degrees, leaning significantly to the left with her head resting directly on the affixed grab bar. During an interview on 6/26/24 at 1:03 p.m., the director of rehab (DOR) stated R26 had been seen by therapy on and off since 2022, with her last therapy case ending 5/31/24. The DOR stated therapy worked with R26 on correct wheelchair positioning and safe swallowing. The DOR stated speech therapy gave instructions upon discharge for staff to ensure R26 was boosted in bed and sitting upright for all oral intake. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 6/27/24 at 7:47 a.m., nursing assistant (NA)-B stated R26 preferred to stay in bed during the day and that she was aware that R26 often laid in bed, leaning to the left with her head resting on the grab bar. NA-B stated staff had tried to use a pillow on her left side but that R26 stated she was more comfortable without it. NA-B and NA-I boosted R26 in bed and assisted with her breakfast set up on her bedside table. R26 was left at only an approximate 25-degree incline to eat but was able to use the bed remote to raise her head of bed to approximately 60 degrees. As NA-B was still in R26's room, cleaning up from morning cares, R26 started to slowly lean over to the left side. NA-B made no attempts to help reposition R26 or use pillows to prop R26 or protect her head from resting directly on the grab bar. R26 was left leaning to the left in bed, with her breakfast on her bedside table, alone in her room to eat. During an interview on 6/27/24 at 9:01 a.m., NA-B confirmed she did not attempt to prop R26 up as she was leaning to the left stating, we stopped putting a pillow there (on her left side) because she (R26) says she is more comfortable without it. During an interview on 6/27/24 at 10:30 a.m., the DOR stated R26 preferred to lay that way and that although she could not physically move herself independently in bed if she was uncomfortable and depended on staff for bed mobility, she could call for help. The DOR stated if she was made aware that R26 was laying with her head resting directly on the grab bar she would recommend trying to pad the grab bar with a towel or pillow for R26's. During an interview on 6/27/24 at 11:00 a.m., the assistant director of nursing (ADON) stated R26's positioning needs, or refusals to reposition, should be care planned and agreed staff should be comprehensively assessing R26 to find a positioning device R26 would tolerate to improve her bed positioning. The ADON stated they should be ensuring R26's positioning preference should be assessed to make her choices in positioning as safe as possible for her. A facility policy on positioning was requested and not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review, the facility failed to provide passive range of motion and palm protector to prevent possible contracture for one of one residents (R38) reviewed for range of motion (ROM) who had limited functional movement of their hands. Findings include: R38's admission Minimum Data Set (MDS), dated [DATE], indicated R38 was on hospice with Alzheimer's dementia, had severe cognitive impairment and required substantial/maximum assistance with eating, toileting and personal hygiene and was dependent on staff for showers and dressing. R38's Therapy Recommendations and Discharge Instructions, dated 4/16/24, indicated R38 was to wear a palm protector at all times, provided hand hygiene and gentle PROM. The form indicated R38 was tolerating both the palm protector and the PROM. R38's sectioned labeled Tasks in the electronic medical record (EMR), for the month of June 2024, indicated a Functional Maintenance Program for a right palm protector at all times to be removed for hand hygiene and skin inspection only. The Tasks section in the EMR also indicated a Restorative Program for PROM to bilateral upper and lower extremities as tolerated. The Functional Maintenance Program had 18 documented shifts of Not Applicable for the palm protector in the month of June. The Restorative Program lacked any documentation that it had been completed in the past 30 days. R38's care plan, dated 4/17/24, indicated R38 was on a Functional Maintenance program and was to wear a right palm protector at all times to be removed for skin checks and hand hygiene only. R38's Care Sheets, used by the nursing assistants for resident information, updated 6/24/24, also indicated R38 was to wear a right palm protector at all times. R38's electronic medical record (EMR) lacked any evidence R38 had refused PROM or her palm protector. During observation on 6/24/24 at 2:10 p.m., R38 was lying in bed without a palm protector on her right hand. R38's bilateral hands were contracted into a fist, with the right hand appearing tighter. During observation on 6/25/24 at 10:20 a.m., an unnamed staff member was bringing R38 downstairs to see the podiatrist. R38 had no palm protector in place and her hands were noted to be clenched into fists. During observation on 6/25/24 at 12:43 p.m., R38 was back in bed, asleep, with no palm protector in place. During observation on 6/26/24 at 10:30 a.m., R38 was lying in bed, no palm protector in place. (continued on next page)

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	245235	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Health Care Center	7012 Lake Road Woodbury, MN 55125

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 10:42 a.m., nursing assistant (NA)-F stated R38 was total assist with cares and that she preferred to stay in bed for breakfast but would get up in her broda chair for lunch. NA-F stated she was unaware of anything that should be put on R38's hand (i.e. a palm protector) or a range of motion program for R38 but she did wear special boots on her feet. During an interview on 6/26/24 at 1:03 p.m., the director of therapy (DOT) stated R38 was seen and evaluated by therapy when she admitted to the facility on [DATE] and discharged from therapy on 4/18/24 when she was admitted to hospice. The DOT confirmed R38 was discharged with instructions for a palm protector to be worn at all times for comfort and skin integrity due to R38's contracted hands. The DOT stated staff should be removing the palm protector to provide gentle PROM to prevent worsening contractures. During an interview on 6/27/24 at 7:47 a.m., NA-B stated R38 had cushy grips for her hands since they were so contracted and that she believed therapy came and did PROM with her. During observation and interview on 6/27/24 at 9:20 a.m., NA-B provided morning cares to R38 including washing her face, under her arms and breasts and peri-area. R38 did not wash R38 hands, provide PROM or apply a palm protector. During a follow up interview on 6/27/24 at 10:30 a.m., the DOT stated there were two different programs available after a resident discharged from therapy; a restorative program that is carried out by a therapy aide and a functional maintenance program that is carried out by the Nas however she was unaware if the therapy aides were seeing R38. During an interview on 6/27/24 at 10:45 a.m., occupational therapist (OT)-A stated he had worked with R38 before she discharged from therapy and recommended the nursing staff (i.e. nursing assistants) to provide hand hygiene, gentle PROM and a palm protector for comfort and skin integrity since R38 was signing onto hospice. OT-A confirmed the therapy staff was not following R38 and the cares should be provided by the NAs. During an interview on 6/27/24, the assistant director of nursing (ADON) stated she would expect that the staff are following the care plan and providing R38 with hand hygiene and applying the palm protector for R38's comfort and to prevent skin breakdown or worsening contractures. A facility policy on functional and restorative programs was requested and not received.

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F 0689 Level of Harm - 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** 47495 Based on observation, interview and document review, the facility failed to implement care plan interventions, including providing required supervision, which resulted in a fall for 1 of 1 residents (R68) reviewed for accidents. This resulted in actual harm when R68 required hospitalization for pain control and sustained a fractured left tibia and fibula (lower leg bones). The facility had implemented and completed corrective action prior to the start of the survey, and the deficient practice is being issued at past non-compliance. Findings include: R68's annual Minimum Data Set (MDS), dated [DATE], indicated R68 was admitted to the facility on [DATE], was cognitively intact and required substantial or maximum assistance with toileting and dressing and partial to moderate assistance with bed mobility. R68's care plan, dated 3/22/23, indicated R68 had an activities of daily living (ADL) self-care performance deficit related to failure to thrive, osteoarthritis (inflammation of one or more joints) of the right knee and generalized weakness. Interventions included assistance of two staff for bathing and bed mobility and to ensure two staff were in the room when receiving daily cares due to a history of false accusations. R68's care plan, dated 6/6/24, also indicated R68 had limited physical mobility r/t [related to] ., which lacked information on what the limited mobility was related to in the blank space on the care plan form, with an additional intervention of contour/defined perimeter mattress or bed bolsters. R68's care sheets (used by the nursing assistants to know what cares to provide the residents), dated 6/24/24, indicated R68 was incontinent of bowel and bladder and required assistance of two staff for toileting in bed and bed mobility. During an interview on 6/25/24 at 12:35 p.m., nursing assistant (NA)-J stated the NAs used the care sheets to know what cares, and how to provide cares, to residents, stating the care sheets should be checked every shift in case there had been a change. NA-J stated R68 required two staff members for cares in bed and they had recently received education on cares in pairs for residents who received cares in bed for safety, so the resident does not fall out of bed. R68's progress notes indicated on 6/6/24, at approximately 1:30 p.m., R68 was found on the floor, on the left side of her bed and had complaints of left ankle pain and left side rib pain. R68 was assessed for injury and transferred back to bed. R68's progress notes further indicated a change in condition on 6/7/24 at 8:56 p.m., indicating R68 had continued pain and a recieved a provider recommendation to transfer to the hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/24 at 1:42 p.m., NA-B stated on 6/6/24, she went into R68's room to help NA-A with cares. NA-B stated R68 was very particular so NA-B told NA-A he could leave, and she would call him back into the room when she needed him. NA-B stated she tried to call NA-A back into the room, but he did not answer the walkie talkie. NA-B stated R68 was on her left side, having a bowel movement, when NA-B noticed she was out of barrier cream. NA-B did not want to lay R68 on her back so her sheets would not be soiled. NA-B then left R68 laying on her left side in bed unsupervised and unassisted in order to go get barrier cream. When NA-B returned, approximately 2-3 minutes later, she found R68 laying on the floor. NA-B stated she called the nurse and NA-A back to the room and R68 was transferred to bed via a hoyer lift. NA-B stated at that time R68 was complaining of left ankle and rib pain and stated she felt herself falling over the left side of the bed but could not stop herself. NA-B stated she was aware at the time of the fall that R68 was to receive cares with two staff members and stated she checked the care sheets daily. NA-B also stated she received education on the importance of always following a resident's care plan, stating R68 would not have fallen if two staff members were in the room providing cares. During an interview on 6/25/24 at 1:27 p.m., NA-A stated on 6/6/24, he went into R68's room with NA-B because R68 required two staff members for cares for safety. NA-A stated NA-B told him she could handle it and R68 did not want him there so he left the room. NA-A stated he did not notify the nurse or another NA to help because NA-B s stated she could handle it. NA-A stated he had received education since R68's fall that all residents who received cares in bed needed two staff members for safety. R68's physician order, dated 6/6/24, indicated an order for a left ankle and chest x-ray to rule out fractures. R68's medication administration record (MAR) indicated the x-ray was completed 6/7/24. R68's after visit summary (AVS) from Woodwinds Hospital, dated 6/10/24, indicated R68 was admitted to the hospital on 6/7/24 due to left ankle pain. The AVS indicated on 6/6/24, facility staff left R68's room after she was placed on the edge of the bed resulting in a fall to the floor. The AVS confirmed R68 sustained a fracture to her left tibia and fibula. R68's hospital discharge orders, dated 6/10/24, indicated a new medication order for hydromorphone (a narcotic used to treat moderate to severe pain) 2 milligrams (mg) by mouth every four hours as needed for severe pain. R68's physician orders indicated an order, dated 6/17/24, for Oxycodone (a narcotic used to treat moderate to severe pain) 5 mg every four hours as needed for pain. R68's medication adminsitration record (MAR), dated 6/24, indicated R68 received hydromorphone 13 times on 6/10/24, 6/11/24 x 2, 6/12/24 x 4, 6/13/24 x 4, 6/16/24 and 6/20/24. The MAR also indicated R68 received oxycodone 14 times on 6/17/24, 6/18/24, 6/19/24 x 2, 6/21/24 x 4, 6/22/24 x 2, 6/23/24, 6/24/24 x 2, and 6/25/24 x 2. R68's Associated Clinic of Psychology (ACP) note, dated 6/11/24, indicated R68 was calm and lethargic likely due to receiving narcotic pain medication. R68's fall from bed was reviewed and how distressing it was for her. R68 indicated she was nervous for facility staff to provide incontinent cares in bed since her return from the hospital and how it will take time for her to regain trust in the facility staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R68's ACP note, dated 6/18/24, indicated R68 updated the ACP practitioner on her post fall experience and how angry she was at the situation and not able to understand how staff walked out of her room allowing her to fall. The ACP note indicated R68 was very averse to pain and complained of the weight of her left leg cast. R68 continued to be anxious when staff provided incontinent cares in bed, stating they have not done anything to help her feel safer about the process. The note explained how R68 was also concerned about how this incident set her back in her rehabilitation process as she was not able to get out of bed due to pain. During an interview on 6/25/24 at 12:49 p.m., the director of nursing (DON) stated he was made aware of the 6/6/24 incident with R68 the day it happened. The DON stated NA-B had told NA-A he could leave R68's room while providing cares and R68 was ultimately left alone, laying on her left side which resulted in R68 falling from bed. The DON stated due to R68's complaints of left ankle and rib pain post fall an x-ray was ordered that same evening but did not get completed until the following day, 6/7/24. The evening of 6/7/24 the X-ray confirmed a fractured left ankle and R68 was sent to the hospital for evaluation. The DON confirmed at the time of the fall R68 was an assist of two staff members for bed mobility and incontinent cares and that the care plan was not followed. The DON stated another resident at the facility had a similar fall out of bed on 5/2/24 and at that time all residents who received cares in bed were reviewed and it was determined that R68 required assistance of two staff members for bed mobility and incontinent cares in bed for safety to prevent falls. The DON further stated R68 did not have a perimeter mattress but an air mattress currently in place on her bed, stating after IDM review they believed this was a better option after the incident for her due to her fractures and current bed bound status. The DON stated if stay were providing cares in pairs for R68 she would be safe in an air mattress since she did not roll ut of bed on her own, but was left up on her side by staff causing her to fall out of bed. The DON stated interventions for R68's fall revolved around education to the entire staff on care in pairs for residents who received cares in bed and the importance of following the care plan. The DON stated even though NA-A was not in the room at the time of the fall he was also coached on the incident because even if NA-B told him to leave, he should have stayed for R68's safety. The DON stated if a second staff member had been in the room with R68 and NA-B, R68 would not have fallen out of bed stating, she (R68) would not have rolled out of bed on her own, it was because she was left on her side alone. The past non-compliance that began on 6/6/24 and was verified, and found to be corrected, during the current recertification survey from 6/24/24 - 6/27/24. Verification of corrective action was confirmed by observation of cares, interview with staff on education received and document review of the all nursing staff education and coaching provided to NA-A and NA-B. Interviews above with NA-A and NA-B indicated they received coaching and education on the importance of following the care plan and cares in pairs for all bed bound residents for safety. During observation on 6/27/24 at 7:47 a.m., R26, a bed bound resident was observed to receive incontinent care in bed with two staff members present. The nursing staff education given to all nursing staff after the 6/6/24 incident and was completed by 6/21/24 and the recertification survey began on 6/24/24. During survey education documentation was reviewed and indicated nursing staff were educated on Two Assist and Why it Matters. Topics included why do some NAR sheet tasks (care sheets) say A-2 (assist of 2)?, who decides who is A-2 or not?, why do assistance levels matter?, and what of the resident tells the 2nd aide to leave?. The form had the following statement on the bottom and was signed by the employee receiving the training; This education was produced as a part of the mitigation action plan. I acknowledge that I have read and understand the contents of this training. If I have any further questions, I will ask either my floor nurse, care coordinator, assistant director of nursing, or the director of nursing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility policy on falls was requested but not received.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure urology orders for catheterization were clarified; and failed to ensure the use of an in-dwelling Foley catheter was comprehensively assessed or care-planned to promote continuity of care for 1 of 1 resident (R20) reviewed for catheter use. Findings include: R20's quarterly Minimum Data Set (MDS), dated [DATE], identified R20 had intact cognition. The MDS outlined a section labeled, H0100, which identified R20 did not use an indwelling catheter. On 6/24/24 at 4:53 p.m., R20 was observed seated in her wheelchair. R20 had a urinary drainage bag attached to her right leg (i.e., leg bag) which was visible at the bottom of her pant leg. The bag had visible, light-yellow colored urine present with a slight cloudy appearance. R20 was interviewed and verified she used a catheter, however, when asked the rationale just shrugged her shoulders and voiced aloud, Don't know. R20 stated it had been placed at the clinic and reiterated they were unaware of it's rationale for use. R20's care center' progress note, dated 3/26/24, identified R20 saw the urologist and a Foley catheter was placed with orders to follow-up in two or three months. R20's Referral Form, dated 3/26/24, identified R20 was seen by the urologist with a progress note listed, Follow-up with overactive bladder . unable to empty. Foley placed. May be 2/2 [secondary] medications + Parkinson's. The form included a section labeled, Orders, which had dictation written, Foley exchange monthly. If you can do intermittent cath, please perform every 4-6 hours and remove Foley . Follow-up 2-3 months. R20's Progress Note, dated 3/29/24 and completed by R20's nurse practitioner (NP), identified R20 was seen for an episodic visit and outlined a Foley had been placed on 3/26/24 (three days prior). The note contained a bolded heading which read, Dysuria, along with dictation reading, On-call updated 3/25/24 due to patient reporting incomplete emptying of bladder, burning . Bladder scan 112 . Urine culture ordered . noted multiple morphotypes present with no predominate organism . probable contamination during collection . Today, patient is sitting in her bed. Talks quietly. Denies having any urinary symptoms. Points to the leg bag on her leg from her foley [sic] catheter. Has had intermittent tachycardia [rapid heartbeat] since facility admission. The note lacked dictation or rationale from the NP on keeping the Foley in place versus proceeding with intermittent catheterization as directed on the referral form. In addition, R20's medical record was reviewed and lacked evidence the orders from urology had been clarified or, at minimum, any indication on whether or not intermittent catheterization had been attempted in accordance with the urology' referral. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's most recent Comprehensive Nursing Data Collection - V7, dated 6/18/24, identified R20 was reviewed for a quarterly assessment and listed a section labeled, BLADDER AND BOWEL, which had a checkmark placed next to an option, NA - Indwelling Catheter in place. The evaluation lacked any further information on the catheter including baseline output, urine characteristics, medical rationale for use, or what, if any, complications had been assessed for and actions to mitigate such risks. R20's care plan, printed 6/25/24, identified R20 was incontinent of bowel and bladder along with several interventions including use of an incontinent product (i.e., brief), barrier cream with moisture exposure, and assistance with toileting. The care plan also included a section which outlined, Resident has an [space] indwelling medical device - urinary catheter [space] requiring EBP precautions, with a creation date listed, 04/23/2024. It listed a single intervention which read, Requires enhanced barrier precautions. However, the entire care plan lacked information on R20's placed catheter including what size device (i.e., 16 Fr), the normal output expected, or expected/baseline urine characteristics. R20's medical record was reviewed and lacked evidence R20's placed Foley catheter had been comprehensively assessed to help determine what, if any, baseline parameters (i.e., output, urine characteristics) were identified to help ensure appropriate continuity of care and reduce the risk of complication. When interviewed on 6/25/24 at 12:27 p.m., nursing assistant (NA)-H stated they had worked with R20 prior and verified she used an in-dwelling Foley catheter adding, We empty her bag [Foley] as [R20] drinks water all day. NA-H stated R20 had the device placed like two or three months prior but was unsure why it had been placed adding aloud, I don't even know why she got that thing placed in. NA-H stated R20 continued to use the toilet for bowel movements and couldn't recall it ever being removed for intermittent catheterization adding, [It's] been constant. NA-H stated if R20 complained about the device, they would report it to the nurse adding the NA staff were tracking her output in the POC charting. NA-H stated they had never been told or recall what R20's baseline output (i.e., normal/shift) was adding, They [nurses] don't actually really say that. NA-H then provided a care sheet for review stating these were used to staff are aware of cares for each resident in the group. The provided Group A sheet, dated 6/24/24, identified R20's name along with her basic care needs including help with activities of daily living (ADLs) and diet. The sheet outlined, EBP-CATHETER, but lacked other information on the device' use or baseline characteristics for it so staff would be aware what, if any, changes or departure from the baseline had happened during their shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 6/25/24 at 12:45 p.m., licensed practical nurse (LPN)-E stated the nurses' follow physician orders to manage a catheter whether a resident admitted with it or had it placed afterward. LPN-E stated the NA staff charted the urinary outputs and felt from [their] experience the staff would report things which were kinda funky or abnormal. LPN-E reiterated they depended on the NA staff working to report changes if noticed and voiced they could use their worksheets [care sheets] for specific resident' information. LPN-E stated any assessment or evaluation of a resident' catheter, including for baseline data, would be completed possibly by the MDS nurse but added they (LPN-E) had never seen one done before on anyone else to their recall. LPN-E verified the care center had equipment to do intermittent catheterization, if needed, and explained orders from appointments were typically checked and entered by the health unit coordinator (HUC) before being second-checked by the nurse adding, We have to second check everything. LPN-E stated R20 had the Foley placed for a good couple months and, at the surveyor' request, reviewed the initial Urology referral order which directed to perform intermittent catheterization, if able. LPN-E stated they didn't recall such ever being attempted or done with R20 and expressed the order should have been clarified as the urologist gave orders for both intermittent and in-dwelling catheters adding, That doesn't make sense. On 6/25/24 at 3:14 p.m., the director of nursing (DON) and assistant director of nursing (ADON) were interviewed. DON verified they had reviewed R20's medical record, and they explained R20 went to the urology appointment on 3/26/24 where the Foley was placed. Upon return, the order from the Urologist then had some confusion which they believed was identified by the HUC who updated the nurse manager with what was two different orders on the referral form. However, with the nurse manager was essentially where is stayed and never acted upon or clarified or, at least, no evidence was in the record to support it had been done. DON explained catheter use was reviewed with the medical provider to ensure an appropriate medical rationale, and voiced the NA staff who work with her [R20] a lot would likely know the normal, baseline characteristics for the catheter. However, DON verified the care center still used agency staff but on a lesser basis than months' previous. DON stated there was not typically a recorded assessment or evaluation of a placed catheter (i.e., to determine baseline characteristics) but reiterated they felt the NA would report changes to the nurse who would then bring such to the nurse managers who would catch a deviation from baseline. A facility' policy on urology order and catheter evaluation was requested, however, none was received.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure proper cleaning of a non-invasive ventilation machine to reduce the risk of complications (i.e., respiratory infection) for 1 of 1 residents (R40) observed for non-invasive ventilation machine use. Findings include: The ResMed AirFit F20 Full Face Mask User Guide dated 12/20, indicated the mask should be disassembled, rinsed, cleaned with a soft brush until dirt was removed, cleaned with warm water and a mild detergent, rinsed and air dried daily or after each use. The guide indicated the headgear should be cleaned with warm water and mild detergent and then rinsed and air-dried weekly. The ResMed AirCurve 10 User Guide dated 4/21, indicated the non-invasive ventilation machine should be cleaned weekly including washing the water tub and air tubing with warm water and mild detergent and wiping the machine's exterior with a dry cloth. The guide recommended regular cleaning of the tubing, water tub, and mask for optimal therapy and prevention of the growth of germs. R40's significant change Minimum Data Set (MDS) dated [DATE], indicated R40 had intact cognition and was diagnosed with heart failure, respiratory failure, and debility. R40 was dependent on staff for bathing, toileting hygiene, and transfers and used a non-invasive ventilation machine. R40's Treatment/Medication Administration Report (TAR/MAR) dated 6/1/24- 6/26/24, indicated R40 had an order to clean mask every morning with soap and water which was documented as completed daily. The report included an order to document how the resident's machine worked every night, with ok written daily during the period. The report indicated the non-invasive ventilation machine should be applied at night and removed upon rising for a diagnosis of obstructive sleep apnea (OSA). The report indicated this had been completed every day and night except for six occasions during the day (6/3/24, 6/6/24, 6/12/24, 6/14/24, 6/17/24, and 6/26/24) where a 9 was charted indicating other/ see progress notes and one occasion (6/4/24) that was left blank. The report did not include documentation of cleaning the machine's tubing, water tub, headgear, or device exterior. R40's progress notes dated 6/3/24, 6/6/24, 6/12/24, 6/14/24, 6/17/24, and 6/26/24, indicated removal of R40's non-invasive ventilation machine was done on PM. During an interview and observation on 6/24/24 at 1:16 p.m., R40 stated she had never seen anyone clean her non-invasive ventilation machine, but it had looked like it needed to be cleaned for a while. R40's ResMed AirCurve 10 with an attached ResMed AirFit F20 Full Face Mask was observed on R40's bedside table with a white and yellow substance partially covering the inside of the mask. During an observation on 6/25/24 at 8:49 a.m., R40's ResMed AirCurve 10 with an attached ResMed AirFit F20 Full Face Mask was observed on R40's bedside table with a white and yellow substance partially covering the inside of the mask. (continued on next page)

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	245235	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Health Care Center	7012 Lake Road Woodbury, MN 55125

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/25/24 at 12:26 p.m., registered nurse (RN)-A stated she was the nurse in charge of R40's care today. RN-A stated she had not seen the non-invasive ventilation machine today or noticed any order to clean the machine. RN-A reviewed the TAR and stated the order had not popped up for her because the night nurse had charted they had already cleaned the mask. On observation of the machine with RN-A, RN-A stated, The mask could use some cleaning, and noted a white residue on the inside of the mask and the machine was still running. RN-A stated she was unsure why the night nurse had charted the mask was cleaned when it was apparent that it had not been. During an interview on 6/26/24 at 6:34 a.m., licensed practical nurse (LPN)-D stated she had just completed her night shift and had been the nurse in charge of R40's care. LPN-D stated, that everyone was responsible for cleaning the non-invasive ventilation machine for R40 but normally the night shift nurse completed it. LPN-D stated she knew how and what part of the machine needed cleaning by following the orders on the TAR and she otherwise did not have a specific process for cleaning the machine. LPN-D stated she had wiped down the machine and mask but had not completed more in-depth cleaning of the machine. During an interview on 6/27/24 at 8:49 a.m., the assistant director of nursing/ infection preventionist (ADON) stated nursing staff should wash the mask daily with soap and water to remove any dirt or bacteria. The ADON stated she would expect the machine cleaning to have been ordered and then documented in the TAR so it was completed consistently. The ADON stated she would worry about R40 developing a respiratory infection if the non-invasive ventilation machine was not adequately cleaned. A policy regarding the cleaning of non-invasive ventilation machines was requested and not received.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 49339 Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and develop a comprehensive person-centered care plan with goals and interventions utilizing a trauma-informed approach including monitoring of PTSD (post-traumatic stress disorder) for 1 of 1 (R39) residents reviewed for trauma-informed care. Findings include: R39's quarterly Minimum Data Set (MDS) assessment dated , 6/6/24, indicated R39 diagnoses included: PTSD, adjustment disorder with mixed anxiety and depressed mood (a mental health condition with symptoms of depression and anxiety), borderline personality disorder (a mental health disorder that is characterized by unstable mood and behavior) and depression. R39 had intact cognition. R39's Trauma Screening, dated 12/20/23, identified R39 identified experiencing a traumatic event. The document identified through questions with radio-button answered yes that R39 experienced nightmares or thought about event when you did not want to; will go out of the way to avoid situations that reminded R39 of the event; been on guard, watchful or easily startled; felt numb or detached from people, activities or surroundings and had felt guilty or blames self for the event. The document further indicated no referrals were made as resident declines referrals at this time. A box at the bottom of the assessment indicated, resident stated that she experienced trauma. Resident did not want to talk about her experience with LSW. Resident declined all referral. LSW continues to be available prn [as needed]. The document did not contain what referrals were discussed and if any triggers for symptoms were discussed. Nursing assistant care sheet, updated 6/24/24, identified R39's needs for ADLs (activities of daily living). The document had a section titled Person Centered Information, which included, likes Classic rock, worked as a school bus driver and CNA. The document lacked identification of any identified triggers or potential triggers for R39. R39's care plan, printed 6/26/24, identified R39 had history of trauma/catastrophic life even with actual/potential for PTSD. [R39] declined to elaborate on trauma experienced, which was initiated on 12/20/23. Interventions failed to identify individualized triggers or interventions to determine triggers, measurable objectives, interventions, and timeframes for how staff are expected to meet R39's desired goals and outcomes concerning her PTSD. Furthermore, the document identified R39 exhibits the following rejection of care, screaming/cursing at others, socially inappropriate/disruptive behavior, initiated on 6/6/24, with no individualized interventions for possible triggers of this behavior. During interview on 6/24/24 at 6:28 p.m., R39 stated, no one here has ever asked me about triggers there are things that make my symptoms worse no one here has ever asked me about what those things are I think it would be helpful. R39 declined to further discuss what those triggers are with surveyor. R39 did state she recently had a room change as there was some conflict with her old roommate and she feels she is doing better since she has a single room. R39 stated, I would like it if they would talk to me about it. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2024 at 1:28 p.m., nursing assistant (NA)-C verified that they are familiar and work with R39 often. NA-C indicated that they get the information that they need to care for the resident off the nursing assistant care sheet. NA-C stated they are aware that R39 has mental health issues as she told me. NA-C stated they are unaware of any triggers and was not sure if R39 has PTSD. NA-C stated, it would be on the care sheet. NA-C verified the care sheet does not identify a history of trauna or any triggers for R39. On 6/26/24 at 10:24 a.m., NA-D verified they work frequently with R39 and are familiar with R39's needs. NA-D stated they get information needed about residents from the nursing assistant care sheets. NA-D stated they are aware R39 has PTSD. NA-D verified they are not aware of any triggers for R39 and verified there is no information relating to history of trauma or triggers on the care sheet. On 6/26/24 at 9:33 a.m., licensed practical nurse (LPN)-C verified they work frequently with R39 and are familiar with her care needs. LPN-C stated that they are aware that R39 has PTSD. LPN-C reviewed the care plan and verified there are no triggers on the care plan for R39. LPN-C indicated it is important to know your residents to help care them better. LPN-C indicated the documentation regarding triggers would be found on the care plan. On 6/27/24 at 9:53 a.m., social worker (SW)-A verified they work with R39 and familiar with their care. SW-A verified a trauma screening was preformed upon admission but not since. SW-A verified R39 recently had a room change due to difficulties with a roommate. SW-A verified there are no triggers identified in her care plan. SW-A stated, If we are able to know her triggers then we are able to avoid her having more emotional distress. On 6/27/24 at 10:06 a.m., assistant director of nursing (ADON) stated, it is important to know the background of our residents, so we are more aware of triggers, so we are caring for them properly. We don't want to agitate or upset them. ADON stated she would expect the triggers to be identified on the care plan. A facility policy titled Person Centered Care plan, reviewed 12/22, identified in the section: Comprehensive person-centered care plans should include specific interventions to eliminate or mitigate triggers that may cause retraumatization in trauma survivors.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon timely, and an appropriate rationale was recorded for not implementing recommendations for 1 of 5 residents (R38) reviewed for unnecessary medication use. Findings include: R38's admission Minimum Data Set (MDS), dated [DATE], indicated R38 was admitted to the facility on [DATE], (was signed onto hospice three days later on 4/18/24) and had severe cognitive impairment. R38's Diagnoses list, dated 4/15/24, indicated R38 had several medical diagnoses including dementia with agitation, generalized anxiety, and major depressive disorder. R38's physician orders, dated 4/19/24, indicated an order for prochlorperazine maleate 10 milligrams (mg) by mouth every six hours as needed for nausea and vomiting (an antipsychotic medication used to treat schizophrenia and anxiety which can also be used to treat severe nausea and vomiting) and an order for lorazepam (medication used to treat anxiety and agitiation) 0.5 mg by mouth every four hours as needed for anxiety. Both orders lacked an end date. R38's June medication administration record (MAR) indicated R38 had not received the as needed prochlorperazine maleate or lorazepam that month. On R38's monthly medication regiment review (MRR), dated 5/14/24, the consultant pharmacist (CP) indicated R38, has been prescribed PRN (as needed) Ativan (lorazepam) since 4/19/24, however there is no stop date/duration listed for this medication on the MAR. Per updated Centers for Medicare & Medicaid Services (CMS) regulations, all new PRN psychotropic medication orders must be re-evaluated within 14 days of initiation, and then at routine intervals thereafter (follow up interval must be specified by the provider). Additionally, when renewing the PRN psychotropic orders, clinical rationale for continuing the medication must be provided. NOTE: CMS has specified that hospice is not exception to this rule. The MRR indicated follow up was expected as soon as possible but no later than 30 days. The MRR indicated under follow up or action taken, rejected per hospice with the physician signature, dated 5/15/24. A second MRR, dated 5/14/24 for R38, the CP indicated, according to CMS's frequently asked questions related to Long Term Care regulations, Compazine or prochlorperazine is considered an antipsychotic, though it can be used to treat nausea and vomiting. Therefore, according to federal requirements, a PRN order for Compazine must be limited to 14 days. A new PRN order cannot be renewed unless the attending physician or prescribing practitioner first evaluates the resident to determine if entering a new order for the PRN medication is appropriate. Additionally, CMS has specified that hospice is not an exception to this rule. The MRR indicated follow up was expected as soon as possible but no later than 30 days. The MRR lacked attending physician/practitioner follow up until 6/26/24, during survey, when the physician discontinued the medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 9:56 a.m., the CP stated for recommendations regarding PRN medications he expected follow up within 30 days, stating past 14 days the facility would be out of compliance. The CP further stated he would expect a clinical rationale on why the PRN medication should remain in place past 14 days other than the resident receiving hospice services. The CP stated the main reason for this was to ensure residents did not have orders for, or receive, unneeded medications. During an interview on 6/27/24, the assistant director of nursing stated the MRRs are sent to the director of nursing monthly who ensure they get to the correct floor specific to the resident. The nurse manager would follow up on recommendations that only required nurse follow up and the recommendations that required physician follow up would be left for review by the rounding physician. A facility policy titled Medication Management, reviewed 9/23, indicated the CP would review each resident's medication regiment at least monthly and report any irregularities in writing to the facility. The policy further indicated the expected follow-up timeline would be documented on the written form. A facility policy titled Mood and Behavior Program, revised 11/22, indicated PRN orders for psychotropic medications (i.e., Lorazepam) are limited to 14 days and if extended beyond that a clinical rationale must be documented by the prescribing provider. PRN orders for antipsychotics (i.e., Compazine) are limited to 14 days and the prescribing provider must assess the resident to determine if renewing the order is appropriate for the resident.

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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 interview and document review, the facility failed to ensure a scheduled antifungal medication without an end date was evaluated for the appropriateness of its continued use for 1 of 5 residents (R40) reviewed for unnecessary medications. Findings include: R40's significant change Minimum Data Set (MDS) dated [DATE], indicated R40 had intact cognition and was diagnosed with heart failure, respiratory failure, and debility. R40 was dependent on staff to complete bathing, toileting hygiene, and transfers. R40's Order Summary Report dated 3/26/24, indicated R40 had an order starting on 3/26/24 with no end date for nystatin (an antifungal medication) powder application to the groin folds two times a day for a rash. R40's Medication Administration Report (MAR) dated 3/26/24- 6/26/24, indicated R40 had received twice daily applications of nystatin powder during this period except for seven incidents where a three was coded indicating drug refused. R40's Body Audits dated 5/2/24, 5/9/24, 5/16/24, 5/23/24, 5/30/24, 6/7/24, 6/14/24, and 6/20/24, indicated no to the question does the resident have any alterations in skin integrity which included but was not limited to rashes, skin tears, and pressure ulcers. R40's progress notes dated 5/2/24 through 6/27/24 were reviewed and did not contain documentation of provider notification when the fungal infection had resolved or an ongoing fungal infection in the groin area. R40's care plan dated 5/16/24, indicated R40 required the assistance of two people for bathing and staff were to report any changes in skin condition to the nurse. The care plan indicated that skin was to be assessed weekly and as needed with a goal of having no related complications through the review date. R40's progress note dated 6/26/24 at 9:53 a.m., indicated R40's skin was currently intact. During an interview on 6/26/24 at 8:50 a.m., the nursing assistant (NA)-A stated she had assisted R40 with her personal cares this morning and had not noted any redness in her groin folds. During an interview on 6/26/24 at 12:07 p.m., licensed practical nurse (LPN)-A stated TMA-A was in charge of applying R40's nystatin powder but she was not aware of R40 having any redness or a rash currently. LPN-A stated that R40's skin condition was documented in her body audits. LPN-A stated the order for the nystatin powder did not say to discontinue use when the yeast infection/rash had healed so they continued the order and applied the medication. (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 6/26/24 at 12:13 p.m., trained medication aide (TMA)-A stated he had applied R40's nystatin powder this morning to her groin, and her skin was without a rash. TMA-A stated he had not told the nurse of R40's skin integrity as this was not new. During an interview on 6/27/24 at 8:14 a.m., doctor of medicine (MD)-A stated she does not recommend R40 to continue using the nystatin powder when she does not have an active fungal infection as demonstrated by a skin alteration and the order should have been discontinued if the rash had cleared. During an interview on 6/27/24 at 8:56 a.m., the assistant director of nursing (ADON)/ infection preventionist stated skin status could be found in a weekly body audit or a nursing progress note. The ADON stated nursing staff should have been assessing skin daily when applying the nystatin powder. The ADON stated if the skin was clear of a rash, the provider should have been updated so the order could be discontinued when it was no longer needed. The ADON stated it was important for R40 to have the nystatin powder discontinued if not needed, so the medication did not become less effective over time. The facility's Medication Management policy dated 9/23, indicated nursing staff were to always know the medications they were administering to residents and the effects of the medication. The policy did not indicate when staff should notify a provider to assess for the need to discontinue a medication when the medication indication was no longer present.

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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** 47495 Based on interview and document review the facility failed to care plan and document resident specific target behaviors for 1 of 5 residents (R38) who was prescribed scheduled antipsychotic medication. Further, the facility failed to ensure that as-needed (PRN) psychotropic medications were limited to 14 days of use or the practitioner documented both a specific order duration and the rationale for extending the PRN psychotropic order, to ensure the medications continued necessity and reduce the risk of complication for 1 of 5 residents (R69) reviewed for unnecessary medication use. Findings include: R38's admission Minimum Data Set (MDS), dated [DATE], indicated R38 had severe cognitive impairment and was dependent on staff for activities of daily living (ADLs). R38's physician order, dated 4/15/24, indicated R38 had an order for quetiapine fumarate (an antipsychotic medication used to treat anxiety and agitation) 100 milligrams (mg) by mouth two times a day for Alzheimer's dementia with agitation. R38's care plan, dated 4/16/24, instructed staff to observe for target behaviors/symptoms and record per facility protocol. However, the care plan lacked target behaviors specifc to R38 related to the use of schedule Seroquel. R38's electronic medical record (EMR), including R38's medication administration record (MAR) and treatment administration record (TAR) lacked documentation of specific target behaviors staff should monitor for to ensure R38's antipsychotic medication was effective and necessary. During an interview on 6/27/24 at 9:56 a.m., the consultant pharmacist (CP) stated he would expect, per center for Medicare and Medicaid services (CMS) guidelines, that the facility develops and care plans resident specific target behaviors for antipsychotic medication use. The CP stated he would expect the facility to have developed R38's target behaviors into her care plan since she had been at the facility for a few months. During an interview on 6/27/24 at 11:00 a.m., the assistant director of nursing (DON) stated it would be expected that resident specific target behaviors should be on the MAR or the TAR for staff to document what behaviors are present. The ADON stated this would be important to track to ensure the antipsychotics were effective or needed an adjustment if behaviors were still present. A facility policy titled Mood and Behavior, revised 11/22, indicated all residents receiving antipsychotic medications would have a physician order to monitor target behaviors and behaviors would be tracked on the MAR. 49034 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R69's admission Minimum Data Set (MDS) dated [DATE], indicated R69 had moderately impaired cognition and was receiving hospice services. R69 did not display any hallucinations, delusions, behavioral symptoms directed toward others, rejection of care, or wandering during the look-back period. The MDS indicated that R69 was diagnosed with cancer and a seizure disorder. The MDS indicated R69 required moderate assistance with personal hygiene, transferring, and bed mobility. R69's Order Summary Report dated 5/2/24, indicated R69 had an order starting on 5/2/24 with no end date for two milligrams (mg) of PRN lorazepam (a psychotropic medication) every 15 minutes for three doses if seizure activity continued. R69's written hard copy order dated 5/2/24 at 1:40 p.m., indicated R69 had an order starting on 5/2/24 for two mg of PRN lorazepam (a psychotropic medication) every 15 minutes for three doses if seizure activity continued. The order did not have an end date. R69's care plan dated 5/5/24, indicated R69 received a psychotropic medication for seizures and had a goal of remaining free from discomfort or adverse medication reactions. R69's Medication Administration Record (MAR) dated 6/1/24 - 6/26/24, indicated the code 9 was documented on 6/22/24 under the 5/2/24 order for two milligrams (mg) of PRN lorazepam every 15 minutes for three doses, indicating other/ see progress notes. The MAR did not indicate any other doses of lorazepam were given under the 5/2/24 PRN lorazepam order during this period. R69's progress note dated 6/22/24 at 9:38 p.m., indicated R69 was observed to have symptoms of a possible seizure and was given PRN lorazepam. The note indicated hospice was updated and a second dose of PRN lorazepam was given. R69's provider order dated 6/27/24 at 12:55 p.m., indicated an updated order for two milligrams (mg) of PRN lorazepam every 15 minutes for three doses if seizure activity continued with an order duration of 90 days. R69's medical record was reviewed and did not include documented rationale by the practitioner before survey entrance for extending the PRN lorazepam order and what duration that order was extended to. During an interview on 6/26/24 at 9:46 a.m., the assistant director of nursing (ADON) acknowledged R69 had an order for PRN lorazepam, a psychotropic without a stop date. The ADON stated hospice was the primary provider for R69. The ADON stated the facility had continued issues with hospice providers ordering psychotropic medications without a stop date or justification for why the provider was extending the stop date beyond 14 days. The ADON stated she would review the medical record for an end date for the PRN lorazepam and the corresponding justification for why the medication was ordered for longer than 14 days. During an interview on 6/26/24 at 1:46 p.m., the ADON stated she had reviewed R69's medical record and could not find documentation of the rationale and duration for the PRN lorazepam order dated 5/2/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 8:46 a.m., the ADON stated she had called but had not heard back from the prescribing practitioner related to the PRN lorazepam without an end date. The ADON stated it was important that the psychotropic medications had an appropriate end date to ensure the resident was not receiving the medication for a longer than necessary duration putting the resident at great risk for medication side effects. The ordering provider was called on 6/26/24 at 1:41 p.m. by the surveyor, with no response received. The facility's Mood and Behavior Program Policy dated 11/22, indicated PRN orders for psychotropic medications should have been limited to 14 days unless the attending physician or prescribing practitioner believed extending the order was appropriate, documented their rationale for doing so, and indicated a specific duration for the PRN medication use.