STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Health & Rehabilitation	3700 Foss Road Northeast St Anthony, MN 55421

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49654 Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R66) observed with medications at bedside. Findings include: R66's admission minimum data set (MDS) dated [DATE], indicated she had intact cognition, did not refuse care or medications and had the following diagnoses: cancer, malnutrition, asthma, chronic obstructive pulmonary disease and/or chronic lung disease. The MDS further indicated R66 took antipsychotic, antianxiety, antidepressant, opioids and required oxygen therapy. R66's order summary report printed on 4/10/25, included antianxiety medications, antidepressant medications, antipsychotic medications and narcotic pain medications which can cause blurriness, dizziness and sedation. Additionally, R66 required nebulizer breathing treatments 4 times throughout the day and the use of supplemental oxygen. The order summary lacked documentation of an order for self-administration of medications (SAM). R66's medication administration record (MAR) dated 4/1/2025-4/30/2025, indicated R66 had been administered all scheduled doses for the month of April. However, the MAR lacked documentation of an order for self-administration of medications. R66's care plan lacked information regarding self-administration of medications. During observation on 4/8/25 at 8:49 a.m., R66 was in bed resting quietly with eyes closed with her bedside table over the right side of the bed. To her immediate left was another facility bed not in use. At the end of her bed was a walker and a wheelchair. Just inside the door to the immediate right, approximately 8 feet from R66, was shower chair covered with a black and white rug. On top of the rug was a white nebulizer machine. Connected to the machine was green tubing connected to a nebulizer cup. The nebulizer cup was approximately two thirds full of clear liquid. A nebulizer solution cap and empty vial was next to the neb machine. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/8/25 at 9:17 a.m., registered nurse (RN)-C stated she had not yet given R66 her morning medications. RN-C picked up the nebulizer cup and confirmed the nebulizer cup was two thirds full and stated it was probably the neb treatment from the night before. RN-C stated R66 wouldn't even be able to reach it where it was located so far from her bed. RN-C went on to say she was unclear if R66 could administer her own medications. During interview on 4/8/25 at 3:46 p.m., registered nurse manager (RNM) stated if a resident wished to administer their own meds they would need to be assessed upon admission and with any significant change of condition. RNM stated the assessment for a nebulizer would include the resident demonstrating they could hold the neb cup during administration and were able to remove it when it was completed. RNM stated without a SAM in place she expected the nursing staff to prepare the medication and stay with the resident during administration. RNM stated if a resident had a SAM order a nebulizer could be left with the resident to self-administer, however, the nurse would be required to come back and complete a respiratory assessment when the nebulizer was completed. RNM reviewed R66's electronic medical record and stated R66 did not have a SAM assessment or an order to self-administer medications and a full neb cup should not have been left in her room to self-administer. Facility policy titled Self Administration of Medications with a last review date of 10/14/24 indicated the following: A resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. When determining if self-administration is clinically appropriate for a resident the IDT consider the residents physical capacity appropriately administer; the resident's capability to follow directions; the resident's comprehension of instructions for the medications they are taking; and the resident's ability to ensure medication is stored safely and securely. The policy went on to indicate all nurses and aides are required to report to the charge nurse any medication found at the bedside not authorized for bedside storage and the care plan must reflect resident self-administration and storage arrangements for such medications.

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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 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** 49654 Based on observation, interview and record review, the facility failed to update a care plan 1 of 1 residents (R66) reviewed for a declining resident. Findings include: R66's minimum data set (MDS) dated [DATE], indicated she had intact cognition, did not refuse care or medications and had the following diagnoses: cancer, malnutrition, asthma, chronic obstructive pulmonary disease and/or chronic lung disease. The MDS further indicated R66 was independent with eating, personal hygiene, toileting, dressing, mobility, transfers and received hospice services. R66's face sheet indicated R66 was contracted Hospice of the Midwest to receive hospice cares and services. R66's care plan indicated R66 had a self-care deficit and required assistance with activities of daily living (ADL's) due to terminal lung cancer/respiratory failure. The care plan also indicated R66 received hospice services, and the nurse manager was the designated facility interdisciplinary team (IDT) member to collaborate with hospice to ensure the needs of R66 were being met. R66's order summary report printed 4/10/25 indicated R66 took antidepressant medication with potential side effects of dizziness, fatigue, and anxiety; antipsychotic mediations with potential side effects of blurred vision, postural hypotension(a sudden drop in blood pressure that occurs when a person changes from a lying or sitting position to standing), sedation, confusion, and restlessness; Gabapentin with potential side effects of drowsiness, dizziness, sedation and blurred vision; an opioid medication with potential side effects of dizziness, delirium, over sedation and changes in mental status. R66's medication administration record (MAR) for April 2025 indicated R66 took the following scheduled medications: 100mg quetiapine at bedtime for anxiety, 0.5mg lorazepam twice a day for shortness of breath, 400mg gabapentin three times a day for pain, 30mg morphine three times a day for pain; and the following as needed medications: 15mg morphine tablet every two hours as needed for pain, and 0.75 ml (20mg/ml) every two hours as needed for shortness of breath. The MAR also indicated R66 had not missed any scheduled medications in April 2025 and had been administered as needed morphine three times between April 1st and April 10th, 2025. R66's bedside Kardex dated 4/9/2025 indicated R66 was able to take showers/baths independently with no staff oversight, was able to toilet independently, and was able to transfer independently with no staff oversight. During observation on 04/08/25 at 3:28 p.m. R66 was lying in bed, eyes closed, deep even breathing noted; dressed in light colored top and dark bottoms and did not respond to knocking on door from staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 04/09/25 7:28 a.m. R66 was lying in bed on her left side with eyes closed. R66 was wearing same light-colored top and dark bottoms as previous day. R66's hair pulled up into bun on top of head and had a greasy appearance. During interview on 04/09/25 at 10:54 a.m. registered nurse (RN)-C stated R66 was very weak, and the aides had been providing toileting cares to include changing soiled incontinent briefs, assisting with bathing or showering and could no longer dress herself or change her clothes. RN-C could not locate any documentation on R66's bathing record and stated she had been previously independent but was now dependent on staff for assistance with 'basically everything'. RN-C stated R66 did not have a hospice aide to assist with personal cares and she had been updated by the nurse manager that R66 was declining, and staff would have to start doing more cares for her. During interview on 04/09/25 at 10:57 a.m. certified nursing assistant (CNA)-C stated R66 received assistance with toileting, bathing and sometimes repositioning in bed. CNA-C stated R66 had been able to do her own shower previously but had been steadily declining and now needed assistance for all her personal cares. CNA-C stated staff would look to the Kardex for instructions on how to care for residents. CNA-C opened R66's Kardex, stated it was incorrect and did not reflect the cares R66 was currently needing. During observation on 04/10/25 at 11:07 a.m. R66 was observed lying in bed with her eyes closed, wearing what appeared to be the same light-colored top and dark bottoms she had been wearing the previous two days. R66's hair was unkept and had stringy strands hanging loose from a ponytail on the top of her head. R66 did not respond to verbal stimulation. During interview on 04/10/25 at 11:51 a.m. registered nurse case manager (NM)-C stated care plans and Kardex's were updated with changes after a fall, beginning or ending therapy, hospitalization s or any significant change of condition. NM-C stated she was ultimately responsible for updating resident care plans and the Kardex. NM-C reviewed R66's care plan and stated it had not been updated. R66 was not independent with bathing or toileting, she required oversight. NM-C stated R66 had been steadily declining and agreed the care plan should have been updated to reflect her increased need of assistance with all personal cares. During interview on 04/10/25 at 12:35 p.m. director of nursing (DON) stated care plans were reviewed by using an IDT approach and depending on the topic it could be updated by the MDS nurse or the NM. DON stated care plans were updated with new therapies, after a fall, hospitalization , or a change of condition. DON stated the process would be the same for all residents regardless of their hospice designation. DON acknowledged R66 had been declining and stated she was aware she required more assistance. DON went on to say it was her expectation care plans were updated as soon as a change was identified. This was important to ensure all resident care needs were met. Facility document titled Care Plan Revisions Upon Status Change with a created date of 9/26/2023 indicated the purpose of the procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The policy indicated the following: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. upon identification of a change in status, the nurse will notify the MDS coordinator, the physician and the resident representative b. the MDS coordinator and the IDT will discuss the resident condition and collaborate on intervention options c. the care plan will be updated with the new or modified interventions d. staff involved in the care of the resident will report resident response to new or modified interventions e. care plans will be modified as needed by designated staff f. the unit manager or other designated staff will communicate care plan interventions to all staff involved in the resident's care g. the designated staff member will conduct an audit on all residents experiencing a change in status at the time of the change in status is identified to ensure care plans have been updated to reflect current resident needs

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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** 49035 Based on observation, interview and document review, the facility failed to provided nail care for 1 of 4 residents (R15) reviewed for dependent activities of daily living (ADLs). Findings include: R15's PPS 5 day scheduled Minimum Data Set (MDS) assessment dated [DATE], included R15 was admitted [DATE] and had moderate cognitive impairment. R15 had impairment on one side and was dependent with bathing. Personal hygiene assessment was not recorded on the MDS submission. R15's undated care plan included a focus of being at risk for excessive bruising and bleeding due to use of coumadin (a blood thinner) with an intervention to remind R15 to use extra caution when shaving. The care plan included R15 had a self care deficit and required assistance with ADLs due to weakness, impaired mobility and having multiple disease processes and had an intervention of needing assistance with all ALDs. On 4/7/25 at 2:52 p.m., R15 was observed to have fingernails that extended past the tips of his fingers on both hands. Fingernails on his dominant left hand were irregular. During interview on 2:52 p.m., R15 stated he does not like his fingernails being as long as they are and that they sometimes get caught on his sheets when he is in bed. R15 stated he preferred to be clean shaven, but is unable to shave at this time due to not having a razor he can use. During observation and interview on 4/8/25 at 11:07 a.m., R15's fingernails remained long and irregular and face unshaven. Facial hair was approximately 1/2 to 1 inch in length. R15 stated he typically would shave his head in addition to his face. R15 stated he spoke with someone at the facility 2 to 3 weeks ago and they said they would get him an electric razor to use. He did not ever receive the electric razor. During interview on 4/8/25 at 11:14 a.m., nursing assistant (NA)-A stated grooming assistance should be completed every morning. A nurse should be updated if a resident refused. During interview on 4/8/25 at 11:35 a.m., registered nurse (RN)-A stated nail care should be completed on bath days or as needed and diabetic residents needed to have nail care completed by a nurse. During interview on 4/8/25 at 4:42 p.m., nurse manager (NM)-D stated fingernail care should have been completed on a resident's bath day but could have been completed another time if the resident refused on bath day. NM-D stated assistance with shaving was available and an electric razor was available if the resident did not have access to one. NM-D confirmed R15 did have long nails that extended about 0.3 centimeters (cm) past his fingertip. NM-D confirmed there was occasionally dark matter visible under the fingernails and the staff should have been assisting R15 with cleaning his nails daily and after meals. NM-D confirmed R15 was on blood thinners and recently had high lab values which put him at a greater risk for bleeding. NM-D stated R15 was at increased risk for bleeding and infection due to his longer fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/9/25 at 2:31 p.m., the director of nursing (DON) stated nail care should have been completed on bath day. A resident should have been reapproached if they refused and a progress note should have been completed. The DON confirmed she was informed R15's fingernails were long and in need of nail care. The DON state routine nail care was important to prevent the nails from getting long and possibly getting caught on something, torn or infected. Facility policy titled Activities of Daily Living dated 10/7/24, included ADLs included bathing, grooming and dressing. The facility would provide necessary services for residents who were unable to complete these tasks. X

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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** 49035 Based on interview and document review, the facility failed to follow current physician orders and parameters for 2 of 5 residents (R28, R61) reviewed for medications. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], included R28 had moderate cognitive impairment. R28 had diagnoses of gastroparesis (a disease of the digestive system), malnutrition, fecal impaction (a blockage of stool in the intestine). R28's last signed physician orders dated 3/4/25, included an order for prochiorperazine maleate (a medication to treat nausea and vomiting) 10 mg by mouth every 5 hours as needed for nausea and vomiting, polyethylene glycol (a medication to treat constipation) 17 grams by mouth one time a day, and metoprolol tartrate 25 mg by mouth twice a day with instructions to hold the medication if systolic blood pressure was less than 100. R28's medication administration record (MAR) for April included record of medication being given different than the most recent provider orders. Administration included prochiorperazine maleate 10 mg by mouth every 8 hours for gastroparesis, polyethylene glycol (a medication to treat constipation) 17 grams by mouth two times a day, and metoprolol tartrate 25 mg by mouth twice a day without instructions to hold the medication. R28's hospital discharge orders with admitted [DATE], included order changes for polyethylene glycol 17 grams two times a day, prochlorpherazine 10 mg every 8 hours for gastroparesis, and metoprolol tartrate 25 mg twice a day without instructions to hold the medication. R28's MAR for February, March and April reviewed and failed to include documentation of blood pressure readings. During interview on 4/10/25 at 9:56 a.m., nurse manager (NM)-C confirmed the last signed physician orders do not match the MAR and what was currently being given. NM-C stated the facility takes all written orders, which include hospital discharge orders and process them as current orders. NM-C stated clarification would be requested from the hospital or nurse practitioner if there were questions or discrepancies. NM-C stated it was not practice to compare the most recent signed orders from the regulatory visits with the current MAR. The facility would review the plan section to look for new orders. R61's significant change MDS dated [DATE], included R61 was cognitively intact. R61's diagnoses included neuromyelitis optica (a disorder of the nervous system which can lead to weakness) and diabetes. (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 last signed physician orders dated 2/3/25, included an order for tacrolimus (a medication to prevent rejection of an organ after transplant) 1.5 mg by mouth two times a day and 2 mg at bedtime for kidney transplant, hydralazine (a medication to treat high blood pressure) 100 mg three times a day with instructions to hold for mean arterial pressure (MAP) <65, and carvedilol 12.5 mg by mouth twice a day with instruction to hold if MAP was <65. R61's MAR for April included record of medication being given different than the most recent provider orders. Administration record included tacrolimus 2.5 mg twice a day. Hydralazine was administered 100 mg three times a day with instructions to hold for MAP <65, however blood pressure was recorded instead of MAP. Carvedilol was administered 12.5 mg by mouth twice a day with instruction to hold if MAP is <65, however no vitals (blood pressures) were recorded. R61's hospital discharge orders with encounter date 11/21/24, included an order change for tacrolimus 2.5 mg twice a day. R61's MAR for February, March and April reviewed and failed to include documentation of MAP and pulse prior to administration of medication. During interview on 4/9/25 at 10:01 a.m., licensed practical nurse (LPN)-A stated parameters and instructions for giving mediation was listed on the MAR. After reading R61's orders for carvedilol and hydralazine with parameters, LPN-A stated she would check the pulse if the instructions stated to hold if <65 and would not give the medication if the pulse was below 65. During interview on 4/9/25 at 10:25 a.m., nurse manager (NM)-C stated she had never seen MAP as a parameter in a nursing home before and she was unsure if the staff would know how to calculate MAP. NM-C stated an order with instructions to check MAP should have been followed up on because it is not something that should have been used in a nursing home. During interview on 4/9/25 at 10:23 a.m., registered nurse (RN)-B stated she would check a heart rate for an order that instructed to check MAP and hold if <65 and not give the medication if it was below 65. During interview on 4/10/25 at 11:18 a.m., medical director (MD) stated a typical parameter for carvedilol and hydralazine would be to measure the heart rate and blood pressure. MD stated the facility did not calculate MAP. He stated a resident could be at increased risk for falls if a blood pressure medication was given outside of parameters. During interview on 4/10/25 at 12:33 p.m., CP confirmed she reviewed ordered parameters to ensure they are standard parameters during her monthly med reviews. CP acknowledged she failed to identify the discrepancies during the monthly reviews. CP stated blood pressure and heart rate are often monitored when a resident is on carvedilol. (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 on 4/9/25 at 2:41 p.m., director of nursing (DON) confirmed the last signed physician orders for R21 did not match what was being given by the facility. DON confirmed R61 tacrolimus order was different on the last signed physician orders and what was being given by the facility. DON confirmed medication parameters should have always been followed and if there was a question, a provider should have been contacted for clarification. DON confirmed checking and documenting a blood pressure would not be the same as checking and documenting a MAP. The DON confirmed the facility was not following their policy and procedure for reviewing signed physician orders to recognize discrepancies. Facility policy for medication orders dated 10/14/24, included to enter new orders onto the MAR. The nurse should verify new orders with the current attending physician before the medication is administered if it was unclear.

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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** 49035 Based on observation, interview and document review, the facility failed to provide range of motion (ROM) exercises for 1 of 1 residents (R61) reviewed for mobility. Findings include: R61's significant change Minimum Data Set (MDS) dated [DATE], included diagnoses of neuromyelitis optica (inflammation of the nerves of the eye and spinal cord which may cause vision loss and muscle weakness), diabetes, encephalopathy (a disorder of the brain which may cause confusion, memory loss and personality changes). R61's MDS included she was dependent for dressing, eating and oral hygiene. R61's undated care plan, included R61 required assistance with activities of daily living (ADLs) due to impaired or decreased mobility, weakness and multiple disease processes. Interventions included to assist with positioning and mobility as needed. R61's care plan failed to include specific ROM exercises. R61's care conference note dated 3/19/25, included R61's family requested therapy for ROM due to stiffness. R61's medical record indicated she was discharged from physical therapy on 11/18/24 and occupational therapy on 12/19/24. No other referral order was provided. During interview on 4/8/25 at 11:14 a.m., nursing assistant (NA)-A stated ROM instructions would be included on a resident's care sheet if they were ordered. During interview on 4/9/25 at 7:53 a.m., NA-B stated ROM exercises would be documented in a resident's chart if they were completed. During interview on 4/9/25 at 7:56 a.m., nurse manager (NM)-C stated a therapy referral would usually be made if a resident had a change in condition, a decrease in ADL ability, or after a hospitalization . NM-C stated a referral for therapy would be made if a family requested it. NM-C confirmed there had not been a referral for therapy since the last care conference. NM-C confirmed the family did request a referral for therapy for ROM exercises. NM-C stated it would typically be nursing who followed up on a requested from family for therapy. During interview on 4/9/25 at 2:34 p.m., director of nursing (DON) stated a referral for therapy should have been completed after the family requested an evaluation. The DON stated the referral should have been made within 2-3 business days of the care conference and family request. The DON confirmed ROM exercises should have been on the care plan or Kardex. The DON stated ROM was important to prevent pain, pressure ulcers and contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Prevention of Decline in Range of Motion dated 10/14/24, included a licensed nurse will assess a resident's range of motion on admission, quarterly and upon significant change. Residents would be referred to therapy for a focused range of motion as appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245267	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Health & Rehabilitation	3700 Foss Road Northeast St Anthony, MN 55421

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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 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** 49035 Based on interview and document review, the consulting pharmacist (CP) failed to identify and report irregularities related to resident parameters for 2 of 2 residents (R28, R61) reviewed for physician ordered parameters. Findings Include: R28's quarterly Minimum Data Set (MDS) dated [DATE], included R28 had moderate cognitive impairment. R28 had diagnoses of gastroparesis (a disease of the digestive system), malnutrition, fecal impaction (a blockage of stool in the intestine). R28's last signed physician orders dated 3/4/25, included an order for metoprolol tartrate 25 milligrams (mg) by mouth twice a day with instructions to hold the medication if systolic blood pressure was less than 100. R28's medication administration record (MAR) for April included record of medication being given without documentation of blood pressure having been checked prior to administration. The order on the MAR included metoprolol tartrate 25 mg by mouth twice a day without instructions to hold the medication. R28's previous six months of pharmacy reviews failed to identify blood pressure parameter was not being followed. R61's significant change MDS dated [DATE], included R61 was cognitively intact. R61's diagnoses included neuromyelitis optica (a disorder of the nervous system which can lead to weakness) and diabetes. R61's last signed physician orders dated 2/3/25, included an order hydralazine (a medication to treat high blood pressure) 100 mg three times a day with instructions to hold for mean arterial pressure (MAP) < 65, and carvedilol 12.5 mg by mouth twice a day with instruction to hold if MAP was < 65. R61's MAR for April included record of medication being given without documentation of provider ordered parameters. Administration record included hydralazine 100 mg three times a day with instructions to hold for MAP < 65, however blood pressure was recorded instead of MAP. Carvedilol was administered 12.5 mg by mouth twice a day with instruction to hold if MAP is < 65, however no vitals (blood pressures) were recorded. R61's previous six months of pharmacy reviews failed to identify MAP parameter was not being followed nor did they recommend reviewing the parameter for a standard nursing home parameter. During interview on 4/9/25 at 10:25 a.m., nurse manager (NM)-C stated she had never seen MAP as a parameter in a nursing home before and she was unsure if the staff would know how to calculate MAP. NM-C stated an order with instructions to check MAP should have been followed up on because it is not something that should have been used as a parameter in a nursing home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/9/25 at 2:41 p.m., director of nursing (DON) confirmed medication parameters should have always been followed and if there was a question, a provider should have been contacted for clarification. DON confirmed checking and documenting a blood pressure would not be the same as checking and documenting a MAP. During interview on 4/10/25 at 11:18 a.m., medical director (MD) stated a typical parameter for carvedilol and hydralazine would be heart rate and blood pressure. MD stated the facility would not typically calculate MAP. He stated a resident could be at increased risk for falls if a blood pressure medication was given outside of parameters. During interview on 4/10/25 at 12:33 p.m., CP confirmed she reviewed ordered parameters to ensure they are standard parameters during her monthly medication reviews. CP acknowledged she failed to identify the discrepancy in parameters order and what was being documented by the facility. CP stated MAP was not a standard parameter for a nursing home and a more common parameter would be to check blood pressure and heart rate for a resident on carvedilol prior to administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49657 Based on interview and document review, the facility failed to ensure the Quality Assurance Assessment and Performance Improvement Plan (QAPI) committee effectively sustained ongoing compliance related to repeat citations from past surveys in regards to quality of care, care plans and self-administration of medications (SAM) which were also identified during this survey. This had the potential to effect all 74 residents residing in the facility. Findings include: Review of the facility CASPER Report dated 3/17/2025, identified the facility was cited F684 for quality of care, F656 development/implementation of comprehensive care plans, and F554 SAM during the survey exited 3/7/2024. See F684: Based on interview and document review, the facility failed to follow current physician orders and parameters for 2 of 5 residents (R28, R61) reviewed for medications. See F656: Based on observation, interview and record review, the facility failed to ensure a care plan was developed and maintained to ensure appropriate care was provided for 1 of 1 residents (R66) reviewed for increased care needs for a declining resident. See F554: Based on observation, interview and document review, the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R66) observed with medications at bedside. The facility's QAPI meeting minutes dated 1/27/25, 2/24/25, and 3/24/25, lacked ongoing data related to the above repeat citations. On 4/10/25 at 1:45 p.m., the administrator confirmed the facility had not been tracking previous compliance with surveys, and have recently became aware and began to form a plan to monitor and maintain compliance in the future. The QAPI policy last reviewed 1/11/25, identified the facility will demonstrate the development, implementation, and evaluation of corrective actions or performance improvement activities.