STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	3720 23rd Avenue South Minneapolis, MN 55407

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure the resident and/or resident representative participated in care conferences for the care planning process and development of care plan interventions for 1 of 1 residents (R82) reviewed for participation of care planning. Findings include: R82's significant change Minimum Data Set (MDS) dated [DATE], identified R82 admitted to facility on 7/18/22, had intact cognition, with diagnoses of anxiety, depression, chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs abbreviated COPD), amputation of left leg above the knee, and right hip replacement. In addition, the MDS indicated R82 participated in the assessment with goal setting. During interview with R82 on 4/1/24 at 3:33 p.m., R82 stated, I haven't been a part of them (care conferences) and denied being invited or made aware of care conferences. I should know what is going on with my stay here. R82's Hospital discharge (DC) summary dated 3/13/24, indicated R82 was hospitalized for right hip replacement with a stay from 3/7/24 to 3/13/24. R82's electronic medical record (EMR), printed 44/24, indicated Care Conference Summary Resident Profile V2-V 10 (CCS) were completed on the following dates: 7/6/23, 9/21/23, 10/10/23, 2/28/24, and 3/19/24. R82's CCS indicated facility failed to document whether R82 was invited or included in any of her care conferences. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R82's CCS document dated 3/19/24 and Signed and Locked on 3/28/24, indicated the type of conference (Quarterly, not Significant Change) with date and time of R82's care conference as 3/28/24 at 00:00 (Midnight). Sections of the document included: Type of Conference, Advance Directives, Cognitive Patterns, Mood, Behavior, Community Life, ADL/Mobility, Bladder and Bowel, Skin Conditions, Nutrition, Therapy/Programs, Special Treatments/Health Conditions/Pain, Illness/Hospital Transfers/ER Visits (failed to indicate the hospital stay from 3/7/24 to 3/13/24), Medication Reconciliation, Discharge Planning, Discharge From Facility, Referrals, Participants/CP Summary (list of individuals that participated in conference, if resident/resident representative not available for conference has contact been initiated to provide update, copy of care plan summary/medication list offered), and Summary. The only Section of R82's 3/19/24 CCS document that was filled in was the Type of Conference which was listed as Quarterly, and the Nutrition area. The remainder of the document was not filled in. During interview with director of social services (DDS) on 4/4/24 at 8:09 a.m., DDS stated it was her responsibility to set the monthly schedule for upcoming quarterly and annual care conferences. DDS stated anything that pops up like hospitalization and significant change care conferences is the social worker on the floors' responsibility. DDS stated, social worker [SW-A]-A was responsible for notifying the resident, inviting family and to have all the services like therapy, dietary, nursing and social worker present to discuss the current plan. [SW-A] is responsible for filling out the care conference summary form completely. It appears this not being done. We will need to provide education to the social workers on their responsibilities. DDS stated, The care conference summary should be filled out each time with who attended and these look like they are not completed or filled out at all. We do not know what was discussed. During interview with SW-A on 4/4/24 at 10:15 a.m., SW-A stated she worked at facility for 8 years and was the facility social worker on the 2nd and 3rd floors for 2.5 years. SW-A stated the DDS provides monthly MDS/care conference schedules for quarterly and annual resident assessments. SW-A stated, the hospitalization , significant change and as needed MDS care conferences are the responsibility of SW-A. SW-A stated she delivers the reminders of upcoming care conferences to the residents. I deliver those to the residents in their rooms and give them verbal reminders. SW-A stated, we do the care conference summary directly in the computer. It should say who is present [sic]staff present, basically all who attend. SW-A reviewed the CCS for R82 and stated, I expect the document to be filled out but it is not, including any admissions to hospital and reconciliation. I should have filled it out and they are incomplete. There should be documentation of completing the sections of the document (CCS). Facility policy titled Care Conferences with revision of 7/2023 identified, Care conference Letter-will be sent to resident and/or family withing two (2) weeks in advance of conference. Also, Documentation: -Documentation will include attendee names, areas discussed, any concerns presented, and any action items for follow up. -Care Conference Summary completed in electronic record. -Offer resident a copy of Care Plan/Service Plan -If resident or family is not present at care conference, Social Services/facility representative will follow up with resident or family and provide an overall written summary.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 3 of 3 residents (R96, R114 and R10) reviewed for call lights. Findings include: R96 R96's quarterly Minimum Data Set (MDS) dated [DATE], identified R96 had intact cognition and diagnoses of schizophrenia (mental disorder in which people interpret reality abnormally), polyneuropathy (malfunction of many peripheral nerves throughout the body), lymphedema (swelling of caused by a blockage in the lymphatic system with a feeling of heaviness or tightness and loss of range of motion), morbid obesity, chronic pain and arthritis. R96 required substantial to maximal assistance with toileting hygiene, shower/bathe, lower body dressing, putting on/taking off footwear, sit to lying transfer and, lying to sitting transfer on the side of bed. R96's care plan (CP) dated 6/17/23, instructed nursing staff to, Orientated to call light/room During observation on 4/1/24 at 2:03 p.m., R96 was observed laying in a bariatric bed with the head of bed elevated. R96's call light was draped over the back of the headboard and was out of sight and reach of R96. During observation on 4/3/24 at 12:15 p.m., R96 was observed laying in a bariatric bed with the head of bed elevated. R96's call light was attached to the fabric room divider and not in reach of R96. R96 stated, I wish it were nearby. I will have to yell to get attention around here. During interview with trained medication aide (TMA)-A on 4/3/24 at 8:07 a.m., TMA-A stated resident call lights, must be in reach of them. She [R96] can't reach the call light if it is draped over the back of the headboard and she is laying in bed. During interview with licensed practical nurse (LPN)-A on 4/3/24 at 8:27 a.m., LPN-A stated, Everyone should have their call light in reach. Additionally LPN-A stated, [a] call light draped over bed board is not in reach of [R96]. R114 R114's annual MDS dated [DATE], documented R114 had severe cognitive impairment and diagnoses of dementia, anxiety, depression, and bipolar disorder (mental illness characterized by extreme mood swings). R114 required substantial/maximal assistance with eating, oral hygiene, upper body dressing, and personal hygiene. In addition R114 was dependent for toileting hygiene, shower/bathes, lower body dressing and putting on/taking off footwear. Also, R114 was documented as receiving hospice services. R114's care plan dated 2/2/23, directed the nursing staff to, Orientated to call light/room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/1/24 at 3:05 p.m., R114 was observed seated in a wheelchair in front of the television in her room. R114's call light was coiled up and attached to wall that had her bed parallel to it and pushed up against it. The call light was out of sight and out of reach of R114. R114 stated, If I needed help I would yell for help. I don't know where it [call light] is now. During observation on 4/3/24 at 1:27 p.m., R114 was observed seated in a wheelchair in front of the television in her room. R114's call light was coiled up and attached to wall that had her bed parallel to it and pushed up against it. The call light was out of sight and reach of R114. During interview with family member (FM)-A on 4/3/24 at 1:51 p.m., FM-A stated, I believe she [R114] can use the call light if it is in her hand and close by. I would hope the staff keep it in reach of her when no one is around. During interview with TMA-A on 4/3/24 at 8:07 a.m., TMA-A stated he had worked for facility for two years and was familiar with all of the residents on the third floor including R114. TMA-A stated, All of the residents must be in reach of them [call lights]. [R114] should be in reach whether they [sic] use it or not. During interview with LPN-A on 4/3/24 at 8:27a.m., LPN-A stated she had worked for facility for [AGE] years and was very familiar with residents including R114. LPN-A stated, [call light for R114] should still be in reach of her. During interview with director of nursing (DON) on 4/3/24 at 8:53 a.m., the DON stated, [it is] important to have call lights in reach of all residents. DON stated facility did not have a call light or dignity policy stating they were standards of care. DON stated facility also did not have a written policy or procedure for standards of care. 49034 R10's quarterly MDS dated [DATE], indicated R10 had moderately impaired cognition and was diagnosed with dementia. The MDS indicated R10 required maximal assistance with toileting hygiene, transferring, and lower body dressing. During an observation on 4/1/24 at 2:23 p.m., R10 was observed in her room, sitting in her wheelchair watching television. R10's soft touch call light was observed sitting in R10's wheelchair but the cord was noted to be unplugged from the wall. During an observation and interview on 4/2/24, R10 was observed in her room sitting in her wheelchair, with her soft touch call light placed in her lap. The call light cord was again noted to be unplugged from the wall. R10 was observed repeatedly yelling, help me, help me! During an interview on 4/2/24 at 9:29 a.m., NA-E stated R10 could use the call light as she had observed in the past and R10 was able to effectively communicate to staff what her needs were. NA-E stated she was unsure why R10 had not used her call light on this occasion.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning, assessment and potential interventions needed for 2 of 2 residents (R26, R68) reviewed for MDS accuracy. Findings include: BEHAVIORAL SYMPTOMS: R26's quarterly Minimum Data Set (MDS) dated [DATE], indicated R26 had a severe cognitive impairment, could wheel at least 150 feet independently once assisted into the wheelchair, and displayed no wandering behaviors. R26's MDS Reference Period Documentation note dated 3/2/24 at 5:38 p.m., indicated R26 had a behavior of wandering. R26's MDS Reference Period Documentation note dated 3/3/24 at 12:41 p.m., indicated R26 had a behavior of wandering. R26's MDS Reference Period Documentation note dated 3/3/24 at 5:50 p.m., indicated R26 had a behavior of wandering. R26's MDS Reference Period Documentation note dated 3/7/24 at 6:25 p.m., indicated R26 had a behavior of wandering. R26's MDS Reference Period Documentation note dated 3/8/24 at 12:20 a.m., indicated R26 had a behavior of wandering. R26's quarterly Social Services evaluation dated 3/8/24 at 4:36 p.m., indicated R26 was diagnosed with dementia, was exiting seeking seven out of the last seven days, attempted to get in the elevator and lure others with her, and was observed wandering in and out of other resident's rooms seven out of seven of the last days. R26's MDS summary note dated 3/8/24 at 8:06 a.m., indicated R26 required a secure unit placement related to Alzheimer's disease, wandering, and an elopement risk. R26's care plan dated 3/15/24, indicated R26 was an elopement and wandering risk related to dementia with interventions including observing for possible wandering triggers, encouraging activities for distraction, and attempting to determine the cause of wandering. R26's Order Summary Report dated 4/4/24, indicated R26 resided on a secure unit due to Alzheimer's disease. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 8:38 a.m., nursing assistant (NA)-D stated R26 would often wander in her wheelchair and consistently attempted to get into the elevator to leave the facility. DENTAL CARE: R68's significant change MDS dated [DATE], indicated R68 had intact cognition with no behavioral symptoms or rejection of care during the look-back period (LBP). The MDS indicated R68 was diagnosed with multiple sclerosis (a disease affecting the nervous system with varying symptoms such as muscle weakness, lack of coordination, and cognitive problems), malnutrition, and depression. The MDS indicated R68 did not have broken or loose fitting full or partial dentures, obvious or likely cavity or broken natural teeth, or abnormal mouth tissue. The MDS indicated R68 required setup assistance for oral hygiene and eating. In Section V of the MDS, the Care Area Assessment (CAA) Summary, dental was not a care area triggered or noted to have been addressed in the care plan. R68's MDS Reference Period Documentation note dated 2/3/24 at 5:08 a.m., indicated R68 had broken or loosely fitting full or partial dentures. R68's MDS Reference Period Documentation note dated 2/5/24 at 6:35 a.m., indicated R68 had broken or loosely fitting full or partial dentures. R68's MDS Reference Period Documentation note dated 2/6/24 at 6:13 a.m., indicated R68 had broken or loosely fitting full or partial dentures. R68's care plan dated 3/7/24, indicated R68 had missing teeth but did not indicate denture use. During an interview and observation on 4/1/24 at 6:56 p.m., R68 was observed in his room sitting in his wheelchair with missing bottom front teeth, and top dentures that appeared to have been partials that moved when R68 spoke with a noticeable resulting lisp as R68 attempted to keep the denture in place. R68 stated he previously used an outside dental agency, but it had been a couple of years since he had seen them related to his dentures. R68 stated he did not recall anyone from the facility discussing his dental needs with him in the last few months but would have liked help setting up a dental appointment to get his dentures fixed. R68 stated he sometimes didn't wear his top denture related to how loosely it fit and had for at least a few months but unsure exactly how long the top denture had been like that. R68 stated he also needed new bottom dentures as they had broken a couple of years ago and it bothered him that he didn't have well-fitted dentures to wear. During an interview on 4/3/24 at 12:08 p.m., licensed practical nurse (LPN)-C stated she had noticed R68 had various missing teething and thought one of his partial dentures was missing. LPN-C stated she was unsure how long the denture had been missing and stated she often saw R68 not wearing his dentures and was unsure why but had not asked R68 about it. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 9:08 a.m., registered nurse (RN)-D, the MDS coordinator, stated she would review the related department notes from the LBP as well as look at nursing assistant (NA) charting and then review the MDS to ensure accuracy before signing it. RN-D stated after reviewing R26's medical record, she now saw R26 did have a history of wandering and it had occurred during the LBP and it should have been reflected in Section E of the MDS, but it must have been missed. RN-D stated after reviewing R68's medical record, the MDS dated [DATE] should have been coded to indicate R68 had broken or loosely fitting full or partial dentures but it also must have been missed. RN-D stated it was important the MDS accurately reflects the resident's status, so the care plan was up to date and to ensure residents received needed interventions. During an interview on 4/4/24 at 11:53 a.m., the director of nursing (DON) stated that the MDS coordinator oversaw taking the assessments that were completed by the nursing team and other departments and ensuring that these assessments were accurately reflected in the MDS. They then used the MDS data to create the resident plan of care, so it was important that it was coded accurately. A policy/procedure regarding the MDS competition was requested and not 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** 49339 Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed, and maintained to ensure appropriate care was provided for 1 of 1 residents (R7) reviewed for lymphedema (localized swelling caused by compromised lymphatic system) care. Findings include: R7's quarterly Minimum Data Set (MDS), dated [DATE], indicated R7 had impaired cognition and required maximum assistance for dressing lower part of body, footwear, toileting, bathing, transfers, and maximum assistance for dressing upper part of body. MDS indicated no behaviors present, and no rejection of care exhibited. R7's diagnoses included lymphedema, fracture of left tibia (left lower leg bone), heart failure, hypertension (high blood pressure), diabetes mellitus, hyperlipidemia (high cholesterol), dementia, presence of cardiac pacemaker, and atrioventricular block (heart rhythm disorder that caused the heart to beat more slowly than it should). Section 0 Special Treatment and Programs indicated R7 was receiving occupational therapy (OT) while a resident in the facility, with a therapy start day of 7/11/2023. R7's care plan, printed 4/3/24, lacked evidence of R7 working with OT for treatment of lymphedema. Care plan lacked evidence of need for compression socks or wraps on lower extremities. Care plan lacked evidence of coordination between providers (facility and therapy). R7's task list, printed 4/4/24, lacked evidence of nursing assistants helping with any leg compression stocking/wraps which would have been triggered from R7's care plan. R7's care guide, copy provided 4/3/24, lacked evidence of R7 having lymphedema wraps. Care guide indicated shower/bath days, sleep/wake preference times, assistance needed for care, toileting schedule, transfer needs, mobility needs and diet. The section under person centered information indicated midday nap, requires assist with all ADLs. The section titled Teds (compression socks) was left blank. On 4/01/24, at 2:09 p.m., R7 was seated in her wheelchair in her room looking out the window. R7 was nonsensical in majority of responses and repetitively stated, I'm bored. R7's legs were observed to be swollen, the left leg was larger than the right leg and both were notably dry. R7 did not have any compression wraps on both lower extremities. On 4/02/24, at 9:13 a.m., R7 was seated in her wheelchair in her room with her breakfast tray. R7 had tubigrips (a multi-purpose support bandage) on both right and left lower extremities. On 4/03/24, at 11:03 a.m., R7 was observed lying in bed without any compression socks or tubigrips on her lower extremities. R7's lower extremities were notably swollen. On R7's night stand, located to the right of her bed, were ace wraps laying on the top of the nightstand. At 4/03/24, at 11:05 a.m., nursing assistant delivered lunch to R7. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 4/03/24, at 11:07 a.m., nursing assistant (NA)-A verified that they are working with R7 today and have worked with R7 previously. NA-A stated that R7 has swelling in both her lower extremities and her left leg is more swollen than the right. NA-A stated they are unsure if R7 gets compression socks as it does not show up on their task list. NA-A reviewed their care sheet and verified that there is no mention of compression socks or wraps for R7. NA-A verified that there is no task in the electronic medical record (EMR) to complete for compression socks or wraps. NA-A stated they are unsure if R7 is receiving therapy. NA-A verified there are wraps laying on the R7's nightstand next to her bed. NA-A stated that care sheets contain the information that is needed for them to complete their job. During interview on 4/03/24, at 10:18 a.m., NA-B stated that they always follow what is on the is on the care sheets which is developed from the care plan. NA-B stated they are very familiar with R7 and work with her frequently. NA-B stated that R7 has swelling her both lower extremities and gets wraps on her legs. NA-B stated that they put the wraps on every day they work with them as that is what is on the care sheet nursing assistants are to follow. On 4/03/24, at 12:09 p.m., R7 was observed laying in bed. OT was in the room with her and providing a lymphedema massage. R7 was smiling and talkative. During interview on 4/03/24, at 11:12 a.m., licensed practical nurse (LPN)-B verified that they are working with R7 today and in charge of her care. LPN-B verified that R7 has lymphedema and has wraps laying on the nightstand in her room. LPN-B reviewed EMR and verified there are no current orders for any lower extremity wraps or compression socks. LPN-B reviewed R7's care plan and verified there is nothing on the care plan regarding treatment for lymphedema regarding wraps or OT being involved in the treatment of R7's lymphedema. During interview on 4/03/24, at 12:25 p.m., occupational therapist (OT)-A verified that they have worked with R7 for over 6 months. OT-A stated treating R7's lymphedema is a collaborative effort. OT-A stated that occupational therapy sees R7 once a week for application of wraps, a lymphedema massage and nursing is to remove the wraps on Saturday's. OT-A stated that a therapy recommendation form is filled out and provided to the director of nursing and the floor's head nurse for collaboration. OT-A stated that OT has been seeing R7 once a week for quite a few months now without changes to the schedule. During interview on 4/03/24, at 12:43 p.m., director of rehab (DOR) verified that occupational therapy currently works with R7 and have worked with her since, at least, March 2023 for lymphedema support. DOR verified that OT has been seeing her once a week since the week of December 10th, 2023, and previous to that was more frequent. DOR stated the collaboration between nursing and therapy is important for the success of treatment. DOR provided a recommendation sheet, dated 4/23, that had been provided to nursing. DOR verified that this was outdated as it indicated Pt [patient] to don (with nursing assistance) lymph pumps to LLE [left lower extremity] 3 times a week. It is preprogrammed to run 60 min. Removed when completed and don TG [sic?] shape. DOR verified this was the most recent recommendation sheet from therapy and it was not up to date with the most current recommendations. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/03/24 at 2:08 p.m., registered nurse (RN)-B indicated that they believe that R7 gets OT services for lymphedema. RN-B reviewed EMR and verified the care plan lacked mention of R7 receiving OT services, wraps for lymphedema, or coordination between providers. RN-B reviewed care guide and verified the guide lacked evidence of information relating to OT services, lymphedema treatments or services provided. RN-B stated nursing gets the direction from the therapy department for the treatment of R7's lymphedema. During interview on 4/04/24 at 11:23 a.m., director of nursing (DON) verified that collaboration between therapy and nursing is important. DON verified that if a resident is receiving OT services that it should be on the care plan. DON stated she was unaware of this concern with R7 and the information not present on the care plan. A facility policy titled Person Centered Care plan, revision date 1/2012, was provided. The policy indicated care plan should be clean and concise and consistent with the nursing assistant care plan.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Place	3720 23rd Avenue South Minneapolis, MN 55407

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47495 Based on observation, interview and document review, the facility failed to ensure routine bathing, nail care and/or shaving assistance was offered or provided for 4 of 5 residents (R20, R35, R52, and R102) reviewed for activities of daily living, who were dependent of staff for assistance with bathing and/or grooming. Findings include: R35 R35's annual Minimum Data Set, dated dated [DATE], indicated R35 had moderate cognitive impairment and required partial to moderate assistance with bathing. R35's care plan, dated 5/1/20, indicated R35 required assistance of 1 staff with a tub bath or shower per resident's preference twice a week. R35's body audits, completed on bath days, were reviewed for the months of February and March 2024 and indicated R35 received four showers in the past two months despite being care planned for two showers a week. Showers were documented on 2/14/24, 2/28/24, 3/6/24 and 3/27/24 with a refusal documented on 3/13/24. R35's Bathing task indicated no documented bathing in the past 30 days. During an interview and observation on 4/1/24 at 12:29 p.m., R35 stated she had a hard time getting her bath, stating she had to ask every week, but it often doesn't happen. R35 stated she should be receiving a bath twice a week but often goes 2-3 weeks without a bath which makes her feel depressed, stating she shouldn't have to ask to get her basic needs met. R35 was sitting in her bed with greasy matted hair stuck to the side of her head with several 1/2 inch long chin hairs. R35 stated she had not asked to have her chin shaved but would like someone to help with it. During an interview on 4/3/24 at 8:00 a.m., nursing assistant (NA)-D stated the bathing schedule was hung near the nurse's station for staff to check at the start of their shift. The expectation was to complete all baths and if a resident refused to reapproach them 2 or 3 times and let the nurse know. NA-D stated she had never heard R35 refuse her cares and R35required assistance with bathing. NA-D stated staff should be offering to shave both male and female residents during their bath or shower. During an interview on 4/3/24 at 8:30 a.m., register nurse (RN)-F stated after a NA gives a resident a bath, they would call the nurse for a body audit and the bath would be documented on the body auidt form. RN-F stated some residents request 2 baths a week but all residnets should get at least 1 bath per week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/24 at 10:31 a.m. registered nurse clinical manager (RN)-B stated the nurses would document the resident bathing when they complete their weekly skin audits. RN-B stated the expectation was for bathing to be complete and refusals to be reapproached. RN-B stated staff should be offering to shave residents or assisting residents between bath days if they asked to be shaved. 49339 R20 R20's quarterly Minimum Data Set (MDS), dated [DATE], indicated R20 had moderately impaired vision and intact cognition with no behaviors or rejection of care. MDS indicated R20 needed maximal assistance with dressing, bathing, and toileting. R20's care plan, printed 4/4/24, identifies that R20 requires maximal assistance of one staff to complete showering/bathing and indicates in capital letters nurse nails. Document further indicated R20 has potential for impairment to skin integrity and to keep fingernails short. Progress notes for R20 for body audits March 2024: -3/27/24: resident received a shower. Finger nails are clean and trim. Nails did not need to be trimmed. -3/20/24: resident received a shower. Finger nails are clean and trim. Allowed nails to be trimmed. -3/13/24: Resident received a shower. Finger nails are clean and trim. Nails did not need to be trimmed. -3/6/24: Resident received a shower. Nails did not need to be trimmed. Progress notes for the months of March and April 2024 which lacked evidence of refusals of nails care. During observation and interview on 4/01/24 at 1:42 p.m., R20 was lying his room in bed. R20's had long nails with dark colored debris underneath. R20 stated staff cuts them for me once in a while and further indicated, I don't like them like this, and I wish staff would cut them for me. A subsequent observation was made on 4/2/24, at 2:05 p.m., and R20 continued to have long fingernails on both hands with dark colored debris underneath. When interviewed on 4/02/24, at 1:31 p.m., registered nurse (RN)-C verified that residents nails are trimmed during showers and as needed. RN-C stated this is done by the nursing assistants unless a resident is a diabetic then it is completed by a nurse. RN-C stated that this is all reported to the nurse and if a resident refused a nail trim, then it is documented. Shower and nail care would be documented in a progress note and body audit form [skin observation] along with refusals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/02/24, at 2:20 p.m., RN-C verified that R20 needs assistance with nail trims. RN-C went to R20's room with surveyor. R20 told RN-C he would like his nails to be cut if it wouldn't be too much of a bother. Outside R20's room, RN-C verified that R20's nails are long, dirty and unkept. RN-C verified they had not been trimmed for a long while. During interview on 4/02/24 at 3:16 p.m., nursing assistant (NA)-C verified that R20's fingernails are very long, dirty, and need to be cut after going into R20's room to look at them. NA-C stated nail care is very important as it plays an important role in infection control and it helps make a person feel better when their nails are clean and trimmed. NA-C stated they were going to trim R20's nails immediately. NA-C stated nails should be trimmed at least weekly with showers and as needed. R52 R52's quarterly Minimum Data Set (MDS), dated [DATE]), documented R52 had moderately impaired cognition with no behaviors or rejection of cares and required maximal assistance to dependent assistance for cares and personal hygiene. R52's care plan, printed 4/4/24, identified that R52 has an ADL deficit. The interventions included check nails length and trim and clean on bath day and necessary, report any changes to nurse. The document identified, R20 requires maximal assistance for personal hygiene tasks and shower/bathing. Progress notes for R52 for body audits: -3/31/24: Resident received a bed bath. Finger nails are clean and trim. Allowed nails to be trimmed. -3/24/24: Resident received a bed bath. Finger nails are clean and trim. Nails did not need to be trimmed. -3/17/24: Resident received a bed bath. Finger nails are clean and trim. Nails did not need to be trimmed. -3/10/24: Resident received a bed bath. Finger nails are clean and trim. Allowed nails to be trimmed. Progress notes for the months of March and April 2024 which lacked evidence of refusals of nail care. On 4/01/24, at 1:30 p.m., R52 was lying in bed in their room and covered with a blanket in bed. Fingernails on right hand were long with dark colored debris underneath. R52 nodded yes when asked if he would like them clipped. During a subsequent observation made on 4/2/24, at 2:07 p.m., R52's fingernails continued to be long, discolored with dark colored debris underneath. On 4/02/24, at 2:25 p.m., RN-C verified that R52's nails are dirty, some needed to trimmed and were unkempt. RN-C stated, they could not have been trimmed a couple of days ago as it has been a while. R52 told RN-C that he would like his nails clipped. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/02/24, at 3:20 p.m., NA-C stated that they were told to trim R52's fingernails as they were long and dirty. NA-C stated they went in to trim them right after report but R52 was on the phone so was going to trim them shortly. During interview on 4/03/24, at 2:08 p.m., registered nurse (RN)-B stated that nail trims are done weekly, usually on bath day and by nursing assistants unless a resident is diabetic then a nurse would do the nail trims. RN-B stated nail care is important for hygiene, helps to not cause any open areas from scratching and for dignity. During interview on 4/04/24, at 11:23 a.m., director of nursing (DON) stated that nails should be kept clean. DON stated it helps keep skin intact and the expectation is that staff is looking at nails at least weekly and if residents are refusing nail care that it documented. DON stated that if they are refusing, we would also put this in their care plan and come up with a plan to trim their nails as it is an important part of infection control. 49654 R102 R102's admission Minimum Data Set (MDS) dated [DATE], indicated substantial/maximal assistance needed for shower/bath, and partial moderate assistance needed for personal hygiene including combing hair, shaving, washing/drying hands and face. R102's care plan with a revision date of 03/01/24, identified an activities of daily (ADL's) self-care performance deficit requiring assistance of one staff for personal hygiene and grooming. During observation and interview on 4/1/24 at 3:32 p.m., R102 was observed in his room lying in bed with gray and white facial hair approximately 3/4's of an inch long on his cheeks, chin, neck, and above upper lip. R102 stated he was usually clean shaved and now I look like a Neanderthal. R102 stated he had been advised staff would assist him with a clippers to remove the facial hair but it had not happened since admission. During observation on 4/2/24 at 10:07 a.m., R102 was observed in his room sitting at edge of bed with gray and white facial hair approximately 3/4's of an inch long on his cheeks, chin, neck, and above upper lip. During observation and interview on 4/3/24 at 10:36 a.m., R102 was observed in chair in front of window with gray and white facial hair approximately 3/4's of an inch long on his cheeks, chin, neck, and above upper lip. R102 stated he asked to have facial hair trimmed and shaved on during his shower the previous day but it had not been completed. During observation on 4/4/24 at 2:12 p.m., R102 was observed in his room lying in bed with gray and white facial hair approximately 3/4's of an inch long on his cheeks, chin, neck, and above upper lip. During interview on 4/3/24 at 10:13 a.m., with certified nursing assistant (CNA-H) who was working with R102 stated the care plan indicated R102 was an assist of one for grooming and that included shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with director of nursing (DON) on 4/3/24 at 12:12 p.m., stated the process to assess a resident for ADL's starts prior to admission when staff reviews the referral for each potential resident. Upon admission resident care needs are assessed by registered nurse care managers, the MDS nurse, floor staff nurses and therapy services. If the MDS indicated partial/moderate assistance with grooming then R102 can't complete the task independently and the expectation would be staff is offering him assistance and assisting with those needs. DON stated it is important staff is honoring the residents grooming needs to promote overall wellbeing. A facility policy on ADLs was requested but not recieved.

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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 reassess and, if needed, develop interventions to ensure a developed skin condition was resolved after initial treatment was completed for 1 of 1 resident (R71) observed to have a non-pressure skin impairment on their feet. In addition, the facility failed to identify and, if needed, ensure consistently elevated blood glucose levels were assessed or acted upon to reduce the risk of complication for 1 of 2 residents (R26) reviewed for diabetes management. Findings include: SKIN NOT ASSESSED: R71's quarterly Minimum Data Set (MDS), dated [DATE], identified R71 had intact cognition, had diabetes mellitus, and had no current foot problems (i.e., infection, ulcers) or other skin-related problems (i.e., lesions, burns, tears) present during the review period. On 4/1/24 at 2:10 p.m., R71 was observed lying in bed while in her room. R71 was questioned on what, if any, skin issues she had present and responded, Just my feet. R71 explained her feet had been bothering her for about a month and had severe dry skin which was flaking off and itching at times. R71 allowed her socks to be removed which exposed her feet. R71's right foot had a visible area of extremely dry, flaking skin present on the inner medial aspect; and the left foot had the same dry, flaking appearance which covered nearly the entire foot and extended up the ankle. R71 stated she had been asking the nursing assistants (NA) to put lotion on her feet to help resolve it but the condition remained. R71 explained the nurses had, for a short period, been applying a cream to it but had stopped adding she felt the nurses hadn't noticed it's [the issue] not getting better. R71 stated she felt more treatment needed to be done on her feet to resolve the skin condition and reiterated aloud, It's really bothersome. R71 added, Maybe soaking them would help? R71's In-House Clinical Note, dated 2/27/24, identified R71 as diabetic was evaluated by podiatry. The note outlined, . a history a peripheral vascular disease. Also has scaly and itching skin to the feet, mild itch, and it is currently not being treated (has RX [prescription] for clotrimazole cream but no one puts it on her). A section labeled, Review of Systems, was listed which outlined each respective body system and the provider' findings including, Integumentary [skin]: . Scaling and itchy skin to feet. An additional section labeled, Derm Exam, outlined again, Dry, flaky skin noted to plantar aspect of bilateral feet consistent with tinea pedis [fungal infection; usually begins between the toes]. Further, the note included an order which read, Order - Ketoconazole 2% cream twice daily for 1 month duration. Physical order left with [staff name]. R71's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 3/2024, were reviewed and identified the Ketoconazole order with a listed stop date, 3/27/24. The order was signed off as being completed for each administration. In addition, R71's MAR and TAR, dated 4/2024, identified an order which read, Triamcinolone Acetonide Cream 0.1% . to bottom of feet topically as needed for for [sic] scaling, with an order date, 10/19/2023. However, there were no recorded administrations of the as-needed cream recorded. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R71's most recent Body Audit 11-15-V8, dated 3/22/24, identified R71 had a shower with no alterations in skin integrity (i.e., bruising, burns, rashes) being identified. The audit included a section labeled, Feet Ankle and Toes, which recorded, a. Clear. The completed audit lacked any evidence R71 had a current skin issue despite ongoing treatment for diagnosed tinea pedis by podiatry on 2/27/24, and R71 stating the condition had never actually resolved. In addition, R71's medical record was reviewed and lacked evidence R71's developed skin condition had been comprehensively reassessed after the implemented treatment was completed on 3/27/24, to ensure the condition had resolved or what, if any, additional interventions were still needed. When interviewed on 4/2/24 at 1:54 p.m., nursing assistant (NA)-B stated they had worked with R71 prior and described her as most often needing help with her socks and shoes being applied or removed. NA-B stated they had not helped R71 that day with them, however, added usually they always do. NA-B stated they had not taken a clear notice of R71's feet or any skin issues on them. On 4/2/24 at 3:11 p.m., licensed practical nurse (LPN)-D was interviewed. LPN-D explained they worked for an outside agency (i.e., POOL) and were new to the care center. LPN-D reviewed R71's medical record, including TAR, and verified R71 had no current treatments or monitoring ordered for their feet. LPN-D stated they were unaware of any skin issues on R71's feet and added, I didn't get that in report. LPN-D stated any applied creams or treatment should have follow-up to determine if it worked or not and reiterated nobody had expressed R71 having a skin condition adding, No one has told me anything. At 3:17 p.m., LPN-D observed R71's feet with the surveyor present. LPN-D verified R71's feet having a dry, scaled appearance and described it as really dry skin, adding further, The left side is worse. R71 stated aloud there had been a cream inconsistently applied to it prior but added it had not [made] a big difference. LPN-D stated R71's feet, after looking closer at them, maybe appeared like psoriasis [condition with skin cells build up, form scales and itchy, dry patches]. LPN-D stated the skin condition needed a treatment and, most likely, should be re-evaluated by podiatry or the medical provider adding, I think she needs another re-visit. On 4/3/24 at 10:30 a.m., registered nurse clinical director (RN)-B was interviewed and verified they helped to complete the campus' wound rounds. RN-B verified they had observed R71's feet and described the appearance as dry, peeling skin, adding R71 had voiced itching had nearly subsided. RN-B stated they had just placed a nursing order into the record for the nurses' to apply lotion to R71's feet and did update the NP [nurse practitioner] in order to get a dermatology referral, if needed. RN-B explained the floor nurse was typically responsibly to ensure any post-treatment evaluation was completed and verified such should be documented in the medical record. RN-B reviewed R71's medical record and verified there was no post-treatment evaluation or assessment of the developed skin condition recorded, and they expressed it was important to ensure skin conditions were re-evaluated and, if needed, acted upon timely just to make sure we're not delaying treatment. A facility' policy on non-pressure skin management was requested, however, none was received. 49034 DIABETES MANAGEMENT: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's quarterly Minimum Data Set (MDS) dated [DATE], indicated R26 had a severe cognitive impairment and was diagnosed with heart failure, kidney disease, diabetes, and dementia. The MDS indicated R26 received insulin (medication used to lower blood glucose levels) injections seven out of seven days in the look-back period. R26's Order Summary Report included the following orders: - Dated 3/25/23, indicated R26 was on a regular diet. - Dated 3/25/23, indicated the provider should be notified of any blood glucose levels less than 70 and greater than 400. - Dated 6/12/23, indicated R26 received insulin lispro (fast-acting medication used to lower blood glucose levels) injections with meals per a sliding scale (if the blood glucose level was 150 199 give two units; 200 - 249 give four units; 250 - 299 give six units; 300 -349 give eight units; 350 - 399 give ten units; 400 or greater, give 12 units call and update provider) - Dated 8/23/23, indicated R26 received 1000 milligrams (mg) of metformin (oral medication used for blood glucose control) two times a day. - Dated 12/12/23, indicated R26 received 20 units of insulin glargine (a medication used to lower blood glucose levels and provide a base level of control) at bedtime and in the morning if blood glucose was greater or equal to 150, 10 units for glucose levels of less than 150, or zero units for blood glucose levels of less than 100. R26's Weights and Vitals Summary dated 3/4/24-4/4/24, indicated R26 had blood sugar levels between 302 and 535 mg/deciliter(dL) 52 times. The summary indicated R26's blood sugar was above 400 twice, once occuring on 3/14/24 at 10:27 p.m. with a result of 535, and once on 3/16/24 at 8:15 p.m. with a result of 435. R26's care plan dated 3/15/24, indicated R26's diabetes was managed with insulin and related oral medication. The care plan indicated diabetes medications were to be given as ordered by the medical practitioner and observed for related side effects and effectiveness. R26's provider progress note dated 12/12/23, indicated R26 had a diagnosis of diabetes and was not at goal regarding this. The note indicated R26's goal hemoglobin A1C (a test that evaluates the average amount of glucose in the blood over the past two to three months) was less than nine percent. The note indicated the insulin glargine order was updated at this time as well as an updated A1C test. R26's provider progress note dated 2/1/24, indicated R26 had a hemoglobin A1C of 9.2 in 8/23 and 9.5 in 12/23. The note indicated the blood sugar levels were not noted in the electronic medical record (EMR) but were to be followed. R26's registered dietician Nutrition assessment dated [DATE] at 9:45 a.m., indicated R26 had diabetes with related hyperglycemia. The note indicated that R26 was at risk for an altered hydration status related to elevated blood glucose levels. The note indicated R26's blood sugar levels were managed by medication as R26 was on a regular diet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's progress note dated 3/14/24 at 10:50 p.m., indicated that R26's blood sugar was 535 so the nurse notified the provider. The provider ordered an additional dose of insulin and to recheck the blood sugar after one hour. R26's progress notes were reviewed and did not indicated that the provider had been notified of the blood sugar above 400 on 3/16/24. R26's nutrition progress note dated 4/3/24 at 12:01 p.m., indicated R26's blood sugars have been trending between 249-435 and the provider was made aware. During an interview on 4/3/24 at 11:37 a.m. with registered dietician (RD)-A and (RD)-B, RD-A stated R26 was not on their list for additional nutrition assessments as that was generally reserved for residents with risk factors such as hospice, pressure ulcers, weight loss, and dialysis or if a provider requested additional assessments. RD-A stated they had recently completed a quarterly nutritional assessment for R26 in 3/24. RD-A stated dietary staff had previously had a conversation with R26's family who had decided that due to R26's cognitive level, a low carbohydrate diet would not have been an appropriate option for her. RD-B stated since dietary changes were not an option for R26 due to family preference, they would have expected nursing staff to evaluate the effectiveness of the medication regimen and reach out to the provider if the regimen proved ineffective in order to avoid adverse outcomes. RD-B stated she would review R26's blood glucose levels for elevation and notify the provider if she didn't see this had been communicated previously. During an interview on 4/4/24 at 9:39 a.m., nurse practitioner (NP)-A stated the goal for R26's A1C was less than 9 as that would help decrease the risk of diabetes-related complications but that goal had not yet been reached. NP-A stated she had reviewed the medical record and did not see any changes that had been made to R26's diabetic management plan since her last visit in 12/23. NP-A stated after reviewing/trending R26's blood glucose levels, she would have considered these levels elevated and would have wanted nursing staff to notify her of this trend. NP-A stated the provider team only reviewed the blood glucose levels every two months unless nursing staff notified them of a change. NP-A stated she was unsure if R26's blood glucose levels had been reviewed by her colleague at the last visit in 2/24, as she did not see evidence of this review. NP-A stated if she had been aware of R26's blood glucose levels, she would have rechecked R26's A1C level and altered her medication regimen to better control R26's blood glucose levels. NP-A stated these changes were important so any possible adverse effects such as further kidney damage or possible infection could have been avoided as much as possible. During an interview on 4/4/24 at 11:32 a.m., LPN-E stated he was the floor nurse in charge of R26's care. LPN-C stated R26 was receiving insulin and corresponding blood glucose checks to manage her diabetes. LPN-E stated he would notify the provider if R26's blood sugar was outside of the ordered 70-400 range. LPN-E stated nursing staff relied on the provider to trend blood glucose levels to see if they were consistently elevated, as he thought that was not something the floor nurses completed. During an interview on 4/4/24 at 11:40 a.m., family member (FM)-B stated the facility had told her that R26's blood sugars have been really good but if they were not, the family would have been open to altering other portions of R26's diabetic management plan for better control. FM-B stated although the family did not want to highly limit R26's diet, they would have been open to altering or using other diabetic management options to better manage R26's blood sugar if that was needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 12:05 p.m., the director of nursing (DON) stated she expected the provider team to trend blood glucose levels. The DON stated she expected the provider team to be notified by nursing staff if the blood glucose level was outside of the ordered parameter but, she did not expect nursing staff to trend blood glucose levels or notify the provider unless the levels were significantly elevated as that was something the provider reviewed. A policy regarding Medication Management dated 9/23, was received but did not discuss diabetic management.

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Providence Place	3720 23rd Avenue South Minneapolis, MN 55407

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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 ensure a range of motion (ROM) restorative program was completed for 1 of 1 resident (R46) who was on a ROM program to prevent contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff that prevents normal movement of a joint or other body part.) Additionally, the facility failed to ensure a recommended splint application was completed and reassessed as needed to treat current contractures and prevent worsening contractures for 2 of 2 residents (R19 and R68) reviewed who had contractures of the hands. Findings include: R46's quarterly Minimum Data Set, dated dated [DATE], indicated R46 had severe cognitive impairment and was dependent on staff for all activities of daily living (ADLs). The MDS further indicated R46 had limited range of motion (ROM) to her upper extremities. R46's Medical Diagnosis list, printed 4/4/24, indicated R46 had several medical diagnoses including a primary diagnosis of cerebral palsy (a group of conditions that affect movement and posture. Symptoms include exaggerated reflexes, floppy or rigid limbs, and involuntary motions.) R46's nursing assistant Tasks indicated a task, dated 3/20/24, labeled RESTORATIVE: Assisted arm ROM exercises to maintain ROM and strength for eating and ADLs. The task was documented as completed once on 3/26/24. R46's care plan, printed 4/3/24, lacked an intervention to provide R46 with ROM to her arms. During an interview on 4/3/24 at 8:00 a.m., nursing assistant (NA)-D stated she had not done ROM with R46 and was unaware of a ROM program for R46, but she would check the care plan to confirm. During an interview on 4/3/24 at 8:30 a.m., registered nurse (RN)-F stated that nursing restorative programs were completed by physical therapy and nursing staff was currently not doing any ROM with R46. During an interview on 4/3/24 the director of rehab (DOR) stated R46 was currently not on a physical therapy restorative program, stating that the nursing staff must be doing it. The DOR stated they use a master binder for all residents on a restorative program and R46 was not there. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 8:50 a.m., the director of nursing (DON) stated they had initiated three programs with a grant the facility had received; a walk well program, restorative nursing program and a functional maintenance program. The nursing staff were responsible for the functional programs and the therapy team was responsible for the restorative programs. The DON stated the functional and restorative programs were recently combined to all be restorative programs done by the therapy team to limit confusion and R46 was changed from a functional maintenance program to a restorative program on 3/20/24. The DON confirmed the therapy team should be completing the ROM for R46. The DON further stated if the DOR was not aware of R46's Restorative program it would be an issue, confirming she did not see R46 on the list for therapy The DON stated R46 should be on a restorative program as she would benefit from the ROM. The DON stated she would work with the DOR to ensure R46 was on the list for a restorative program with the therapy team. 49034 R19's quarterly Minimum Data Set (MDS) dated [DATE], indicated R19 had severely impaired cognition with no rejection of care behaviors during the look-back period (LBP). The MDS indicated R19 was diagnosed with multiple sclerosis (a disease affecting the nervous system with varying symptoms such as muscle weakness, lack of coordination, and cognitive problems), dementia, and hemiplegia (one-sided weakness or complete paralysis). The MDS indicated R19 was dependent on staff for toileting hygiene, bathing, and lower body dressing. The MDS indicated R19 received no occupational therapy or physical therapy and was not on a restorative nursing program during the LBP. R19's care plan dated 5/15/23, indicated R19 was enrolled in a restorative nursing program for risk reduction of further contractures. R19 was directed to receive assistance applying a palm protector to the left upper extremity. R19 was also directed to receive active and passive range of motion (ROM). R19's restorative therapy progress note dated 3/1/24, indicated R19 was tolerating her ROM exercises but had been refusing splint application so a towel was indicated to be used instead to help prevent contractures. R19's therapy progress note dated 3/22/24, indicated ROM exercises were directed to be completed and a palm protector orthotic was supposed to be applied to the left upper extremity. The note indicated R19 had been refusing to use her palm protector. R19's aide sheet dated 3/29/24, indicated R19 was supposed to have a hand splint applied in the morning and removed in the evening. R19's therapy aide record dated 3/3/24-4/3/24, indicated R19 had: - Strength exercises completed with no noted splint application on 3/4/24, 3/6/24-3/8/24, 3/11/24, 3/14/24, 3/15/24, 3/18/24- 3/21/24, 3/25/24-3/28/24, 4/1/24, and 4/3/24. - Been unavailable for therapy on 3/13/24 and had no note indicating if therapy was refused or missed on 3/22/24 (the fifth restorative therapy day). - noted to wear the splint on 3/19/24, 4/1/24, and 4/3/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Refused therapy on 3/5/24, 3/12/24, 3/30/24, and 4/2/24. R19's Order Summary Report dated 4/4/24, did not include an active order for splint use or restorative therapy. During an observation on 4/1/24 at 12:44 p.m., R19 sat in her wheelchair in the common area. R19's left hand was in a tight fist with her arm hugged against her chest with no noted brace or towel present. During an observation on 4/2/24 at 9:10 a.m., R19 was observed lying in bed with her left hand in a tight fist with her arm hugged against her chest with no noted brace or towel. During an interview on 4/2/24 at 9:33 a.m., nursing assistant (NA)-D stated that she worked with R19 frequently and R19 was unable to move her left arm and staff had to complete most of her care for her. NA-D stated that she had never seen R19 with a brace or towel on/in her left hand. NA-D stated she had not been told she was supposed to put anything in R19's hand. During an interview on 4/2/24 at 2:31 p.m., the DOR stated the restorative aides worked with R19 five days a week and usually saw her around 8 a.m., but it depended on their workload. The DOR stated that the aides were to complete ROM and ensure a palm protector brace was applied to her left hand. The DOR stated that if R19 was not tolerating the palm protector other braces could have been attempted but he had not been notified that the brace was not tolerated. The DOR stated that he would talk with the aide and review R19's medical record to assess for brace refusal and application. During an interview on 4/3/24 at 9:58 a.m., the DOR stated that he had talked with the restorative aide who had told him that R19 was not tolerating the brace. The DOR stated the last time he could find in the record that R19 had worn the brace was on 3/19/24 but refusals were also noted previously. The DOR stated that he now saw that it had been noted on 3/22/24 that R19 had been refusing to wear her palm protector but he did not see a therapist had reassessed her to see if a different brace would have been better tolerated. During an interview on 4/4/24 at 1:29 p.m., the director of rehabilitation (DOR) stated he had clarified with the therapy aide and the RB section in the therapy aide record was where they charted if a splint or brace had been applied and when the section was left blank, the therapy aide said he had been putting a towel in R19's hand. R68's significant change MDS dated [DATE], indicated R68 had intact cognition with no behavioral symptoms or rejection of care during the LBP. The MDS indicated R68 was diagnosed with multiple sclerosis, malnutrition, and depression. The MDS indicated R68 required setup assistance for oral hygiene and eating, was dependent on staff for toileting hygiene and lower body dressing, and required substantial assistance for upper body dressing and showering. The MDS indicated R68 received no occupational therapy or physical therapy and was not on a restorative nursing program during the LBP. R68's care plan dated 7/15/21, indicated that R68 was supposed to have a left-hand splint applied every evening and removed every morning related to a left-hand contracture that R68 had refused to wear per recommendations. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68's Order Summary Report dated 9/7/23, indicated R68 had a completed order for an occupational therapy evaluation for a left-hand splint related to a contracture. The order summary did not have an active order for splint use or restorative therapy. R68's aide sheet dated 3/29/24, indicated that R68 had a left-hand splint that he refused to wear and was to receive ROM and strengthening exercises five times a week. R68's Occupation Therapy Discharge Summary dated 12/5/23, indicated that R68 was independent with taking off his left-hand splint but required maximal assistance with applying it. The note indicated therapy staff had created a schedule for staff to follow and initial after applying R68's splint every night. The note indicated there had been poor staff follow-through with the wear schedule, so therapy followed up with them to encourage applying this brace to improve R68's skin integrity. Progress notes dated 1/3/24 through 4/4/24, were reviewed and lacked documentation indicating splint application refusal and if refusal had occurred, that notification of provider or therapy department was completed. During an interview and observation on 4/1/24 at 7:02 p.m., R68 stated that staff had previously exercised his hand, but it had not been occurring recently. R68 stated he was supposed to be wearing a hand splint and pointed to a splint lying on a side table in his room. R68 stated no one had offered to help him put it on in a long time and he was not able to put it on himself and he wanted to wear it. R68's left hand was observed in a fist position and R68 stated he was unable to move his fingers out of that position. During an interview on 4/2/24 at 1:58 p.m., nursing assistant (NA)-G stated R68 was independent with most of his care activities. NA-G stated she was not aware of R68 requiring help applying left-hand splint and if he did, she thought this would have been something the therapy aides would have assisted with. During an interview on 4/2/24 at 2:05 p.m., licensed practical nurse (LPN)-A, the floor nurse in charge of R68's care, stated she was unaware of R68 wearing a left-hand brace or an order indicating he was supposed to wear one. During an interview on 4/2/24 at 2:25 p.m., the DOR stated that he was in charge of the restorative program for the facility related to a grant they had received. The DOR stated his department had been seeing R68 at the end of 2023 for orthotic management but R68 was not on a restorative program. The DOR stated although R68 was discharged from therapy services, he was still supposed to wear the left-hand splint. The DOR stated that R68 had been compliant with wearing the left-hand splint while therapy was seeing him. THE DOR stated that R68 had declined to participate in a ROM program but had been agreeable to wearing the left-hand splint when they had last seen him. The DOR stated the left-hand splint application was an important part of treating and preventing the worsening of contractures and if any resident was for any reason refusing, he would have expected nursing staff to notify him so they could try other options before discontinuing splint wear altogether. DOR stated that he had a weekly meeting with nursing and would have expected that if R68 was refusing the brace application, he would have been notified of this occurrence, but this was not something he was aware of. During an observation on 4/3/24 at 7:35 a.m., R68 was observed in bed with his eyes closed with no noted left-hand splint in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/24 at 2:13 p.m., NA-F stated that he had been working at the facility for over a decade and knew R68 very well. NA-F stated that R68 never wears the brace and it had been months since he had offered it to R68. NA-F stated that it had previously been very painful for R68 when they had attempted to apply the left-hand splint, so they had stopped offering it to him. NA-F stated he had not told a nurse or anyone else about R68 not wearing the brace because they could see that he was not wearing it every day so they should know. During an interview on 4/4/24 at 12:01 p.m., the director of nursing (DON) stated she expected nursing staff to notify the provider, therapy, and/or the resident representative if a resident was refusing to wear a needed orthotic device. The DON stated she would have expected staff to complete a risk versus benefits with the resident if refusals of care were occurring and a progress note entered documenting that this education/conversation had occurred. The DON stated she expected care plans and aide's sheets to have been updated with refusals or changes related to splint use. The DON stated she would review the residents chart and see if this had occurred and she was not immediately aware that it had. A policy regarding ROM and splint application was requested and not received.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to implement or maintain an appropriate communication and collaboration system with an outside dialysis clinic to promote continuity of care and reduce the risk of complication (i.e., missed orders, insufficient preparation for treatment) for 1 of 1 resident (R80) reviewed for dialysis care. Findings include: R80's quarterly Minimum Data Set (MDS), dated [DATE], identified R80 had moderate cognitive impairment along with several medical conditions including anemia, high blood pressure, and renal insufficiency and/or renal failure. In addition, the MDS outlined R80 received dialysis care while a resident at the care center. On 4/1/24 at 5:58 p.m., R80 was interviewed and verified she was on dialysis. R80 explained she went to an offsite clinic for the treatment multiple times per week but was unsure where her dialysis access was located when asked (i.e., graft, port). R80 denied issues with bleeding or her dialysis care, in general, but was unsure what, if any, processes the facility used to communicate with the clinic when asked. R80's care plan, last reviewed 3/7/24, identified R80 had end-stage renal failure, required hemodialysis and had potential for a fistula/graft malfunction. A goal was listed which read, Will have no s/sx [symptoms] of complications from dialysis through the review date, along with several interventions including not taking a blood pressure using R80's right arm, observing her intake and output, and communicating to the medical provider any complications or signs of bleeding. However, the care plan lacked evidence or direction on how, or how often, the care center would coordinate or collaborate with the offsite dialysis clinic for R80's care. When interviewed on 4/3/24 at 9:23 a.m., nursing assistant (NA)-B stated R80 needed a lot of help to do cares and, at times, would even refuse help. NA-B stated R80 was on hemodialysis and went to an offsite clinic three times a week on Tuesday, Thursday, and Saturday. NA-B stated R80 was supposed to limit her fluid intake but often didn't comply adding when staff attempted to re-direct her it would often become a fight. Further, NA-B stated any treatments or communication with dialysis would be done by the nurse adding, The nurses do that. R80's progress notes, dated 3/1/24 to 4/3/24, were reviewed and identified: On 3/16/24, R80's blood pressure medication was held. R80's blood pressure was listed as, 91/64. On 3/19/24, R80's blood pressure medication was again held with dictation, HOLD low b/p. On 3/21/24, R80 was listed as, OUT to Dialysis. On 3/24/24, R80's blood pressure medication was not given. The note outlined, Not given. BP <110. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/24, R80 was recorded as being found on the floor next to her bed with a suspected fall. The note lacked evidence R80's dialysis clinic was updated on this incident. On 3/30/24, R80 was listed as, Out to Dialysis. However, R80's electronic medical record (EMR) and hard chart were reviewed, and the following was identified: A Dialysis Communication Record, dated 3/14/24, identified R80's name along with spaces for the care center nurse to record medications given prior to dialysis, access site characteristics (i.e., bruit, thrill, bleeding), special instructions, medications sent with, and if a meal or supplement was provided. This space only recorded the access site characteristics with black-colored X marks placed on the corresponding answers (i.e., yes, no) and the word, Lunch, was circled to indicate the meal was provided prior. The remainder of the fields for the care center nurse to address were left blank and not completed. The form continued and provided a space labeled, Dialysis Nurse Report, with spaces for the clinic nurse to record medications given during or after treatment, pre/post treatment weights, vital signs, lab work results and special instructions, if any. However, none of these were completed and the entire section was left blank. A subsequent Dialysis Communication Record, dated 3/16/24, again identified R80's name along with spaces for the care center nurse and dialysis nurse to record their various communications or information. However, both of these sections were left blank and not completed. There were no other scanned records in R80's electronic EMR. R80's physical hard chart was reviewed. An additional Dialysis Communication Record, dated 3/21/24, again identified R80's name along with spaces for the care center nurse and dialysis nurse to record their various communications or information. However, both of these sections were left blank and not completed. There were no other records located in R80's hard chart after 3/21/24, despite R80 continuing to go to the clinic and receive dialysis treatment. In addition, the medical record was reviewed and lacked evidence R80's offsite dialysis clinic had been updated on the continued, repeated medication hold(s) for R80's low blood pressure readings or the recent fall (on 3/25/24). There were no completed Dialysis Communication Record(s) located for 3/23/24, 3/26/24, 3/28/24, 3/30/24, or 4/2/24 despite R80 having treatments on those days. When interviewed on 4/3/24 at 9:48 a.m., registered nurse (RN)-A explained they were assigned care of R80, however, expressed it was not my regular floor. RN-A explained R80 was on dialysis and verified she went every Tuesday, Thursday and Saturday to the offsite clinic for the treatment. RN-A explained the staff send a Medication Administration Record (MAR) along with a paper sheet to document the site, instructions, and stuff like that which the health unit coordinator (HUC) prepared. RN-A verified this paper as the Dialysis Communication Record and stated one should be completed and sent with R80 for each dialysis treatment adding the clinic would then use the same form to write back if [there was] something they want us to know. RN-A reviewed R80's blank forms and expressed the forms were not always completed and, at times, sent back blank adding, Sometimes they do [send back blank]. Further, RN-A verified R80 had been attending all the scheduled dialysis treatments over the past few weeks to their knowledge. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 12:57 p.m., HUC-D was interviewed and verified they covered R80's unit. HUC-D explained they started working on the unit about a month prior and helped set-up appointments and, if needed, dialysis correspondence to send with the resident to their treatments. HUC-D provided a prepared vanilla-colored envelope which had R80's name and, 4/4/24, written on it which HUC-D stated was ready to go for her appointment the next day. The envelope was reviewed and included a printed Order Summary Report with R80's medication list, a face sheet and a sheet labeled, Appointment Referral, which had spacing to record subsequent physician orders; however, lacked any spacing to record the other information as outlined on the Dialysis Communication Record (i.e., site characteristics, etc.). HUC-D stated they were not for sure if a Dialysis Communication Record was sent with or not as they had never been told to send one with R80 prior. HUC-D reviewed R80's medical record and verified there was nothing scanned into the medical record since 3/16/24, and again pointed to the Dialysis Communication Record and stated, I haven't been told of this specific form. Further, HUC-D stated they had just today been told to scan all of the information which comes back from dialysis into the medical record and, prior to then, had likely been just tossing them. When interviewed on 4/3/24 at 1:10 p.m., the health information system manager (HIM) explained the Dialysis Communication Record should be sent with for a resident' going to dialysis treatments and all other appointments (i.e., dental visit, physician appointment) should have the Appointment Referral sheet sent with them adding it was maybe inconsistent. HIM verified the Dialysis Communication Record should be sent with, returned completed, and then scanned into the medical record adding, That's the process. HIM verified there was no scanning 'backlog' to their knowledge and if the records weren't in the EMR or hard chart, then they wondered, Are they not coming back? HIM reviewed R80's medical record and verified it lacked evidence any additional communication records had been sent or received. On 4/4/24 at 8:35 a.m., registered nurse clinical director (RN)-B was interviewed and verified they had reviewed R80's medical record. RN-B explained the offsite dialysis clinic was pretty infamous at not completing or returning the Dialysis Communication Records and, as a result, they had just that morning talked with HIM and obtained R80's run reports to keep in the medical record. RN-B stated they felt a discussion with the clinic about getting those reports back was needed, however, had not reached out to them about it prior to survey. A provided Dialysis Care Plan and Treatment Sheet policy, dated 12/2022, identified multiple guidelines for a resident' care plan and treatment sheet while on dialysis treatments. However, the policy lacked information on how, or how often, the care center would collaborate or coordinate care with the offsite clinic.

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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** 44656 Based on interview and document review, the facility failed to act upon the consultant pharmacist's recommendation for 1 of 5 residents (R73) reviewed for unnecessary medications. Findings include: R73's quarterly Minimum Data Set (MDS) dated [DATE], identified R73 had intact cognition with diagnoses of renal insufficiency(inadequate kidney function), coronary artery disease, anemia, hyponatremia (low blood sodium levels), hyperkalemia (high blood potassium levels), depression, psychosis (severe mental condition of the mind resulting in difficulties determining what is real and what is not real), rectal abscess and a multi-drug resistant infection. In addition, it documented R73 had a colostomy (opening in the large intestine to channel stool from the body) and R73 received antipsychotic medication on a routine basis. R73's physician orders (PO) dated 3/15/24, documented R73 had a provider order for Prochlorperazine Maleate Oral Tablet (used to treat nausea, migraines, schizophrenia, psychosis and anxiety) 5 milligrams [mg], Give 5 mg by mouth three times a day for . The PO for R73 failed to have a diagnosis. Per R73 PO the Drug Class for this medication is ANTIPSYCHOTIC/ANTEMITIC [sic]. R73's February 2024 Consultant Pharmacist's Medication Review documented, Diagnosis does not appear on the antipsychotic medication orders for olanzapine and prochlorperazine. Additionally it documented, Suggested Course(s) of action: Recommend updating diagnosis for these orders, and Implementation Time Frame: Nursing staff to address ASAP but no later than 30 days. The form was signed by consultant pharmacist (CP) on 2/13/24 and physician/practitioner on 2/21/24. A comment was handwritten next to the words, prochlorperazine DX: (in black ink) of nausea, vomiting in the same blue ink as the physician/practitioner signature and date. The remainder of the document was handwritten in black ink. Facility document titled, Nursing Report-February 2024 page 3 of 7 dated 2/14/24, identified R73 with prochlorperazine order and indicated, Irregularity: Diagnosis does not appear on the antipsychotic medication orders. Also, Course of Action: Recommend updating diagnosis of these orders. The form indicated in purple inked handwriting on top of R73's name of prochlorperazine order with d on it. During interview with R73 on 4/3/24 at 7:37 a.m., R73 stated, I don't know why I take Compazine [prochlorperazine]. R73 stated facility doesn't talk to me about my meds. R73 stated, I am very frustrated with this place because they don't communicate with me. I feel like I am being medicated [prochlorperazine] for no good reason. Again, I don't understand. During interview with trained medication aide (TMA)-A on 4/3/24 at 7:59 a.m., TMA-A stated, he was unaware of why prochlorperazine was prescribed for R73. TMA-A looked in R73's electronic medical record (EMR) and the PO. TMA-A stated, The order should really tell me the diagnosis for why I am giving this medication. (continued on next page)

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	245271	A. Building B. Wing	04/04/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with licensed practical nurse (LPN)-A on 4/3/24 at 8:12 a.m., LPN-A stated she had given R73 his meds many times. LPN-A reviewed R73 PO and stated, I don't know why it [diagnosis] is not in the EMR. It is important to know why or rationale why [we give a med]. Also, They [facility] should have the diagnosis written in there [EMR]. During interview with director of nursing on 4/3/24 at 8:42 a.m., the DON stated the monthly medication regimen review (MRR) by the CP are collected and reviewed by her. DON stated when the facility receives the MRRs from the CP, the facility will provide the physician with them and the physician will either sign the form with Accepted or Rejected and then provide a reason, if needed. DON stated she then uses a Nursing Report form to ensure the facility is following up on each recommendation. DON stated she then goes through each MRR and compares it to the resident PO in the EMR. DON stated, once she confirms the orders are updated in each residents EMR then she will make a notation on the left hand margin on top of each resident name next to the recommendation to show that it was completed and checked by the DON or facility per pharmacist and physician orders. DON stated the purple inked handwritten d on top of R73's Nursing Report-February 2024 document was hers and that the d meant that the diagnoses was put in the prochlorperazine order for R73. DON reviewed R73's PO for prochlorperazine and stated, there should be a diagnosis in the EMR for Compazine (prochlorperazine) order and Yes the pharmacist recommended the diagnoses be put in with the medication but it was not done. During interview with facility's CP on 4/3/24 at 11:07 a.m., CP stated he performs the monthly MRR's for facility and as part of the facility's interdisciplinary team he reviews all of the resident medications. CP stated R73 was prescribed Compazine for nausea in February 2024. CP stated, CMS (centers for medicare and medicaid) considers Compazine as an antipsychotic. CP stated, I write my expectation and recommendations down [on Consultant Pharmacist's Medication Review report]. I expect my recommendations to be addressed [by the facility]. Facility policy on medication regimen review was requested but not provided.

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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 ensure appropriate side effect monitoring (orthostatic blood pressure monitoring) was completed, in accordance with standards of care, related to antipsychotic medication use for 1 of 5 residents (R76) who had frequent falls and was reviewed for unnecessary medications. Findings include: A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) from antipsychotic medication. The article outlined, All antipsychotics carry some risk of orthostatic hypotension [which can] lead to dizziness, syncope, and falls. It should be evaluated by both history and routine measurement. R76's quarterly Minimum Data Set (MDS), dated [DATE], indicated R76 had severe cognitive impairment and required a wheelchair for locomotion around the facility. The MDS further indicated R76 had the following medical diagnoses; legal blindness and vascular dementia (A condition caused by the lack of blood to a part of the brain) with psychotic disturbance. R76's Orders in the electronic medical record (EMR), printed 4/4/24, indicated R76 had the following orders; quetiapine furmate (belongs to a class of drugs known as atypical antipsychotics) 25 mg three times a day, dated 1/16/24 and orthostatic blood pressure and pulse monthly: resident to rest supine for at least 5 minutes, take blood pressure and pulse, ask resident to stand and repeat blood pressure and pulse. If resident is unable to stand, perform in the sitting position, dated 12/23/23. R76's care plan, dated 3/15/22, indicated R76 had limited physical mobility and was a fall risk related to an unsteady gait. The care plan, dated 5/16/22, further indicated R76 used antipsychotic medication related to hallucinations, psychosis, and a diagnosis of vascular dementia with behavioral disturbances. The care plan lacked an intervention to monitor orthostatic hypotension. R76's January 2024 treatment administration record (TAR) indicated a treatment to obtain R76's orthostatic blood pressure and pulse on the 23rd of the month at bedtime. The documentation section on the 23rd was left blank with a 9 denoted. The TAR indicated 9 was other/see progress note. The EMR lacked a progress note to indicate why the orthostatic blood pressure and pulse were not obtained. R76's February 2024 TAR indicated a treatment to obtain R76's orthostatic blood pressure and pulse on the 23rd of the month at bedtime. The documentation section on the 23rd was left blank with a 9 denoted. The EMR lacked a progress note to indicate why the orthostatic blood pressure and pulse were not obtained. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R76's March 2024 TAR indicated a treatment to obtain R76's orthostatic blood pressure and pulse on the 23rd of the month at bedtime. The documentation section on the 23rd was left blank with a 7 denoted. The TAR indicated 7 was sleeping. The electronic medical record (EMR) lacked evidence R76 was reapproached when awake. During an interview on 4/3/24 at 10:31 a.m., registered nurse (RN)-B stated resident's who are on antipsychotic medications should have an order for orthostatic blood pressure monitoring that would link to the TAR for documentation. RN-B stated the expectation was for orthostatic blood pressure monitoring to get done monthly and to follow up with the provider if the resident was having falls or dizzy spells. During an interview on 4/3/24 at 11:07 a.m., the pharmacist stated side effect monitoring for antipsychotic medications should include monthly orthostatic blood pressure monitoring. During an interview on 4/4/24 at 8:50 a.m., the director of nursing (DON) stated the expectation for residents taking antipsychotic medication was for there to be an order for monthly orthostatic blood pressures and for them to be completed. The DON confirmed R76's EMR lacked orthostatic blood pressure monitoring for the months of January, February, and March 2024. A facility policy on antipsychotic medication use and side effect monitoring was requested but not received.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure routine dental needs were evaluated and, if needed, acted upon or addressed timely to promote oral hygiene for 4 of 5 residents (R26, R68, R92 and R102) reviewed for dental care. Findings include: R92's quarterly Minimum Data Set (MDS), dated [DATE], identified R92 had severe cognitive impairment but demonstrated no delusional thinking behaviors. R92's previous significant change in status (SCSA) MDS, dated [DATE], identified R92 had no broken, ill-fitting dentures or obvious/likely cavities for the review period marked with, Z. None of the above were present. Further, R92's Clinical Census, printed 4/3/24, identified R92's current payer source, Medical Assistance - MN, with an effective date, 4/11/2023. On 4/1/24 at 3:37 p.m., R92 was observed seated in a standard wheelchair on the unit with her family member (FM)-C present and seated adjacent. R92 was interviewed, and expressed she used an upper partial denture but it had a few teeth missing due to being struck in the mouth prior to admission to the care center. R92 smiled and showed the broken teeth which were in the front of the denture. R92 stated she had not been seen by a dentist to have them fixed but added she should, expressing, If we can arrange it. FM-C and R92 both expressed they could not recall any discussion from the care center on having the denture fixed or evaluated. When interviewed on 4/3/24 at 9:29 a.m., nursing assistant (NA)-B explained R92 need[s] help with everything including oral cares. NA-B stated R92 used a top denture and verified it had chipped teeth present adding, I think that's how it is. NA-B stated R92 had never complained about her teeth prior and expressed, to their recall, R92 had been seen by the dentist two or three months ago as they were onsite and seeing multiple residents' the same day. NA-B stated they were unsure about any subsequent dental appointments for R92 since the last visit a few months prior. R92's Comprehensive Nursing Data Collection - V6, dated 2/20/24, identified a section labeled, Oral/Dental, which outlined areas to mark to demonstrate a corresponding condition or issue. The evaluation outlined R92 as having, Broken or loosely fitting dentures, and, Obvious or likely cavity ., with a corresponding checkmark placed. The evaluation outlined R92 had both her own teeth and upper dentures with a field labeled, Date of last Dental Exam, which was answered, 11/6/2023 - denies dental concerns today. R92's corresponding MDS 3.0 Oral/Dental Assessment Form, dated 11/6/23, identified R92 was seen by Apple Tree Dental for an annual evaluation. The completed evaluation outlined a section labeled, Assessment Notes, which had writing present, . #8/9 broken teeth on [upper] denture - loose - hard to eat + collects lots of debris. A subsequent section labeled, Dental Care Referral Recommendations, outlined a checkmark placed next to an option which read, Routine Dental Referral. Resident has non-urgent dental care needs, with adjacent handwriting which read, Repair [upper] denture. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, R92's medical record was reviewed and lacked evidence the identified concern of a broken upper denture had been acted upon or referred to a dental provider to be addressed despite the recommendation in R92's chart from over three months prior and direct care staff having knowledge of the broken dental device. When interviewed on 4/3/24 at 9:57 a.m., registered nurse (RN)-A stated R92 was quite alert but also sometimes forgetful with her recall. RN-A explained the care center had an in-house dental service which came onsite periodically and, if concerns with resident' dental needs existed, would be communicated to the medical provider who could refer them to that service. RN-A stated the health unit coordinators (HUC) were the people who set up those appointments, if needed. On 4/3/24 at 12:57 p.m., HUC-D was interviewed and verified they covered R92's unit. HUC-D explained they helped to schedule various resident' appointments, including dental appointments, and tracked them using a schedule book which was provided to review. The provided book lacked evidence R92 had been seen by a dentist since 1/1/24 (when it started). HUC-D stated they typically did not see or review the completed Apple Tree Dental consultation forms (i.e., MDS 3.0 Oral/Dental Assessment Form) and expressed Apple Tree Dental typically kept their own schedule and would track or follow up with resident' needs on their own. HUC-D stated to check with the health information manager (HIM) for more information. When interviewed on 4/3/24 at 1:10 p.m., health information manager (HIM) reviewed R92's medical record and verified it lacked evidence of subsequent dental follow-up since 11/2023. HIM explained the care center had Apple Tree Dental onsite usually once a month and expressed they were actually onsite right then, however, R92 was not on the listing to be seen despite having the identified denture issue. HIM stated they felt if a resident had dental issues, then Apple Tree Dental should track it themselves and follow up, if needed, but added there was not, to their knowledge, a follow-up process in place by the care center to ensure any identified dental needs were addressed. HIM added, Not to my knowledge. However, HIM stated the care center had identified dental visits as a project which needed to be addressed and, as a result, they were working on a PIP (Performance Improvement Project) to address it. On 4/4/24 at 8:32 a.m., registered nurse clinical director (RN)-B was interviewed and verified they had reviewed R92's medical record. RN-B explained there was no evidence located to demonstrate a dental re-visit or appointment had been made or completed adding, I didn't see anything. RN-B stated they did not reach out to Apple Tree Dental, either, to inquire about a re-visit but added R92 had likely not been seen as there was no signed consent on file. RN-B verified a dental re-visit should have been attempted or scheduled and expressed a PIP was in motion to help address the issue. RN-B stated it was important to ensure dental services, when needed, were provided to reduce the risk of infection, pain or trouble eating adding, To address any of those concerns. 49034 R26's quarterly MDS dated [DATE], indicated R26 had a severe cognitive impairment and was diagnosed with heart failure, kidney disease, diabetes, and dementia. R26's Nutritional Assessment note dated 6/12/23 at 12:58 p.m., indicated R26 had poor dentition and previously had partial dentures but they were not present at the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R26's care plan dated 3/13/24, indicated R26 required set-up help with oral care. R26's medical record was reviewed and did not indicate that R26 had been offered, refused, or had received dental services. During an interview on 4/1/24 at 1:44 p.m., family member (FM)-B stated R26 had lost her dentures at the hospital before admittance. FM-B stated no one at the facility had ever offered to help set up a dental appointment for R26 to get new dentures. FM-B stated wearing dentures was always important to R26 in the past. During an interview and observation on 4/4/24 at 8:44 a.m., R26 was observed and confirmed by licensed practical nurse (LPN)-E to have missing front middle bottom teeth with the surrounding bottom teeth being broken and discolored. LPN-E stated that he couldn't view R26's back teeth but it appeared as if R26's upper teeth were missing. R26 confirmed she did not have upper teeth as her dentures were missing, and she wanted them back. LPN-E stated he was unsure if R26 wore dentures. R68's significant change MDS dated [DATE], indicated R68 had intact cognition with no behavioral symptoms or rejection of care during the look-back period (LBP). The MDS indicated R68 was diagnosed with multiple sclerosis (a disease affecting the nervous system with varying symptoms such as muscle weakness, lack of coordination, and cognitive problems), malnutrition, and depression. The MDS indicated R68 did not have broken or loose fitting full or partial dentures, obvious or likely cavity or broken natural teeth, or abnormal mouth tissue. The MDS indicated R68 required setup assistance for oral hygiene and eating. In Section V of the MDS, the Care Area Assessment (CAA) Summary, dental was not a care area triggered or noted to have been addressed in the care plan. R68's Apple Tree Dental Assessment Form dated 1/5/22, indicated R68 had broken natural teeth, and used both upper and lower dentures. The form indicated R68 required staff supervision with dental care and utilized both upper and lower dentures. The form indicated R68 required routine dental visits. R68's Veterans Affairs (VA) dental progress note dated 3/7/22, indicated R68 had seen the dentist and wanted to progress to a full set of dentures instead of partials. The note indicated that R68 was supposed to return to the clinic for a future appointment regarding full dentures. The note was faxed by RN-E at the VA on 4/3/24 and indicated that RN-E could not find that a consultation order had been placed and an appointment had not been scheduled. R68's dental Appointment Referral record dated 2/24/23, indicated R68 had seen [NAME] Family Dentistry for swelling noted to the right lower jaw. R68's progress note dated 3/26/23 at 8:21 p.m., indicated that R68 had a reemergence of a lump on his jaw and R68 was going to set up a dental appointment with the VA for this. R68's MDS Reference Period Documentation note dated 2/3/24 at 5:08 a.m., indicated R68 had broken or loosely fitting full or partial dentures. R68's MDS Reference Period Documentation note dated 2/5/24 at 6:35 a.m., indicated R68 had broken or loosely fitting full or partial dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R68's MDS Reference Period Documentation note dated 2/6/24 at 6:13 a.m., indicated R68 had broken or loosely fitting full or partial dentures. R68's care plan dated 3/7/24, indicated R68 had missing teeth but did not indicate denture use. During an interview and observation on 4/1/24 at 6:56 p.m., R68 was observed in his room sitting in his wheelchair with missing bottom front teeth, and top dentures that appeared to have been partials that moved when R68 spoke with a noticeable resulting lisp as R68 attempted to keep the denture in place. R68 stated he previously used an outside dental agency, but it had been a couple of years since he had seen them related to his dentures. R68 stated he did not recall anyone from the facility discussing his dental needs with him in the last few months but would have liked help setting up a dental appointment to get his dentures fixed. R68 stated he sometimes didn't wear his top denture related to how loosely it fit and had for at least a few months but unsure exactly how long the top denture had been like that. R68 stated he also needed new bottom dentures as they had broken a couple of years ago and it bothered him that he didn't have well-fitted dentures to wear. During an interview on 4/3/24 at 8:27 a.m., the HIM stated that the facility relied on Apple Tree Dental to review the updated census and inform the facility of which residents needed dental appointments. The HIM stated that when a resident used an outside dental service, staff were to review the recommendations made by the dental service and then make sure a follow-up appointment was made when needed. The HIM stated that when the HUCs would receive documentation after a dental appointment occurred, they were supposed to make sure follow-up appointments were made and orders were added to the resident chart. The HIM stated that the HUCs were expected to call the dental agency and request follow-up information if it was not received after an appointment was completed. The HIM stated he had reviewed the scheduling book and stated that he did not note any previous or future dental appointments that were made for R26 and could not verify that she was offered and declined an appointment but he would look into it. During an interview on 4/3/24 at 9:48 a.m., dental coordinator (DC)-A for [NAME] Family Dentistry, stated that after reviewing R68's visit note from 2/24/24, it indicated that R68 was solely seen for jaw swelling, and the dental clinic had not completed a comprehensive dental assessment or assessed his denture use. During an interview on 4/3/24 at 10:17 a.m. with the HIM and the assistant director of nursing (ADON), the ADON stated that they had reviewed R68's medical record and did not see that a summary/recommendation had been received from R68's last dental appointment in March of 2022. The ADON stated that after reviewing the medical record, there was no evidence that R68 had been seen by a dentist for a comprehensive assessment since 2022 as they had been relying on R68 to set up his dental appointments. The HIM stated that the facility had noticed in March of 2024 that they had a facility-wide issue of residents not receiving needed dental care and the issue was ongoing. The HIM stated they did not yet have a process to ensure residents using an outside dental agency received regular dental appointments. The HIM and the ADON confirmed that R26's medical record was reviewed and did not indicate that R26 had been offered or received needed dental services. During an interview on 4/3/24 at 12:08 p.m., licensed practical nurse (LPN)-C stated she had noticed R68 had various missing teething and thought one of his partial dentures was missing. LPN-C stated she was unsure how long the denture had been missing and stated she often saw R68 not wearing his dentures and was unsure why but LPN-C had not asked R68 about it. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/24 at 2:04 p.m., RN-E stated R68 was last seen by the VA in 3/22 when R68 had asked to have full dentures made. RN-E stated that the VA had missed making a dental consultation for R68. RN-E stated that once a dental consultation was made, it would have been up to the facility or the resident to follow up and schedule a dental appointment. RN-E stated that she did not see that the facility or the resident had followed up with the agency until today to ensure R68 received needed dental services. During an interview on 4/3/24 at 11:16 a.m., social worker (SW)-A stated she thought today was the first time anyone had offered to set up a comprehensive dental appointment for R68. During an interview on 4/3/24 at 1:28 p.m., the assistant director of nursing (ADON) stated that she had reviewed R68's medical record and did not find evidence that R68 had refused or been offered a dental appointment since his last appointment in 2022. During an interview on 4/4/24 at 11:55 a.m., the DON stated that she had reviewed R68's medical record and confirmed that the last time R68 had been seen by a dentist for a comprehensive visit was in March of 2022. The DON stated that she was unaware that R68 had any dental issues until it had been brought up this week. 49654 R102's admission Minimum Data Set (MDS) dated [DATE], did not identify any missing or broken natural teeth. R102 had diagnoses of moderate protein-calorie malnutrition, mild cognitive impairment, anxiety, and dysphagia (difficulty swallowing). R102's Order summary report signed and dated 1/16/24, indicated resident may be seen by audiology, podiatry, optometry and dental per facility policy. R102's care plan with last review date of 3/7/24, indicated R102 had an activities of daily living (ADL's) self-care performance deficit and required partial/moderate assistance of 1 staff to complete; R102 had potential nutritional problem, chewing difficulty and a need for mechanically soft textured foods. R102's speech therapy evaluation and plan of treatment dated 1/19/24, indicated R102 was missing all top teeth, bottom right molars, and back 2-3 bottom left molars. R102 was given regular texture toast, mechanical soft hashbrowns and eggs, and puree cereal. Evaluation indicated R102 difficulty and was uncomfortable chewing with regular textured items and reportedly stated it feeling like a mouthful of razors. During interview on 4/1/24 at 3:36 p.m., R102 stated facility staff was aware he had no upper teeth and was missing multiple bottom teeth. R102 stated he would like to receive top dentures, but facility staff had not assisted to set up a dental appointment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 4/2/24 at 9:50 a.m., health unit coordinator (HUC-E) stated when a resident is admitted they are given a dentist consent form from Apple Tree Dental to be filled out and appointments are then scheduled. The consent form is then placed in the resident's hard chart at the nursing station. In the case of a dental emergency the resident would go to the ER or arrange with Apple Tree Dental to be seen in clinic. For regular dental visits the resident would be placed on list for the next scheduled date when Apple Tree dental came to the facility. HUC- confirmed resident was admitted on [DATE], stated the next scheduled date for the dentist was 4/3/24 and provided a list of residents who would be seen that date. R102 was not scheduled. A review of R102's hard chart did not reveal a consent form for dental had been completed. During interview on 4/3/24 at 7:58 a.m., HUC-E stated R102 had not completed the intake form and that it should have been completed while he was in the transitional care unit (TCU). HUC- stated R102 should not have had to wait so long. During interview on 4/3/24 at 12:12 p.m., director of rehab (DOR) stated assessments are completed by therapists upon admission and those findings are shared on a communication form that goes to the director of nursing (DON), assistant director of nursing (ADON), and the floor nurses to update their records. Furthermore, the findings of the assessments, and/or therapy progress are discussed daily during interdisciplinary team meetings. DTS stated R102 received speech therapy services from 1/19/24 thru 3/5/24 and had reportedly had difficulty chewing regular textured foods. During interview on 4/3/24 at 1:09 p.m., DON stated the facility was working on a performance improvement project (PIP) because there was no formal process in place to track dental services. DON stated her expectation was the HUC would fill out the referral slip for Apple Tree dental upon admission and if the resident changed units the HUC for the receiving unit would review the resident's chart to ensure the referral had been made. DON stated this is important to have those processes in place to support resident oral hygiene and oral health. A policy for dental services was requested but not received.

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	245271	A. Building B. Wing	04/04/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview and document review, the facility failed to offer or provide the pneumococcal vaccine to 2 of 5 residents (R20 and R76) reviewed for immunizations. The facility further failed to offer or provide shared clinical decision making on the pneumococcal vaccine for 2 of 5 residents (R35 and R46) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R20's quarterly Minimum Data Set (MDS), dated [DATE],n indicated R20 was [AGE] years old, cognitively intact and admitted to the facility on [DATE]. R20's immunizations in the electronic medical record (EMR) indicated R20 had received the following pneumococcal vaccines; PCV13 on PPSV23 on 9/28/1999 and 7/27/2011, respectively. Due to R20 receiving the PPSV23 before the age of 65, the Centers for Disease Control and Prevention (CDC) indicated for R20 to receive a dose of the PCV20 or PPSV23 again (at least 5 years after the last dose). R76's quarterly MDS, dated [DATE], indicated R76 was [AGE] years old, had severe cognitive impairment and was admitted to the facility on [DATE]. R76's immunizations in the EMR lacked evidence R76 had received the pneumococcal vaccine(s). R76's EMR lacked evidence R76 had been offered the vaccine or educated on the risks and benefits or receiving or refusing the vaccine(s). R35's annual MDS, dated [DATE], indicated R35 was [AGE] years old, had moderate cognitive impairment and was admitted to the facility on [DATE]. R35's immunizations in the EMR indicated R35 received the following pneumococcal vaccines; PCV13 on 12/26/2014 and the PPSV23 on 10/9/2003 and again on 10/26/2010. The CDC indicated based on shared clinical decision making, decide whether to administer one dose of PCV20 at least five years after the last pneumococcal vaccine dose. R35's EMR lacked evidence of shared clinical decision making on whether R35 could benefit from a dose of PCV20. R46's quarterly MDS, dated [DATE], indicated R46 was [AGE] years old, had severe cognitive impairment and was admitted to the facility on [DATE]. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R46's immunizations in the EMR indicated R46 received the following pneumococcal vaccines; PCV13 on 6/3/2015 and PPSV23 on 10/17/2000 and again on 3/20/2018. The CDC indicated based on shared clinical decision making, decide whether to administer one dose of PCV20 at least five years after the last pneumococcal vaccine dose. R46's EMR lacked evidence of shared clinical decision making on whether R46 could benefit from a dose of PCV20. During an interview on 4/4/24 at 11:05 a.m., the infection preventionist (IP) stated the expectation was when a resident was admitted to the facility a consent for the influenza, COVID, and pneumococcal vaccines was completed that covered historical data of vaccines received. The resident could decline or consent for the vaccines at that time. The IP stated she was alerted in November 2023 about the new CDC guidance to ensure the pneumococcal vaccines included shared clinical decision making however she had not implemented it with any residents at this time, and stated finding the time to implement it was a barrier. The IP had completed an audit of which residents needed the pneumococcal vaccine. The IP stated she was aware R20's pneumococcal vaccines were not completed and she was not sure why R76 was not offered the pneumococcal vaccines at admission as she was not in the IP role at the time he admitted to the facility. A facility policy, titled Pneumococcal Vaccine, revised 5/20/22, indicated the facility would refer to the CDC pneumococcal vaccine timing for adults and the vaccine would be offered to all residents admitted to the facility who were [AGE] years of age or older.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49339 Based on observation, interview and document review, the facility failed to ensure resident room walls were maintained in a clean, sanitary manner for 1 of 1 residents (R52) whose walls were soiled and in a state of disrepair. In addition, the facility failed to ensure 1 of 2 commerical ovens used in the main production kitchen was kept in the clean, sanitary manner to reduce the risk of particle cross-contamination. This had potential to affect all 138 residents, visitors, or staff who could consume food made using the device. Findings include: RESIDENT ROOM: On 4/01/24, at 1:30 p.m., R52 was lying in bed in room and covered with a blanket in bed. R52's bed was positioned parallel with the wall. The wall was noted to have bubbling paint, torn in areas, multiple dark-brown colored smears along with other various colors of streaks on the wall. There were places on the wall, by the grab bars, where the sheet rock was exposed, and the area was larger than a fist. R52 was questioned about his walls at this time; however, R52 was unable to answer how the walls became scraped or how long they had been in such condition. A subsequent observation was made on 4/2/24 at 2:07 p.m., R52's wall along his bed continued to look the same as the previous observation: bubbling pain, torn in areas, multiple dark-brown colored smears with other various colors of streak on the wall, with areas by the grab bars where the sheet rock was exposed. During interview on 4/02/24, at 2:20 p.m., registered nurse (RN)-C verified that she works on the floor. After observing R52's wall, RN-C stated, the wall is very soiled with dried human feces and other organic material maybe food on it. RN-C verified that was not acceptable and was going to notify maintenance as they were unsure if maintenance or housekeeping were aware. RN-C stated it appears as though it has been like that for a while and further indicated they had not been in that room as they typically work on the other side. RN-C stated that it is all staff's responsibly to notify maintenance or housekeeping when they see something and through the Tels (maintenance work order) system. During interview on 4/02/24, at 3:04 p.m., maintenance (M)-A verified that they do repairs for the building. M-A indicated they are notified of repairs needed through Tels systems. M-A verified that R52's room needed work and housekeeping needed to clean it before maintenance can do any drywall work. M-A verified that there is stuff on the wall and stated they just got notified today of any issue. M-A stated that all staff are responsible for notifying maintenance and housekeeping of concerns. During interview on 4/02/24, at 3:06 p.m., housekeeping director (HD) verified that housekeeping cleans the rooms daily. HD verified that they have a cleaning schedule for every day cleaning and deep cleans. HD stated that the last time R52 room was deep cleaned (which would include walls being washed) was on March 3rd, 2023. HD verified R52's room had been cleaned on 4/2/23, prior to the interview, and the walls had not been cleaned. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/04/24, at 11:23 a.m., director of nursing (DON) stated the Tels system is used to alert maintenance and housekeeping of any environmental concerns. DON indicated these should be addressed. On 4/04/24, at 11:41 a.m., administrator verified the Tels system is used for housekeeping and maintenance needs. Administrator stated all staff should report issues and would expect this to be done. 33925 KITCHEN OVEN: On 4/1/24 at 11:47 a.m., an initial kitchen tour was completed. A Vulcan double-stack convection oven was placed under the ventilation hood, and a silver-colored card was affixed to the side of the machine which identified the model as VC4GD. The oven was in-use with metallic serving pans placed inside. However, the top of the machine had a thick, copious amount of black and gray-colored dust and debris present with an overall greasy-looking (i.e., shiny, sticky) appearance. There were also multiple pieces of burnt food product on top and, in addition, placed directly on top of this surface were multiple metallic oven racks (used inside the oven to place food/pans onto). The following day, on 4/2/24 at 8:37 a.m., a return visit to the kitchen was made. The Vulcan oven was not in use at this time, however, the top of the machine remained soiled with visible debris and burnt food product visible. In addition, there was now only a single metallic oven rack present on top of the machine, however, was again, directly in contact with the surface of the machine. Cook (CK)-A was present and making pancakes at the adjacent griddle-top oven. When interviewed on 4/2/24 at 8:51 a.m., CK-A explained kitchen cleaning tasks, including oven cleaning, was done like a committee and everyone was responsible to help adding, Everybody works together. CK-A stated cleaning tasks were tracked using a flow sheet which was provided. A Front of the House (FOH) Cleaning Log, dated April 2024, listed a location which read, Kitchen, along with various tasks to be completed on daily, weekly, and monthly cleaning schedules, respectively. However, the provided log lacked any direction or prompts to clean the oven' surfaces or racks. CK-A reviewed the provided flow sheet and verified it lacked any oven cleaning schedules but expressed they had been listed before to their recall. CK-A observed the oven and verified it's condition adding it appeared like gunk on top. CK-A stated the racks for inside the oven, used to hold food and/or pans, were usually stored on top of the machine as observed. CK-A stated the oven surfaces should be cleaned on a weekly basis to their knowledge, but added it had been a few weeks since they had cleaned them personally. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 8:56 a.m., the nutrition service director (NSD) was interviewed. NSD observed the Vulcan oven and verified it's condition adding it had black crumbs and burnt product on top. NSD explained the cooks should be cleaning the machine and, any completed cleaning, was tracked using a flow sheet. NSD provided the same flow sheet CK-A had prior, but expressed someone had hung up the wrong one which didn't list the ovens on it. NSD provided another flow sheet, from March 2023, which listed a section labeled, Weekly, and outlined, Clean Ovens. However, this was last checked off as completed on 3/16/24 (nearly three weeks prior) with no dictation or rationale why the ovens had not been cleaned, as directed. NSD stated they were unaware why the cleaning had not been completed on a weekly basis and reiterated the cook' responsibility to do such adding, It will be a coaching for them. NSD stated it was important to ensure food service equipment, including the ovens, were kept clean as the surfaces could come in contact with food and present cross contamination risks. A facility policy titled, reporting it items requiring maintenance &/or housekeeping, undated, was provided. It indicated the purpose is to support the quality of like and safety for our residents and staff at Providence Place, all employees must report items requiring maintenance and/or housekeeping. The system used is Tels and it provides examples of items to reports including outlets or fixtures that may be damaged and floor mopping and identifies who (housekeeping or maintenance) to report area of concern to. A Vulcan Installation & Operation Manual, dated 3/2021, identified the manual applied to several models including the VC4GD and outlined a section labeled, Cleaning, which outlined exterior stainless steel oven panels should be cleaned with a damp cloth and, if needed, using detergent. This was to be completed on a daily basis after use. A facility' policy on kitchen equipment cleanliness was requested, however, none was received.