STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Rehabilitation Center	1900 Sherren Avenue East Maplewood, MN 55109

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to ensure a resident's right to determine their own healthcare decisions for 1 of 1 resident (R30), and failed to ensure R30 had a right to revoke a power of attorney. Findings include: According to Minnesota Statutes 145C.06, a health care directive is effective for a health care decision when it meets the requirements of section 145C.03, subdivision 1; and the principal in the determination of the attending physician, advanced practice registered nurse, or physician assistant of the principal, lacks decision making capacity to make the health care decision; or if other conditions for effectiveness otherwise specified by the principal have been met. A health care directive is not effective for a health care decision when the principal , in the determination of the attending physician, advanced practice registered nurse, or physician assistant of the principal, recovers decision -making capacity; or if other conditions for effectiveness otherwise specified by the principal have been met. R30's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have evidence of an acute change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have physical, verbal, or other behaviors, was not important at all to have a family or close friend involved in discussions about care and had the following diagnoses: anemia, hypertension (high blood pressure), dementia, anxiety, depression, borderline personality disorder, and personal history of other mental and behavioral disorders. R30's quarterly MDS dated [DATE], indicated intact cognition, did not have an acute change in mental status from baseline, did not have inattention, disorganized thinking, or altered level of consciousness, and did not have hallucinations or delusions. R30's quarterly MDS dated [DATE], indicated intact cognition, did not have an acute change in mental status from the baseline, did not have inattention, disorganized thinking, altered level of consciousness, and did not have hallucinations or delusions. R30's quarterly MDS dated [DATE], indicated intact cognition, did not have an acute change in mental status from the baseline, did not have inattention, disorganized thinking, or an altered level of consciousness, and did not have hallucinations or delusions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's significant change in status MDS dated [DATE], indicated severe cognitive impairment, did not have inattention, disorganized thinking, or an altered level of consciousness, and did not have hallucinations or delusions. R30's Profile form in the electronic medical record (EMR) indicated R30's FM-A was her financial power of attorney (POA) and next to the heading, Power of attorney-care indicated, Do Not Use. R30's medical record was reviewed and lacked information R30 had a guardian. Additionally, R30's attending physician was (P)-K. R30's care plan dated 11/16/22, indicated R30 was alert and oriented to person and sometimes place, but needed cues and reminders for time and had short-term memory loss and family assisted in decision making. Interventions indicated ACP (Associated Clinic of Psychology) provide brief instructions, repeat instructions as needed, explain all cares and procedures, if having trouble with word finding, take time to listen, observe for changes in cognitive status. R30's care plan dated 3/17/23, indicated R30 was able to ask questions and answer questions, was easily distracted, had difficulty with word finding and interventions indicated to allow R30 enough time to process and answer questions, ask yes or no questions, gain attention before talking, speak in simple and direct terms, and speak clearly and distinctly and adjust tone of voice. R30's care plan dated 11/28/23, indicated R30 required assistance in reading and understanding health documents and interventions included, family would read instructions, pamphlets, or other written materials, from doctors or pharmacies. R30's IDT (Interdisciplinary team) Care Conference form dated 2/12/24, 5/14/24, and 8/7/24, indicated FM-A attended the care conference. The form lacked documentation R30 attended or declined to go to the care conference. R30's medical record lacked evidence R30 refused to go to care conferences, and documentation lacked evidence R30's participation in care planning was not practicable. R30's Honoring Choices Minnesota Health Care Directive signed by R30 on 9/23/2019, indicated the document gave treatment choices and preferences, and or appointed a health care agent to speak on a person's behalf if a person cannot communicate or make their own health care decisions. R30 identified family member (FM)-A as her primary health care agent. The form indicated the health care agent had the following powers when R30 was not able to communicate for herself: agree to, refuse, or cancel decisions about her healthcare, interpret any instruction in the document based their understanding of R30's wishes, review and release medical records, arrange for healthcare and treatment, decide which health care providers and organizations provide healthcare, make decisions about organ and tissue donation. Further, the document indicated R30 made the document willingly and was thinking clearly and if R30's wishes changed, would complete a new health care directive. Additionally, the health care instructions directed the health care agent to communicate choices and the health care team to honor them, if R30 could not communicate or make her own choices. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's Resident Vaccine Administration Consent Form dated 10/1/24, indicated vaccines consented for included a check mark in the box next to influenza. In the box next to COVID-19 Vaccine/Booster appeared to be scribbled out and under the heading, Vaccines Declined, included a check mark in the box next to COVID-19 Vaccine/Booster. Next to the heading, Resident/Resident Representative's Signature, indicated the form was reviewed over the phone with FM. on 10/1/24. R30's physician progress notes dated 10/11/22 at 12:41 p.m., provided by the director of nursing (DON) on 11/7/24 at 11:06 a.m., indicated R30 had a rectovaginal fistula (an abnormal connection between the vagina and rectum) and wall thickening of the colon compatible with colitis (a disease that causes inflammation of the colon) and colonic diverticulosis (a condition where small pouches form in the large intestine). R30 was admitted to the hospital with acute (an illness that has a rapid onset but usually clears up) metabolic encephalopathy (a problem in the brain) likely secondary to rectovaginal fistula and colitis which were managed with antibiotics. Further, the note indicated R30 did not currently have the ability to make medical decisions for herself possibly due to acute encephalopathy and FM-A expressed concern over the past year R30 did not have the capacity to make medical decisions with progression of her memory issues. The note further indicated the next of kin would need to be involved for decisions. R30's hospital department of psychiatry follow up consultation note dated 3/16/23, indicated psychiatry was consulted to evaluate new visual hallucinations and was seen by neurology who felt the presentation was consistent with delirium. R30's diagnoses included acute encephalopathy that was improving, dementia with Parkinson's, history of major depressive disorder, borderline personality disorder, and seizure disorder. R30 was not currently demonstrating capacity and the note further indicated to involve next of kin for all decision making. The note further indicated R30 did not have visual hallucinations at baseline and at baseline, was social and enjoyed talking to people. R30 was admitted to the hospital for an acute perforated diverticulitis with associated abscess (a condition where a pouch in the colon ruptured, causing a hole in the bowel wall and a pocket of pus formed) and status post drain placement. R30's Associated Clinic of Psychology (ACP) noted dated 2/15/24, indicated R30 was clear cognitively. R30's ACP note dated 10/17/24, indicated R30 had verbal aggression toward FM-A because R30 felt FM-A was preventing her from receiving a vaccine. Additionally, the note indicated R30 was alert and oriented to person, place, and month. The note further indicated R30 clarified she did not need help with decisions, and was agreeable to the idea if she had others helping with health and financial decisions as necessary and feasible and staff were aware and working with FM-A regarding an alternate for decisions. Further, R30 felt strongly about voting and was receptive to potentially changing her decision making helper to a professional if an option as staff and sister have been discussing. R30's nurse practitioner ACP note dated 10/30/24, indicated R30 was alert and oriented, long term recall was adequate, and R30's short term recall was fair and did not want FM-A to be her power of attorney any longer and was planning to look into a non-family member assist with making decisions and managing her finances. Further, R30 was upset staff had to notify FM-A for everything. R30's progress notes dated 10/10/22 at 3:16 p.m., indicated R30 was sent to the hospital for altered mental status. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's progress notes dated 10/20/22 at 3:57 p.m., indicated severe cognitive impairment. R30's progress notes dated 10/31/22 at 5:03 p.m., indicated R30 was not feeling well and was sent to the hospital. R30's progress note dated 11/15/22 at 9:05 a.m., indicated R30 returned to the facility from the hospital due to a diagnoses of a fistula of vagina to the large intestine and had a new colostomy. R30's progress note dated 2/13/23 at 4:00 p.m., indicated R30 had intact cognition. R30's progress note dated 3/1/23, at 1:05 p.m., indicated R30's was doing well cognitively and family has seen improvement at times logic was impaired and was able to make her needs known. R30's progress note dated 3/8/23, at 5:30 p.m., indicated R30 had increased confusion and difficulty with communication. R30's progress note dated 3/9/23 at 1:45 p.m., indicated R30 was lethargic. R30's progress note dated 3/9/23 at 6:59 p.m., indicated R30 was sent to the hospital for an evaluation. R30's progress note dated 3/17/23 at 10:12 p.m., indicated R30 returned, had a JP drain, and was on antibiotics for an abscess. R30's progress note dated 3/20/23 at 3:48 p.m., indicated R30 returned to the facility on [DATE] from the hospital with abdominal pain and diverticulitis. R30's progress note dated 4/4/23 at 1:47 p.m., indicated R30's cognition fluctuated a lot and was her judgement and reasoning. R30's progress note dated 6/16/23 at 4:59 p.m., indicated R30 was sent to the hospital for evaluation. R30's progress note dated 6/22/23 at 2:56 p.m., indicated R30 returned from the hospital with a diagnosis of severe sepsis with shock from an abdominal abscess. R30's progress note dated 7/31/23 at 10:19 a.m., indicated R30 was not oriented to place and asked if she could go back to the care center. R30 has been confused in the past about where she is after returning from a hospitalization or appointment. R30's progress note dated 9/13/23 at 11:16 a.m., indicated R30 was in the hospital for a planned surgery. R30's progress note dated 10/6/23 at 9:02 p.m., indicated R30 returned to the unit and was stable with no pain, ate 100% had a wound vac. R30's progress notes dated 10/9/23 at 2:25 p.m., indicated R30 was admitted to the facility and R30's emergency contact was FM-A. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's progress note dated 10/9/23 at 4:16 p.m., indicated moderate cognitive impairment. R30's progress note dated 11/1/23 indicated severe cognitive impairment. R30's progress note dated 11/3/23 at 4:06 p.m., indicated R30 was recently diagnosed with pneumonia. R30's progress note dated 11/29/23 at 2:38 p.m., indicated R30's 48 hour care plan and summary was reviewed with FM-A. R30's progress note dated 12/28/23 at 4:55 p.m., indicated R30 tested positive for influenza A and the nurse received new orders for Tamiflu. R30's social services progress note dated 7/24/24 at 3:49 p.m., indicated R30 had intact cognition with no signs or symptoms of depression and R30 had a guardian. R30's nursing progress note dated 10/21/24 at 2:54 p.m., indicated R30 requested a COVID-19 vaccination and consent was obtained from the guardian via email and the vaccine was administered in the left arm. R30's social service progress note dated 10/23/24 at 4:16 p.m., indicated R30 was upset with FM-A and FM-A was looking into 3rd party guardian so FM-A was no longer the guardian. R30's progress note dated 10/29/24 at 3:17 p.m., indicated social services spoke to FM-A, resident's guardian who agreed to have R30 seen by in-house psychiatrist instead of going to the community. The progress notes lacked any re-evaluation following the acute illnesses whether R30 had the ability to make medical decisions. During interview on 11/4/24 between 2:19 p.m., and 2:39 p.m., R30 stated the facility contacted FM-A for a care conference, but nobody contacted R30. R30 stated she was upset the facility contacted FM-A and did not include R30 in decisions about her healthcare. R30 stated FM-A was her power of attorney (POA) and it was not working and R30 wanted to change that. R30 stated one of the nurses told R30 that FM-A did not want R30 to get the COVID shot and the next morning FM-A called and gave them her ok for R30 to receive the COVID shot which R30 stated should have been a given. R30 stated she informed social worker (SW)-A she was trying to change her POA and had also informed FM-A. During interview on 11/7/24 at 8:07 a.m., FM-A stated she was not R30's guardian, but was her POA and further stated R30 had gone to care conferences in the past, but has not gone recently and did not know why R30 had not gone to care conferences. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/7/24 at 8:17 a.m., social worker (SW)-A stated care conferences were held per the MDS schedule and held on Tuesdays and on Wednesdays for memory care. SW-A stated they typically send invitations to therapy, activities, nursing, and dietary and discuss medications, code status, appointments, activities, and funeral home. SW-A stated she calls or emails the guardian or family and the resident is notified and can choose if they want to come. SW-A further stated she would document a note under social services in the care conference note if a resident did not want to attend. SW-A stated they looked on the profile form to know if a resident was capable of making their own decisions. SW-A stated if a resident had a guardianship, the guardianship paperwork was scanned into the miscellaneous file and would be identified on the Profile form in the electronic medical record (EMR). SW-A stated a resident would have to go through the court for a guardianship and stated it was up to the family to complete a POA and stated she did not assist residents in completing paperwork, but instructs the family to fill it out and she provided a contact card for the notary. SW-A further stated FM-A was R30's POA and guardian, then stated FM-A was not R30's guardian after viewing the Profile form, and thought FM-A was working on becoming R30's guardian and R30 made her own decisions and FM-A respected her decisions. SW-A stated FM-A lived in another state and started the process for guardianship and added R30 did not attend care conferences, but she could ask her if she wanted to attend her care conference 11/8/24, and stated they didn't want to confuse anyone or upset them and further stated R30 had intact cognition and should have been asked if she wanted to attend care conferences and further stated they would have the POA sign consents if a resident had a POA, even if the resident was their own decision maker, and added she could not speak for nurses for consents. SW-A stated FM-A wanted to look into a third party guardianship and thought she contacted somebody from Minnesota and would get in contact with FM-A for the care conference 11/8/24, and stated it would be up to FM-A to make a determination whether R30 needed a guardian because the facility does not have anything to do with it and stated she would enter a note about FM-A wanting a 3rd party guardian. During interview on 11/7/24 at 8:43 a.m., the director of nursing (DON) stated SW-A scheduled care conferences quarterly and asks residents if they want to participate and documents a note in the care conference summary if a resident does not want to be present and stated if R30 hasn't been deemed incapacitated or incompetent should be invited to care conferences and sign consents. A policy was requested on resident rights and the DON stated they had a bill of rights they review upon admission. During interview on 11/7/24 at 1:34 p.m., the administrator stated they had no other documentation for incapacitation and were going off a document the DON sent in an email on 11/7/24 at 11:06 a.m. A form, Resident [NAME] of Rights Minnesota Nursing Home and Boarding Care Home, dated 12/4/2015, indicated residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. A policy, Care Planning-Interdisciplinary Team, dated 7/21/23, indicated the resident, the resident's family and or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan and every effort will be made to schedule interdisciplinary (IDT) care plan meetings at the best time of the day for the resident and family.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and record review, the facility failed to notify the physician of a change in condition for 1 of 1 resident (R18) who was experiencing new vision loss. Findings include: R18's 5-day Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of type II diabetes mellitus, hypertension (HTN), and congestive heart failure (CHF). It further indicated R18 had adequate vision and didn't wear corrective lenses. R18's care plan dated 4/1/24, indicated adequate vision, able to read 12 point font, and does not wear glasses with an intervention to observe for signs and symptoms of changes in visual status and to notify the medical doctor (MD) if noted. R18's visit summary note from his last eye exam dated 7/30/24, indicated to schedule an appointment with a local retinal specialist/ophthalmology as soon as possible (ASAP) for evaluation and treatment. R18's physician's orders dated 11/6/24, indicated R18 had an appointment on 11/21/24 at 9:00 a.m. to see the retina specialist. R18's progress notes for the begining of November (11/1/24-11/6/24) lacked documentation the physician had been notified or an appotinment had been made. During observation and interview on 11/04/24 at 1:11 p.m. R18 had a band-aid taped over some gauze on his right eye, stating he lost his vision yesterday, it had been happening for 3 weeks, and nobody had done anything. R18 further stated it was like he was looking through a red fog. During interview on 11/06/24 at 10:11 a.m. the assistant director of nursing (ADON) stated R18 came back from Dialysis on Monday (11/4/24) with a patch over his right eye, stating he needed to make an eye appointment because his eye was irritated. The ADON further stated she had asked him what happened but since R18 had come back from Dialysis with new orders and they hadn't sent him to the hospital (right from Dialysis) that she didn't feel it was a cause for concern. The ADON stated she didn't know if anyone had assessed his eye and she would expect the nurses on each shift, (especially the nurse who worked on Monday, unkown) to have looked at his eye, assessed it, and documented on it. The surveyor asked the ADON how they would determine if R18's injury was severe or was an emergency situation and the ADON responded that's a good question. The provider was walking out of the building on Monday and the ADON stopped her and stated R18's eye was irritated and he had an eye appointment scheduled (did not tell her the date), and was wondering if he was still able to go out into the community. The ADON verified she did not document anything about the incident or that she had notified the provider stating It was my fault, I should have put in a note. The ADON also verified none of the nurses had documented they had assessed R18's eye or notified the provider. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 11/6/24 at 12:46 p.m., R18 stated LPN-B put the eye patch/bandage on his eye on Monday (11/4/24) before he went to Dialysis and no one had looked at his eye or assessed it since then. It's bleeding inside and swirls of blood are coming into my sight, it's irritated, if I look into the light, it hurts. If I take the patch off my right eye, it screws up my vision in my left eye. The eye doctor had told him previously he had bleeders in both eyes but it wasn't that bad and his vision was still clear, but he should see a specialist to get a better scan. R18 stated his eye has been irritated for 3 weeks and felt like he had hair in his eyes. They (facility) was supposed to make another appointment in early September but they never did. During interview on 11/6/24 at 1:05 p.m., licensed practical nurse (LPN)-B stated R18 had the eye patch on before leaving for Dialysis on Monday (11/4/24). R18 told him he had the patch because the light was bothering his eye and the night nurse had put the eye patch/bandage on for him. LPN-B further stated he only applied more tape to the bandage because R18 stated the light was shining through it but didn't assess his eye or document on it. LPN also stated he looked in the physician's orders but he didn't see anything regarding R18's eye. During interview on 11/7/24 at 9:35 a.m. the doctor of Optometery (OD) stated R18 had bleeding in both eyes and it was getting very close to the macula. When the blood get's into the macula it can cause vision loss and at the time of the appointment his vision was 20/20 therefore it was very important to get him into the retina specialist to prevent that from happening. The OD stated that was why she indicated on the visit summary to make him an appointment ASAP stating she rarely puts ASAP for a follow up appointment but felt very strongly about it in this case. During interview on 11/7/24 at 9:50 a.m. registered nurse (RN)-A stated if a resident had a new injury/bandage, they would ask the resident what happened, remove the dressing/bandage to assess the area, notify the physician, and document it. During interview on 11/7/24 at 9:55 a.m. (RN)-C stated if a resident had a new injury or bandage/dressing, etc. they would ask the resident how it happened, remove the bandage, assess the area, document, and notify the nurse practioner (NP). During interview on 11/7/24 at 10:07 a.m., the Health Information Manager (HIM) stated she and one other staff HIM-B were responsible for scheduling appointments for residents. She further stated R18 came to her at the begining of the week (not sure what day, possibly Tuesday) and said he needed to see the eye doctor so she went to look for the documentation of last visit (with Healthdrive) and couldn't find it, so she called them to fax it to her. The HIM further stated she wasn't aware R18 was supposed to make a follow up appointment and the first time she heard about it was when R18 told her his eye was bothering him. Usually Healthdrive sends the documentation over after each appointment and there was no system in place to check and make sure the documentation was sent over. The surveyor asked the HIM why the appointment for the retina specialist was scheduled out a few weeks when the visit summary from the last eye appointment stated it should be made ASAP. The HIM verified she thought it indicated to schedule a follow up appointment in 1-2 months but verified she missed seeing that it actually said to schedule it ASAP. During interview on 11/7/24 at 12:15 p.m., the director of nursing (DON) stated if a resident had a change in condition or new injury/bandage the nurses were responbile for removing the bandage, assessing the area, try to find out how it happened, fill out a risk management, call the provider to receive further instruction, and doumen (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy on notification of a change in condition dated 3/2024, indicated it is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview, and document review, the facility failed to ensure residents were invited to care conferences for 1 of 1 resident (R30) reviewed for care planning. Findings include: R30's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have evidence of an acute change in mental status, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have physical, verbal, or other behaviors, was not important at all to have a family or close friend involved in discussions about care and had the following diagnoses: anemia, hypertension (high blood pressure), dementia, anxiety, depression, borderline personality disorder, and personal history of other mental and behavioral disorders. R30's Profile form in the electronic medical record (EMR) indicated R30's FM-A was her financial power of attorney (POA) and next to the heading, Power of attorney-care indicated, Do Not Use. R30's medical record was reviewed and lacked information R30 had a guardian. R30's care plan dated 11/16/22, indicated R30 was alert and oriented to person and sometimes place, but needed cues and reminders for time and had short-term memory loss and family assisted in decision making. Interventions indicated ACP (Associated Clinic of Psychology) provide brief instructions, repeat instructions as needed, explain all cares and procedures, if having trouble with word finding, take time to listen, observe for changes in cognitive status. R30's care plan dated 3/17/23, indicated R30 was able to ask questions and answer questions, was easily distracted, had difficulty with word finding and interventions indicated to allow R30 enough time to process and answer questions, ask yes or no questions, gain attention before talking, speak in simple and direct terms, and speak clearly and distinctly and adjust tone of voice. R30's care plan dated 11/28/23, indicated R30 required assistance in reading and understanding health documents and interventions included, family would read instructions, pamphlets, or other written materials, from doctors or pharmacies. R30's IDT (Interdisciplinary team) Care Conference form dated 2/12/24, 5/14/24, and 8/7/24, indicated FM-A attended the care conferences. The form lacked documentation R30 attended or declined to go to the care conference. R30's medical record lacked evidence R30 refused to go to care conferences, and documentation lacked evidence R30's participation in care planning was not practicable. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's Honoring Choices Minnesota Health Care Directive signed by R30 on 9/23/2019, indicated the document gave treatment choices and preferences, and or appointed a health care agent to speak on a person's behalf if a person cannot communicate or make their own health care decisions. R30 identified family member (FM)-A as her primary health care agent. The form indicated the health care agent had the following powers when R30 was not able to communicate for herself: agree to, refuse, or cancel decisions about her healthcare, interpret any instruction in the document based their understanding of R30's wishes, review and release medical records, arrange for healthcare and treatment, decide which health care providers and organizations provide healthcare, make decisions about organ and tissue donation. Further, the document indicated R30 made the document willingly and was thinking clearly and if R30's wishes changed, would complete a new health care directive. R30's ACP note dated 10/17/24, indicated R30 had verbal aggression toward FM-A because R30 felt FM-A was preventing her from receiving a vaccine. Additionally, the note indicated R30 was alert and oriented to person, place, and month. The note further indicated R30 clarified she did not need help with decisions, and was agreeable to the idea if she had others helping with health and financial decisions as necessary and feasible and staff were aware and working with FM-A regarding an alternate for decisions. Further, R30 felt strongly about voting and was receptive to potentially changing her decision making helper to a professional if an option as staff and sister have been discussing. R30's nurse practitioner ACP note dated 10/30/24, indicated R30 was alert and oriented, long term recall was adequate, and R30's short term recall was fair and did not want FM-A to be her power of attorney any longer and was planning to look into a non-family member assist with making decisions and managing her finances. Further, R30 was upset staff had to notify FM-A for everything. During interview on 11/4/24 at 2:39 p.m., R30 stated the facility contacted FM-A for a care conference, but nobody contacted R30. R30 stated she was upset the facility contacted FM-A and did not include R30 in decisions about her healthcare. During interview on 11/7/24 at 8:07 a.m., FM-A stated she was not R30's guardian, but was her POA and further stated R30 had gone to care conferences in the past, but has not gone recently and did not know why R30 had not gone to care conferences. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/7/24 at 8:17 a.m., social worker (SW)-A stated care conferences were held per the MDS schedule and held on Tuesdays and on Wednesdays for memory care. SW-A stated they typically send invitations to therapy, activities, nursing, and dietary and discuss medications, code status, appointments, activities, and funeral home. SW-A stated she calls or emails the guardian or family and the resident is notified and can choose if they want to come. SW-A further stated she would document a note under social services in the care conference note if a resident did not want to attend. SW-A stated they looked on the profile form to know if a resident was capable of making their own decisions. SW-A stated if a resident had a guardianship, the guardianship paperwork was scanned into the miscellaneous file and would be identified on the Profile form in the EMR. SW-A stated a resident would have to go through the court for a guardianship and stated it was up to the family to complete a POA and stated she did not assist residents in completing paperwork, but instructs the family to fill it out and she provided a contact card for the notary. SW-A further stated FM-A was R30's POA and guardian, then stated FM-A was not R30's guardian after viewing the Profile form, and thought FM-A was working on becoming R30's guardian and R30 made her own decisions and FM-A respected her decisions. SW-A stated FM-A lived in another state and started the process for guardianship and added R30 did not attend care conferences, but she could ask her if she wanted to attend her care conference 11/8/24, and stated they didn't want to confuse anyone or upset them and further stated R30 had intact cognition and should have been asked if she wanted to attend care conferences and further stated they would have the POA sign consents if a resident had a POA, even if the resident was their own decision maker, and added she could not speak for nurses regarding the consents nurses obtained. SW-A stated FM-A wanted to look into a third party guardianship and thought she contacted somebody from Minnesota and would get in contact with FM-A for the care conference 11/8/24, and stated it would be up to FM-A to make a determination whether R30 needed a guardian because the facility does not have anything to do with assisting with guardianship and stated she would enter a note about FM-A wanting a 3rd party guardian. During interview on 11/7/24 at 8:43 a.m., the director of nursing (DON) stated SW-A scheduled care conferences quarterly and asks residents if they want to participate and documents a note in the care conference summary if a resident does not want to be present and stated if R30 hasn't been deemed incapacitated or incompetent should be invited to care conferences and sign consents. A policy was requested on resident rights and the DON stated they had a bill of rights they review upon admission. During interview on 11/7/24 at 1:34 p.m., the administrator stated they had no other documentation for incapacitation and were going off a document the DON sent in an email on 11/7/24 at 11:06 a.m. A form, Resident [NAME] of Rights Minnesota Nursing Home and Boarding Care Home, dated 12/4/2015, indicated residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. A policy, Care Planning-Interdisciplinary Team, dated 7/21/23, indicated the resident, the resident's family and or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan and every effort will be made to schedule interdisciplinary (IDT) care plan meetings at the best time of the day for the resident and family.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation and interview, the facility failed to ensure swallow study referral discharge needs were identified in the post-discharge plan for 1 of 1 resident (R54) reviewed for discharge. Findings include: R54's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition and diagnoses of type one diabetes mellitus (DM1), dysphagia (difficulty swallowing), heart failure, hypertension, kidney disease and depression. R54 was on a therapeutic diet and active discharge planning was place. R54's Care Area Assessment (CAA) dated 9/25/24, identified functional abilities (self-care and mobility) was triggered. R54 was admitted with poorly controlled DM1, end stage renal disease on dialysis, dysphagia, weakness, and muscle spasms. Physical, occupational and speech therapy were to evaluate. R54 had a history of noncompliance with medications and was at risk for decline related to medication noncompliance and diabetic complications. R54's care plan dated 9/13/24, identified the goal was to return to the community once rehab was completed and medically stable. Interventions included staff would make necessary referrals as needed to carry out discharge goals. The care plan lacked intervention of R54 making her own post discharge appointments for a swallow study. R54's speech language pathologist (SLP) Evaluation and Plan of Care dated 9/13/24 through 10/12/24, identified R54 reported a swallow study was previously recommended, which has yet to be scheduled. Additionally, dysphagia was present and without skilled therapeutic intervention the patient was at risk for aspiration. Additionally, R54 lacked capacity for chronic disease management. R54's SLP Discharge Summary dated 9/13/24 through 9/25/24, identified she was referred for a swallow study and nursing would schedule the appointment. R54's SLP order dated 9/19/24, identified a swallow study was recommended for esophageal like symptoms. R54's progress notes dated 9/12/24 through 11/4/24, lacked documentation if the swallow study was scheduled, or if a discussion was held with R54 regarding any arrangements. R54's Care Conference Form dated 9/20/24, identified SLP worked on swallowing strategies, and a swallow study was recommended for follow up. The care conference had not addressed who would set up the swallow study. R54's progress note dated 9/26/24 at 1:56 p.m., identified she declined dialysis because while eating popcorn the night before, a hub got stuck in her throat, causing coughing to the point of vomiting. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's Discharge Instructions and Summary form dated 11/1/24 identified the reason for discharge was OT/PT (occupational and physical) therapy were completed and R54 was ready to discharge home with home care. Follow up appointments were included to see the primary doctor seven to 10 days after discharge. R54's corresponding Order Summary Reort dated 11/1/24, identified on 9/19/24, a swallow study was recommended but lacked identification of R54's needs related to making the appointment. During an interview on 11/6/24 at 11:13 a.m., R54 stated she was discharged recently but was not made aware of arrangements for her recommended swallow study. R54 stated the appointment should have been set up before she was discharged because she feels food gets stuck in her throat. R54 stated instructions or appointments for swallow study were not on her discharge paperwork. During an interview on 11/6/24 at 11:35 a.m., the therapy program manager (TPM) stated SLP evaluated and treated R54 while she was a resident of the facility, and a recommendation was made for a swallow up study. The TPM stated the order was given to nursing and would have expected the appointment to be scheduled. The order was placed on 9/19/24 and R54 discharged on [DATE], which was 45 days after the order was placed. During an interview on 11/6/24 at 11:46 a.m., licensed practical nurse (LPN)-A stated typically social services (SW)-A would coordinate the discharge planning and was not aware of any SLP referrals for swallow study. If there was one, it would be present on the discharge summary in the electronic health record (EHR). During an interview on 11/6/24 at 11:48 a.m., SW-A stated updates from therapy should be included in the discharge summary given to the patient along with any referrals. SW-A stated SW-B had managed R54's discharge and was not aware of the status of a swallow study. During an interview on 11/6/24 at 11:54 a.m., R54's home health care intake provider (HHC) stated they were not made aware of any referrals for a swallow study but could pursue one if needed. During an interview on 11/6/24 at 12:04 p.m., SW-B stated referrals would be documented on care conferences and discharge summary. SW-B stated she made home health referrals for physical and occupational therapy but not for swallow study. During an interview on 11/6/24 at 1:15 p.m., the SLP stated she made R54's recommendation on 9/19/24, for a swallow study because of esophageal dysphagia. The SLP reviewed R54's medical record and could not find documentation on the follow up arrangements for a swallow study. The SLP stated she would have expected nursing to set up the appointment while a resident to ensure safe swallowing. During a follow up interview on 11/6/24 at 2:00 p.m., LPN-A reviewed R54's medical record and stated the swallow study arrangements should have done while R54 was a resident. LPN-A added nursing would not schedule it, but the health unit coordinator would (HUC). During an interview on 11/6/24 at 2:41 p.m., the HUC stated when she gets an order for a referral, she puts it in the computer and nursing verifies the order. The HUC stated she would schedule appointments as needed. The HUC stated she thinks she remembers when the order was written and R54 was also scheduled to discharge, but she thought R54 would make the appointment independently. However, R54's medical record and discharge summary lacked instructions for R54 to do so. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 11/7/24 at 8:08 a.m., R54 stated she wanted the facility to help her schedule it as she was not aware how to do that. R54 denied stating she would make the appointment independently. During an interview on 11/7/24 at 12:00 p.m., the director of nursing (DON) stated outside referrals such as swallow studies should have instructions included on the discharge summary. The facility's Discharge Planning Policy dated 11/2016, identified a discharge planning would be coordinated is coordinated by the interdisciplinary team in cooperation with community resources. The discharge plan would provide the resident with needed care and services, and to work out an acceptable solution for all concerned. Discharge planning was done to assure continuity of care to meet the needs of a resident returning to independent living in the community.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 During observation, interview, and record review the facility failed to ensure that residents received proper treatment to maintain vision for 1 of 1 resident (R18) reviewed for vision services. Findings include: R18's 5-day Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of type II diabetes mellitus, hypertension (HTN), and congestive heart failure (CHF). It further indicated R18 had adequate vision and didn't wear corrective lenses. R18's care plan dated 4/1/24, indicated adequate vision, able to read 12 point font, and does not wear glasses with an intervention to observe for signs and symptoms of changes in visual status and to notify the medical doctor (MD) if noted. R18's visit summary note from his last eye exam dated 7/30/24, indicated to schedule an appointment with a local retinal specialist/ophthalmology as soon as possible (ASAP) for evaluation and treatment. R18's physician's orders dated 11/6/24, indicated R18 had an appointment on 11/21/24 at 9:00 a.m. to see the retina specialist. R18's progress notes for the begining of November (11/1/24-11/6/24) lacked documentation the physician had been notified or an appotinment had been made. During observation and interview on 11/04/24 at 1:11 p.m. R18 had a band-aid taped over some gauze on his right eye, stating he lost his vision yesterday, it had been happening for 3 weeks, and nobody had done anything. R18 further stated it was like he was looking through a red fog. During interview on 11/06/24 at 10:11 a.m. the assistant director of nursing (ADON) stated R18 came back from Dialysis on Monday (11/4/24) with a patch over his right eye, stating he needed to make an eye appointment because his eye was irritated. The ADON further stated she had asked him what happened but since R18 had come back from Dialysis with new orders and they hadn't sent him to the hospital (right from Dialysis) that she didn't feel it was a cause for concern. The ADON stated she didn't know if anyone had assessed his eye and she would expect the nurses on each shift, (especially the nurse who worked on Monday, unkown) to have looked at his eye, assessed it, and documented on it. The surveyor asked the ADON how they would determine if R18's injury was severe or was an emergency situation and the ADON responded that's a good question. The provider was walking out of the building on Monday and the ADON stopped her and stated R18's eye was irritated and he had an eye appointment scheduled (did not tell her the date), and was wondering if he was still able to go out into the community. The ADON verified she did not document anything about the incident or that she had notified the provider stating It was my fault, I should have put in a note. The ADON also verified none of the nurses had documented they had assessed R18's eye or notified the provider. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 11/6/24 at 12:46 p.m., R18 stated LPN-B put the eye patch/bandage on his eye on Monday (11/4/24) before he went to Dialysis and no one had looked at his eye or assessed it since then. It's bleeding inside and swirls of blood are coming into my sight, it's irritated, if I look into the light, it hurts. If I take the patch off my right eye, it screws up my vision in my left eye. The eye doctor had told him previously he had bleeders in both eyes but it wasn't that bad and his vision was still clear, but he should see a specialist to get a better scan. R18 stated his eye has been irritated for 3 weeks and felt like he had hair in his eyes. They (facility) was supposed to make another appointment in early September but they never did. During interview on 11/6/24 at 1:05 p.m., licensed practical nurse (LPN)-B stated R18 had the eye patch on before leaving for Dialysis on Monday (11/4/24). R18 told him he had the patch because the light was bothering his eye and the night nurse had put the eye patch/bandage on for him. LPN-B further stated he only applied more tape to the bandage because R18 stated the light was shining through it but didn't assess his eye or document on it. LPN also stated he looked in the physician's orders but he didn't see anything regarding R18's eye. During interview on 11/7/24 at 9:35 a.m. the doctor of Optometery (OD) stated R18 had bleeding in both eyes and it was getting very close to the macula. When the blood get's into the macula it can cause vision loss and at the time of the appointment his vision was 20/20 therefore it was very important to get him into the retina specialist to prevent that from happening. The OD stated that was why she indicated on the visit summary to make him an appointment ASAP stating she rarely puts ASAP for a follow up appointment but felt very strongly about it in this case. During interview on 11/7/24 at 9:50 a.m. registered nurse (RN)-A stated if a resident had a new injury/bandage, they would ask the resident what happened, remove the dressing/bandage to assess the area, notify the physician, and document it. During interview on 11/7/24 at 9:55 a.m. (RN)-C stated if a resident had a new injury or bandage/dressing, etc. they would ask the resident how it happened, remove the bandage, assess the area, document, and notify the nurse practioner (NP). During interview on 11/7/24 at 10:07 a.m., the Health Information Manager (HIM) stated she and one other staff HIM-B were responsible for scheduling appointments for residents. She further stated R18 came to her at the begining of the week (not sure what day, possibly Tuesday) and said he needed to see the eye doctor so she went to look for the documentation of last visit (with Healthdrive) and couldn't find it, so she called them to fax it to her. The HIM further stated she wasn't aware R18 was supposed to make a follow up appointment and the first time she heard about it was when R18 told her his eye was bothering him. Usually Healthdrive sends the documentation over after each appointment and there was no system in place to check and make sure the documentation was sent over. The surveyor asked the HIM why the appointment for the retina specialist was scheduled out a few weeks when the visit summary from the last eye appointment stated it should be made ASAP. The HIM verified she thought it indicated to schedule a follow up appointment in 1-2 months but verified she missed seeing that it actually said to schedule it ASAP. During interview on 11/7/24 at 12:15 p.m., the director of nursing (DON) stated if a resident had a change in condition or new injury/bandage the nurses were responbile for removing the bandage, assessing the area, try to find out how it happened, fill out a risk management, call the provider to receive further instruction, and doument. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy regarding ancilliary appointments was requested but not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure resident was adequately assessed for safe smoking for 1 of 1 resident (R15) reviewed for smoking. In addition, the facility failed to ensure an identified safety hazard was acted upon for 1 of 2 residents (R50) reviewed for resident to resident abuse. Findings include: R15's PPS (prospective payment system) Part A-Minimum Data Set (MDS) dated [DATE], indicated R15 was cognitively intact, was independent or required supervision with most activities of daily living (ADLs), used intermittent oxygen therapy, and required a wheelchair for mobility. R15's diagnoses included hereditary motor and sensory neuropathy (nerve condition causing tingling, swelling or muscle weakness), and chronic respiratory failure. R15's care plan last updated prior to survey start on [DATE], indicated R15 smoked independently, agreed to wear a smoking apron, and required smoking material to be stored in the treatment cart. The care plan further indicated a smoking incident occurred on [DATE] and instructed staff to complete a smoking evaluation per facility policy and as needed. R15's smoking assessment dated [DATE], indicated R15 was safe to smoke independently, could keep cigarettes and lighter in room, did not require adaptive equipment (smoking apron), and did not use oxygen. R15's smoking assessment dated [DATE], indicated R15 was safe to smoke independently, could keep cigarettes and lighter in room, and used oxygen. The assessment further indicated, Resident had old clothes with holes. Resident has agreed to throw away any clothes with holes .and remove items with burn holes . Resident understands that if new burn holes are seen cigarettes/lighter will be locked and will need to wear a smoking apron. R15's smoking assessment dated [DATE], indicated R15 was not deemed safe to store/handle cigarette and lighter and used oxygen. The assessment further indicated, Resident had lit a cigarette in her room .While observing resident on [DATE] at one time and ash dropped from her cigarette onto her sweater. Writer had to tell her it was there .Cigarettes/lighter will be locked in the nurse cart. She needs to wear a smoking apron, has to ask the nurse for her cigarettes and lighter each time she goes out and return them to the nurse when she comes in. R15's electronic health record (EHR) lacked evidence of any additional smoking assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on [DATE] at 9:12 a.m., R15 was lying in bed and was not wearing oxygen. The oxygen tank was not turned on. R15 stated having an incident a couple weeks ago when she lit up a cigarette in her room upon waking but put it out right away. R15 stated she was confused upon waking and did not have her oxygen on at that time and was independent with her oxygen use, which was primarily overnight. R15 stated staff evaluated her ability to smoke safely when she admitted in February and could not recall another evaluation until October when they found burn holes in her clothing. During interview on [DATE] at 9:58 a.m., R15 stated staff just recently watched her smoke and saw that she dropped some ash on her sweater. R15 stated she also had several burn holes in her clothing but could not say when the burn holes happened. R15 stated, they want to make sure I don't burn the place down or burn myself so now they hold onto my cigarettes and lighters, and I put this apron on before I can get them from the nurse cart. During interview on [DATE] at 10:11 a.m., registered nurse (RN)-A stated R15's cigarettes were stored in the cart and that R15 had to have the apron on prior to retrieving. RN-A stated social services performed the smoking assessments to determine if the residents were safe to smoke, but did not know how often those assessments occurred. During interview on [DATE] at 10:22 a.m., social work (SW)-A stated all residents were assessed on admission for smoking status and if they identified as a smoker then social services would complete a smoking assessment. SW-A further stated additional smoking assessments were completed by social services quarterly, with significant change and as needed. SW-A stated R15 had an assessment on admission and was identified as a safe smoker and did not have another assessment until [DATE] when they identified burn holes in her clothing. SW-A stated another assessment was completed after a smoking incident on [DATE] when R15 lit a cigarette in her room. SW-A stated during that assessment, R15 was observed dropping ash on her sweater and therefore, an apron was then required. SW-A further stated R15 should have had two additional quarterly smoking assessments between admission and [DATE], and that they could not determine when the burn holes had occurred. During interview on [DATE] at 10:43 a.m., assistant director of nursing (ADON) stated smoking assessments were completed upon admission, quarterly and as needed. ADON stated R15 recently had a smoking incident and had burn holes identified and observed with shaky hands and dropping ash on her clothing. ADON stated they took her smoking materials away to be stored in the cart and provided a smoking apron. ADON confirmed R15 lacked two quarterly smoking assessments and could not identify when the burn holes had occurred. During interview on [DATE] at 10:56 a.m., director of nursing (DON) stated residents were assessed upon admission by the admission nurse and that the smoking assessment included observation to determine if the resident was safe to smoke independently and hold their own material. DON stated social services would follow up with additional assessments and ensure appropriate interventions were in place and care plan up to date. DON stated the expectation was that smoking assessments were completed on admission, quarterly and with significant changes. Facility policy Resident Smoking Policy dated ,d+[DATE], indicated, Residents who choose to smoke will be evaluated upon admission, quarterly, annually and if significant change in condition/cognition exists or resident exhibits inability to follow safe smoking practices. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46885 R50's annual Minimum Data Set (MDS) dated [DATE], indicated moderate cognitive impairment, and prior Brief Interview for Mental Status (BIMS) indicated intact cognition, did not have hallucinations or delusions, physical, verbal, or other behaviors directed towards others, did not reject care, had a motorized wheelchair, and had depression, alcohol use with intoxication, nicotine dependence, and took antipsychotics, antianxiety, and antidepressant medications. R50's Medical Diagnosis form undated, indicated the following diagnoses: major depressive disorder, recurrent, severe with psychotic symptoms, nicotine dependence, alcohol use with intoxication, and depression unspecified. R50's care plan dated [DATE], indicated R50 became frustrated and overwhelmed at times on the smoking patio with others and knew to call the nurse on-call in this situation. R50's care plan dated [DATE], indicated R50's safety would be protected through staff interventions that included R50 to report to staff if feeling threatened or bothered by other residents and or staff, remove R50 from potentially abusive situations, provide a safe environment for individual and others and ensure the safety of others, and if R50 displayed persistent or inappropriate behaviors, remove R50 to an area away from others. R50's care plan dated [DATE], indicated R50 had a behavior problem due to a diagnoses of depression, dementia and had a judgment or reasoning deficit and could be irritable at times and make comments about others especially when R50 felt disrespected and will tell others they are rude and inconsiderate and will attempt to defend others when R50 feels they are being disrespected especially female staff and residents and was in a resident to resident altercation ,d+[DATE]. Interventions included not to argue with resident and encourage R50 to come to staff when upset. R50's care plan dated [DATE], indicated R50 could easily become agitated by noise and environment and required redirection as able. An intervention included to redirect resident as needed from environment that can upset him. R50's care plan dated [DATE], indicated R50 had psychosocial issues and impaired coping mechanisms due to depression, judgement or reasoning deficit and became upset when other residents do not keep the smoking area clean and interventions dated [DATE], indicated to remind resident he does not need to clean the smoking area, and R50 has the on-call nurse number to call when he is upset with what other residents are doing or saying on the patio and agreed to call the number when upset. R50's care plan dated [DATE], indicated R50 was at risk for alterations in behavior related to trauma including resident to resident altercation and triggers included when people say dumb stuff and are rude. R50's care plan dated [DATE], indicated R50 had a history and diagnosis of substance use and interventions indicated monitoring R50 for intoxication or impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R50's nursing progress note dated [DATE] at 9:58 a.m., indicated a nurse reported when attempting to change R50's catheter, R50 stated, If you mess it up, I will kill you. R50 then refused catheter change and wanted a male nurse to complete. The director of nursing (DON) followed up with R50 who stated he did not mean what he said and was just kidding. R50's interdisciplinary team (IDT) progress note dated [DATE] at 12:08 p.m., indicated R50 had a resident to resident incident on [DATE]. R50 was outside smoking and heard another resident (R71) who was intoxicated make sexually inappropriate comments to other female residents and staff. R50 asked multiple times for R71 to stop and R50 rammed his wheelchair into R71. The two residents were separated by a visitor. The note further indicated R50 had been easily agitated. R50's social services progress note dated [DATE] at 4:46 p.m., indicated R50 was instructed he could not tell people to leave the smoking area and felt he needed to clean the area all the time and the assistant director of nursing (ADON) came in and explained to R50 he had to allow others to use the smoking area and to ignore the residents. R50 became upset and was not able to be redirected. R50's social services late entry progress note created on [DATE] at 7:24 p.m., for [DATE], indicated social worker (SW)-A followed up with R50 regarding smoking on the patio and provided R50 a nurse on call phone number and directed R50 to call the nurse on call if he had concerns with other residents and R50 stated he would do this moving forward rather than approaching other residents himself. R50's Incident Review and Analysis form dated [DATE], indicated on [DATE] at 8:40 p.m., R50 had a resident to resident altercation. R50 was outside smoking and overheard R71 being vulgar and inappropriate towards another resident and R50 became frustrated and asked R71 to stop. When R71 did not stop, R50 used his wheelchair to sit in front of R71. R50 continued to tell R71 to stop and R71 began threatening R50. R50 then wheeled his chair into R71's chair causing R71 to move backwards. Under a heading, Contributing Factors that Impacted Incident, included, Easily irritable. R50 reported feeling safe and did not want to file a police report. R50's Trauma Questionnaire form dated [DATE], at 9:24 a.m., indicated R50 had trauma that occurred after another resident made inappropriate comments and reported his triggers included when people said dumb stuff and were rude. R50 was not comfortable disclosing any coping strategies and allowing the strategies to be included with his plan of care. R50's nurse practitioner (NP) progress note dated [DATE], indicated when R50 was first admitted to the facility had frequent complaints, issues with compliance, and impulsivity and has less behavioral issues. Further R50's seroquel (antipsychotic) was decreased slightly in September and R50 was drinking heavily for a couple of weeks in September and had an altercation with another resident. The note indicated R50's cognitive impairment seemed more mild and had no significant mood disturbance and planned to continue tapering Seroquel very slowly, and R50's brief excessive drinking appeared to be resolved. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 5:53 p.m., R50 stated R71 made the most profane remarks. R50 further stated R71 hasn't tried to do anything after the incident, except yell at him and give him the finger and stated he noticed R71 was back to smoking in the smoking area again. R50 stated R71 was not going to change and stated he tried to stay away from R71, but if R71 started again, R50 stated he would either call the nurse on call or if it becomes like last time will call 911. R50 stated he told SW-A he had a flashlight in case anybody tried to hit him and he could not get away, otherwise planned to call the nurse and 911. During interview on [DATE] at 6:35 p.m., R15 stated R71 was showing up outside after he was banned and nobody liked it. During interview on [DATE] at 6:59 p.m., SW-A stated there was an interaction in the smoking area where R50 pushed R71 and was determined R71 would smoke in the front to avoid altercations from happening and there had been no further incidents, and R71 could smoke in the back again and R50 was aware. SW-A stated R50 showed her the flashlight the other day and they tried to take it away, but R50 wanted it as protection and SW-A stated they reminded R50 there were nurses that could come down and instructed R50 to remove himself from the situation. SW-A stated R50 would not allow her or the assistant director of nursing (ADON) to take the flashlight. SW-A verified there was no mention of the flashlight in the care plan and stated R50 told them about the flashlight on [DATE], and they asked R50 to please not use it and keep it in his room and stated it should be on the care plan. SW-A stated she would have to talk with the ADON whether she changed the nurse aide sheets because SW-A did not touch those forms. SW-A stated R71 started going on the smoking patio again on [DATE]. Further, SW-A stated they wanted to take the flashlight out of the room for safe keeping so R50 wouldn't hurt anyone, but R50 refused and R71 was on a leave of absence. During interview on [DATE] between 2:45 p.m., and 2:52 p.m., with the administrator, SW-A, and the director of nursing (DON), the DON stated R50 had the flashlight in case the lights went out or if out on a leave of absence. At 2:52 p.m., the DON stated she did not know why the facility would want to take a flash light and kept emphasizing it was a flashlight and stated they didn't take it and R50 did not make any threat of violence. SW-A verified notes from interview [DATE], they wanted to take the flashlight away. When asked why take the flashlight away if there were no concerns, they did not provide a response and the DON stated she thought R50 wanted the flashlight in case of an emergency. During interview on [DATE] at 3:04 p.m., the DON stated she clarified with R50 and R50 stated he would rather she take the flashlight than think he had bad intentions and stated residents could smoke in the back or the front and stated both residents had no restrictions on smoking and stated they gave guidance on where to smoke and those had been lifted and further stated R50 and R71 avoid each other and did not hang out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 10:30 a.m., the certified occupational therapy assistant (COTA)-J stated he had been working in this building since [DATE], and had worked in previous facilities prior. COTA-J stated he did not know the process for when residents were evaluated for safety with power wheelchairs and was not familiar with R50 and stated occupational therapy (OT) completed the power chair screens. COTA-J stated for power wheel chair screens they look at whether a patient was the right size for the chair and not falling out and for safety wise, looked at whether a resident could control the wheelchair and get in safely and a resident's mental capacity and whether a resident was going to race through hallways or adjust the wheelchair so they weren't going too fast, and was not sure if they would conduct an assessment if a resident used a power chair purposefully to run into somebody and would have to ask their director of rehab. COTA-J viewed therapy notes and stated R50 had no OT notes. During interview on [DATE] at 10:44 a.m., nursing assistant (NA)-G stated she worked at the facility 5.5 years and stated the hearsay was R71 was drinking and rude to the women and R50 told him to stop and rammed into R71's chair. NA-G stated R50 sometimes states R71 is rude to ladies but does not associate with R71. During interview on [DATE] at 10:50 a.m., nursing assistant (NA)-F stated she worked at the facility for two years and was not aware R50 had a flashlight. During interview on [DATE] at 10:56 a.m., the assistant director of nursing (ADON)-F stated prior to the incident, everyone smoked on the back patio and after the incident with R50 and R71, the plan was R71 would smoke in the front and R50 still smoked in the back and when things died down they approached R50 and R71 to see if both were ok with going to the smoking patio and both seemed ok with no concerns so they went back to smoking in the same area and have not heard any issues, but was aware R71's alcohol use bothered R50. ADON-F further stated she and SW-A spoke with R50 on [DATE], because R50 was telling people they could not smoke and R50 was very upset and they didn't want R50 to get into another resident to resident incident. R50 was upset so she left and went back and R50 was calm and stated he would let the nurse know if he was bothered. ADON-F stated she was directed by the DON to provide the on-call phone number for the nurse and R50 agreed to use if he was feeling mad or overwhelmed. ADON-F stated they had a live camera outside, but other than that did not know it was safe for R50 and R71 to smoke together again and stated R50 was only bothered by R71 when R71 was drunk. ADON-F stated she did not think OT assessed R50 after the incident and reviewed the Power Operated Vehicle policy that indicated the resident will be expected to complete an assessment with OT upon presentation of a power operated vehicle (POV) at the facility. Updated assessments may be required annually or more often as determined by a change of condition, or incident related to operating POV. ADON-F stated R50 should have had an assessment completed according to the policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 8:52 a.m., the director of nursing (DON) stated every conversation they had was for lighting and R50 never mentioned physically using the flashlight on anyone. Further, was told ADON-F and SW-A went in to talk to R50 about a smoking plan and did not know where the conversation led and stated R50 was upset and had a flashlight in his hand and was told they asked if they could hang on to the flashlight, and R50 did not say he was going to use it to harm anyone and did not know why they were trying to take it because he was using it for light purposes. Further, the DON stated the wheelchair policy indicated if an incident occurred additional evaluations may be required and stated it wouldn't be appropriate because R50 had the dexterity and could drive the POV and further stated they discussed it as a team and decided no additional assessment was needed and stated she would have to check where that information was documented and stated it might be in the OHFC file and stated IDT discussions were documented in the chart of OFHC file and no where else. An email from the DON sent on [DATE] at 11:06 a.m., indicated there was documentation R50 was not appropriate for an OT assessment on a daily follow up check list and the facility did not have a policy pertaining to resident safety. During interview on [DATE] at 1:34 p.m., the administrator provided a form, [DATE] Follow Up, that indicated to complete the POV form and that no OT was needed as per discussion in stand up.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure supplemental oxygen was properly maintained and accurately documented per professional standards for 1 of 1 resident (R20). Findings include: R20's significant change Minimum Data Set (MDS) dated [DATE], indicated R20 had intact cognition and the following diagnoses: pulmonary embolism (a blockage in the lung artery) without acute cor pulmonale (enlarged right ventricle due to a lung condition), enterocolitis due to clostridium difficile, and unspecified dyspnea. R20's Physician Orders form indicated the following orders: 8/26/24, monitor for skin breakdown around the nose and behind the ears caused by oxygen tubing every shift. 8/27/24, and discontinued on 10/29/24, staff to follow enteric contact precautions (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) due to C. Difficile (a bacteria that causes infection of the colon) every shift. 8/30/24, and discontinued on 10/2/24, oxygen sats 2 liters every shift for maintaining oxygen saturations at 88% or above and wean oxygen as able. 9/1/24, change oxygen tubing weekly every night shift every Monday. 10/2/24, oxygen sats 2 liters every shift for hypoxia wean oxygen as able, maintain oxygen saturations at 88% or above. R20's medication administration record (MAR) and treatment administration record (TAR) dated September 2024, indicated the following: 8/27/24, to 10/29/24, Staff documented they were following contact precautions due to C. Difficile (a bacteria that causes infection of the colon) every shift. R20 was on 1 to 2 liters of oxygen 28 out of 30 days. R20's oxygen tubing was documented as changed on the night shift on 9/2/24, 9/9/24, 9/16/24, 9/23/24, and 9/30/24. R20's MAR and TAR dated October 2024, indicated the following: Staff documented they followed contact precautions due to C. Difficile from 10/1/24, to 10/29/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20 was on 2 liters of oxygen 31 of 31 days. R20's oxygen tubing was documented as changed on the night shift on 10/7/24, 10/14, 24, 10/21/24, and 10/28/24. R20's MAR and TAR dated November 2024, saved on 11/4/24 at 4:40 p.m., indicated the following: R20 was on 2 liters of oxygen for 4 of 4 days. R20's care plan dated 11/13/22, indicated R20 had frequent bladder incontinence and was occasionally incontinent of the bowel and required brief changes. R20's care plan dated 9/9/24, indicated R20 had an altered respiratory status and difficulty breathing due to pulmonary edema. During observation on 11/4/24 at 1:33 p.m., R20 was on 2 liters of oxygen in her room and the sticker on the tubing was dated 9/3. The tubing had not been signed off as changed in the MAR/TAR as of 4:42 p.m. During observation on 11/5/24 at 9:23 a.m., R2's oxygen tubing still contained the tape that indicated a date 9/3. During interview and observation on 11/5/24 at 9:34 a.m., registered nurse (RN)-A stated oxygen tubing was changed weekly when a resident used oxygen and further stated they sometimes dated the tubing and the order was also in the computer to change weekly. At 9:38 a.m., RN-A verified the oxygen tubing plugged into the oxygen unit contained a piece of tape and stated the tape was dated 9/3/24, and thought the extension and nasal cannula tubing was supposed to be changed weekly. During interview on 11/5/24 at 1:53 p.m., the assistant director of nursing (ADON) stated oxygen tubing should be changed weekly and dated with the date the tubing was changed and the old tubing discarded and further stated it was on the TAR and expected the nasal cannula and extension tubing to be changed and stated staff should document in the TAR once they changed the tubing. ADON stated staff should not have signed off they completed the task in the TAR because it was false documentation and was also important to change for infection control. A policy on respiratory care was requested. An email from the director of nursing (DON) dated 11/6/24 at 9:22 a.m., indicated they did not have a policy on oxygen tubing, but followed batch orders that instructed staff to change the tubing weekly. Additionally, they did not have a policy on accurate documentation and expected nurses follow orders and document accurately and if not completed, would follow the corrective action procedure. During interview on 11/7/24 at 8:50 a.m., the DON stated she expected staff to follow orders and not document if something was not completed and further stated she completed corrective action with their nurse and added the other nurse was an agency nurse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP) were implemented with the use of personal protective equipment (PPE) during high-contact resident care activities for 1 of 1 residents (R39) who had a central line, 1 of 1 residents (R38) who had wound dressings changed, and 1 of 3 residents (R11) observed during personal cares. The facility also failed to ensure appropriate hand hygiene was utilized for 1 of 2 residents (R38) observed during personal cares, and failed to ensure shared resident equipment was disinfected between uses for 1 of 1 residents (R3) observed for shared equipment. Lastly, the facility failed to ensure re-usable ice packs for clinical use were stored separately from food storage in 3 of 3 kitchen refrigerators. Findings include: R39's admission Minimum Data Set (MDS) dated [DATE], identified intact cognition, no rejection of care or behaviors, partial/moderate assistance needed for upper body dressing and supervision for personal hygiene. Diagnoses included extradural and subdural abscesses and type two diabetes mellitus. Injections and antibiotics were received 7/7 days. R39's functional abilities Care Area Assessment (CAA) worksheet dated 10/20/24, identified a history of infection following lumbar spine surgery which required intravenous (IV) antibiotics. The surgical site became reinfected and required additional surgery. Then, he was admitted to the facility on IV antibiotics, wound care and peripherally inserted central catheter (PICC) line (long, thin tube that's inserted through a vein in the arm and passes through to the larger veins near the heart, requires careful care and monitoring for complications, including infection) care. R39's care plan dated 10/17/24, identified contact precautions were in place due to VRE (vancomycin-resistant enterococci which is resistent to antibiotics, in lumbar area due to abscess. The care plan was marked as resolved on 10/25/24. There was no care plan in place for EBP until 11/4/24. R39's orders identified: 10/16/24, flush line (PICC) with 10 milliliters (mL) of normal saline prior to IV drug administration daily. 10/15/24, PICC/midline monitor site, location left arm every shift for s/s of infection and infiltration every shift. 10/21/24, PICC/midline change dressing location left arm using sterile technique weekly and as needed. 10/15/24, complete infection nurses note and document what antibiotics, how long, why, symptoms, side effects, effectiveness every day shift until 11/20/24. There were no orders for EBP until 11/4/24 at 11:00 p.m. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/4/24 at 12:50 p.m., R39's door lacked EBP signage or nearby PPE. R39 was in bed and awake. A PICC line with dressing was observed on his left upper arm. He stated he got IV antibiotics through the PICC line, and he had not noticed staff wearing a gown while providing this care. During an observation on 11/4/24 at 1:50 p.m., registered nurse (RN)-D prepared to give R39 his IV antibiotic. RN-D performed hand hygiene, entered the room, put gloves on, used an alcohol wipe to clean the port of the PICC line and flushed the line with 10 mL of normal saline. He attached the antibiotic to the PICC line and opened (unclamped) the line to start the infusion. RN-D also assisted R39 to put on his back brace. RN-D had not worn a gown in accordance with EBP. During a follow up interview on 11/4/24 at 2:04 p.m., RN-D was not immediately sure if a gown was required for R39 high-contact cares since there was no signage or PPE bin outside. However, he added, he should have due to the PICC line. During an observation and interview on 11/5/24 at 1:52 p.m., R39's door had EBP signage and PPE organizer on the door. EBP signage directed staff to wear gloves and a gown for high-contact resident care activities including dressing, bathing, transfers, hygiene, incontinence care, and device care including lines, catheters, tubes tracheostomy and wound care. The PPE organizer contained gloves and gowns. RN-E prepared to give R39 his IV antibiotic. RN-E performed hand hygiene, entered the room, put gloves on, opened an alcohol wipe to clean the port of the PICC line, said he was going to start the IV antibiotics, and was stopped by surveyor and asked if EBP were required. RN-E initially had not known what EBP stood for and exited the room to check the orders. RN-E re-entered the room and came back with a gown, put it on and then put on gloves. R39 asked RN-E what the gown was for, and it was explained it was for IV site care and flushed the line with 10 mL of normal saline. RN-E attached the antibiotic to the PICC line and opened the line to start the infusion. After RN-E exited the room he stated for PICC line care staff needed EBP PPE on, he explained he had not thought of it today. 22580 R38 EBP R38's significant change MDS dated [DATE], indicated R38 had moderate cognitive impairment, was dependent on staff for personal cares, and received hospice services. R38's diagnoses included dementia, mood disturbance, anxiety, and adult failure to thrive. R38's care plan updated 4/8/24 indicated R38 required enhanced barrier precautions (EBP) related to a foley catheter and history of ESBL/MRSA [extended-spectrum beta-lactamase (an enzyme that make bacteria resistant to many antibiotic)]/methicillin-resistant Staphylococcus aureus (a type of staph bacteria that is resistant to many antibiotics)]. R38's provider orders dated 6/5/24, indicated, Follow EBP while providing wound cares and other high contact care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 11/7/24 at 8:15 a.m., R38's door had EBP signage on door and PPE organizer outside the door. EBP signage directed staff to wear gloves and a gown for high-contact resident care activities including dressing, bathing, transfers, hygiene, incontinence care, and device care including lines, catheters, tubes tracheostomy and wound care. The PPE organizer contained gloves, masks and gowns. Doctor of Medicine (MD)-A (rounding wound doctor) entered R38's room. MD-A was wearing a mask, and applied gloves, but did not don a gown. MD-A observed R38's coccyx wound , and bilateral heels. MD completed an ultra sound mist treatment to R38's heel, removed her gloves, washed her hands and left the room. Interview on 11/7/24 at 8:30 a.m., MD-A indicated she missed the sign on the door that indicated R38 was on Enhanced Barrier Precautions., and indicated if she would have seen the sign, she would have put a gown on. R38 Hand Hygiene R38's significant change MDS dated [DATE], indicated R38 had moderate cognitive impairment, was dependent on staff for personal cares, and received hospice services. R38's diagnoses included dementia, mood disturbance and anxiety, and adult failure to thrive. R38's care plan updated 4/8/24 indicated R38 required enhanced barrier precautions (EBP) related to a foley catheter and history of ESBL/MRSA [extended-spectrum beta-lactamase (an enzyme that make bacteria resistant to many antibiotic)]/methicillin-resistant Staphylococcus aureus (a type of staph bacteria that is resistant to many antibiotics)]. During observation on 11/6/24 at 7:43 a.m., Trained medication assistant (TMA)-A washed R38's rectal area, changed her gloves, but did not perform hand hygiene. TMA -A repositioned R38 in bed and removed her gloves and left the room. Interview on 11/06/24 at 07:58 a.m., TMA-A indicated that she should have used hand sanitizer or washed her hands after removing her gloves. Shared Equipment During observation on 11/6/24 at 9:10 a.m. TMA -A and nursing assistant (NA) - A transferred R3 into bed with a Hoyer lift (a lift that helps caregivers safely transfer patients from chair to bed). TMA-A removed the lift from R3's room into the spa room, and walked away. Interview on 11/6/24 at 9:21 a.m., TMA-A stated the lift should be cleaned when brought out of a resident's room, and left the spa room. TMA-A returned to the spa room at 9:30 a.m. and proceeded to clean the lift with wipes that were in the bag on the back of the lift. 42584 R11 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's quarterly MDS dated [DATE], indicated R11 had severe cognitive impairment, was frequently incontinent of bowel and bladder, and was dependent on staff for personal cares. R11's diagnoses included dementia, cerebral atherosclerosis (a condition causing plaque buildup in the arteries and decrease blood flow to the brain), and reduced mobility. R11's care plan updated 11/1/24, indicated R11 had a stage II pressure ulcer on sacrum and required enhanced barrier precautions (EBP) related to the wound. The care plan instructed staff to don/doff [put on/take off] PPE per [EBP] when providing high contact cares. R11's provider orders dated 11/1/24, indicated, Follow EBP while providing wound cares and other high contact care activities. During observation on 11/5/24 at 12:55 p.m., nursing assistant (NA)-B and NA-C wheeled R11 into her room to transfer back to bed and complete a brief change. Signage for EBP and all appropriate PPE observed on R11's door. Both NA-B and NA-C donned gloves, but neither donned a gown. R11's sling was attached to the Hoyer lift and R11 was lifted up and transferred to bed. R11's pants removed, and brief checked and found to have bowel movement (BM). Brief removed and dressing noted over the sacral wound. NA-B completed peri care wiping R11's bottom up to and including the bottom edge of the dressing. A new brief placed. R11 positioned and tucked in bed for a nap. During interview on 11/5/24 at 1:16 p.m., NA-B stated was not sure what the signage meant or if it was for R11 or her roommate. NA-B stated did not think he needed to wear a gown for peri care on R11. During interview on 11/5/24 at 1:23 p.m., NA-C stated EBP was for residents with a catheter or wound and that staff need to gown and glove when caring for those residents. NA-C stated R11's precautions must be new this week and did not notice the signage or PPE on her door. NA-C further stated he and NA-B should have donned gowns while performing cares on R11 since she had a wound. 42586 R35's annual MDS dated [DATE], indicated intact cognition and diagnoses of chronic kidney disease (CKD) and type II diabetes. It further included R35 required staff assistance with activities of daily living, mobility, had a catheter and was frequently incontinent of bowel. R35's care plan dated 4/1/24, indicated R35 was currently on EBP related to a wound and foley catheter. It further included the following interventions: -staff to follow EBP -explain reason for and use of EBP -staff to don (put on)/doff (take off) personal protective equipement (PPE) when providing high contact cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 11/04/24 at 3:02 p.m., R35 put on his call light and the assistant director of nursing (ADON)- entered the room. R35 stated he wanted to be boosted up in bed. The ADON applied gloves and assisted him to roll onto his left side, adjusted his brief, assisted him to roll onto his back, and pulled the trapeze bar down and handed it to him. R35 then used the bar to boost himself up in bed. The ADON then removed her gloves and left the room. The ADON was not wearing a gown while assisting R35. During interview on 11/4/24 at 3:13 p.m., the ADON verified she was not wearing a gown when assisting R35 with cares and was only required to wear a gown for catheter and wound care stating R35's order indicated he only need to be on enhanced barrier precations (EBP) for catheter and wound care. The ADON also stated EBP was specific to what each resident had for instance if a resident had a wound staff only needed to follow EBP when caring for the wound. During interview on 11/7/24 at 9:38 a.m., nursing assistant (NA)-C stated if a resident was put on EBP, staff were required to wear a gown and gloves when performing any personal cares. During interview on 11/7/24 at 9:45 a.m., NA-E stated staff were supposed to wear a gown, gloves, and a mask when performing cares on a resident who is on EBP. During interview on 11/7/24 at 9:50 a.m., RN-A stated when a resident was on EBP, staff were required to wear gloves and a gown for all personal cares. During interview on 11/7/24 at 10:00 a.m. RN-C stated staff are supposed to wear gown and gloves when performing any type of cares for a resident on EBP. 51577 Ice packs During observation on 11/5/24 at 9:45 a.m., the resident freezer in the third-floor kitchenette contained a reusable blue ice pack. It was touching residents' labeled containers of food. A sign posted on the refrigerator indicated for resident food only. During observation on 11/5/24 at 9:50 a.m., the resident freezer in the second-floor kitchenette contained a blue reusable ice pack, touching residents' labeled items. A sign posted on the refrigerator indicated for resident food only. When interviewed 11/5/24 at 10:00 a.m., registered nurse (RN)-B stated ice packs were not supposed to be in freezer in kitchenettes, and stated there was a freezer for residents' ice packs in the nursing office. Reusable ice packs were not supposed to be with food for infection control reasons. (RN)-B removed the ice pack from the freezer. During observation on 11/5/24 at 10:13 a.m., the resident freezer in the first-floor kitchenette contained multiple blue reusable ice packs. The ice packs were touching residents' frozen labeled items including ice cream and containers of food. A sign posted on the refrigerator indicated for residents' food only. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 11/5/24 at 10:15 a.m., nursing assistant (NA)-D stated ice packs should not be stored in the freezer. At 10:17 a.m., the culinary director (CD)-G entered the kitchenette, removed the reuseable blue ice packs swiftly out of the freezer, and stated they didn't belong there, and stated there was medication freezer for the ice packs. When interviewed on 11/6/24 at 10:29 a.m., director of nursing (DON) stated the reusable ice packs should be stored separately in the medication room freezers and not freezers in the kitchenettes due to infection control concerns, and they expected all staff to know and follow this procedure. During an interview on 11/7/24 at 12:00 p.m., the director of nursing (DON) stated EBP should always be utilized for high-contact resident care activities for residents that meet the requirements, for infecton control purposes, and to help prevent the spread of multi-drug resistent organisms, and signage with directions including the needed supplies should be in place to assist with staff compliance. The DON stated hand hygiene should be completed between glove changes during major cares such as incontinence care. Shared resident equipment such as transfer lifts should be cleaned between uses, and have the disinfectant wipes in a bag on the lifts. The facility's EBP policy dated 4/1/24, defined EBP as the implementation of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at increased risk of MDRO acquisition (for example residents with wounds or indwelling medical devices). Indwelling medical devices included central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, and wounds including chronic owund ssuch as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers. Review of Monarch Healthcare Management Handwashing Policy dated 2/2024 directed staff: When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on interview and document review the facility failed to ensure 2 of 5 residents (R5 and R20) were offered and/or provided updated vaccinations for pneumococcal disease in accordance with the Centers for Disease Control (CDC) vaccination recommendations. Findings include: R5's Resident Information form dated 11/7/24, identified she was admitted on [DATE], and was currently [AGE] years old with diagnoses which increased the risk of pneumococcal disease including chronic obstructive pulmonary disease, heart failure and history of acute respiratory failure. R5's undated Immunizations form identified the PCV-13 and PPSV23 were given on 2/23/15. R5's vaccine consent form dated 9/7/24, identified she consented to receive the pneumococcal vaccines per primary care provider order and CDC guidelines. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 9/12/24, identified based on R5's age and vaccine history: though the vaccines were considered complete, based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. R5's medical record lacked a discussion of shared clinical decision making regarding additional pneumoccocal vaccines. R20's Resident Information form dated 11/7/24, identified she was admitted [DATE], and was currently [AGE] years old with diagnoses increasing the risk of pneumococcal disease including pulmonary embolism, dyspnea (difficulty breathing), chronic heart failure and obstructive sleep apnea. R20's vaccine consent form dated 11/12/22, identified she already had the PPSV23 and PCV-13 but there was a question mark by the date. R20's undated Immunizations form identified no history of the pneumococcal vaccinations. R20's medical record lacked follow up regarding declination or administration of the pneumococcal vaccines. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 9/12/24, identified based on R20's age and vaccine history: give one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 12:00 p.m. the director of nursing (DON) who was also the infection preventionist, stated shared clinical decision making for additional pneumococcal vaccines was not completed with R5 because her vaccines were considered complete according to the Minnesota Immunization Information Connection (MIIC). The DON had not reviewed the vaccines in accordance with updated CDC recommendations. The DON stated no one had followed up to verify R20's vaccine history and should have. The facility's Pneumococcal Policy dated 2/2024, identified the current practice was to offer all residents the vaccines to aid in the prevention of pneumococcal/pneumonia infections. Within 30 days of admission, the resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. If the immunization status was unknown, staff would contact the physician to determine record of immunization status or verify using MIIC. The facility would refer to the current CDC Recommended Adult Immunization Schedule.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure a multi-resident shower room ceiling exhaust fan was cleaned. This had the potential to affect all residents on the third floor who used the shower room. Findings include: R71's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition. A Monthly Deep Clean Schedule form undated, indicated the 3rd floor long-term care north and south unit spa/bathrooms were deep cleaned on day 6 of the month. A Deep Clean Calendar dated October 2024, indicated spas were scheduled to be cleaned on 10/6/24. A November 2024 Deep Clean Calendar form was not provided. A procedure, undated, Deep Clean Procedures, indicated to check the posted deep clean schedule and clean the scheduled deep clean room. Further, the procedure directed staff to wipe the top and all sides of heating units and check top vents for accumulation of dust or other debris for resident rooms and to use a high duster to clean vents in restrooms. During interview and observation on 11/4/24 at 12:09 p.m., R71 stated he previously worked as a janitor and staff should dust the vents in the room by the window. R71's vent in the room contained dark colored debris and gray particles hanging off the grates and vent and R71 stated the common shower room vent was worse. During observation on 11/4/24 at 12:54 p.m., the shower room located across from room [ROOM NUMBER] had a vent on the ceiling that was coated with gray debris and some of the debris was hanging off of the vent. During interview and observation on 11/7/24 at 9:02 a.m., social worker (SW)-A stated it was maintenance's responsibility to clean the vents and viewed the vent on the ceiling in the community shower room on the third floor and stated it looked like it contained lint or dust and stated there was a lot of it and thought it was possible it had been there more than a couple of months and further stated they used to have another maintenance person who covered the building and would check with M-A or M-B to see when it was last cleaned. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview and observation on 11/7/24 at 9:13 a.m., maintenance (M)-A stated he worked for the facility for [AGE] years and stated vents were cleaned monthly when they changed the filters and vents on the ceiling were cleaned by housekeeping. M-A stated this was a new company and further if they deep cleaned, cleaning was done when people were moved and housekeeping completed the shower room deep cleaning. M-A viewed the vent in the 3rd floor shower room and stated it was an exhaust fan and when residents showered, the room became a rain forest and stated the vent had been wetter than wet and it looked like there was fuzzy fuzz on the vent and did not know how long it had been there and then checked the light fixture for dust, which did not contain any and stated that was housekeeping's responsibility and added they would get that cleaned up. During interview on 11/7/24 at 9:32 a.m., housekeeping (H)-A stated she had been at the facility since 7/2024 and stated the shower room was cleaned daily from top to bottom and included dusting, cleaning mirrors, the sink, toilet, and stated the vents, grab bars, and shower head were all cleaned daily. During interview on 11/7/24 at 9:37 a.m., H-B stated shower rooms were cleaned daily as part of a routine as well as if needed and entailed the showers, tubs, toilets, sink, stocking, sweeping, mopping and dirty linen. H-B stated they did a deep cleanings monthly. At 9:42 a.m., H-B stated staff should have looked at the vent as part of a daily cleaning and expected the vent to be cleaned. A policy for cleaning schedules for deep cleaning and daily cleaning was requested. During interview on 11/7/24 at approximately 10:57 a.m. M-A stated he cleaned the bathroom exhaust fan in the 3rd floor shower room and had not spoken to the administrator. During interview on 11/7/24 at 11:03 a.m., with the administrator, a policy or check list for daily cleaning was requested.