STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emeralds at St Paul LLC	420 Marshall Avenue Saint Paul, MN 55102

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842 Based on observation, interview and document review the facility failed to perform a self-administration of medication assessment and obtain provider order to have medication left in room and self-administered for 1 of 1 (R46) resident reviewed for self-administration of medication. Findings included, R46's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R46 was cognitively intact. Diagnoses included renal insufficiency5 diabetes, and Asthma. R46's care plan undated, indicated R46 chose to self-administer Arnuity Ellipta Aerosol Powder Breath Activated 200 MCG/ACT (Fluticasone Furoate) and PRN Proventil HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA). All other medication would be administered by nursing. R46's Self Administration of Medication Evaluation form dated 5/25/23 indicated R46 was approved to self-administer inhalation meds-meds taken orally by breathing in the medication. R46's Order Summary dated 5/23/24 indicated an order written on 8/15/23 okayed R46 to self-administer inhalation medications. During an observation on 5/20/24 at 3:38 p.m., R46's had a bottle of [NAME] lotion on the window seal, next to the bed. A follow up observation on 5/22/24 at 2:36 p.m., the bottle of [NAME] lotion was still on window seal. During an interview on 5/22/2024 at 2:37 p.m., licensed practical nurse (LPN)-A, if a resident was approved for meds at bedside and self-administer then there would be a notification in the mediation administration record (MAR) letting staff know. LPN-A confirmed R46's [NAME] lotion was kept at bedside and used for the daily orders. LPN-A reviewed the MAR and reported there was nothing in the MAR that showed R46 could keep and self-medicate the [NAME] lotion. LPN- A then walked down a different hallway, opposite the direction of R46. During an interview on 5/23/24 at 11:32 a.m. the pharmacy consultant stated they were unsure what requirements were needed for a resident to self-administer medication and keep it at bedside. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 11:59 a.m., registered nurse (RN)-A stated if medications were to be left at resident bedside there needed to be a self-administration of medication assessment (SAM) and a provider order to leave at bedside. RN-H stated R46 did not have a SAM or orders to self-administer or leave [NAME] lotion at bedside. During an interview on 5/23/24 at 2:00 p.m., the director of nursing (DON) stated and expectation the nurse would observe the medications given to R46 and then would return the medications to the medication cart unless a SAM and order were in place. Facility policy Self-Administration of Medication last revised 2/24, indicated a resident could self-administer medication if the SAM determined that self-administration was clinically appropriate.

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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** 42580 Based on observation, interview, and document review, the facility failed to ensure a physician was notified of elevated blood glucose results for 1 of 1 resident (R20) reviewed who had specific physician's orders with parameters for physician notification of high blood glucose results. Findings Include: R20's admission Minimum Data Set (MDS) dated [DATE], indicated R20 was cognitively intact, did not exhibit rejection of care during the assessment period, and diagnosis included diabetes mellitus and peripheral vascular disease. R20 also received insulin seven days during the assessment period. R20's care plan printed 5/22/24, indicated a focus for potential for alteration in blood sugar related to diagnosis of diabetes with history of refusing blood sugar checks, and medications. Goals included R20's blood sugar would be maintained between 60 and 120. Interventions included resident and family education provided and to monitor resident for signs/symptoms of hyperglycemia and hypoglycemia. R20's face sheet printed 5/22/24, indicated R20's diagnosis included type 2 diabetes mellitus with ketoacidosis without coma and epilepsy without status epilepticus (a seizure with 5 minutes or more of continuous clinical and/or electrographic seizure activity or recurrent seizure activity without recovery between seizures). R20's physician order dated 5/3/2024, indicated blood sugars: notify nurse practitioner or physician if two blood glucose results are <75 or >350 in a 24 hour period and/or condition change, before meals and at bedtime related to related to type 2 diabetes mellitus with ketoacidosis without coma. R20's medication administration record (MAR) for 5/2024, indicated the following blood glucose readings: 5/9/24, evening blood glucose result was 594. 5/10/24, evening blood glucose was 450; bedtime blood glucose was 418. 5/11/24 evening blood glucose was 420; bedtime blood glucose was 460. 5/12/24, evening blood glucose was 368. 5/13/24 morning blood glucose was 440; evening blood glucose was 385. 5/14/24, morning blood glucose was 387; evening blood glucose was 591; and bedtime blood glucose was 369. 5/15/24, night blood glucose was 375. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/16/24, evening blood glucose was 400 and bedtime blood glucose was 400. 5/17/24, morning blood glucose was 393; evening blood glucose was 434. 5/18/24, morning blood glucose was 357; evening blood glucose was 450; and bedtime blood glucose was 436. 5/20/24, evening blood glucose was 482. 5/21/24, evening blood glucose was 400. R20's progress notes dated 5/9/24, indicated BG >500, 5 units one time given per nurse practitioner (NP). R20's progress notes lacked documentation the physician was updated on the other dates indicated above, when R20's blood glucose results were elevated. R20's physician regulatory visit progress notes dated 5/17/2024, indicated type 2 diabetes mellitus with other circulatory complications. Multiple diabetic ketoacidosis (DKA, a life-threatening problem that affects people with diabetes. It occurs when the body starts breaking down fat at a rate that is much too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic) episodes: 12/26/23, 1/15/24, and 2/18/24. Also, with hypoglycemic episode on 4/7/24. Endocrinology was consulted. R20's physician progress notes printed 5/24/24, indicated R20 was hospitalized [DATE] - 2/22/2024, for evaluation of elevated blood sugar. During interview on 5/22/24 at 8:23 a.m., nurse manager, registered nurse (RN)-A stated R20 refused cares and medications often, however staff should have notified the provider with blood glucose results that were elevated per the physician orders. RN-A explained the facility utilized the nursing agency on the evening shift often and as a result the physician notification was not being completed for R20. RN-A also clarified as the nurse manager they were responsible to monitor R20's elevated glucose level and to ensure physician was updated per R20's physician order. R20's nurse practitioner was called on 5/22/24 at 8:48 a.m., with message left with answering service staff, however a return call was not received. During interview on 5/22/24 at 1:55 p.m., the director of nursing (DON) stated nursing staff should have notified the provider per the physician order with R20's elevated blood glucose results. DON further clarified that the agency staff also viewed the providers' orders when they on duty and were expected to follow the physician orders as prescribed. The facility policy on physician notification was requested but not received.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to provide a homelike environment for 1 of 1 residents (R65) reviewed who had enteral feeding liquid spilled on the bottom of the tube feeding pump pole and on the floor. Findings include: R65's significant change Minimum Data Set, dated dated dated [DATE], included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, had a diagnosis of traumatic brain injury, and indicated they had a feeding tube through which they received more than 50% of their nutrition. During observation and interview on 5/20/24 at 2:13 p.m., R65 was lying in bed in their room with tube feeding running and their representative present. The tube feeding pump was attached to a pole, the base of which was covered in more than 50 drips of tube feeding liquid nutrition. The floor under the base of the pole had an area approximately12 inches by 6 inches covered in tube feeding liquid. R65's representative stated the tube feeding mess bothered them and they were frustrated by the lack of cleanliness. During observation on 5/21/24 at 9:30 a.m., and 2:29 p.m., the tube feeding pump pole and floor were soiled as previously described. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated housekeeping staff cleaned the floor daily, but if nurses spilled something they cleaned it up at that time. They stated if they noticed the tube feeding equipment was not clean, they would clean it themselves. During interview on 5/21/24 at 2:50 p.m., housekeeper (HSK)-A stated housekeeping cleaned floors in the residents' rooms five days per week, and they had just finished R65's room, however housekeepers was not responsible for cleaning the poles. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated housekeeping cleaned the floors and the poles because they used a special spray to help remove any stuck-on substances. RN-C viewed the floor and tube feeing pump pole in R65's room, verified they needed to be cleaned, and indicated they would not leave it in that state in their own home. During interview on 5/22/24 at 12:56 p.m., director of nursing stated staff should ensure the pole and floor are clean each time they change the feeding equipment, and if they could not remove any soiled areas, notify housekeeping. They expected spills to be cleaned, and indicated the drips and spills were not conducive to a homelike environment. In an email dated 5/22/24, the administrator indicted the facility did not have a policy regarding homelike environment or cleaning of resident equipment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to develop a comprehensive resident-centered care plan with resident-specific target symptom monitoring and resident-specific interventions for 1 of 5 residents (R72) reviewed for unnecessary medications. Findings include: R72's quarterly Minimum Data Set (MDS) dated [DATE], indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs). MDS indicated R72 had non-traumatic brain dysfunction, respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing), and depression. R72's MDS indicated she had no hallucinations, no delusions and had exhibited no verbal or physical behaviors. R72's MDS indicated she received an antidepressant medication. R72's Care Area Assessment (CAA) for cognitive loss and dementia dated 10/24/23, indicated she had moderate cognitive impairment. R72's Care Area Assessment (CAA) for psychosocial well-being dated 10/24/23, indicated she had moderate depression as evidenced by her score on an assessment scale for depression. The CAA indicated R72 reported difficulty with sleep and feeling tired. The CAA indicated R72 declined additional services offered by the facility, including psychological services. R72's CAA for mood dated 10/24/23, was triggered but lacked additional data. The CAA lacked documentation of R72's specific target symptoms staff would monitor and failed to identify what, if any, non-pharmacological interventions were effective. No CAA for psychotropic medication use was triggered. R72's orders included the following: - Sertraline hydrochloride (HCl) oral tablet (Zoloft); Give 100 mg via gastrostomy (G)-Tube in the morning for depression, dated 2/16/24. - Target Behavior Monitoring (Specify Target Behaviors): Non-Pharmacological, Document # of those Interventions used: 0: N/A, 1: Redirection, 2: Ambulate, 3: Offer Activity, 4: Essential Oils, 5: Reposition, 6: Toileting, 7: Provide 1:1, 8: Offer food/fluids, 9: Offer pain relief every shift for Offer prior to PRN Psychotropic medications If Target Behavior was observed. Select chart other and enter findings in the Nursing Progress Notes. Dated 5/22/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Target behavior monitoring (specify target behaviors): Non-pharmacological, Document # of those Interventions used: 0: N/A, 1: Redirection, 2. Provide re-assurance, 3: Offer Activity, 4: Essential Oils, 5: Reposition, 6: Provide 1:1, 7: Offer pain relief. Dated 5/23/24. R72's treatment administration record (TAR) for May 2024 revealed no behavior monitoring was documented for 5/1/24 through 5/22/24. R72's care plan dated 10/19/23, indicated she had an alteration in her mood and behavior related to her respiratory failure and depression. The care plan indicated she was prescribed the medication sertraline and identified a goal of responded to interventions by staff to calm and redirect. Interventions included medications per provider order, inform the provider of changes in R72's mood state, approach R72 in a calm manner and provide her with choices as able, and remove from crowded area if she becomes anxious. The care plan also identified R72's alteration in psychosocial well-being related to her depression and respiratory failure. The care plan identified interventions of explaining new routines and tasks to avoid confusion and monitoring for changes in her mood to meet R72's psychosocial needs. The care plan also identified R72's potential for adverse drug reactions related to her daily use of psychotropic medication dated 2/8/24. The care plan lacked resident-specific target symptom monitoring and resident-specific interventions, including non-pharmacologic interventions. A behavior monitoring log dated 4/29/24 - 5/28/24, revealed documentation of either none noted or not applicable for the entirety of the 30-day lookback period. The behaviors identified on the monitoring log lacked resident-specific target symptoms. A review of progress notes dated 1/22/24 - 5/22/24 lacked documentation of behaviors or interventions. A review of the nursing assistant care sheet lacked documentation of R72's target symptoms or behaviors and resident-specific interventions or non-pharmacologic interventions, unless contraindicated. During interview on 5/23/24 at 11:08 a.m., registered nurse (RN)-D stated for residents receiving psychotropic medications, there is a spot to document behaviors on the TAR. RN-D was unable to locate any target behaviors for R72 in her TAR. RN-D stated nurses could also document behaviors in a progress note. RN-D stated behaviors R72 exhibited included grimacing, flushing of the face, and rapid breathing. During interview on 5/23/24 at 11:23 a.m., RN-C stated for residents taking psychotropic medications, the documentation requirements would be listed in the resident's TAR. RN-C stated if a staff person was documenting an intervention in the TAR, there would be a prompt to re-evaluate and document the effectiveness. RN-C stated the expectation for nurses was to document on the TAR and for nursing assistants (NA) to report back to their charge nurse. RN-C stated non-pharmacologic interventions should be documented in the TAR and stated they should be listed on the NA care sheets. During interview on 5/23/24 at 1:26 p.m., the director of nursing (DON) stated residents on psychotropic medications were expected to have resident-specific interventions and symptom monitoring in place if they were receiving psychotropic medications. Furthermore, the DON stated staff were expected to documented behaviors and whether interventions were effective. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Psychotropic Medication Use dated 7/28/21, indicated psychotropic medications included antidepressants, anti-anxiety mediations, stimulants, antipsychotics, mood stabilizers and other medications. The policy indicated the interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy guided the interdisciplinary team and the provider to identify, evaluate and document symptoms that may warrant the use of psychotropic medications as well as pertinent non-pharmacological interventions that must be attempted, unless contraindicated, and documented.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on interview, observation and document review the facility failed to ensure diagnostic standards of practice were followed for 1 of 1 resident (R24) who was newly diagnosed with schizophrenia. Findings include: The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) guidelines dated 2013, identified to be diagnosed with schizophrenia, a person must have two or more of the following symptoms occurring persistently in the context of reduced functioning: delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms. Additionally, continuous symptoms should have persisted for at least six months including one month of active phase symptoms listed above. The National Alliance on Mental Illness (NAMI) schizophrenia information page dated 2024, identified although schizophrenia could occur at any age, the average age of onset tended to be in the late teens to the early 20s for men, and the late 20s to early 30s for women. It was uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40. R24's face sheet dated 5/23/24, identified age of [AGE] years and a diagnosis of schizophrenia added on 5/2/24. R24's annual Minimum Data Set (MDS) dated [DATE], identified severely impaired cognition, no behaviors, psychosis, or rejection of care. Diagnoses included bipolar disorder in full remission and non-Alzheimer's dementia. R24 required total dependence with transfers, extensive assistance with bed mobility, and was independent with eating after set-up. No diagnosis of schizophrenia was identified on the MDS. R24 took an antipsychotic medication daily. R24's previous quarterly MDS's dated 12/6/23, 9/6/23 and 6/6/23, identified no behaviors, psychosis, or rejection of care and no diagnosis of schizophrenia. R24's mood state Care Area Assessment (CAA) dated 3/5/24, identified the Patient Health Questionnaire (PHQ-9) was completed with a score of 10/27 which indicated moderate depression. R24's mood was affected by acute illness and room change. R24 had diagnoses of dementia, mood disorder, and bipolar disorder. R24 had scheduled Seroquel (antipsychotic medication) daily and participated in group activities. R24's psychotropic medication CAA dated 3/5/24, identified a potential for adverse effects from Seroquel 50 milligrams (mg) three times daily (TID), and escitalopram (antidepressant medication) 30 mg daily related to bipolar disorder. R24 had not shown any adverse effects of the medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's care plan dated 1/19/24, identified a risk for alteration in mood and behavior related to diagnoses of dementia, behavioral disturbance, bipolar disorder, adjustment disorder with mixed and depressed mood. Target behaviors included anxiety as evidenced by distracted thoughts and fast speech. R24 needed constant reassurance from staff. R24 would occasionally not use her call light and instead would scream for help. R24 had a history of suicidal ideations thoughts of self-harm such as statements of God take me now. Interventions included: provide emotional support, validation, and comfort measures as needed, keep call light within reach and answer promptly as this promoted reassurance. R24's order dated 6/13/23, identified Seroquel oral tablet, give 50 mg by mouth TID for dementia related to bipolar disorder in full remission, most recent episode manic. R24's Consultant Pharmacy (CP) Recommendation to Physician form dated 2/26/24, identified clarification was needed due to diagnosis of dementia related to bipolar disorder, which was not considered an appropriate diagnosis for antipsychotic medication. Acceptable diagnoses may include schizophrenia/schizoaffective disorder/schizophreniform disorder, Tourette's disorder, or Huntington's disease, or attempt a gradual dosage reduction (GDR) if clinically appropriate. Medical doctor (MD)-A from Associated Clinic of Psychiatry (ACP) signed the form and schizophrenia/schizoaffective disorder/schizophreniform diagnosis was circled. Interview with MD-A was attempted on 5/22/24 at 10:36 a.m., and 5/23/24 at 8:38 a.m., with no return call received. R24's ACP Diagnostic assessment dated [DATE], identified psychological testing was completed and bipolar disorder, current episode mixed, moderate, and adjustment disorder, with mixed anxiety and depressed mood were the diagnostic impressions. R24's ACP visit notes dated 12/14/23 through 5/2/24, lacked documentation of two or more of the symptoms of schizophrenia occurring persistently in the context of reduced functioning in accordance with DSM-5. R24's Follow Up Question Report (behavior documentation task) dated 1/23/24 through 5/22/24, lacked documentation of two or more of the symptoms of schizophrenia occurring persistently in the context of reduced functioning in accordance with DSM-5. During an observation and interview on 5/20/24 at 4:42 p.m., R24 was seated in her wheelchair by the main entrance desk and well groomed. Various staff conversed with her as they walked by. R24 was smiling and in good spirits and displayed no behaviors. During an observation and interview on 5/21/24 9:09 a.m., R24 was in bed, well groomed, stated she was looking forward to bingo today. R24 was smiling and in good spirits and displayed no behaviors. During an observation on 5/22/24 at 10:30 a.m., R24 was up in her wheelchair, well groomed, and conversing politely with other residents and staff. R24 was smiling and displayed no behaviors. During an interview on 5/21/24 at 9:11 a.m., nursing assistant (NA)-C stated she worked with R24 routinely and the only behavior noted was not using the call light appropriately. Otherwise, R24 was easy to get along with and easily redirected. If behaviors occurred, they would be charted in the Follow Up Questions task. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 3:52 p.m., NA-B stated she worked with R24 routinely and her mood was stable, the behaviors she observed were not using call light appropriately and occasional crying, however she was easily redirected and had not interfered with preferred activities. If behaviors occurred, they would be charted in the Follow Up Questions task. During an interview on 5/22/24 at 10:17 a.m., registered nurse (RN)-A stated she worked with R24 routinely and knew her well. Behaviors included crying if her family had not called, however she was easily redirected with activities and R24 liked to be around people. RN-A stated R24's mood was stable. During an interview on 5/22/24 at 10:00 a.m., the social services designee (SSD) stated she worked with R24 routinely and knew her well. R24 had no persistent behaviors but was known to cry and might make a statement such as God take me now, however was easily redirected with activities and 1:1. R24 especially liked bingo and could keep track with the game despite her dementia. During an interview on 5/23/24 at 10:10 a.m., the director of nursing (DON) stated resident behaviors were charted in ACP visit notes and Follow Up Questions. For appropriate diagnoses the facility would refer to providers, the CP would also make recommendations to ensure compliance with the Center for Medicare and Medicaid Services (CMS) regulations. The DON stated MD-A recently diagnosed R24 with schizophrenia, however, could not locate an assessment or rationale, only the CP form signed 5/2/24, with the diagnosis circled. The DON stated antipsychotics were considered a high-risk medication and required a thorough review. During an interview on 5/23/24 at 10:28 a.m., the facility medical director (MD)-B stated a person was not usually diagnosed with schizophrenia later in life such as age 77 and the diagnosis would usually go along with persistent delusions and hallucinations. MD-B would refer to a psychiatrist for appropriate assessment and diagnostic criteria. During an interview on 5/23/24 at 11:31 a.m., the CP stated diagnostics were not her specialty, therefore she would refer that to the providers based off CMS standards. It was important to ensure antipsychotics were used for the essential indications. During an interview on 5/23/24 at 2:30 p.m., ACP therapist social services (SS)-A stated she worked with R24 for about one year and was familiar with symptoms of schizophrenia but had not observed any in R24. SS-A reviewed the medical record and stated R24 had some psychosis symptoms on 3/7/24, however it was ruled out by a urinary tract infection. R24's main symptoms were depressed mood related to bipolar disorder. On 5/28/24, a letter from MD-A dated 5/23/24, was provided which indicated a diagnosis of schizophrenia was made after an episode of paranoid psychosis which occurred last month. Additionally, R24's diagnosis was bipolar 1 disorder, however, it appeared as if the paranoid psychosis was not due to an exacerbation of manic or depressive symptoms. The letter indicated schizoaffective disorder described R24's symptoms more accurately than bipolar 1 disorder. However, a review of R24's medical record lacked description of the described symptoms and in accordance with the DSM-5. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated policy titled Psychotropic Medication Use, identified the Interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. Diagnosis of a specific condition for which psychotropic medications were necessary to treat would be based on a comprehensive assessment of the resident. Antipsychotic medications should generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms (e.g., neoplastic disease or delirium) and/or treatment-related psychosis or mania (e.g., high-dose steroids); h. Tourette's Disorder; i. Huntington Disease; j. Hiccups (not induced by other medications); or k. Nausea and vomiting associated with cancer or chemotherapy. l. Behavioral or psychological symptoms of dementia (BPSD) that present a danger to the resident or others. The facility policy had not matched the recommedations from the CP based on CMS regulations.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were available for 1 of 2 residents (R64) reviewed for activities. Findings include: R64's annual Minimum Data Set (MDS) dated [DATE], identified he was rarely/never understood. No behaviors or rejection of care occurred. Diagnoses included traumatic brain injury and respiratory failure. The family interview identified it was very important to listen to preferred music and do preferred activities. R64's communication Care Area Assessment (CAA) dated 10/30/23, identified R64 rarely understood and had not spoken or used gestures due to a brain injury. R64 may have been able to hear staff voices but was not able to respond. R64's quarterly MDS dated [DATE], identified no behaviors or rejection of care. R64 was totally dependent on staff for all activities of daily living. R64's care plan dated 9/15/23, identified there was an alteration in socialization and potential for activity deficit. R64 was fully dependent on staff to anticipate his needs. Per family member (FM)-A, R64 enjoyed listening to healing traditional Native American music and staff were directed to turn on the television (TV) in his room to listen to this and for programs of interest. R64's therapeutic recreation (TR) visit log dated 2/5/24 through 5/14/24, identified facetime calls were completed with R64 and FM-A, and identified when he was awake, emotional, happy, and sometimes cried. The logs lacked listening to healing traditional Native American music as an intervention. The TR log also indicated there was a sign in R64's room with music he liked. During an observation on 5/20/24 at 11:53 a.m., R64 was awake in bed with the television on playing the news. R64 turned his head when spoken to but was unable to respond to questions. A sign on the wall indicated to intermittently put on Native American YouTube or flute music to clear negative energy. Registered nurse (RN)-A was in the room, provided cares, exited the room, and had not asked R64 if he wanted anything different on the TV. During an interview on 5/20/24 at 2:43 p.m., R64's family member (FM)-A stated she placed the sign on the wall for native American YouTube or flute music for him. FM-A stated she was not sure how often R64 was involved in preferred activities. During an observation on 5/20/24 at 4:31 p.m., R64 was up in his wheelchair with the same news channel on. R64 was asked by surveyor if he wanted to watch the news and he had no reaction. R64 was asked by surveyor if he liked Native American shows and flute music and he smiled. During an observation on 5/21/24 at 9:13 a.m., R64 was awake in bed with the television on the same news channel. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 3:48 p.m., nursing assistant (NA)-A stated he was unsure how to tell what a resident's preferred activities were if they were unable to talk. During an interview on 5/21/24 at 3:52 p.m., NA-B stated R64 had a sign on his wall to put on native American music or shows but she was unsure how to do that on the TV. NA-B stated she did not think R64 could voice any preferences. During an observation on 5/21/24 at 3:54 p.m., R64 was awake in bed and turned his head when spoken to. R64's television was off. Surveyor asked R64 if he wanted the TV on, and he smiled. During an observation and interview on 5/22/24 at 2:42 p.m., R64 was awake in bed. The TV was on the menu screen and no shows were on. Registered nurse (RN)-A stated she knew R64 since his admission almost two years ago, and he sometimes made a face like crying and knew he was in pain, otherwise, was unsure how much he comprehended. RN-B also entered the room and cares were provided. After cares were provided RN-A and RN-B were asked by surveyor how to turn on Native American YouTube shows or flute music, and RN-A stated his TV lacked that capability, and she would put in a work order to get him a TV that would accommodate the preference. During an interview on 5/23/24 at 9:30 a.m., the director of therapeutic recreation (DTR) stated R64 had a sign in his room placed by FM-A with preferences for music and shows. The DTR stated care planned activities should be implemented by staff to promote enrichment and preferred activities. The DTR verified R64's TV lacked the option to play Native American music. A policy for TR was requested, however, not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure blood thinner medications were held per provider order for 1 of 1 resident (R65), and failed to implement a physician order for 1 of 1 resident (R57) related to a rash. Findings include: R65's significant change Minimum Data Set, dated dated dated [DATE], included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, and had diagnoses of traumatic brain injury due to a gunshot to the chest and subsequent cardiac arrest, seizure disorder, muscle spasms, myoclonus (quick, jerky uncontrollable movements), convulsions, tracheostomy, anxiety, and depression. The MDS indicated R65 took an anticoagulant (blood thinner) medication. R65's care plan dated 3/21/24, included they took a blood thinner to prevent blood clots and indicated they were at increased risk of bruising and bleeding complications due to medication use. The care plan instructed staff to administer medication as ordered. R65's pain focus included R65 displayed signs of pain from muscle spasms and provide pain medications as ordered. A neurology provider order dated 11/10/23, included an order for cervical spine baclofen pump for spasticity. R65's MHM IDT Care Conference Form V-4 dated 1/24/24, indicated R65's guardian wanted R65 to remain in the facility until they received a baclofen pump and then take them home. Appointment Referral dated 3/27/24, included Patient evaluated for baclofen pump. Excellent candidate. Will need intrathecal baclofen trial 1st (first). R65's Order Summary Report dated 5/22/24, included: * Baclofen Oral Tablet 20 milligrams (mg - a muscle relaxant) four times daily for muscle spasms starting 3/21/24. *Apixaban Oral Tablet 5 mg (a blood thinner), give 5 mg twice daily to prevent blood clots starting 3/21/24, hold from 5/15/24 at 10:59 a.m., until 5/16/24 at 12:00 a.m. * Appointment on 5/16/24 at 8:00 a.m. for baclofen test starting 5/15/24. R65's North Memorial Health pre-procedure directions dated 4/11/24, included R65 was scheduled for a trial of intrathecal baclofen on 5/16/24 at 9:30 a.m., to determine if they were a candidate for a baclofen pump and instructed that R65's Eliquis should be held 2 days prior to the procedure, starting 5/14/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65's provider progress note dated 5/14/24, included R65 had a baclofen trial this coming Thursday and indicated nursing staff reporting R65 had continuous jerking/muscle spasms. There was improvement with baclofen but continued with frequent muscle spasticity and jerking movements. Baclofen 20 mg was increased from three to four times per day. The note indicated Referral to Neurology for baclofen pump consideration, apt [appointment] scheduled. R65 was noted to have muscle spasms in arms and legs, increased muscle tone in a spasticity in lower legs, and a severe right upper arm contracture. R65's medication administration record (MAR) for Mat 2024, indicated R65 received their blood thinner medication on 5/14/24 at 8:00 a.m., and 8:00 p.m., and 5/15/24 at 8:00 a.m. During interview on 5/20/24 at 1:31 a.m., R65 was lying in bed in the company of their significant other serving as resident representative (RR). RR stated R65 had a baclofen trial procedure scheduled to see if it would help release the tightness in their arm muscles. They stated they waited several months for the appointment, and on the day of the procedure the facility gave R65 and RR paper records to provide to the proceduralist. When they arrived for the procedure, the staff was unable to read the documents and contacted the facility who faxed the information over so they could be read clearly. Upon review of the records, the proceduralist determined the facility did not follow instructions and gave R65 an anticoagulant against orders. The procedure was cancelled due to the risk of bleeding. R65 and RR were very upset about the delay because they wanted to make plans for discharging from the facility after the baclofen pump procedure. R65's provider progress note dated 5/21/24, indicated the baclofen pump trial was moved to June. During observation on 5/22/24 at 7:03 a.m., R65 was lying in bed asleep and appeared relaxed and calm. Licensed practical nurse (LPN)-D entered R65's room at 7:30 a.m., to administer medications. While the head of the bed was elevated, R65's body had slid down toward the foot leaving their body nearly flat. LPN-D stated aides recently repositioned R65, however R65 moved around a lot due to muscle spasms and uncontrolled movements. At 7:46 a.m., R65 appeared to be agitated and started to twitch, their right arm held tightly contracted to their upper right chest. Nursing assistant (NA)-F and NA-G began providing cares at 7:52 a.m., and R65 continued to have muscle spasms and twitching movements throughout cares until they fell asleep at 7:58 a.m., when NA-F left the room to get supplies. Upon the NA's returning, R65 was awakened and once again started to appear agitated and had uncontrolled twitching movements until cares were completed at 8:20 a.m. During interview on 5/22/24 at 11:16 a.m., registered nurse (RN)-C stated R65 had an order to hold their blood thinner for two days prior to their baclofen trial procedure, however R65 received at least one dose during those two days which resulted in the cancellation of the procedure. They indicated they thought the order was added on the evening shift instead of the day, and if the procedure had gone forward there was a potential risk of bleeding complications. During interview on 5/22/24 at 1:58 p.m., director of nursing (DON) stated R65 was supposed to have a baclofen pump trial and had orders to hold their anticoagulant for two days before the procedure, however they received a dose they were not supposed to receive. R65's procedure was being rescheduled. DON expected orders to have been entered accurately on the day they were received to ensure residents are given medications according to provider orders to prevent complications. The Medication Administration - General Guidelines policy dated 5/22, included medications are administered in accordance with written orders of the prescriber. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45842 R57's quarterly Minimum Data Set (MDS) dated [DATE], indicated R57 was severely cognitively impaired. Diagnoses included heart failure and hypertension, R57's provider orders dated 1/5/24 indicated R57 was started on Amiodarone (medication for heart rhythm concerns) 400 milligrams (mg) twice a day for two weeks and then start 400 mg daily after that. The orders also indicated amiodarone monitoring checklist of labs: thyroid function (TSH) at baseline, 3 months and 6 months and liver function (AST) test at baseline and every 6 months thereafter. Documentation for Drugs.com undated, indicated Amiodarone could cause dangerous side effects on the heart, liver, lungs, and thyroid. Recommended to follow labs per provider orders to decrease risk of serious side effects. Review of R57's medical record form 1/5/24 to 4/23/24, was reviewed and lacked documentation any thyroid function or liver function blood tested were performed. During an interview on 5/23/24 at 11:58 a.m., registered nurse (RN)-A stated when orders were given from providers they were entered into the computer and lab orders were generated that way. Lab would then come in and draw the labs. Results were place on the chart to be reviewed by the nurse and the provider. RN-A reviewed R57's medical record and stated orders for the labs were in place but there were no results on the chart. RN-A also reviewed the labs draw record and acknowledge no labs had been drawn on R57 for the Thyroid function or liver function test. RN-A acknowledge the labs are important to monitor the effects of the medication Amiodarone. During an interview on 5/23/24 at 200 p.m., the director of nursing (DON) stated all orders were to be signed off by the nursing staff and the nursing staff would monitor to make sure all labs were completed as orders for the safety of the residents. Policy for following provider orders was requested but not received.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to ensure a resident was positioned appropriately with the head of the bed (HOB) at 30-45 (degrees) or higher during and after medication administration via gastric tube, failed to label tube feeding nutrition when started, and failed to replace a tube feeding administration set daily for 1 of 1 residents (R65) reviewed for tube feeding. Findings include: R65's significant change Minimum Data Set, dated dated dated [DATE], included R65 was severely cognitively impaired, dependent on staff for all activities of daily living, and had diagnoses of traumatic brain injury, seizure disorder, muscle spasms, myoclonus (quick, jerky uncontrollable movements), convulsions, tracheostomy, anxiety, and depression. The MDS indicated they had a feeding tube through which they received more than 50% (percent) of their nutrition. R65's Hospitalist Discharge Summary dated 1/17/24, indicated R65 was hospitalized with vomiting, fever, and gastroparesis (a condition where food stays in the stomach for a longer period of time than it should), was diagnosed with aspiration pneumonia, and instructed staff to keep R65's HOB at 30-45 at all times including sleep. R65's After Visit Summary dated 3/7/24, included R65 was sent to the emergency department for abdominal pain at feeding tube site and evaluation for possible pneumonia. R65's Feeding Tube Care Area Assessment (CAA) dated 3/20/24, included R65 could eat pureed foods but was fed primarily via gastric tube. R65 had respiratory distress after eating on 3/16/24, and was sent to the hospital with probable pneumonia. R65's care plan nutrition focus dated 3/21/24, included R65 was at risk for aspiration related to the presence of a feeding tube and directed staff to keep the HOB elevated to 45 at all times, and change syringe, feeding bag, and graduate every 24 hours. R65's Order Summary Report dated 5/22/24, included: * Enteral Feed Order Vital 1.5 rate of 80 milliliters per hour for 24 hours per day via g-tube. May stop during cares. Elevate HOB above 30 while feeding is running starting 5/16/24. * Ensure HOB is 30 or higher with tube feeding, hold if repositioning, every shift starting 3/22/24. R65's care plan aspiration focus dated 4/4/24, included R65 was at risk for aspiration related to the presence of a feeding tube, with instructions to administer tube feedings as ordered, change tube feeding bag and syringe every 24 hours, and keep the HOB elevated at least 45 during and for one hour after feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 5/21/24 at 9:30 a.m., R65 was lying in their bed with tube feeding running at 80 cubic centimeters (cc) per hour. The bottle was not labeled with a date, rate, initials, or a start time, and the tubing had not been changed since the prior day. During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated when staff hung a new bottle of nutrition, they changed the tubing at the same time. They stated they always labeled the bottle and the tubing with the date and time it was started, the rate of flow, and the nurse's initials. LPN-B verified R65's tube feeding bottle was unlabeled, and the tubing set was the same one used the prior day, despite noting a new bottle of nutrition was started early that morning on the previous shift. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated it was important to label both the bottle and the tubing, so staff knew when it was hung and by whom, and to discard any leftover nutrition in addition to the administration tubing for infection control purposes to prevent illness. During interview on 5/21/24 at 3:28 p.m., director of nursing (DON) stated staff should throw out any leftover tube feeding supplement and changing the whole tubing every 24 hours to prevent illness. During observation on 5/22/24 at 7:30 a.m., licensed practical nurse (LPN)-D entered R65's room to administer their medications. R65's HOB was at approximately 30 , however R65 had slid toward the foot of the bed, leaving their body flat and their head slightly elevated. R65's feet hung off the end of the bed, the left one off to the left side over the edge of the corner. LPN-D paused R65's running tube feeding pump, disconnected the tubing from R65's gastrostomy tube, gave R65 their medications, flushed the tube, reconnected R65's feeding, and started the pump again. LPN-D confirmed R65 should always be sitting at 30-45 so they don't regurgitate their medications or tube feeding, however their body scoots down often because of their movements. LPN-D called for another staff to assist in repositioning R65. At 7:52 a.m., nursing assistant (NA)-F arrived to R65's room, lowered the head of the bed further to a nearly supine (flat) position, and removed R65's pillow from under their head. LPN-D paused R65's tube feeding and at 7:58 a.m. , NA-F left the room to get supplies. LPN-D raised the head of R65's bed up to approximately 45 and turned T65's tube feeding back on at 8:00 a.m. while they were still low on the bed, body nearly flat. NA-F returned to the room and stated they were waiting for another aide to assist, and LPN-D left the room. NA-G arrived at the room at 8:11 a.m., paused R65's tube feeding, put the head of the bed fully flat, and both aides provided personal cares until 8:18 a.m., when NA-F and NA-G repositioned R65 up toward the HOB. The head of R65's bed was elevated to approximately 35 at 8:21 a.m. and R65's tube feeding was started again. During interview on 5/22/24 at 8:25 a.m., NA-F stated they always turned off R65's tube feeding pump when providing cares, put their head down, and brought the head back up and restarted the pump afterward. NA-F indicated they would have no way of knowing what time R65 received medications and could not plan to wait until one hour after administration as outlined in the care plan. During interview on 5/22/24 at 11:31 a.m., RN-C stated R65 had a history of aspiration and the HOB should be up above 30 degrees while medications and tube feedings are given. R65's HOB should be left elevated for 30 minutes after administration, however there was no way for the NAs to know when the nurse gave medications via g-tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/22/24 at 12:56 p.m., DON stated resident with tube feedings should have their HOB elevated at least 30 for any medication administration, water flushes, and tube feedings. They stated R65 had a lot of jerky, involuntary movements which made it difficult to keep them upright in bed, however, it was expected that the nurse reposition R65 prior to giving medications, and to limit the time lower than 30 to prevent aspiration. The Enteral Tube Feeding by Continuous Pump policy dated 3/23/23, included position the head of the bed at 30 - 45 (semi-Fowler's position) for feeding, unless medically contraindicated. Ensure that feeding tube bag/bottle/tubing have been marked with date and time. If over 24 hours or not marked, dispose of bag/tubing, and obtain new supplies. If opening a new container, mark with date and time it was opened.

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care/assistance for a resident with a prosthesis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44651 Based on observation, interview, and document review, the facility failed to provide assistance and coordination of services to ensure timely referral and treatment for prosthetic fit for 1 of 1 resident (R37) reviewed who needed a prosthesis. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], included R37 was cognitively intact, had a limb prosthesis, required maximal assistance for lower body dressing, putting on footwear, standing, and transfers, and had diagnoses of diabetes, depression, heart failure, tracheostomy, and severe morbid obesity. R37 received 2 days of occupational therapy (OT) and 15 minutes of physical therapy (PT) in the previous 7 days. R37's care plan dated 10/20/23, included R37 had an alteration with transfers related to right BKA (below the knee amputation). The care plan indicated R37 would like to improve her transfer abilities as much as possible and instructed staff to ensure resident has prosthetic on prior to any transfer. R37's provider progress notes dated 1/9/24, 2/9/24, 2/16/24, 3/1/24, 3/5/24, 3/13/24, 3/15/24, 3/22/24, 5/7/24, and 5/21/24 all identified R37 had a history of nontraumatic above-the-knee amputation of the right lower extremity related to diabetes and was motivated to ambulate to increase independence. Patient previously ambulatory prior to amputation. Expected to achieve stand pivot transfer to decrease risk for falls from wheelchair if able to reposition with both lower extremities. A podiatry note dated 3/25/24, indicated the provider encouraged mobilization of LLE (left lower extremity) to maintain circulatory status to the leg, particularly while [they] await adjustment to prosthesis. R37's PT note dated 3/28/24, included R37 had a right BKA and had a prosthesis. The note indicated R37 was discharged from therapy and would resume once their new prosthetic was available. R37's medical records lacked evidence of follow up to ensure R37's had a well-fitting, usable prosthetic leg. During interview on 5/20/24 at 12:44 p.m., R37 was seated in their wheelchair in their room. A prosthetic leg was standing upright on the far edge of the wall next to their nightstand wearing one pink athletic shoe. R37 stated they could not put the leg on themselves, and it took 2-3 people to secure it. They indicated it was extremely uncomfortable and needed to be re-evaluated by the vendor for fit or a new prosthetic, however the facility had not made any arrangements. During observation on 5/21/24 at 8:03 a.m., R37 was in their wheelchair in the hallway and was not wearing their prosthesis. (continued on next page)

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	245295	A. Building B. Wing	05/23/2024

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F 0696 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/21/24 at 2:32 p.m., licensed practical nurse (LPN)-B stated R37 had a leg amputation and staff used a mechanical lift to transfer R37. LPN-B had never seen them wear a prosthetic leg. During interview on 5/21/24 at 2:46 p.m., nursing assistant (NA)-G stated R37 was transferred with a mechanical lift and did not use a prosthetic leg, however they used to wear it when they worked with therapy and could pivot transfer when they first arrived at the facility. NA-G was unsure why they weren't using it anymore. During interview on 5/21/24 at 3:01 p.m., registered nurse (RN)-C stated the last time R37 wore their prosthetic leg was in therapy the previous year. R37 stood once with therapy assistance, however RN-C was not sure why R37 no longer wore it. RN-C was unsure if R37 was supposed to wear it, reviewed their medical records, and confirmed there was an order for the shrink sock and the application of the prosthesis was outlined in the care plan. During interview on 5/21/24 at 3:19 p.m., physical therapist (PT) indicated R37 was not receiving physical therapy services but did get occupational therapy. During interview on 5/21/24 at 3:25 p.m., certified occupational therapy assistant (OT) reviewed R37's records and indicated R37 was discharged from PT on 3/28/24, prior to receiving their new prosthetic leg. OT stated they were not aware R37 received their new prosthetic but could now step in and evaluate them to identify R37's goals and abilities. OT stated usually nursing staff completed a communication form to update therapy on resident needs, however OT had not received any communication re R37. During observation 5/21/24 at 3:42 p.m., R37 was in their wheelchair exiting the elevator and not wearing their prosthetic leg. During interview on 5/22/24 at 12:56 p.m., director of nursing (DON) stated R37 had a condition, was unable, and preferred not to wear their prosthesis. They indicated they were unsure when R37 received their current prosthesis, but staff would help them don and doff the leg, and if it did not fit, they would communicate with therapy and contact the prosthetic company to make adjustments to the prosthetic and ensure R37 could have as much independence as possible. A policy pertaining to coordination of prosthetic care was requested but not provided. In an email dated 5/23/24 at 2:12 p.m., the administrator indicated staff worked with therapy on prosthetic care coordination.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and document review, the facility failed to ensure gradual dose reductions (GDR) were attempted, or an adequate medical justification for the use of psychotropic medications for 1 of 5 residents (R42) reviewed for unnecessary medications. Findings include: R42's annual Minimum Data Set (MDS) dated ,d+[DATE], indicated no cognitive impairment and no reports of feeling down, depressed, or hopeless. R42's MDS indicated he did not experience any hallucinations or delusions, did not reject care, and did not exhibit any verbal or physical behaviors. The MDS indicated R42's diagnoses included depression, and respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing). Furthermore, R42's MDS indicated he was taking an antipsychotic on a routine basis and no GDR had been attempted. A GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. The MDS indicated a provider had documented it was clinically contraindicated on 4/9/24. R42's Care Area Assessment (CAA) dated 4/12/24, for psychotropic drug use indicated he had a potential for adverse effects from his medication use. The CAA indicated R42 had a degenerative disease and suffered from depression because of it. The CAA indicated his symptoms were well-controlled and R42 reported minimal symptoms of depression. The CAA indicated staff would continue to provide medications that helped R42 cope with his disease and would assess for adverse effects. The CAA lacked documentation of resident-specific target symptoms to monitor. The CAA lacked documentation of resident-specific interventions to address symptom management. R42's order summary dated 5/23/24, included the following physician orders: - Olanzapine oral tablet 5 milligrams (mg) (Zyprexa), Give 5 mg via gastrostomy (G)-Tube two times a day for depression, dated 3/21/24. - Sertraline hydrochloride (HCl) oral tablet 100 MG (Zoloft HCl), Give 200 mg via G-Tube one time a day for depression, dated 3/21/24. - Mirtazapine oral tablet 15mg (Remeron), Give 15 mg via G-Tube at bedtime for depression, dated 3/21/24. - Lorazepam oral tablet 0.5mg (Ativan), Give 2.5 mg via G-Tube at bedtime for anxiety, dated 3/21/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42's treatment administration record (TAR) dated 5/2024, revealed an order dated 12/6/23, for psychotropic monitoring for antianxiety medication. The TAR guided staff to monitor for side effects of drowsiness, dizziness, hypotension (low blood pressure)/hypertension (high blood pressure), weight gain, dry mouth, nausea, constipation, blurred vision, and extrapyramidal reaction (a cluster of symptoms caused by medications that include muscle spasms and contractions, restlessness, tremors, and irregular, jerky movements known as tardive dyskinesia). Similarly, the TAR also revealed an order dated 12/6/23, for antidepressant medication and antipsychotic medication side effect monitoring. R42's undated care plan indicated he used psychotropic medications related to his depression. The care plan identified R42's medications of Zyprexa, sertraline, and Remeron daily and lorazepam as needed for anxiety. The goal was to remain free of drug related complications, including cognitive and behavioral impairment. R42's care plan identified interventions of attempting a GDR of medications as evaluated by the interdisciplinary team (IDT) that included the pharmacist, primary provider, and resident and family. The undated care plan also indicated R42 had an alteration in mood and behavior as it related to his depression and anxiety diagnoses. The undated care plan identified R42 had an alteration in psychosocial well-being related to his complex medical conditions and his depression and anxiety disorders. The care plan lacked resident-specific target symptom monitoring. A review of R42's behavior monitoring lookback log dated 4/30/24 - 5/28/24, revealed one instance of documented behaviors. On 5/15/24, staff documented R42 exhibited a behavior of repetitive questions. The remaining documentation reflected either not applicable or none noted. A consultant pharmacist recommendation to physician report dated 2/27/24, indicated R42 was receiving olanzapine for a diagnosis of major depressive disorder which was not considered an appropriate indication for antipsychotic use. The consultant pharmacist's recommendation was if R42 was receiving an antipsychotic without an appropriate diagnosis in accordance with the Centers for Medicare and Medicaid Services (CMS) guidance, to consider a GDR if clinically appropriate. The monthly medication regimen review (MRR) lacked a provider's signature or associated orders. During interview on 5/23/24 at 11:23 a.m., registered nurse (RN)-C stated for residents taking psychotropic medications, the documentation requirements would be listed in the resident's TAR. RN-C stated if a staff person was documenting an intervention in the TAR, there would be a prompt to re-evaluate the effectiveness and document that as well. RN-C stated the expectation for nurses would be to document on the TAR and for nursing assistants (NA) to report back to their charge nurse. RN-C stated non-pharmacologic interventions should be documented in the TAR and stated they should be listed on the NA care sheets. RN-C identified R42's resident-specific interventions in the care plan but was unable to identify any resident-specific target symptoms or documentation of behavior monitoring. RN-C stated the clinically contraindicated GDR documented on the MDS dated [DATE] could be an error. RN-C reviewed R42's MRRs and was unable to locate documentation of clinical contraindication of a GDR. During interview on 5/23/24 at 1:26 p.m., the director of nursing (DON) stated staff were expected to documented behaviors and whether interventions were effective for residents receiving psychotropic medications. Additionally, the DON stated the facility collaborated with the consultant pharmacist (CP) for MRRs and the expectation for MRR turnaround was approximately 30 days. The DON indicated GDRs were important to avoid overuse of medication and avoid unnecessary medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/23/24 at 2:23 p.m., the consultant pharmacist (CP) stated during a resident's first year of admission to a facility, two GDRs should be recommended to be attempted. On a resident's second year of living in a facility, one GDR should be recommended to the provider. The CP verified being aware of R42's medication regimen and stated in February of 2024, a clarification was sent out regarding his antipsychotic and diagnosis. The CP stated that there had not been any follow up received from the provider or facility related to the MRR dated 2/27/24. The CP stated it is generally preferred to hear back within the first month or two, but the expectation was to have heard back by the time of the interview. The CP stated R42 was on the list to review for the month of May. During subsequent interview on 5/23/24 at 3:00 p.m., the DON stated R42's GDR was contraindicated because when the MDS was collected, R42 had just returned from the hospital. A request for the provider's documentation of clinical contraindication was requested but not receive. A facility policy titled Psychotropic Medication Use dated 7/28/21, indicated psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review as outline with the Gradual Dose Reduction Policy. The policy also indicated the interdisciplinary team and the primary provider would gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The policy guided the interdisciplinary team and the provider to identify, evaluate and document symptoms that may warrant the use of psychotropic medications as well as pertinent non-pharmacological interventions that must be attempted, unless contraindicated, and documented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to adhere to infection control evidence based practices for a resident urinary catheter bag being placed on the floor for 1 of 1 resident (R72) reviewed for infection prevention and control practices. Findings include: R72's quarterly MDS dated [DATE], indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs) and had an indwelling catheter. MDS indicated R72 had non-traumatic brain dysfunction, chronic respiratory failure with a tracheostomy, and had Extended-Spectrum Beta Lactamase (ESBL) resistance (ESBL are found in some bacteria that cannot be killed by many types of antibiotics used to treat infections). R72's CAA for communication dated 10/24/23, indicated she had impaired ability to express herself due to her tracheostomy and mechanical ventilation, caused by myasthenia gravis (a chronic weakening autoimmune disorder involving the communication between nerves and muscles). R72's CAA for self-care and mobility dated 10/24/23, indicated R72 was unable to participate in ADLs and indicated needed assistance would be provided to maintain hygiene. R72's CAA for dehydration and fluid maintenance dated 10/23/24, indicated [NAME] as at risk for infection and had a history of UTI. Physician orders for R72 included the following: - Follow EBP while providing tracheostomy and/or ventilation care, Foley, wounds, enteral feeding and other high-contact care activities every shift, dated 4/23/24. R72's care plan undated indicated she was on EBP related to her urinary catheter, tracheostomy, and enteral feeding. The care plan stated staff would follow EBP and explain the reason for EBP. R72's quarterly Minimum Data Set (MDS) dated [DATE], indicated R72 had an absence of spoken words, was rarely or never understood, and sometimes understood others. MDS indicated R72 was dependent on staff for all activities of daily living (ADLs) and had an indwelling catheter. MDS indicated R72 had non-traumatic brain dysfunction, chronic respiratory failure with a tracheostomy (a surgical airway created in the windpipe as an alternative method for breathing) and had Extended-Spectrum Beta Lactamase (ESBL) resistance (ESBL are found in some bacteria that cannot be killed by many types of antibiotics used to treat infections). R72's Care Area Assessment (CAA) for cognitive loss and dementia dated 10/24/23, indicated she did not have a speaking valve (a removable device that can be use with a tracheostomy for speaking) but was able to mouth yes or no. The CAA indicated R72 had moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R72's CAA for communication dated 10/24/23, indicated she had impaired ability to express herself due to her tracheostomy and mechanical ventilation, caused by myasthenia gravis (a chronic weakening autoimmune disorder involving the communication between nerves and muscles). R72's CAA for self-care and mobility dated 10/24/23, indicated R72 was unable to participate in ADLs and indicated needed assistance would be provided to maintain hygiene. R72's CAA for urinary incontinence and indwelling catheter dated 10/24/23, indicated she had both bowel and bladder incontinence. The CAA also indicated R72 had a Foley catheter in place due to an unstageable pressure ulcer on her sacrum, which put her at risk for a urinary tract infection (UTI) and urinary retention. Additionally, the CAA indicated R72 required total assistance with toileting hygiene and to maintain patency of her Foley catheter. R72's CAA for dehydration and fluid maintenance dated 10/23/24, indicated [NAME] as at risk for infection and had a history of UTI. Physician orders for R72 included the following: - Foley catheter: change Foley catheter and drainage bag once per month dated 10/17/23, - Follow Enhanced Barrier Precautions (EBP) while providing tracheostomy and/or ventilation care, Foley, wounds, enteral feeding and other high-contact care activities every shift, dated 4/23/24. R72's care plan undated indicated she was on EBP related to her urinary catheter, tracheostomy, and enteral feeding. The care plan stated staff would follow EBP and explain the reason for EBP. The care plan also identified R72's alteration in elimination and her use of a Foley catheter. The goal was to remain free from signs and symptoms of UTI by having staff assistance will her toileting needs, including Foley catheter cares every shift and as needed. A provider progress note dated 5/7/24, indicated R72 had a recent hospitalization for sepsis due to UTI. The progress note indicated R72 had been treated twice for positive urine cultures (laboratory test used to confirm bacteria growth in urine) between 3/8/24 and date of progress note (5/7/24). A progress note dated 5/22/24 indicated R72 was started on Levaquin (and antibiotic) related to UTI with a urine culture pending. On 5/21/24 at 2:27 p.m., R72's catheter drainage bag was observed to be on the floor next to her bed. During interview on 5/21/24 at 3:32 p.m., registered nurse (RN)-C verified there was a spot the drainage should be hanging from. RN-C demonstrated the drainage bag had a clamped drainage port and hung bag from R72's bed. RN-C stated the facility utilized a closed-system drainage bag and did not believe it was a problem that R72's catheter drainage bag was on the floor because it was clamped. During interview on 5/22/24 at 9:11 a.m., nursing assistant (NA)-D stated catheter bags should not be on the floor because of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/23/24 at 8:45 a.m., R72's nurse practitioner (NP) stated the catheter drainage bag should not be left on the floor as this could introduce new bacteria. During re-interview on 5/23/24 at 12:03 p.m., RN-C stated the catheter bag should be hanging up off the floor for infection prevention, especially for residents that have indwelling catheters because they are already at a high risk for UTIs. RN-C stated the expectation moving forward for catheter cares is to ensure the catheter drainage bag is not set on the floor. RN-C stated there will be increased monitoring and audits to verify this. During interview on 5/23/24 at 1:40 p.m., the director of nursing (DON), stated the catheter bag should absolutely not be on the floor for infection control reasons. A facility policy titled Infection Prevention and Control Program dated 3/13/23, indicated important facets of infection included instituting measures to avoid complications or dissemination, educating staff and ensuring that they adhere to proper techniques and procedures, and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). According to a CDC article titled Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009 last updated 6/6/19, the collection bag should not rest on the floor.

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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** 42580 Based on interview and document review, the facility failed to ensure 2 of 5 residents (R24, R52) reviewed for immunizations were offered or received the pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The CDC Pneumococcal Vaccine Timing for Adults dated 3/15/23, indicated adults aged [AGE] years and older who have had no prior pneumococcal vaccinations could either have option A which indicated PCV20, or option B, give PCV15 and follow with PPSV23 after at least one year of giving PCV15. If only the PPSV23 vaccination was administered prior at any age, option A indicated PCV20 could be administered after 1 year or option B indicated PCV15 could be administered after 1 year. If only the PCV13 vaccination was administered at any age, option A indicated PCV20 could be administered after 1 year, or PPSV23. If PCV13 was administered at any age, and PPSV23 was administered prior to [AGE] years of age, option A indicated PCV20 could be administered after five years, or option B indicated PPSV23 could be administered after 5 years. Additionally, for those who already completed PCV13 at any age, and PPSV23 at age 65 or greater, together, with the patient, vaccine providers may choose to administer PCV20 to adults greater than [AGE] years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years old. R24 R24's annual Minimum Data Set (MDS) dated [DATE], indicated R24 was cognitively intact, did not reject cares, pneumococcal vaccine was offered and declined. R24's face sheet printed on 5/22/24, indicated R24 was [AGE] years old, and diagnosis included chronic kidney disease. R24's Resident Vaccine Administration (RAC) form signed 9/15/22, indicated vaccines to be given included influenza, pneumococcal and Covid-19 vaccine/booster. R24's 10/17/23, RAC form indicated, with a check mark, R24 was administered the influenza and COVID-19 vaccine/booster. However, next to the pneumococcal vaccine indication, the box was unchecked, indicating the resident did not receive the vaccination. Additionally, the form had a box to indicate I do not wish to have the following vaccinations at this time, which was unchecked. During survey on 5/21/24, the facility provided a signed RAC form by the resident dated 5/21/24, for pneumococcal vaccine administration. This form indicated the resident consented to the pneumococcal vaccination, however one was not administered. R52 R52's quarterly MDS dated [DATE], indicated R52 was cognitively intact, did not reject cares, or medications and was up to date with his pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52's face sheet printed 5/22/24, indicated R52 was [AGE] years old, and diagnosis included chronic respiratory failure with hypercapnia (presence of higher than normal level of carbon dioxide in the blood.) and hypoxia (low levels of oxygen in your body tissues) and had type 2 diabetes mellitus. R52's immunization record in the electronic health record (EHR) indicated R52 received Pneumococcal Conjugate Vaccine (PCV13) in 3/3/2015, and received the Pneumococcal Polysaccharide Vaccine (PPSV23) in 8/9/2007. R52's recommendation per CDC guidelines included: give one dose of Prevnar 20 (PCV20) at least five years after the last pneumococcal vaccine dose or give one more dose of PPSV23 at least one year after PCV13 and at least 5 years after previous PPSV23 dose. R52's consent for pneumococcal vaccine was requested but not received. During interview on 5/22/24 at 1:55 p.m., director of nursing (DON), who is also the infection preventionist, stated the facility tracked immunizations and completed audits to ensure vaccines were offered and consents were being reviewed with residents. DON further clarified the facility was implementing a new system to better track immunization consents and administration documentation and would be training staff to pull resident's vaccination records from Minnesota Immunization Information Connection (MIIC) system into the resident's EHR. The facility Pneumococcal policy updated 2/2024, indicated prior to or upon admission to the facility (within 5 days), all residents will be assessed for current immunization status and eligibility to receive the pneumococcal vaccine. Within 30 days of admission, resident will be offered the vaccine, when indicated, unless the resident has already been vaccinated or the vaccine is medically contraindicated. Consent will be obtained and the pneumococcal vaccination will be administered to residents, per physician order and CDC recommendations, and will be documented in the resident ' s medical record.