STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flagstone	12500 Castlemoor Drive Eden Prairie, MN 55344

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 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** 46885 Based on interview, observation, and document review, the facility failed to ensure resident room walls were in good repair to create a home-like environment for 1 of 1 resident (R26) reviewed for room environment. Findings include: R26's Optional State Assessment (OSA) dated 2/26/23, indicated severe cognitive impairment, did not reject care, required extensive assist with bed mobility and toileting, and was dependent on staff for transfers. R26's significant change Minimum Data Set (MDS) dated [DATE], indicated it was somewhat important to take care of personal belongings or things, had a wheelchair, was dependent on staff for transfers and wheeling self in the wheelchair. R26's care plan dated 3/1/24, indicated R26 had an alteration in physical mobility and did not ambulate, used a wheelchair to reach all destinations and staff were to assist with mobility as needed. R26's care plan dated 10/6/20, indicated the facility was R26's home and interventions included encouraging R26 to bring personal belongings to decorate the room. The care plan lacked information regarding reporting any maintenance needs to environmental services. R26's care sheet indicated R26 transferred with assist of two with a full lift and had a Juditta (a tilting and comfort wheelchair for adults with reduced mobility) wheelchair. During observation on 3/18/24 at 4:21 p.m., R26's walls in her room had scuff marks next to the closet and television and the plaster was coming off the wall and the wall had dents and dings and there were black scuff marks along the wall next to the television. During interview on 3/18/24 at 5:35 p.m., family member (FM)-C stated the marks had been on the walls for a while and stated staff used a mechanical lift and thought the lift hit the walls and stated it was something that could be fixed and added the area by the closet was pretty visible. FM-C stated he saw R26 yesterday and stated the marks on the walls had been there for more than a month. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/18/24 at 12:05 p.m., nursing assistant (NA)-A stated they repair walls but the marks on the walls in R26's room had been there a couple of months and stated the marks were caused from R26's wheelchair. During interview on 3/19/24 at 1:07 p.m., the environmental services director (ESD)-A stated they utilized a Tells system which functioned as a work order for everything. ESD-A stated they were alerted to work order requests on their phone and stated they never had a work order longer than half an hour and further they had 24 hours to complete the work order, but they got them completed in about half an hour. ESD-A looked at the current work orders and stated one was to clean a room that a resident moved out of and the other was a blind string that was undone. ESD-A further stated if staff know of an issue they were expected to notify maintenance right away and all staff put work orders in. During interview on 3/20/24 at 6:51 a.m., the ESD-A provided a list of 5 work orders. The work orders were reviewed and lacked evidence a work order was in place for fixing R26's walls. During interview on 3/20/24 at 8:00 a.m., registered nurse (RN)-B stated if there was a maintenance issue, you had to put in a work order. During interview on 3/20/24 at 12:06 p.m., the director of nursing (DON) verified R26's room had about a 3 foot area on the wall with scratches and a two foot area of the wall with areas of plaster coming off the wall and stated they had an application for a Tells system and staff could place a request if they knew how, or if the staff was in training, they would tell the nurse and the nurse would report to maintenance to fix. DON further stated maintenance issues should be reported at the time it was discovered and stated she would send a Tells and verified it should have been reported. The administrator sent an email on 3/20/24 at 2:50 p.m., they did not have a policy on a home like environment, however, all residents were provided a resident's rights booklet upon admission. A booklet, Your Rights Under the Combined Federal and Minnesota Resident [NAME] of Rights dated 11/1/2019, indicated the resident had a right to a safe, clean, comfortable and homelike environment. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

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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 care plan for psychotropic medications that included resident-specific interventions for 1 or 4 residents (R54) reviewed for psychotropic medications. Findings include: R54's admission Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment and identified R54 was taking psychotropic medications and an antipsychotic on a routine basis. The MDS indicated R54's diagnoses included Alzheimer's disease (a brain disorder that affects behavior and slowly destroys memory and thinking skills), psychotic disorder (symptoms affecting the mind where someone may lose contact with reality), and legal blindness. R54's Care Area Assessment for cognitive loss and dementia dated 2/20/24, indicated R54 had unclear speech and was rarely understood, and her vision was highly impaired, and staff should tell her prior to touching her for transfers or cares. The CAA indicated R54 had restlessness, agitation, and a history of hallucinations treated with psychotropic drugs, including the antipsychotic medication Zyprexa. The CAA indicated R54's mood was being monitored and her medications be observed for potential side effects. R54's CAA for psychosocial well-being dated 2/20/24, indicated staff would care plan for potential psychosocial well-being trigger[sic] by staff interview. The CAA indicated R54 had little pleasure in doing things and not being able to do her favorite activities. The CAA lacked documentation of previous favorite activities. R54's CAA for psychotropic drug use dated 2/20/24, indicated R54's medication use and treatment of her mood during end-of-life care would be care planned. The CAA indicated R54's hallucinations were being treated with the antipsychotic medication Zyprexa. R54's physician orders included the following, - escitalopram oxalate oral tablet (Lexapro), Give 1 tablet by mouth at bedtime for mood dated 2/14/24. - haloperidol oral tablet (Haldol) 0.5 milligram (mg), Give 0.5mg by mouth every 1 hours as needed for agitation or nausea. Call Hospice if ineffective after 3 consecutive doses, dated 3/7/24 through 3/21/24. - haloperidol oral tablet (Haldol) 0.5mg, Give 1 tablet by mouth every 4 hours for agitation, dated 3/7/24 and discontinued 3/19/24. - haloperidol oral tablet (Haldol) 0.5mg, Give 1 tablet give times a day for agitation, dated 3/19/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's care plan, dated 3/5/24, lacked resident-specific goals and interventions for psychotropic medication use, including person-centered goals and resident-specific interventions to address target behaviors. The care plan identified R54 was using antidepressant, antianxiety, and antipsychotic medications but lacked details about the medications and resident-specific behaviors and interventions. Target behavior task sign-off dated 2/19/24 through 3/19/24, indicated R54 exhibited behaviors such as seeing or hearing things that don't exist, trembling or shaking, crying, or being unable to fall asleep or stay asleep on 2/28/24 and 2/29/24. During interview on 3/19/24 at 11:47 a.m., R54's hospice case manager stated R54 was started on a low dose of the antipsychotic medication haloperidol to treat fearful hallucinations. The hospice case manager stated R54 might not show outward signs of agitation about the hallucinations, but she would whisper it. The hospice case manager stated R54 seemed to really perk up after starting the haloperidol and her status improved. The hospice case manager stated due to her improve status and some reported morning drowsiness, the haloperidol dose was being re-evaluated. During interview on 3/20/24 at 11:43 a.m., registered nurse (RN)-C identified R54's target behaviors were being documented and were specific to her. RN-C reviewed R54's care plan for dementia care and psychotropic drug use and stated for residents with dementia, it was expected the care plan would be resident-specific and resident-centered. RN-C stated they would expect R54's care plan to be a little more specific and verified it was pretty general. During interview on 3/20/24 at 1:09 p.m., the director of nursing stated the care plan was built to auto-populate, but there was a place to document about resident's individually and specifically. The DON identified R54's target behaviors were being monitored and documented in the tasks. The DON reviewed R54's care plan and stated, I don't see the specifics, just the blanket one. The DON acknowledge there were no non-pharmacologic interventions identified in R54's care plan but stated the facility does have those interventions listed out for others. The DON expected the care plan to be more resident-centered. A facility policy titled Psychotropic and Unnecessary Medication Use Policy modified 12/2022, indicated individual interventions will be addressed for residents receiving psychotropic medications. A facility policy titled Care Plan Policy and Procedure modified 11/2022, indicated it is the policy of Presbyterian Homes to develop a care plan that reflects what the resident desires for himself/herself, and includes unique interventions which meet the needs of that resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to provide grooming and shaving for 1 of 1 residents (R22) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], R22 had moderate cognitive impairment and required partial to moderate assistance with personal hygiene. R22's diagnoses included depression, anxiety, dementia (a loss of memory, language, problem-solving and thinking abilities), and psychosis (symptoms affecting the mind where someone may lose contact with reality). R22's Care Area Assessment (CAA) for cognitive loss and dementia dated 1/16/24, indicated R22 was residing in the facility for ongoing care related to self-care deficits. R22's CAA for functional abilities indicated she needed assistance for dressing, toileting, bathing, personal hygiene, transfers, eating, bed mobility, and on and off unit locomotion. The CAA indicated the resident was at risk for further functional decline due to decreased physical mobility. R22's care plan dated 5/3/23, indicated R22 had an activities of daily living (ADL) self-care performance deficit related to impaired mobility, chronic pain, muscle weakness and cognitive impairment. The care plan identified a goal to be clean and well dressed daily and listed interventions of one staff to assist with personal hygiene and oral care. Task sign-off for personal hygiene dated 2/19/24 through 3/18/24, indicated R22 was independent with personal hygiene cares on 12 occasions, required staff supervision for 15 occurences, limited assistance for 5 occurences, extensive assistance for 18 occurences, and total assistance for 4 occurences. During observation on 3/18/24 at 5:47 p.m., R22 was sitting in the doorway in her wheelchair and had facial hair above her upper lip and chin that were approximately 1/2-inch in length. R22 was unable to answer if the facial hair bothered her. During observation on 3/19/24 at 8:39 a.m., nursing assistant (NA)-B pushed R22 in her wheelchair into the dining area for breakfast. R22's facial hair remained unchanged. During a dining observation at 12:06 p.m., R22 was in the dining room and her facial hair remained unchanged. During a later observation at 2:06 p.m., an unidentified staff member greeted R22 in her doorway and asked if she wanted to join a group exercise activity. The unidentified staff member pushed R22 down the hallway and her facial hair remained unchanged. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continuous observation and interview on 3/20/24 between 8:22 a.m. and 9:11 a.m., NA-B was observed providing morning ADL cares for R22. She performed hand hygiene, knocked on R22's door before entering and introduced herself. After NA-B finished assisting R22 in the bathroom with toileting cares, NA-B provided set-up for oral cares. NA-B stated R22's morning cares included getting her up and dressed, toileted and cleaned up afterwards, transferring her into the wheelchair, brushing her hair and teeth and providing her glasses. NA-B stated R22 required extensive assistance for toileting cares, shaving, trimming her fingernails, and dressing. NA-B stated R22 was able to perform oral cares with a lot of cueing after set-up as well as brushing her hair. NA-B stated R22 did not refuse cares. When asked about R22's facial hair, NA-B stated R22 had an electric razor that maybe needed new batteries. NA-B stated dislike for the length of R22's facial hair and it should be shaved. At 8:56 a.m., the administrator pushed R22 in her wheelchair into the dining room where there were 11 other residents having breakfast. R22's racial hair remained unchanged. At 9:43 a.m., R22's facial hair remained unchanged. During interview on 3/20/24 at 11:29 a.m., registered nurse (RN)-C stated NAs were expected to help male and female residents shave as a part of ADL cares and verified it would be a problem for a NA to not shave a female resident's upper lip facial hair. RN-C stated there are batteries on the unit and staff could ask if they were unable to find them. During interview on 3/20/24 at 1:05 p.m., the director of nursing (DON) stated shaving residents should occur every bath day. The DON was unaware of any special preferences that R22 had for facial hair. The DON stated basic batteries, like AAA or AA, were easy to find and NAs could get them from the supply room. A facility policy titled Resident Care Policy last reviewed 2/2016, indicated the policy was every resident to have morning and bedtime cares done daily which included shaving residents in am [morning].

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure interventions were in place for 1 of 2 residents (R26) reviewed for pressure ulcers. Findings include: A stage three pressure ulcer is full thickness loss of the skin in which subcutaneous fat may be visible. Additionally, slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) may be visible but does not obscure the depth of the tissue loss. An unstageable pressure ulcer is obscured full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If slough or eschar is removed, a stage three or stage four pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then reclassified stage should be assigned. A diabetic ulcer is an ulcer on the foot caused by a combination of poor circulation and nerve damage in patients with diabetes. Moisture associated skin damage (MASD) is caused by prolonged exposure to various sources of moisture, including urine, stool, perspiration, and wound exudate. R26's Optional State Assessment (OSA) dated 2/26/23, indicated severe cognitive impairment, did not reject care, required extensive assist with bed mobility and toileting, and was dependent on staff for transfers. R26's significant change Minimum Data Set (MDS) dated [DATE], indicated R26 was frequently incontinent of bowel and bladder, had peripheral vascular disease, diabetes type two with diabetic neuropathy (nerve damage), and dementia. The MDS further indicated R26 was at risk of developing pressure ulcers, had one unhealed stage three pressure ulcer, one unstageable pressure ulcer with suspected deep tissue injury in evolution. Further, R26 had a diabetic foot ulcer and moisture associated skin damage (MASD), and treatments included a pressure reducing device for the chair, bed, nutrition or hydration interventions, and pressure ulcer care. R26's care area assessment (CAA) dated 2/26/24, indicated R26 had two new pressure ulcers and a diabetic ulcer and had a stage three pressure injury to the left heel, a deep tissue injury to the left lateral leg, and a diabetic ulcer to the left hallux along with excoriation to the buttocks. R26 had a pressure reducing mattress and a wheelchair cushion in place, and received 4 ounces of Gelatin for wound healing along with protein snacks. R26's clinical physician orders indicated the following orders and dates started: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/8/24, left heel wound cleanse with Vashe and gauze. Do not soak with Vashe, skin prep to wound edges, cut to fit Urgotul AG mesh to the wound bed, wrap with an ABD, Kerlix, and tape and change daily. 2/22/24, Left lateral leg wound cleanse with wound cleanser, skin prep wound edges, apply foam adhesive every 3 days and as needed. 2/20/24, Left great toe paint with betadine daily 2/16/24, blue Prevalon boots on at all times. Elevate legs on pillows at all times in bed and in the wheelchair. R26's care plan dated 3/1/24, indicated R26 was at risk for impaired skin integrity due to age, fragile skin, diabetes, incontinence, peripheral vascular disease, and impaired mobility. an Intervention revised on 3/1/24, indicated R26 was to use blue heel boots on at all times, and have a pillow placed under feet and calves when in bed and in the wheelchair. R26's care sheet dated 3/14/24, indicated R26 was to have blue boots on at all times and elevate legs on pillows in bed and the wheelchair. R26's Elevate Feet on Pillows At All Times Task form from 2/19/24, to 3/19/24, indicated R26 did not refuse the task and was documented the task was completed each day. During observation on 3/18/24 4:07 p.m., R26 was up in her wheelchair and had her blue boots on but there was no pillow located in the chair under her feet and calves. A staff person entered the room at 4:35 p.m., and asked R26 if she was ready to eat and brought her out to the dining room. During observation on 3/19/24 at 8:42 a.m., R26 was in the dining room and there was no pillow under her legs. During observation on 3/19/24 at 8:43 a.m., R26's treatment administration record (TAR) was viewed and licensed practical nurse (LPN)-A signed off on the TAR that R26 had the Prevalon boots on at all times and elevate legs on pillows at all times in bed and in wheelchair. During observation on 3/19/24 at 11:39 a.m., R26 was in her room in her wheelchair and there was no pillow under R26's legs. During interview on 3/19/24 at 11:54 a.m. licensed practical nurse (LPN)-A went into R26's room to administer R26's insulin. R26 was in her room and did not have the pillow under her legs. LPN-A stated R26 can refuse, but when you explain what you are doing, she is agreeable and did not refuse cares with the aides. If a resident refused, it was documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 3/19/24 at 12:05 p.m., nursing assistant (NA)-A stated he was taking care of R26 and they looked to the care plan to know what cares a resident required and stated he did not have a care plan on him. NA-A stated R26 required total assist with a full body lift and two people to reposition, additionally NA-A stated R26 was supposed to have pillows under her legs when in bed and used the boots when R26 was in the room and stated that was how it was identified on the care plan. NA-A obtained and viewed the nursing care sheet and then stated when R26 was in her room, they elevate her legs and put a pillow under them and verified R26 did not have a pillow under her legs in the chair and verified the care sheet indicated she should have a pillow under her legs at all times. During interview on 3/19/24 at 12:14 a.m., LPN-A stated R26 had boots and required repositioning and stated the last time he checked, R26's wounds were improving. LPN-A stated because of the foot peddles, R26 was supposed to have pillows under her legs to elevate the foot and reduce the pressure and expected the pillow to be under her and verified there was no pillow under her legs when he gave R26 her insulin in the room. During observation on 3/19/24 at 12:25 p.m., LPN-A and the director of nursing (DON) brought R26 into her room. During observation on 3/19/24 at 12:27 p.m., LPN-A came out of R26's room and R26 had a pillow positioned under her legs. During interview on 3/19/24 at 12:27 p.m., the DON stated the pillow under the legs should be on the care sheet and expected staff follow the care sheet. During interview on 3/19/24 at 3:05 p.m., registered nurse (RN)-A stated R26 had diabetes and peripheral vascular disease and had a pressure ulcer on her left heel and stated they were using a Rooke boot that caused the other areas of breakdown and are now on a third type of boot. RN-A stated the pillow was used to keep the R26 more offloaded and would have expected the pillow to be in place and the CNA should have had the group care sheet. A policy, Skin Integrity Management Policy, dated October 2022, indicated it was the policy of the facility to properly identify, assess and monitor residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers injuries to implement preventative measures, and to provide appropriate treatment modalities for pressure ulcers injuries according to industry standards of care. The results of the comprehensive assessment are used to develop, review and revise the resident's comprehensive plan of care. Based upon the findings of the clinical assessment in partnership with the resident and or family input a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The care planned interventions will be communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and or through report.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure adequate monitoring of orthostatic blood pressures for antipsychotic drug use for 1 of 4 residents (R22) reviewed for psychotropic drug use. Additionally, the facility facility failed to ensure adequate monitoring of weights and fluid status for 1 of 5 residents (R22) reviewed for unnecessary medications. Findings include: R22's annual Minimum Data Set (MDS) dated [DATE], R22 had moderate cognitive impairment and received a diuretic (water pill), an antidepressant, and an antipsychotic on a routine basis. R22's diagnoses included high blood pressure, high cholesterol, peripheral vascular disease (a circulation disorder caused by a narrowing of the blood vessels), edema (swelling caused by too much fluid trapped in the body's tissues), depression, anxiety, insomnia (sleep disorder), dementia (a loss of memory, language, problem-solving and thinking abilities), and psychosis (symptoms affecting the mind where someone may lose contact with reality). R22's Care Area Assessment (CAA) for cognitive loss and dementia dated 1/16/24, indicated further cognitive decline was anticipated with dementia disease progression. The CAA indicated R22 was at risk for skin breakdown due to her cognitive deficit. R22's CAA for psychotropic drug use dated 1/16/24, indicated R22 had scheduled antidepressants and antipsychotics and staff were monitoring for side effects and targeted behaviors. The CAA for nutritional status dated 1/16/24, indicated R22's body mass index (BMI) was too high at 40. 5049 and identified medical problems that could affect eating and appetite as poor memory, cardiovascular disease, depression, and anxiety. The CAA also identified R22's diuretic could affect her nutritional status. R22's physician's orders included the following, - escitalopram oxalate oral tablet (Lexapro), to give 15 milligrams (mg) at bedtime for anxiety/depression, dated 5/25/23. - furosemide 20mg (Lasix), to give 1 tablet by mouth in the morning for edema, dated 5/11/22. - quetiapine fumarate tablet 25mg (Seroquel), to give 1 tablet by mouth one time a day for yelling/psychosis, dated 3/11/22. - quetiapine fumarate tablet 50mg (Seroquel), to give 50mg by mouth at bedtime for psychosis/agitation, dated 8/15/22. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flagstone	12500 Castlemoor Drive Eden Prairie, MN 55344

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor for side effects of antipsychotic which may include slow movement, drooling, restlessness, mask like face, Tardive Dyskinesia (abnormal, recurrent, involuntary movement), abnormal blood pressure, trembling, lethargy, urine retention, shuffled gait, abnormal movement, muscle stiffness. If any abnormal, recurrent, involuntary movements are noted, complete AIMS assessment. If side effects noted complete progress note and update MD as needed. Every evening shift every month, starting on the 4th for one day for side effect monitoring, complete orthostatic blood pressure (laying, sitting, and standing) and complete orthostatic blood pressure progress note with results, dated 1/4/23. - Enter weekly weight. For 5-pound difference from previous weight, notify MD/NP, dated 9/30/21. R22's care plan dated 5/03/23, identified her alteration in cardiovascular status related to high blood pressure and high cholesterol. R22's care plan indicated she was receiving aspirin and a diuretic and was at risk for dehydration or fluid deficit related to her diuretic use. The care plan identified interventions of monitor weights per facility policy, monitoring and recording vital signs and notifying the provider of significant abnormalities. Additionally, R22's care plan identified she had a nutritional problem related to undesirable weight gain complicated by high blood pressure and morbid obesity. The care plan identified interventions of obtaining R22's weight per provider's order and following for edema and diuretic impact on weight status. R22's care plan also identified she was using an antipsychotic medication for behavior management for treatment of psychosis. The goal identified for R22 was to be free from drug-related complications, including hypotension. Interventions listed in the care plan included administering medications as ordered and monitoring for side effects and documenting effectiveness. R22's treatment administration record (TAR) showed documentation of completion for side effect monitoring of antipsychotic medication and orthostatic blood pressures for 2/4/24 and 3/4/24. R22's electronic health record (EHR) lacked documentation of orthostatic blood pressures. Additionally, R22's EHR revealed the following weights, - 1/11/24 at 8:06 a.m., R22's weight was documented as 236.0 pounds (lbs). - 1/22/24 at 1:55 p.m., R22's weight was documented as 236.0lbs. - 2/1/24 at 8:18 a.m., R22's weight was documented as 244.2lbs. - 2/8/24 at 10:21 a.m., R22's weight was documented as 237.8lbs. - 2/8/24 at 1:04 p.m., R22's weight was documented as 237.8lbs. R22's EHR lacked documentation that her provider was updated regarding these 5-pound weight differences. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a provider progress note dated 1/29/24, under the diagnosis, assessment and plan header, R22's diagnosis of lower extremity edema was addressed. The assessment indicated the edema was chronic with no signs or symptoms of congestive heart failure, skin breakdown, or pain. The provider wrote consider permanently increasing Lasix to 40mg daily if leg edema becomes painful/skin breakdown. The provider indicated the weight gain could be a combination of increased caloric intake and fluid. The plan for R22's leg edema was to continue to the current dose of Lasix and elevate her feet twice daily. Under the Plan header, the provider wrote no new orders, and see under diagnosis and assessment for R22's plan. During observation on 3/18/24 at 5:49 p.m., R22 was sitting in the doorway in her wheelchair. She had on compression stockings with notable swelling to both of her lower legs, the left leg with greater swelling than the right. R22 stated she needed to use the bathroom and self-propelled outside of her doorway. While moving in her wheelchair, R22 had audible expiratory wheezing. She denied feeling short of breath or having trouble with her breathing. During continuous observation and interview on 3/20/2024 between 8:30 a.m. and 8:48 a.m., nursing assistant (NA)-B assisted R22 with morning cares. NA-B introduced herself and asked how R22 felt. R22 stated she had a headache and wanted something for it. NA-B stated she would get her morning medications before breakfast and that should help. NA-B applied compression stockings to R22's lower legs and R22 verbalized right leg tenderness. NA-B explained the indication for the compression stockings was for her edema and finished putting the stockings on. NA-B assisted R22 from a laying to a seated position on the edge of her bed and R22 stated she was dizzy. NA-B instructed her to take deep breaths while she positioned a lift sling behind R22's back and tightened the safety straps. R22 could be heard audibly wheezing while breathing. NA-B instructed R22 to stand up and used the mechanical lift to assist her into a standing position and transferred her into the bathroom to finish morning cares. When asked about R22's complaints of pain during cares, NA-B stated, she gets really dizzy, she has vertigo, I think, positional vertigo. I just tell her to breathe. NA-B stated if R22 was having pain, that would be something to report to the charge nurse. NA-B indicated that R22 had said she had a headache, but that was her baseline. NA-B stated she reported this once previously and the nurse told her that was her normal. During interview on 3/20/24 at 11:11 a.m., registered nurse (RN)-C stated the expectation for orders for weekly weights and to notify the provider of weight changes would be to weigh the resident and if there was a significant difference, to re-weigh the resident before notifying the provider. RN-C reviewed R22's weights and verified the 5-pound differences between 1/11/24 and 1/18/24 and 2/1/24 and 2/8/24. RN-C reviewed R22's EHR for documentation of provider notification and acknowledged and stated I don't see anything for January. I don't see anything for February. RN-C stated the provider should have been updated on the weight changes to follow R22's orders. RN-C verified being responsible for reviewing provider progress notes RN-C reviewed the provider progress note dated 1/29/24 and stated, It says no new orders and instead of scanning the whole thing, I will look to the end and see. RN-C acknowledged R22 did not have daily monitoring for her leg edema. RN-C stated NAs were expected to report any pain or skin issues to the nurse or clinical coordinators. RN-C stated for residents with increased or new pain, skin issues, increased fluid, or difficulty breathing, the expectation was to report those things because there could be clinical significance. RN-C stated for residents using antipsychotic medications, orthostatic blood pressures are checked monthly. RN-C was unable to locate documentation of R22's orthostatic blood pressures. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/20/24 at 12:51 p.m., the director of nursing (DON) stated when providers write orders and recommendations, the process was for the nurses to transcribe the orders and then the health unit coordinator to encode the orders. The DON reviewed the provider progress note dated 1/29/24 for R22 and stated, we should have followed up on that plan to monitor weight and fluid status. When asked about the instances of 5-pound weight difference in January and February, the DON reviewed R22's EHR and verified the weight differences and stated, I don't see any notes. The DON acknowledged the provider was not updated. The DON stated a task could be created to monitor specifically for weight, shortness of breath, or edema, however, R22 did not have that task. The DON stated concern for fluid overload and the risk of not reporting signs of fluid overload like edema and difficulty breathing, could indicate a change of condition. The DON stated R22 had a lot of behaviors and that could be the manifestation for that. A facility policy titled Psychotropic and Unnecessary Medication Use Policy, modified 12/2022, indicated each resident's drug regiment must be free from unnecessary drugs. The policy indicated unnecessary drugs are any drug when used in excessive dose (including duplicate therapy), for excessive duration, without adequate monitoring, without adequate indications for its use, or in the presence of adverse consequences, which indicate the dose should be reduced or discontinued. Additionally, the policy indicated for antipsychotic medication the side monitoring will include a monthly orthostatic blood pressure.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to implement a system to ensure appropriate follow up on wound culture results to prevent potential inappropriate use of antibiotics and determine whether to use special precautions for 1 of 1 resident (R1). Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, was dependent on staff for all activities of daily living (ADLs), had an indwelling catheter, was frequently incontinent of bowels, was at risk for pressure ulcers, and had a stage 4 pressure ulcer (A stage four pressure ulcer is full thickness loss of the skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some parts of the wound bed. Undermining and or tunneling often occur. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer). R1's Medical Diagnosis form indicated the following diagnoses: multiple sclerosis, paraplegia, pressure ulcer of the sacral region stage 4, history of urinary tract infections, and functional quadriplegia. R1's physician orders indicated the following orders and start dates: 3/20/24: daily monitoring of skin to coccyx pressure if any signs or symptoms of complications complete a progress note and update the physician or nurse practitioner (NP) as needed. Otherwise considered clean, dry and intact with no signs and symptoms of complications. Symptoms of infection: warm, red, purulent drainage, tender surrounding skin: indicate if macerated, denuded, erythematous, indurated. Drainage: indicate amount, color, and odor if not within normal limits. 3/20/24: infection: wound infection refer to the infection progress note template for assessment and documentation requirements. Document at least with the start and end of an antibiotic regimen and during the course of treatment with a clinical change or vital signs assessment that is not within normal limits. 3/13/24: Bactrim DS oral tablet 800-160 milligram (MG) sulfamethoxazole-trimethoprim (an antibiotic) give 1 tablet two times daily for wound infection for 10 days. 3/8/24: Coccyx (tailbone) wound care: apply Vashe (a wound cleanser that inhibits microbial contamination)-moistened gauze into wound bed for 10 minutes then remove and pat dry. Nystatin powder (an antifungal) over fungal rash and crust into place with skin prep. Apply two layers of Alginate AG Rope (A dressing used to absorb moderate to heavy amounts of wound exudate) dressing into the wound bed, cover with an occlusive foam dressing to prevent soiling from stool or urine. R1's medication administration record (MAR) and treatment administration record (TAR) for March 2024, was reviewed and lacked information regarding following up on a wound culture report. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan revised 6/23/23, indicated R1 was at risk for infection related to suprapubic catheter in place, pressure ulcer of coccyx, history of infections (Septic shock), cellulitis, strep bacteremia, COVID, and urinary tract (UTI). Interventions indicated change my dressing per orders, give the medication as ordered, monitor for signs and symptoms of illness, encourage fluids per facility policy, isolate per facility policy, review with the resident the risk versus benefits of his decisions, monitor for increased symptoms of infection which may include increased temperature, altered mental status or vital signs, increased drainage, lethargy or redness of site. Additionally, interventions indicated to monitor lab results per physician orders. R1's care plan lacked information R1 had a current wound infection. R1's After Visit Summary note dated 3/7/24, in the electronic medical record (EMR) indicated R1 was seen at the wound clinic 3/7/24, and a wound culture was obtained. R1's progress notes dated 3/1/24, indicated R1 had a stage 4 full thickness pressure ulcer and the note indicated the dressing was done and the wound bed had moderate drainage and was co-managed by the wound clinic. R1's progress notes dated 3/7/24, indicated R1 had new orders from the wound clinic. R1's progress notes were reviewed from 3/6/24, to 3/20/24, and lacked evidence a request for R1's culture and sensitivity report of the wound infection had been requested until 3/20/24, when a progress note was entered at 8:50 a.m., indicating staff requested the culture and sensitivity of the wound infection from the wound clinic. R1's care sheet dated 3/15/24, indicated R1 required assist of two to reposition every two hours and as needed. The care sheet lacked information R1 had a current wound infection. R1's medical records were reviewed and lacked information a culture and sensitivity for the wound culture was received by the facility. The facilities antibiotic tracking log indicated R1 had a cellulitis/soft tissue/wound to skin and the infection according to the wound doctor was in the sacral pressure ulcer and the date of onset was 3/8/24. The log indicated R1 had a wound culture, however there was no follow up of the results from the culture documented and under the heading, transmission based precautions required indicated transmission based precautions were not required. On 3/20/24 at 12:16 p.m., an emailed wound clinic progress note indicated R1 was seen at the clinic on 3/7/24, had subcutaneous wound debridement with a wound culture obtained by the NP, and the clinic would contact the facility if antibiotics were required. Additionally, the note indicated the sacral wound had moderate to large amount of serosanguinous drainage, and under instructions, indicated wound care orders with an occlusive foam dressing to prevent soiling from stool or urine. The urine had been bypassing the catheter. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 1:15 p.m., an emailed wound culture and sensitivity report for R1 indicated the final results for the wound culture was dated on 3/10/24, and acknowledged by the nurse practitioner (NP) on 3/11/24. The clinic nurse contacted the facility on 3/13/24, to call in the prescription for Bactrim DS one table twice daily for 10 days. The wound culture indicated R1 had staphylococcus aureus and under the comment indicated the isolate was MRSA (methicillin resistant Staph aureus, a bacteria that is difficult to treat because of resistance to some antibiotics). Additionally, the wound culture indicated there was mixed flora present and Providencia rettgeri (a bacteria). During interview on 3/18/24 at 12:32 p.m., the administrator stated the infection preventionist worked at a couple of campuses and would be on site at this facility on 3/19/24. During interview on 3/18/24 at 1:20 p.m., R1 stated he was on an antibiotic for his wound and his wound was biopsied and his catheter had been leaking. During interview on 3/19/24 at 12:35 p.m., the infection preventionist (IP) stated lab results were located under the Miscellaneous form in the electronic medical record (EMR). The IP stated if a resident went to the clinic and an antibiotic was ordered they sometimes asked for the culture and sensitivity report and stated they would call if a resident was on an antibiotic and the culture and sensitivity was not located in the chart and added the clinical coordinators were good at following up. IP further stated they tried to get the culture and sensitivity report back as soon as they are available and stated they would enter a progress note when the culture came in. IP further stated when asked how they made sure obtaining the culture and sensitivities didn't get missed that she was not the only staff person who checked for cultures and stated the clinical coordinators were also making sure to follow up on cultures and sensitivities. During interview on 3/20/24 at 8:27 a.m., registered nurse (RN)-A stated they followed up on cultures by monitoring and reporting cultures to the nurse practitioner to make sure the sensitivities were in line with the antibiotic ordered and if they were not, they followed up with the provider for a change in medication. RN-A stated R1 had a culture completed at the wound clinic and verified they did not have the wound culture report at the facility. RN-A further stated R1 started on an antibiotic on 3/13/24, and stated sensitivities typically took three days for urine cultures to come back, and R1 went to the wound clinic on 3/7/24, and did not know how long it took for wound cultures to be finalized. RN-A stated she would have to follow up and get the culture and sensitivity. When asked about the process to make sure a culture and sensitivity didn't get missed, RN-A stated the IP tracked infections with a form that indicated check for sensitivities. RN-A further stated she was not able to answer who followed up with the sensitivities when the IP was only at the facility two days a week, and would have to look at the process. RN-A verified there was no documentation anyone followed up with the culture and sensitivity and would check on it today. RN-A further stated the wound clinic would be looking at their own sensitivity, however the nursing facility would be expected to look at the sensitivity as well. During phone interview on 3/20/24 at 9:03 a.m., the IP stated R1 was on Bactrim for a wound infection and stated as far as she knew, R1 did not have a wound culture done. When asked how staff know to follow up if there was a culture, the IP stated the lab reported back and faxed information over and staff communicate there is a culture pending and to watch for it, but would have to pull the director of nursing into the conversation to know the steps on a day to day basis because the IP reviews notes and was not a fly on the wall for each shift. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/20/24, 9:24 a.m., the wound clinic provided an email for a request for medical records for R1's wound progress notes and culture results. During interview on 3/20/24 at 1:56 p.m., NP-E stated she would defer any special precautions to the facilities infectious disease policy and further stated she did not order the wound culture and did not know if the two organisms required special precautions. During interview on 3/20/24 at 2:07 p.m., the medical director (MD) stated he would advise not to complete a wound culture unless it was a tissue biopsy. MD further stated he thought it was the responsibility of the ordering provider to keep track of culture results especially if it was completed outside the facility and stated special precautions depended whether there was unprotected drainage from the wound and stated R1 was in his room all the time and if up, was confined to a wheelchair and stated standard precautions should be more than sufficient. During interview on 3/20/24 at 2:23 p.m., the director of nursing (DON) stated the IP handled infection control and had an infection log that was provided. The DON stated once they have the culture and sensitivity report, it is faxed to the provider. If the NP or physician orders a culture, they collect it at the facility and send it to the lab and wait for the result. The staff can look and monitor the process and follow up on the result and stated for example if a urine culture (UC) was completed, the treatment administration record (TAR) would indicate a UC was collected and they had a paper tracking form in a lab book. The DON stated the wound clinic would send a wound culture. At 2:29 p.m., the DON grabbed a pathway lab book and clarified since R1 had a culture completed at the wound clinic, the culture would not be in the pathway lab book because this book was for in house only labs. DON further stated the medical director called and said standard precautions was fine for R1 because R1 did not leave the room. Now we will plan to do contact precautions and stated they put the cart in there already and stated in practice, they should follow up on the cultures, but was difficult to track when the clinics did the labs. DON further stated it was important to complete contact precautions in theory, but R1 had minimal risk. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Infection prevention and Control Antibiotic Stewardship and MDROs, dated 2020, indicated antibiotic stewardship refers to systematic efforts to optimize the use of antibiotics not just reduce the total volume used to maximize their benefits to patients, while minimizing both the rise of antibiotic resistance as well as adverse effects to patients from unnecessary antibiotic therapy. Stewardship involves identifying the microbe responsible for disease, utilizing evidence based definitions when indicated; selecting the appropriate antibiotic along with documentation indicating the rationale for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed. CMS requires an antibiotic stewardship program as a condition of participation for Medicare and Medicaid programs. There are 7 core elements for antibiotic stewardship in nursing homes outlined by the Centers for Disease Control (CDC): leadership commitment, accountability, drug expertise, action, tracking, reporting, education. The IP will be responsible for surveillance, infection definition based on standards of practice, education, tracking, data management, analysis of data, communication with the DON, medical and consultant pharmacist and ongoing system review. Tracking and reporting of antibiotic use and outcomes will be completed in the facility to identify adherence to facility policy and procedures, use and outcomes. Tracking will allow the facility to identify patterns, prevalence of antibiotic use as well as specific ordering data. Outcomes (i.e. adverse drug events, antibiotic resistant organisms, C. Difficile infections, etc.) will be tracked by the infection preventionist and discussed with the quality assurance committee for action planning. If an antibiotic therapy is ordered, documentation will include diagnosis or indication, medication, dose, route, and duration. In the event that diagnostic testing had been ordered, prompt communication of results will be provided to the practitioner. Monitor review response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. Multi-drug resistant organisms (MDROs) pose a serious threat to the health and well-being of our nation. Facilities must develop an action plan to include outbreak response processes in place to prevent the spread of and reduce the dangerous outcomes of these multi drug resistant organisms or superbugs. MDROs found in facilities can include, but are not limited to MRSA, VRE, CRE, KPC, and Clostridium difficile. Transmission based precautions may be employed for residents who have actively infected with MDROs. Aggressive infection control measures and strict compliance by healthcare personnel can help minimize the spread of MDROs to other susceptible individuals. It is important for facilities to have good systems in place to keep residents safe.