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	01/29/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48740 Based on observation, interview and document review, the facility failed to ensure the resident's ability to self-administration of medications (SAM) was assessed prior to leaving medications with the resident for 3 of 3 residents (R33, R267, R9) reviewed who had medications in their rooms. R33 R33's admission Minimum Data Set (MDS) dated [DATE], identified R33 had no cognitive impairment and diagnoses which included: muscle weakness, depression, and diabetes. R33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activity of daily living (ADL) self-care performance deficits due to encephalopathy, aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be clean and well-dressed. R33 required one assist for dressing, grooming, and hygiene. The care plan lacked information regarding self-administration of medication or medications that were kept in the resident's room. During an observation on 1/27/25 at 12:41 p.m., Nystatin powder (medication used to treat fungal skin infections) was located on the table next to the bed. R33 indicated his Nystatin powder is always there. Review of orders dated 1/21/25 revealed an order for Nystatin 1000 units/gram powder applied topically daily and twice a day as needed. No order to leave medication at bedside. Review of assessments revealed a lack of an assessment to self-administer medication. During an interview on 1/27/25 at 6:21 p.m., registered nurse (RN)-A, verified Nystatin power was on the side table next to the bed. RN-A indicated it must have been left out by mistake and removed the Nystatin powder. RN-A locked up the Nystatin powder in the medication cart. During an interview on 1/28/25 at 8:41 a.m., RN-B indicated Nystatin powder should not be have been left on the nightstand as it was a medication. RN-B verified R33 did not have an order for medications to be left at the bedside. R267 (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	R267 quarterly MDS dated [DATE], identified R267 had no cognitive impairment and diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal assistance with personal hygiene including combing hair and shaving. R267's care plan revised on 11/22/24, revealed R267 chose not to self-administer medications. Care plan directed staff to administer medications per orders. During an observation on 1/28/25 at 12:19 p.m., R267 had refresh eye drops (for dry eyes) present on the side table. On the nightstand, R267 had one bottle of Tums (treatment for heartburn) 1000 mg, one bottle of antacids (used to neutralize acid in the stomach), one roller-ball anti-itch hydrocortisone (decrease inflammation/ itchy skin), and one hydrocortisone 1% cream (a cream to treat skin conditions such as itchy or inflamed skin). Review of signed orders dated 1/24/25, revealed R267 did not have orders for medications to be left at bedside. R267 did not have an order for Tums or refresh eye drops. R267 did have an order for hydrocortisone cream however, no order for the medication to be left at the bedside. Review of the electronic medication administration record (EMAR) for January 2025, revealed hydrocortisone cream 2.5% apply to perineal area topical two times per day, order start date of 1/20/24. No self-administration order or order to be left in the room was noted. No order for Tums, antacids, or refresh eye drops on the EMAR. Further review of EMAR for January 2025, revealed, artificial tears ophthalmic solution 0.1-0.3 %, install 1 drop in both eyes as needed for dry eyes, four times a day. Medication was discontinued on 1/20/25. Review of assessments revealed R267 did not have an assessment to self-administer medications. During an interview on 1/28/25 at 2:42 p.m. licensed practical nurse (LPN)-B confirmed R267 had no orders for medications to be left at the bedside. LPN-B confirmed eye drops were on the side table, one bottle of Tums 100 mg, one bottle of antacids, one roller-ball anti-itch hydrocortisone, and one hydrocortisone 1% cream on the nightstand. Progress note from 1/28/25 at 8:09 p.m., revealed: resident was found to have one bottle of Tums, one bottle of antacids, one roller-ball anti-itch, hydrocortisone tube and refresh eye drops in the room. Writer explained why we could not let him keep the medication in there, and that they would be given to his daughter to take home. Writer then called the daughter to explain the situation and let her know that nurse practitioner would be informed and see if at all possible to have these medications ordered as needed so facility staff could administer them. R9 R9's MDS dated [DATE], identified R9 had no cognitive impairment and needed moderate assistance with activities of daily living. R9 had diagnoses which included hypertension, arthritis, and pain in right leg. During an observation on 1/27/25 at 12:13 p.m., Aspercream with lidocaine (medication used for pain relief) was noted on the bedside table. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/28/25 at 8:54 a.m., Aspercream with lidocaine continued to be next to the bed on the bedside table. During an observation on 1/28/25 at 12:28 p.m., aspercream with lidocaine continued to be next to the bed on the bedside table. R9 care plan revised on 10/7/24, revealed R9 chose not to self-administer medications, except for aspercream. Review of R9's assessments revealed R9 did not have an assessment to self-administrator medications. Review of signed orders dated 11/12/24, revealed aspercream lidocaine external cream 4% (for pain relief) apply to affected area(s) topically as needed for pain apply 2 grams twice a day to painful area and apply to lower legs topical in the morning for pain apply two grams to each lower leg before compression stockings. No orders for self-administration of medications was noted. Review of EMAR for January 2025, revealed staff signed off the administration of Aspercream Lidocaine external cream 4% apply to lower legs topically in the morning for pain apply two grams to each lower leg before compression stockings, order start date was 12/12/23. EMAR lacked orders to leave medication at bedside. During an interview on 1/27/25 at 12:13 p.m., R9 stated she kept the aspercream with lidocaine at the bedside otherwise R9 would forget to apply it. R9 indicated the cream had always been on the bedside table. During an interview on 1/27/25 at 6:19 p.m.,. RN-A reported the nurse would complete the self-administration order for a resident to self-administrate a medication in their room. RN-A revealed staff put on the aspercream for R9. RN-A verified R9 did not have an order to self-administer the medications. RN-A verified R9 did not have a self-administration assessment completed. RN-A verified that R9 had aspercream with lidocaine was left on her bedside table. During a follow-up interview on 1/28/25 at 4:41 p.m. director of nursing (DON) indicated if a resident was assessed to be able to self-administer medications, it would have been identified in the care plan, otherwise medications were kept in the medication cart. DON verified R33, R267 and R9 did not have self-administration assessments completed. A policy titled Medication Administration Policy dated May 2021 revealed Procedure: 17. Medication would not be left at beside unless resident had an order for self-administration of medications and had been assessed to be safe to do so and the care plan reflected the resident's ability.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 Based on interview and document review, the facility failed to ensure residents were provided a private meeting place without staff present for resident council meetings. This deficient practice had the potential to affect all five residents (R29, R39, R45, R35, and R12) who regularly attended the monthly resident council meetings. Findings include: R29's quarterly Minimal Set Data (MDS) dated [DATE], revealed R29 had mild impaired cognition. R39's annual MDS dated [DATE] ,revealed R29 had no cognitive impairment. R45's annual MDS dated [DATE], revealed R45 had no cognitive impairment. R35's quarterly MDS dated [DATE], revealed R25 had mild cognitive impairment. R12's significant change MDS dated [DATE] ,revealed R12 had no cognitive impairment. During an interview on 1/28/25 at 10:01 a.m., with resident council members R29, R39, R45, R35, and R12 revealed none of the residents had been to a resident council meeting. R29, R39, R45, R35, and R12 indicated they had not been invited to attend a resident council meeting. The residents denied staff offering to bring them to a resident council meeting. The review of the resident council meeting minutes on 1/27/25 at 6:39 p.m., revealed a list of residents (R45, R39, R29, R12, and R35) who attend resident council meetings regularly. The resident council meeting minutes revealed the resident council reviewed nursing services, culinary, activities, housekeeping, and maintenance during each resident council meeting and reviewed old concerns. The review of the resident activity calendar for Thursday, 1/21/25, revealed 12:00 p.m., resident council on the first floor, and 12:30 p.m., resident council on the second floor. The resident activity calendar laced identification where the meetings were located. The review of the activity calendar for Friday, 12/27/24 revealed 12:00 p.m., resident council first floor, and 12:30 p.m., resident council on the second floor. The resident activity calendar lacked documentation on where the resident council meeting was located. During review of the activity calendar for Friday, 1/24/25, revealed resident council at 12:00 p.m., for the first floor. Resident council 12:30 p.m., for the second floor. The activity calendar did not identify the location of the resident council meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/25 at 10:51 a.m., activity director (AD) revealed the resident council was once a month during lunch. AD indicated her process was to go to the first-floor dining room and have resident council while residents were in the dining room eating lunch. AD then went to the second floor and had a resident council meeting while the residents were eating lunch. AD was unable to answer how people were invited. AD was unable to answer how residents who ate in their rooms or were fed by a feeding tube, attended resident council meetings. During an interview on 1/28/25 at 3:09 p.m., R12 stated she did not know that the dining room meetings were resident council meetings. R12 stated she did not bring up concerns during those meetings however, did listen to the information. R12 felt a private meeting would have been helpful to share things that should have been discussed in a more private setting. During an interview on 1/29/25 at 8:33 a.m., R45 stated she did not know that the resident council meetings were held in the dining room. R45 indicated during meals, staff would bring up topics while residents were eating. R45 indicated no one informed her that talking in the dining room was a resident council meeting. R45 would have rather had a private meeting to bring up topics she had concerns with. During an interview on 1/28/25 at 4:14 p.m., the administrator indicated resident council was on the resident activity calendar and that all residents received a resident calendar. The calendar was also hung in the hallway. The administrator was unable to verify how everyone was invited to participate if the resident did not come to the dining room for lunch. The administrator felt a resident could talk to the AD in private if there was a concern or fill out a grievance form. The administrator did not feel there was a concern with the meetings not being private and was held with dietary and nursing staff in the dining room. The administrator felt residents could have asked a staff member to discuss their concerns one-on-one if needed. A facility policy titled Resident Council Policy dated 8/24, indicated it was the policy of Presbyterian Homes and Services to provide an opportunity for residents to meet in a private space and for the facility to take reasonable attempts with the approval of the group to make residents aware of upcoming meetings in a timely matter. Procedure: 1. Staff, visitors or other guests may only attend resident group meetings only at the respective group's invitation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on interview and document review, the facility failed to follow the comprehensive care plan for 1 of 1 residents (R62) whose care plan was reviewed. Findings include: R62's significant change Minimum Data Set (MDS)dated 12/24/24, identified R62 had no cognitive impairment and had diagnoses which included depression and malnutrition. R62 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. R62's clinical nutrition assessment dated [DATE], identified R62 was on a regular diet and was independent with eating after set up. R62's care plan revised 12/30/24, identified R62 had limited physical mobility and self-care deficits related to failure to thrive, protein malnutrition and weigh loss. R62's intervention included: R62 needed to get up in her wheelchair for all meals. R62's care sheet dated 1/17/25, identified R62 was to be up in wheelchair for all meals. During an observation on 1/28/25 at 12:20 p.m., nursing assistance (NA)-F entered R62's room with R62's meal tray. NA-F set R62's meal tray on the bedside table and asked R62 if she wanted to be boosted up in bed prior to eating. NA-F boosted R62 up in bed, elevated the head of the bed and pushed R62's bedside table over R62's bed. NA-F asked R62 if she wanted the head of bed up higher so R62 could eat better. R62 indicated she did and NA-F raised the head of her bed. NA-F told R62 what was on her tray and left R62's room. During an interview on 1/28/25 at 12:28 p.m., NA-F stated staff were to expected to get R62 up into her wheelchair for all meals. NA-F further stated she did not ask R62 to get up into her wheelchair because, R62 would probably refuse anyway. NA-F reviewed the care sheet for R62 and indicated the care sheet stated R62 was to be up in her wheelchair for all meals. During an interview on 1/28/25 at 3:10 p.m., registered nurse (RN)-C confirmed R62 was to be up in her wheelchair for all meals. RN-C stated staff were to report if R62 refused to get up in her wheelchair. During an interview on 1/28/25 at 4:39 p.m., household coordinator (HC) confirmed that R62 was to be up in her wheelchair for all meals for repositioning and quality of life. HC indicated R62's careplan and caresheet stated R62 was to be up for all meals. During an interview on 1/29/25 at 10:33 a.m., director of nursing (DON) confirmed the above findings and stated it was her expectation that staff would follow residents care plans. DON stated she would expect staff to report any refusals to the RN and document the refusal. Requested a careplan policy, however, one was not provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 4 of 4 residents (R7, R33, R267) reviewed for activities of daily living (ADL)'s. Findings include: R7 R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 had severe cognitive impairment and had diagnoses which included renal insufficiency, dementia, and depression. Identified R7 required one person physical assist from staff with personal hygiene. R7's current care plan revised 2/27/24, indicated R7 had deficits with ADL's related to dementia and muscle weakness. Indicated R7 required staff assistance with personal hygiene and preferred to have staff assistance with removing facial hair. R7's annual comprehensive Care Area Assessment (CAA) dated 6/6/24, identified R7 required assistance with ADL's. Identified R7 had an activity intolerance related to weakness, physical limitations and dementia. R7's care sheet undated, identified it was a standard for staff to shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R7 was sitting in her wheelchair in the day room and had several half inch long white facial hairs on her chin and above her upper lip. During an interview on 1/27/25 at 1:26 p.m., family member (FM)-A stated R7 preferred to be shaved when facial hair was visible. During an observation on 1/28/25 at 8:11 a.m., R7 was sitting in her wheelchair at the dining room table. R7 continued to have several half inch long white facial hairs on her chin and above her upper lip. During a joint interview on 1/28/25 at 8:51 a.m., nursing assistant (NA)-A and licensed practical nurse (LPN)-A verified R7 had several long white facial hairs. NA-A stated R7 required staff assistance to shave facial hair. NA-A stated she had not assisted R7 with shaving recently and was unsure the last time R7 had been shaved. LPN-A stated her expectation was that R7 would have been shaved as soon as facial hair was present. 48740 R33 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's MDS dated [DATE], identified R33 had no cognitive impairment and diagnoses which included muscle weakness, depression, and diabetes. R33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activities of daily living (ADL) self-care performance deficitsdue to encephalopathy, aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be clean and well dressed. R33 required one assist for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/28/25, revealed stands of care: call light in reach, encourage use. Shave residents daily. During an interview on 1/27/25 at 12:30 p.m., R33 had approximately 2 cubic centimeters (cm) of facial hair on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:47 a.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. During an observation at 1/28/25 p.m. at 3:28 p.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. During an interview on 1/27/25 at 12:30 p.m., R33 reported his shaver did not work and was under the impression the facility requested residents buy their own shavers and did not want to spend money on a shaver. R33 had approximately 2 cubic centimeters (cm) of facial hair. During an interview on 1/28/25 at 3:28 p.m., nursing assistant (NA)-A verified R33 had long facial hair around 2 or 3 cm and needed to be shaved. NA-B verified that the care sheet stated to shave residents daily. NA-A stated shaving tasks did not get completed daily. NA-B indicated residents did not get shaved often. NA-B indicated that the facility had shavers for residents to sue however would have to ask a supervisor to obtain one since they were not kept in the storage room. During an interview on 1/28/25 at 2:28 p.m., registered nurse (RN)-B indicated a resident should have been shaved on their shower day or shaved more often depending on the resident preference. R267 R267 quarterly MDS dated [DATE], identified R267 had no cognitive impairment and had diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal assistance with personally hygiene, including combing hair and shaving. R267 care plan revised on 11/22/24, revealed R267 had an ADL self-care performance deficit related to weakness, impaired mobility, self-care ability, severe malnutrition, dysphasia, and pain in legs. R267 wanted to be clean and well dressed. R267 needed assist of one for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/27/25, revealed Standards of care: call light in reach, encourage use. Shave residents daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/27/25 at 1:18 p.m., R267 had approximately 2 cubic centimeters (cm) of hair growth on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:07 a.m., R267 had a razor sitting on his bedside table with 2-3 cm of hair growth on his on his chin, upper lip, and cheeks. During an observation on 1/29/25 at 7:58 a.m., R267 was laying in bed dressed ready to get up, R267 had approximately 3 cm of facial hair. Licensed practical nurse (LPN)-B and nursing assistant (NA)-C entered the room and proceeded to assist R267 with ADLs. LPN-B then shaved R267. During an interview on 1/27/25 at 1:18 p.m., R267 indicated he was supposed to be shaved on Mondays once a week when he has his bath. R267 stated he liked to be shaved often. During an interview on 1/29/25 at 12:19 p.m., R267's daughter indicated R267 liked to be shaved often and did not want facial hair. R267 daughter had bought R267 two different razors. During an interview on 1/28/25 at 1:42 p.m., NA-D did not know how often R267 should have been shaved. NA-D verified that R267 had long facial hair around 3 cm and should have been shaved. R267 stated to NA-D, I like my face shaved, I don't like a mustache. NA-D took out care sheet and verified R267 received a bath on Monday and that R267 would have to request to be shaved. During an interview on 1/28/25 at 2:52 p.m., director of nursing (DON) indicated R7 required staff assistance with shaving. DON stated her expectation was R7 would have been shaved when facial hair was present. During a follow-up interview on 1/28/25 at 4:38 p.m., DON stated the expectation was for staff to shave residents as needed. Staff were expected to do a body audit once a week with the shower and shave at that time if needed. The facility could have provided a razor if the resident did not have their own. A Facility policy titled Activities of Daily Living (ADL's) dated 3/15/21, indicated the facility would have provided care and services for hygiene per the resident's individualized plan of care. Further indicated ADL care would have been provided based on resident preferences.

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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** 48583 Based on observation, interview and document review, the facility failed to provide meaningful and engaging activities for 1 of 1 residents (R62) reviewed for activities. Findings include: R62's significant change Minimum Data Set (MDS) dated [DATE], identified R62 had no cognitive impairment and had diagnoses which included depression, failure to thrive and was currently receiving hospice services. R62 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. R62's LTC therapeutic recreation and activities assessment dated [DATE], indicated R62 preferred day/activity room and independent activities in her room. R62's preferences were visits from her daughter, talking with staff, watching television, one to one visits, and activities in a group setting. R62's care plan revised 12/30/24, identified R62 had a long term goal to choose her own activities. R62's careplan further indicated R62 was to be invited to scheduled activities, provided an activities calendar, and provided supplies to pursue her activity interests. During an observation and interview on 1/27/25 at 5:03 p.m., R62 stated she had not been offered any visitors throughout the day and was feeling very sad. R62 further sated she had not been offered any activities since she was admitted . R62 indicated she did not remember seeing an activities calendar in her room. A scan of the room was completed and no activities calendar was noted. During an observation and interview on 1/28/25 at 12:11 p.m., R62 was laying in her bed using her personal cellular telephone. R62 continued to state she did not have an activities calendar in her room and had never received one for the month of January 25. R62 stated she had no way of knowing what activities were going on in the facility. R62 verbalized that she not had any visitors today. R62 stated this is what I do all day, just lay here in this bed. R62 further stated she wished she had an activities calendar, was invited to actives throughout the day, and had visits from the staff. During an interview on 1/28/25 at 12:28 p.m., nursing assistant (NA)-F stated the life enrichment team was in charge of handing out activity calendars to each resident. NA-F further stated the life enrichment team had daily activities in the community room and R62 enjoyed attending them at times. During an interview on 1/28/25 at 2:38 p.m., life enrichment director (LED) confirmed calendars were handed out to each resident on the first of every month. LED stated life enrichment staff were expected to go to R62's room and invite her to group activities. LED further stated she was not aware R62 did not have an activities calendar in her room and that R62 had not been invited to any group activities. LED indicated staff do not document when a resident completed an activity so she had no way of knowing what activities R62 had been invited to. LED confirmed R62's activity interests. During an interview on 1/29/25 at 10:33 a.m., director of nursing confirmed the above findings and stated no documentation was completed to indicate residents received activities throughout the day. DON stated her expectation was staff were to invite and engage all resident in daily activities. (continued on next page)

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	245312	A. Building B. Wing	01/29/2025

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Requested facility for the Activities Program, however, one was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 Based on observation, interview and document review, the facility failed to implement interventions for 1 of 1 residents (R17) who had a recent fall with a significant injury in the facility and remained at high risk for falls. Findings include: R17's significant change Minimum Data Set (MDS) dated [DATE], identified R17 had severe cognitive impairment and had diagnoses which included anxiety disorder, dementia, and left humerus (bone in the arm) fracture. Identified R17 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. Identified R17 had one fall with a major injury since last assessment. R17's significant change Care Area Assessment (CAA) dated 12/27/24, identified R17 had one fall since prior assessment. Identified R17 had a fall while using a standing lift and fractured her left humerus Identified R17 remained at high risk for falls related to dementia, cognitive impairment with agitation and depression. Further identified R17 was now to use a full body lift for transfers. R17's Fall Risk Screening Tool dated 12/21/24, identified R17 was at high risk for falls related to a recent fall which resulted in a fracture of the left humerus. Identified R17 now required a full body lift with assist of two. R17's care plan revised 12/27/24, identified R17 had a history of falls with fractures and was at risk for further falls related to mobility/balance problems. R17's interventions included: Reassess for standing lift when appropriate, keep bed in lowest position, and place wheelchair next to bed when in bed. Identified R17 wore a sling to left arm and required assistance with dressing, toileting and transfers. R17's care sheet undated, identified staff were to place R17's wheelchair next to bed. Review of R17's progress notes from 12/14/24 to 12/15/24, identified the following: -12/14/24 at 2:40 p.m., NA was transferring R17 in a standing lift when R17 let go of the bar and NA lowered 17 to the floor, called for assistance and used a full body lift to place R17 into bed. -12/15/24 at 10:14 a.m., R17 complained of increased pain in left shoulder, Xray and sling to left shoulder were ordered. -12/15/24 at 12:58 p.m., Fracture to left Humeral head and neck. During an observation on 1/28/25 at 3:03 p.m., R17 was lying in bed and wheelchair was five feet from R17's bed facing the opposite direction. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/29/25 at 7:11 a.m., R17 was lying in bed and wheelchair was in the bathroom approximately 10 feet from R17's bed. During an interview on 1/29/25 at 7:15 a.m., nursing assistant (NA)-A stated R17 had a recent fall and broke her left arm. NA-A stated R17's wheelchair was to be placed next to R17's bed as a fall intervention. During an interview on 1/29/25 at 7:20 a.m., nurse manager (NM)-A verified R 17's bed was lying in bed and the wheelchair was in the bathroom which was approximately 10 feet from R17's bed. NM-A stated R17 was at risk for falls and had a recent fall with a fracture. NM-A further stated her expectation was that the wheelchair would have been placed next to R17's bed. During an interview on 1/29/25 at 8:03 a.m., director of nursing (DON) verified R17 had a recent fall with a fracture. DON verified R17's wheelchair was to be placed next to the bed when R17 was in bed. DON stated her expectation was that the care plan would have been followed to help prevent future falls. Review of a facility policy titled Fall Prevention and Management Program Policy revised 4/21, identified all residents were to be assessed for fall risk and nursing staff would implement interventions according to resident specific risk factors. Further identified care plans would indicate the resident specific interventions to prevent falls . .

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583 Based on interview and document review, the facility failed to ensure newly admitted residents received 30 day physician visits for the first 90 days for 1 of 1 residents (R30) reviewed for 30 day physician visits. Findings include: R30's admission Minimum Data Set (MDS) dated [DATE], identified R30 had no cognitive impairment and had diagnoses which included chronic kidney disease (CKD), an indwelling catheter, and a history of urinary tract infections. R30 required moderate assistance with activities of daily living (ADL's) bathing, transfers, and toileting. R30's facesheet indicated R30 was admitted to the facility on [DATE]. R30's medical record lacked evidence R30 was seen by a physician since admission. During an interview on 1/27/25 at 6:29 p.m., R30 stated he had not seen a physician since he was admitted to the facility. R30 further stated he had requested to see a physician and staff avoided him when he asked. R30 indicated he had seen a nurse practitioner however had wanted to see a physician. During an interview on 1/29/25 at 10:08 a.m., nurse manager (NM)-B stated R30 had been seen three times by a nurse practitioner (NP) since admission however, R30 had not been seen by a physician since admission. During an interview on 1/29/25 at 10:38 a.m., administrator and director of nursing (DON) confirmed the above findings. Administrator stated her expectations were residents received physicians visits every 30 days for the first 90 days after admission. Review of facility policy titled Physicians Services, modified 11/19, the frequency of physicians visits would consist of at least every 30 days for the first 90 days after admission.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on interview and document review, the facility failed to implement a system to ensure medications were available to administer as ordered for 2 of 2 residents (R61, R57) identified who did not receive medications as ordered. Findings Include: R61 R61's admission Minimum Data Set (MDS) dated [DATE], identified R61 had moderate cognitive impairment and diagnoses which included: Crohn's disease (chronic condition that causes inflammation of gastrointestinal tract), heart failure and chronic kidney disease. During an observation on 1/27/25 at 4:38 p.m., trained medication aide (TMA)-A set up R61's medications. TMA-A indicated R61 was to receive Creon (medication that replaces digestive enzymes in body) however it was not available to administer, so would contact the pharmacy to order it again. R61's Discharge Orders And Information hospital form dated 12/30/24, included the following: -Creon 24000-76000 units oral capsule, take one capsule by mouth three times daily. R61's January Electronic Medication Administration Record (EMAR) identified the following: -Creon Oral Capsule Delayed Release Particles 24000-76000 Unit. Give 1 capsule by mouth with meals for pancreatic insufficiency, from January 22 at 1200 p.m. to January 28 at 8:00 a.m., it was not administered 18 times. Review of R61's progress notes from 1/22/25, to 1/27/25, identified the following: -1/24/25 at 5:05 p.m., Creon Oral Capsule, no supply, called pharmacy and informed nurse. -1/27/25 at 4:46 p.m., Creon Oral Capsule, need to be reordered. R61's progress notes lacked documentation R61's provider had been notified R61's Creon medication was not available. During an interview on 1/28/25 at 10:16 a.m., clinical coordinator registered nurse (RN)-B confirmed R61's Creon was not available, and had not been administered since 1/22/25. RN-B stated she became aware that morning that R61 was out of Creon medication, and would make sure it was available to give later that day. RN-B indicated the facility's usual process was to reorder medication when the medication ran out from pharmacy. RN-B stated she would need to contact director of nursing (DON) to see if anything else could be done. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/28/25 at 12:37 p.m., pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy, and if not available to try a different pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. PC-A stated that if R61 did not have Creon as ordered, R61 could have gastrointestinal (GI) upset. PC-A indicated if a resident did not receive Zoloft as ordered, they may be fine, or it may affect their depression, or cause anxiety. During a telephone interview on 1/28/25, at 11:54 p.m., nurse practitioner (NP)-A confirmed she was familiar with R61's care and had not been notified R61 was not receiving Creon as ordered. NP-A stated if R61 did not have Creon medication available to administer, her expectation was that pharmacy would be notified, and if still unavailable that she or triage would be contacted because it was important residents receive their medications as prescribed. During a follow up interview on 1/29/25 at 8:45 a.m., RN-B stated R61's Creon had been ordered and would be delivered that day. RN-B indicated they notified R61's provider of R61's missed Creon medication, and they spoke to PC-A who advised them to monitor for possible effects of gastrointestinal symptoms from R61 not receiving receiving the Creon as ordered, so R61 would be monitored. 48740 R57 R57's quarterly MDS dated [DATE], identified R57 had moderate cognitive impairment and diagnoses which included: hypertension, depression Alzheimer's, aphasia, and seizure disorder. During an observation on 1/28/25 at 9:01 a.m., TMA-E went to set up R57 medications. TMA-E went to take Zoloft (for depression) 25 Milligram (mg) out of the medication cart. TMA-E was unable to locate the medication in the medication cart. TMA-E indicated the medication could have been in the medication room and would check and if unable to locate the medication, then the pharmacy would be contacted. During an interview on 1/28/25 at 1:46 p.m., TMA-E verified that R57 did not have the Zoloft medication in the medication cart but was able to locate the medication in the medication room and was able to give the medication. TMA-E indicated the process would be to reorder the medication according to the date on the medication card. If a resident missed a medication the facility would make the pharmacy aware the medication was currently out and needed to be refilled. The nurse was responsible for updating the physician on the missed medication dose. TMA-E verified the EMAR reflected R57 and did not receive Zoloft 25 mg on 1/26/25 and 1/27/25. Review of the EMAR revealed that R57 did not receive Zoloft 25 mg on 1/26/25 and 1/27/25. Review of the signed physician orders signed 1/27/25 revealed R57 had an order for Zoloft 25 mg, take one tablet by mouth daily. After review of the progress notes from 1/25/25 to 1/27/25, revealed the pharmacy and physician were not updated that R57 missed two doses of Zoloft 25 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 2:52 p.m., RN-B indicated the facility process to reorder medication was to pull the sticker on the medication card when the medication was low and fax the sticker to the pharmacy. It was the responsibility of the floor nurse to let the provider know a medication dose was missed. RN-B indicated she was unaware R57 had missed two doses of Zoloft 25 mg on 1/26/25 and 1/27/25. During a joint interview on 1/28/25 at 2:56 p.m. with director of nursing (DON) and medical director (MD), DON stated facility's usual process was a medication was not available to administer, the TMA would inform the nurse, the pharmacy would be called and a refill form would be completed. DON confirmed she had been made aware earlier that day that R61 had been out of Creon medication since 1/22/25. DON stated they had discovered it was an insurance reason why R61's Creon medication had not been sent, and the facility would be purchasing the medication for R61, so would be available. MD stated he would expect the resident's provider would be contacted if a medication was not available to administer, so they could determine if the resident could wait for the medication to be filled, or if it needed to be urgently refilled. MD stated R61's Creon was not a life threatening medication, they had assessed R61, who did not have diarrhea, which could have been a symptom of not receiving the Creon, so he felt R61 had not suffered consequences of not receiving the medication. DON also confirmed R57 had been out of Zoloft medication to administer, but the medication was now available. MD stated R57 did not suffer any consequences of the two missed Zoloft doses as 25 mg. was a low dose. The facility policy titled Medication Administration Policy revised 5/21, identified the policy was to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. The policy included that the eight rights of drug administration would be followed when administering all medications: right resident, right drug, right dose, right dosage form, right route, right time, right reason and right documentation. The policy included instruction to fax or call the pharmacy for medications, and if medication was not available the emergency kit may be used according to policy. The policy did not identify instruction of what to do if medication was not available to administer from the emergency kit, or to notify the resident's provider if a medication was not available to administer.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905 Based on observation, interview and document review, the facility had a 7% percent medication error rate for 2 of 4 residents(R61, R44) observed during medication administration. Findings Include: R61 R61's admission Minimum Data Set (MDS) dated [DATE], identified R61 had moderate cognitive impairment and diagnoses which included: Crohn's disease (chronic condition that causes inflammation of gastrointestinal tract), heart failure and chronic kidney disease. R61's Discharge Orders And Information hospital form dated 12/30/24, included the following: -Creon 24000-76000 units oral capsule, take one capsule by mouth three times daily. During an observation on 1/27/25 at 4:38 p.m. trained medication aide (TMA)-A set up R61's medications. TMA-A indicated R61 was to receive Creon (medication that replaced digestive enzymes in body) however it was not available, so she would contact the pharmacy to order it again. R44 R44's admission MDS dated [DATE], identified R44 was cognitively intact, and had diagnoses which included: arthritis, sciatica right side (pain that travels nerve from buttocks down leg) and other low back pain. R44's Order Summary Report signed and dated 1/23/25, included the following: -Lidocaine External Patch 5% apply to back topically in the morning for pain. on for 12 hours, off for 12 hours and remove per schedule. Order date 1/16/25. During an observation on 1/29/25, at 7:21 a.m., TMA-A set up R44's medications which included: Lidocaine patch labeled: 4%, apply 1 patch every day for 12 hours and leave off for 12 hours. TMA-A indicated the order was for a Lidocaine 5% patch, but stated the nurse had called the pharmacy and they did not have 5% Lidocaine so they sent the Lidocaine 4% patches instead. At 7:39 a.m., TMA-A entered R44's room, and administered medications, which included applying the Lidocaine 4% patch to R44's lower back. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/25 at 10:16 a.m., clinical coordinator registered nurse (RN)-B confirmed R61's Creon was not available, and not administered since 1/22/25. RN-B indicated the facility's usual process was to reorder medication if out from pharmacy. RN-B stated she would need to contact director of nursing (DON) to see if anything else should be done. During a follow up interview on 1/29/25 at 8:45 a.m., RN-B stated TMA-A had informed her that R44's Lidocaine administered was not the correct dosage. RN-B confirmed that R44's Lidocaine patch order had recently been updated to 5% instead of 4%. RN-B indicated the facility health unit coordinator (HUC) entered orders into the electronic health record, which was verified by a nurse, then faxed the pharmacy. RN-B stated it was important that R44 received the correct Lidocaine patch dosage, for pain relief and to administer medications as ordered. During a telephone interview on 1/28/25 at 12:37 p.m. pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy, and if not available to try a different pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. C-A stated that if R61 did not have Creon as ordered, R61 could have gastrointestinal (GI) upset. During a joint interview on 1/28/25 at 2:56 p.m., with director of nursing (DON) and medical director (MD), DON stated facility's usual process if a medication was not available to administer, the TMA would inform the nurse, the pharmacy would be called and a refill form would be completed. DON confirmed she had been made aware earlier that day that R61 had been out of Creon medication since 1/22/25. DON stated they had discovered it was an insurance reason why R61's Creon medication had not been sent, and the that the facility would be purchasing the medication for R61, to be available. MD stated he would expect the resident's provider would be contacted if a medication was not available to administer, so they could determine if the resident could wait for the medication to be filled, or if it needed to be urgently refilled. During a follow up interview on 1/29/25 at 10:04 a.m., DON verified R44's lidocaine 5% patch order was updated on 1/16/25, with a start date of 1/17/25. DON stated the facility's usual practice for new orders included the HUC to transcribe the orders, a nurse confirmed the order, then HUC would send order to pharmacy. DON indicated her expectation was for TMA-A to follow the facility's policy for medication checks before administering the patch. The facility policy titled Medication Administration Policy revised 5/21, identified the policy was to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. Medication Administration procedure identified: the eight rights of drug administration would be followed when administering all medications: right resident, right drug, right dose, right dosage form, right route, right time, right reason and right documentation.