STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R112) reviewed for Physician Orders for Life Sustaining Treatment (POLST) had the correct code status (i.e., full code, DNR) information outlined within the medical record. This could cause R112 to receive resuscitation efforts (i.e., CPR) against his wishes. Findings include: R112's Medical Diagnosis listing, printed [DATE], identified R112's medical history and diagnoses. This identified R112 had a history of suicidal ideation, opioid use, sleep apnea, diabetes mellitus, and acute kidney failure. R112's PointClickCare (electronic medical record) displayed demographic information (i.e., room number, date of birth, allergies) along the top with a banner-like field. This identified R112 admitted to the care center on [DATE], and included a section labeled, Code Status, which directed, Advanced Directives [click-able link] Code Status: Full code. The link, when clicked, brought up another click-able link to a document saved as, POLST.pdf, with an assigned category reading, Advanced Directives. R112's POLST, dated [DATE], identified R112's name along with options to place a checkmark next to their corresponding wishes in the event he would be found without pulse or breathing. However, a handwritten X was placed next to the option which read, Do Not Attempt Resuscitation / DNR (Allow Natural Death), along with an additional handwritten X was placed next to, Comfort-Focused Treatment (Allow Natural Death) ., The POLST was signed by R112 and the nurse practitioner (NP). There were no additional POLST(s) located in R112's medical record or rationale to explain why R112 was recorded as 'Full Code' on the EMR banner of information. The main-level care center nursing station, located central to each of the respective hallways (i.e., units), contained a black-colored binder labeled, 400 Hallway POLSTS, on the spine. This was reviewed and contained R112's same scanned POLST (dated [DATE]) which directed DNR/DNI orders. When interviewed on [DATE] at 9:41 a.m., R112 recalled someone having a conversation with him about his wishes should he be found without a pulse. R112 stated he wanted nothing done and just let me die. R112 verified a DNR/DNI was his choice as outlined on the completed POLST form (dated [DATE]). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE] at 11:51 a.m., registered nurse (RN)-G stated they were currently assigned care for R112 and had worked with him prior. RN-G stated if R112 was found without a pulse or not breathing, they would check him and call for help. RN-G explained they would check the [EMR] banner first to see R112's code status but then double check with the POLST before starting CPR on him. RN-G stated the nurse managers typically reviewed the POLST(s) with each resident and the floor nurse was responsible to update the EMR with the information. RN-G reviewed R112's EMR banner (which indicated 'Full Code') and his POLST (which indicated DNR) and verified they conflicted. RN-G stated they were obviously contradicting and needed to be clarified, however, RN-G stated they would go with this as pointing to the POLST. RN-G stated the EMR and POLST should match otherwise R112 could get CPR when it wasn't wanted adding, It's very huge risk, huge risk there. On [DATE] at 12:18 p.m., the director of nursing (DON) and registered nurse unit manager (RN)-C were interviewed, and DON verified they had reviewed R112's medical record. DON stated the code status information was entered into the EMR via a collective effort but verified the EMR and POLST should match adding the nurse manager should double check to ensure accuracy. RN-C stated R112 admitted on a Friday and they were not there adding they didn't 'double check' the POLST on Monday as they believed the NP had not signed it yet. DON reiterated the expectation was to check the POLST the following day. DON stated it was important to ensure the information matched so staff would be honoring the resident wishes and so there would be clear directions on what they're supposed to do if R112 was found without pulse. Further, DON verified the completed POLST (dated [DATE]) was the only one for R112 they could locate. A provided POLST, DNR, ACP policy, dated ,d+[DATE], identified a physician order with either DNR or Full Code was required in all medical records. The policy directed if resuscitation was needed, the decisions outlined within the POLST would be followed. Further, the policy directed POLSTs would be contained, . in the front of the chart under the Advanced Directive tab. However, the policy lacked information or direction on how staff would ensure the EMR and POLST matched.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure privacy was maintained during the provision of personal cares for 1 of 1 resident (R4) observed to be receiving peri-care with their window blinds open to the outside parking lot. Findings include: R4's admission Minimum Data Set (MDS), dated [DATE], identified R4 had intact cognition and demonstrated no delusional thinking. On 12/4/24 at approximately 7:05 a.m., R4 was observed laying in her bed from the parking lot with her room lights on, and the window blinds pulled up approximately three-quarters (i.e., 3/4) of the window height. R4's window was at ground-floor level and a single female staff member was observed dressed in dark-blue colored scrubs and assisting R4 whose legs and peri-area were exposed and visible from the sidewalk leading up to the main entrance of the care center. The staff member had gloves on and was observed wiping R4 with a cloth on her peri-area. At 7:09 a.m., the surveyor knocked and opened R4's room door. R4 remained in bed but was now covered with linens as nursing assistant (NA)-B was observed standing in the room. NA-B was alerted to the open blinds, looked at them and stated aloud, Oh, thank you. NA-B then finished care after closing the blinds. Following, at 7:15 a.m., NA-B was interviewed and verified they were the staff providing cares to R4 for the past 15 minutes or so. NA-B verified the blinds were left open but should have been closed adding because it was still dark out it had confused them and maybe caused them to not recognize they were open. NA-B stated they had told R4 the blinds were left open during care after the surveyor knocked on the door, and R4 responded in a calm manner adding, She [R4] was not even aware someone could see her. On 12/4/24 at 7:22 a.m., R4 was interviewed, and stated staff did not always close the blinds while doing cares adding, Sometimes yea [they do]. R4 stated she wasn't necessarily bothered by them being left open, however, then added aloud, Sometimes I'd rather have them closed. R4 stated NA-B did not ask her about leaving the blinds open prior to starting care just prior adding at least being asked or offered about them (i.e., closed or open) would be appreciated. When interviewed on 12/4/24 at 10:41 a.m., the director of nursing (DON) stated staff receive competency training which included the need to ensure privacy was provided during provision of care. DON stated staff should close the doorway and ensure the blinds were pulled down before cares adding such was kind of an expectation. DON stated providing privacy during cares was needed to promote resident dignity along with ensuring their rights to privacy. Further, DON stated they did periodic audits on care, including privacy being provided with it, however, had not completed any of them in recent time. A facility policy on privacy with cares was requested, however, none was received.

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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 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** 48065 Based on observation, interview and document review, the facility failed to clean and maintain a resident's wheelchair for 1 of 1 residents (R39) reviewed for safe, clean and homelike environment. Findings include: R39's quarterly Minimum Data Set (MDS) dated [DATE], indicated R39 was cognitively intact and had no delusions, no hallucinations, or behaviors. The quarterly MDS also indicated R39 was dependent with dressing, toileting, and personal hygiene and indicted R39 needed moderate assist with oral hygiene and was independent eating. R39's clinical diagnosis report printed on 12/5/24, indicated diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture), essential hypertension (high blood pressure) , functional quadriplegia (a condition that causes a person to be unable to move due to a severe disability from another medical condition), and constipation. R39's care plan printed on 12/5/24, indicated R39 independently used a motorized tilt wheelchair for locomotion. During observation on 12/2/24 at 2:10 p.m., R39 was sitting on her motorized wheelchair. Dust, and food particles were observed on R39's wheelchair joystick controller, arms rest, foot pedal and wheelchair's frame. The wheelchair cushion and a metal plate covering the motor behind the footrest had yellowish/grey dry stains. During interview on 12/3/24 at 2:26 p.m. nursing assistant (NA)-C verified R39's was unclean. NA-C stated housekeeping was responsible to clean resident's wheelchairs and added NAs don't wipe wheelchairs, it's not expected. During interview on 12/4/24 at 12:31 p.m., NA-B stated we [NAs] clean the wheelchair if it was dirty. NA-B stated she didn't know if there was a cleaning schedule for the wheelchairs but I will think the NAs will wipe the motorized chairs. During interview on 12/4/24 at 1:18 p.m., NA-D stated 'I don't know who cleans the wheelchairs. NA-D added If I see a dirty spot I will clean it up. During interview on 12/4/24 at 12:29 p.m., housekeeper aid (H)-A stated housekeeping cleaned the non-motorized wheelchairs when residents discharged from the facility and the electric WC's were cleaned by the NAs. During interview and observation on 12/5/24 at 8:33 a.m., R39 was sitting on her motorized wheelchair and the wheelchair still had dust, food particles and stains. R39 stated nobody cleaned her wheelchair and added I go out places like the library, doctors' appointments and other places with my wheelchair looking like this [used her hands showing her WC], it's dirty and I don't like it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/5/24 at 8:50 a.m., registered nurse/nurse manager (RN)-C stated the wheelchairs could be cleaned by nursing or housekeeping. RN-C verified R39's wheelchair was dirty and stated, we need to put an order to clean her [R39] chair. RN-C stated the concern with R39's wheelchair being dirty was it could lead to disease or infections. During interview on 12/5/24 at 9:48 a.m., director of nursing (DON) stated her expectations was wheelchairs would be cleaned and if the nursing staff they were unclean, they should be cleaned right away. The DON stated the concern using a unclean wheelchair joystick controller was an infection control issue due to potential germs and bacteria. DON also stated, R39 going out into the community using an unclean wheelchair was also a dignity issue. A facility's policy related on cleaning of wheelchairs was requested, however, none was received.

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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. 48065 Based on observation, interview, and document review the facility failed to ensure nails were trimmed and cleaned for 1 of 1 resident (R9) who was dependent upon staff for cares. Findings include: R9's quarterly Minimum Data Set (MDS) indicated R9 was cognitively intact, had no behaviors and did not refuse personal cares. R9's Clinical Diagnosis report printed 12/5/24, indicated diagnoses of post-polio syndrome (a condition that causes gradual muscle weakness and atrophy), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), Type 2 diabetes mellitus (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), candidiasis of skin and nails(a fungal infection caused by an imbalance of healthy bacteria and yeast in the body) , functional quadriplegia (a condition that causes a person to be unable to move due to a severe disability from another medical condition), essential hypertension (abnormally high blood pressure that's not the result of a medical condition) and heart failure(a chronic condition in which the heart doesn't pump blood as well as it should). R9's care plan printed 12/5/24, indicated R9 had an activity of daily living (ADL) self-care performance deficit related to a history of stroke, post-polio syndrome and obesity. During observation and interview on 12/2/24 at 1:31 p.m., R9 was observed seated in his motorized wheelchair, his fingernails were a 1/4 to 1/2 inche long and had a light brown substance under fingernails on both hands. R9 stated the staff never offer to trim his nails and when he asked the nurses to trim his nails, they say sure, and never come back. During this interview registered nurse on duty (RN)-F entered the room and R9 asked her to please cut his nails. RN-F responded she would return and cut his nails. During observation and interview on 12/3/24 at 1:41 p.m., R9 was resting in his recliner chair and his fingernails were still long and had similar debris under his fingernails. R9 stated he got three bed baths a week and the nurses were supposed to cut his fingernails because he was diabetic. During observation on 12/3/24 at 1:46 p.m., RN-E was observed to enter R9's room and R9 stated The state lady asked about my nails, can you cut them for me. RN-E responded, I will. During interview on 12/3/24 at 1:50 p.m. RN-E verified R9's nails were long and dirty. RN-E stated, he is diabetic, and we (nurses) usually trim the diabetic nails on bath days. During observation and interview on 12/4/24 at 11:36 a.m. R9 stated he was happy because yesterday afternoon RN-E trimmed his nails. R9's nails were observed to be clean and short. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/5/24 at 9:16 a.m., director of nursing (DON) stated resident's nails should be trimmed weekly with showers and the nurses are expected to trim the diabetic resident's nails. DON stated the expectation was for the nurses to follow these protocols and trim nails weekly. DON added, especially with diabetics who have a risk for skin breakdown and a compromised healing process. A facility's policy on nail care was requested, however, a policy was not provided.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to have a therapeutic recreation director (i.e., activities director) whom was successfully qualified and/or credentialed, as required, to ensure competent assessment and implementation of activities programming within the care center. This had potential to affect all 66 residents at the time of survey. Findings include: R32's quarterly Minimum Data Set (MDS), dated [DATE], identified R32 had intact cognition. On [DATE] at 5:03 p.m., R32 was interviewed. R32 stated she enjoyed the activities programs during the week but expressed there was not enough of them on weekends adding, On weekends, no. R32 stated she, at times, became bored on the weekends adding she would wander around to find people to converse with mostly. R32's POC Response History, dated [DATE] to [DATE], identified spaces to record what, if any, activities were attended. The listed activities included Arts/Crafts, Bible Study, Comedy, Exercise, Games, and more. However, none was recorded. The field to record had dictation, No Data Found. During the recertification survey, from [DATE] to [DATE], no additional resident concerns about the activities programming were raised or expressed. On [DATE] at 9:37 a.m., the current therapeutic recreation director (TRD) was interviewed, and verified they were in charge of the activities programming at the care center. TRD stated they had not been recording any activities' attendance for resident since they started adding, Do you [surveyor] think that would be a good idea? TRD explained they had been in the role for approximately three months and prior had worked in elementary education. TRD verified they were responsible to do the assessments and care planning for each resident with minimal help from other assistants adding, It's mainly just me. TRD stated they had taken some steps to improve the weekend activities but acknowledged it had been items we just started implementing. TRD verified they were not an occupational therapist (OT) and had not worked in a recreation program within healthcare prior. TRD stated they had enrolled in an online course to become certified in activities programming for a nursing home but had not completed it yet. TRD stated the course was self paced with multiple modules adding they (TRD) had not completed the first one in it's entirety yet adding, I'm almost done with the first one. The provided Modular Education Program for Activity Professionals, Part I curriculum was provided and list multiple lessons to be completed. The listed lessons included reference to Appendix PP (nursing home regulations) F679 and F680. A corresponding Practicum Assignment/Task Time Log sheet, used to track progress and grading of completed modules, was provided. However, this was blank with no recorded progress. On [DATE] at 11:09 a.m., the administrator was interviewed. He explained TRD was relatively new to the role and was working on getting the course completed adding, We're working on it. The administrator acknowledged the need to ensure the coursework was finished adding a credentialed activity director was important to ensure complete quality of care of our residents. (continued on next page)

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	A facility provided Job Description: Life Enrichment Coordinator, dated ,d+[DATE], identified the role would help create activities' calendars, interview residents for their preferences with activities, and assist in coordinating the campus activities programming. The listing listed a section labeled, Education & Qualifications, which directed the following was needed for the role; a high school diploma or equivalent, minimum of one year experience in a social or recreational program, certified nursing assistant or home-health aide preferred, and CPR training within 30 days of employment. However, the provided description lacked direction on how persons would be credentialed further in accordance with F680 (i.e., State-approved certification, OT).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to assess potential signs of constipation to determine what, if any, interventions were needed to promote comfort and reduce the risk of complication (i.e., impaction) for 1 of 1 residents (R15); failed to comprehensively assess and develop interventions to ensure a consistent nursing approach with a developed, non-pressure skin condition for 1 of 2 (R5); and failed to ensure orders for a peripherally inserted central catheter (i.e. PICC line) were clarified and the line was managed in accordance with professional standards of care for 1 of 1 residents (R28) reviewed who had a PICC. Findings include: BOWEL MANAGEMENT: R15's quarterly Minimum Data Set (MDS), dated [DATE], identified R15 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS outlined R15 was totally incontinent of bowel and consumed multiple medications including both psychotropic and narcotic medications. On 12/2/24 at 3:07 p.m., R15 was observed laying in bed while in her room. R15 was interviewed and expressed she felt constipated adding she had only been having a stool every other day when her normal pattern was daily. R15 stated nobody from the care center, at least to her recall, had visited with her or asked about constipation nor what, if any, interventions could help it (i.e., prune juice, medication adjustment). R15 stated she wished someone would though. R15's care plan, printed 12/4/24, identified R15's current and potential issues or complications. The care plan identified R15 needed assistance of one for toileting and R15 was incontinent of bladder and bowel due to limited mobility and hospice-focused cares. The care plan listed interventions for this identified problem including barrier cream applied to her skin, observing for signs of a urinary tract infection (i.e., UTI), and peri-cares after incontinent. Further, the care plan identified R15 was at risk of dehydration due to constipation and listed two interventions for this including observing her skin integrity and, Observe/document bowel sounds and frequency of BM [bowel movement]: provide medication per order. The care plan lacked any further information on R15's constipation including what, if any, other interventions for it aside from medication administration were being done or had been discussed/used prior. When interviewed on 12/4/24 at 9:01 a.m., nursing assistant (NA)-A stated they had worked with R15 and described her as having poor mobility adding, [She] stays in bed mostly all the time. NA-A stated R15 had incontinence of bladder and bowel but felt she was good at calling for someone to change her. NA-A stated residents' bowel movements were tracked in the point-of-care charting on their computer system, and staff could select the size of stool each time. NA-A stated they had last helped R15 with bowel incontinence about two weeks prior and, at that time, the stool didn't seem hard adding R15 had not reported any concerns about her bowels to them. NA-A stated if a resident complained about constipation, then it was the nurses' job to address it adding, They handle it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's POC (Point of Care) Response History, printed 12/4/24, identified a 14 day look-back period and recorded R15's bowel movements. A labeled field reading, Size of BM, was listed which provided a check mark on the corresponding size of stool (i.e., small, large) for each date R15 had one recorded. This information identified the following: 11/23/24 - R15 had one large BM recorded. 11/24/24 - R15 had one small BM recorded. 11/25/24 to 11/27/24 (three days) - R15 had no BM recorded. 11/28/24 - R15 had one large BM recorded. 11/29/24 - R15 had one medium BM recorded. 11/30/24 - R15 had one large BM recorded. 12/1/24 to 12/2/24 (two days) - R15 had no BM recorded with dictation, Response Not Required. 12/3/24 - R15 had one large BM recorded. R15's medical record was reviewed and lacked evidence R15's bowel patterns (i.e., multiple days without one, no staff data) had been identified or evaluated to determine what, if any, interventions were needed to promote more regular bowel movements and reduce the risk of complication despite R15 consuming narcotic medications, having a history of constipation as identified on the care plan, and going multiple day periods without a stool. Further, R15's medical record contained multiple previous assessments labeled, Continence Evaluation, however, the last completed or recorded one was dated 12/2022 (two years prior). When interviewed on 12/4/24 at 10:22 a.m., registered nurse (RN)-A stated the night shift nurse typically pulled a report and would tell the morning shift nurse what residents were on multiple days without a bowel movement. RN-A stated the morning nurse would then follow-up, if needed, and could use the facility' standing orders to address it. RN-A stated R15 was already on some scheduled bowel medications, such as Senna and Miralax, adding the nurse manager would help oversee assessments and complete them, if needed. RN-A verified the NA staff use only the POC charting to record bowel movements. On 12/5/24 at 10:16 a.m., the director of nursing (DON) and registered nurse unit manager (RN)-C were interviewed. DON verified they had reviewed R15's medical record and explained bowel status should be evaluated upon admission, quarterly and when warranted. DON stated this was done using the Continence Evaluation, however, one had not been completed for several years adding, It has not been done. DON verified there was no documented evidence to show R15's bowel status had been evaluated and expressed it should be done adding aloud, That is the expectation. DON stated the NA staff use the POC to document residents' bowel movements and, upon reviewing R15's charting, it seemed the aides were not documenting well and recording incontinence but no bowel movement adding there was room for education on appropriate documentation. DON stated it was important to ensure bowel status was assessed due to the high risk of constipation for R15. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility' policy on bowel status assessment or evaluation was requested, however, none was received. 47495 Non-Pressure Skin Condition R5's admission Minimum Data Set (MDS), dated [DATE], indicated R5 was admitted to the care facility on 10/4/24, was cognitively intact and required substantial/maximum assistance with bathing and lower body dressing and partial assistance with upper body dressing. R5's Hospital History and Physical (H&P), dated 9/25/24, indicated R5 had a past medical history of Darier [NAME] disease (a rare genetic skin condition that causes a number of symptoms, including wart-like bumps that are hard, greasy, and yellowish in color. They can be itchy, weepy, or raw. The lesions can appear on the scalp, forehead, upper arms, chest, back, knees, elbows, and behind the ears. They can also appear in skin folds, like under the breasts or in the groin area) complicated by recurrent wounds and cellulitis. The H&P indicated R5 was hospitalized at that time with worsening of chronic skin wounds, indicating visible skin from head to arms cracked and dry with sloughing and wounds in various stages of healing. R5's Orders, printed 12/5/24, indicated R5 had the following orders related to her Darier [NAME] disease: Wound Care 1. Avoid debridement of skin 2. OK to substitute dilute bleach baths with hydrogen peroxide skin soap, will defer to patient preference. 3. Recommend after cleansing, patient rinse and PAT DRY GENTLY, no rubbing or scrubbing or debriding skin 4. Apply emollients to include betamethasone-clotrimazole, mupirocin and Aquaphor to affected skin. Important to apply barrier repair immediately (within 2-3 mins after bathing) every day shift every Mon[day], Wed[day], Fri[day] and Okay to use stockinette vest after wound and rash treatment. Vest should wash and reuse. Wound care was scheduled for day shift despite R5's showers scheduled for evening shift per her preference. R5's Orders, dated 12/5/24, also indicated the following topical ointment orders: Mupirocin External Ointment 2%; apply to skin topically two times a day for skin care, Emollient External Ointment; apply to skin typically four times a day for skin care, and Clotrimazole External Cream 1%; apply to affected skin area topically two times a day for Darier [NAME] Disease. In addition, R5's Orders, dated 12/5/24, indicated the following oral medications: Seroquel (medication to treat anxiety) Oral Tablet 25 milligrams (mg); give 1 tablet by mouth every 6 hours as needed for anxiety for 14 days, Hydroxyzine Oral Tablet 50mg; give 1 tablet by mouth every 4 hours as needed for anxiety for 14 days, and Oxycodone Oral Tablet; give 10mg by mouth every 4 hours as needed for pain may give 1-1.5 tablets (10mg - 15mg) AND give 15 mg by mouth every 4 hours as needed for pain 6-10. R5's Care Plan, dated 10/4/24, indicated R5 had potential/actual impairment to skin integrity r/t [related to] decreased mobility, incontinence, and Darier [NAME] Disease. Interventions included keep linens dry, wrinkle free, keep skin clean and dry. Apply lotion to dry skin during cares. DO not apply lotion between toes or to open, rashy areas, and observe skin during care. Report changes to nurse. However, R5's Care Plan lacked any specific interventions related to her Darier [NAME] Disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Medication (and treatment) Administration Record (MAR), dated 11/1/24 - 11/30/24, indicated R5 received wound care to her skin 6 times on 11/8/24, 11/15/24, 11/18/24, 11/20/24, 11/25/24, and 11/29/24. The MAR indicated R5 did not receive wound care to her skin due to refused or other/see progress note 6 times on 11/4/24, 11/5/24, 11/11/24, 11/13/24, 11/22/24, and 11/27/24. R5's MAR, dated 12/1/24 - 12/5/24, indicated R5 did not receive any wound care to her skin due to other/see progress note on 12/2/24 and 12/4/24. R5's Progress Notes, dated 10/4/24 - 12/5/24, lacked an explanation of why wound care was not provided on 11/22/24 and 12/4/24 despite the MAR indicating to see progress note. On 12/2/24 it was documented resident refused wound care and treatment creams. Did fall back to sleep til 1130 am after taking AM morning meds. Writer offered and asked resident if she wanted to get wound done couples of times. Resident stated wanted to take a shower before wound get done. Residents left downstairs for some time. Wirer followed her on 2nd floor and asked if still wanted wound to get done before shift end. Kept pushing til the end of shift and was unable to do it. Reported to evening RN [registered nurse] to follow up. During an interview and observation on 12/2/24 at 3:30 p.m., R5 stated she sat in dirty bandages for 5-6 days when she was first admitted and had concerns about her wound care still not getting done properly, stating she had been doing her wound care for 9 years due to her Darier [NAME] Disease and it required ABD pads, stockinettes, and a 14-ounce jar of Aquaphor with each dressing change since her skin was effected from head to toe. R5's entire skin from head to toe was dry and flaking with denuded areas that were red and shiny in appearance. R5 stated she was supposed to use a vest made of a soft mesh material to hold the abd pads in place on her chest and back, however the facility had not supplied her with the vest and so the skin on her torso was open to air, causing her pain and her skin to weep onto her clothing which caused yellow staining of her clothes. R5 stated she would always need to shower before her wound care to help remove the old dressings and to prevent and remove keratin build up on her skin, stating when she didn't get frequent showers it would cause worsening of her skin breakdown. However, R5 stated without the correct amount of Aquaphor and supplies, she could not shower because of how painful the air was to her skin, stating the facility was also unable to provide her with the needed amount of Aquaphor, the correct stockinettes or the mesh vest that would hold the ABDs in place. R5 stated at her last care conference, on 11/20/24, they scheduled her showers for Monday, Wednesday, and Friday evenings because she preferred to sleep in late, but that due to supply and scheduling issues she was not getting wound care as needed which caused her bandages to have a foul odor and her clothes to have yellow staining. R5 stated, I shouldn't have to feel that undignified, that belittled when other residents tell her that her bandages have a foul odor. During an interview on 12/4/24 at 8:41a.m., nursing assistant (NA)-F stated she does not help with R5's wound care but helps a lot with her showers, stating after her showers she gets ointment over her whole body. NA-F stated she did not believe that R5 refused her showers but that the showers were painful for R5 due to her skin condition and raw, open skin, that at times R5 just felt like she needed to wait to shower. NA-F further stated when R5 was admitted to the care facility, they did not have the supplies she needed for about a month, stating she believed R5 had everything she needed now but could not be 100% sure. NA-F also confirmed R5 had a lot of weeping from her skin which caused her and her room to have an odor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/4/24 at 10:08 a.m., registered nurse (RN)-H stated she believed R5 was supposed to receive a shower three times a day, during the day shift, stating R5 would postpone and postpone her shower until the end of her shift and it would frequently get missed. RN-H further stated R5 was in pain and bleeding during her showers and that staff try to give her PRN Hydroxyzine, Seroquel and Oxycodone prior to her showers. RN-H stated R5 would use her Aquaphor all over her body, her other ointments (Clotrimazole and Mupirocin) were only used to spot treat any open areas on her skin and a mesh body suit over her ointments with no other dressings (i.e. ABD pads) between her skin and the mesh body suit. RN-H also stated R5's skin was very weepy and would often leak a yellow substance through her clothes creating an odor on the bandages. During an interview, nurse manager and RN-D stated R5 did not come with an order that specified how much Aquaphor she should use, stating a 14 once jar was excessive, however confirming she did use it to cover her entire body. RN-D stated he received an order from the nurse practitioner to use a mesh vest and stockinettes, however they were not able to get a mesh vest for R5 to use and R5 had just received the appropriate size stockinettes on 12/2/24 at approximately 9:30 p.m. RN-D stated R5 was supposed to receive PRN Oxycodone, Seroquel and Hydroxyzine prior to a shower but confirmed the order did not specify that. RN-D further confirmed that while he supplied the ABDs for R5's wound care, the order in her chart did not specify to use the ABDs because she was not admitted to the care facility with the order and the ABDs were only R5's preference. RN-D confirmed the orders did not specify how staff were supposed to use R5's 3 ointments (Aquaphor, Clotrimazole and Mupirocin), but he believed they should all be mixed together and then applied to her skin. RN-D stated R5 did refuse showers a lot but was unable to confirm any comprehensive assessment or reassessment that had been done to determine what R5 needed for her showers and wound care, when she wanted them done, risks vs benefits or refusing and/or why she was refusing her showers and wound care. During an interview on 12/4/24 at 12:45 p.m., R5 stated she had finally received the correct size stockinettes late Monday night. R5 further stated she needed to keep up with her three times a week showers, stating she did not want to refuse them but when she did not have the right supplies she could not shower. R5 stated she could not take her old bandages off, shower and have nothing to put on her skin as it would be too painful causing her to feel forced to keep dirty bandages on. R5 stated she was concerned about still not having a mesh vest to wear which would allow her to cover her chest and back with the appropriate ABDs. R5 further stated was about to run out of Aquaphor sating, I don't know what I am going to do when that happens, I can't afford it on my own. R5 stated she was worried she would end up in the hospital again without the correct supplies to manage her skin properly. During an interview on 12/5/24 at 10:33 a.m., RN-G stated R5's showers were all over the place and sometime NA-F would do it during the day, so it was not clear when her scheduled shower times were. NA-C confirmed R5 should be getting showers in the evenings since R5 preferred to sleep in late in the mornings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 11:41 a.m., the director of nursing (DON) confirmed that the showers and wound care for R5 were not clear, stating it was because the wound care process R5 wanted was a preference and not an order. The DON stated they tried to work with R5 but was unable to show documentation of a comprehensive assessment or reassessment of R5's wounds/wound care, refusals, or risk versus benefits. The DON further stated the Aquaphor and mesh vest was not covered by R5's insurance, however lacked evidence staff worked with R5 and/or her provider to find an agreeable alternative or to attempt to get it covered. The DON stated she did not believe R5 needed a whole tub of Aquaphor despite R5 needing it to protect her skin on her entire body after every shower. 48065 PICC DRESSING: R28's quarterly Minimal Data Set (MDS) dated [DATE], indicated R28 was cognitively intact, had no behaviors and did not refuse personal cares. The quarterly MDS indicated R28 needed maximal assistance with showers, dressing, toileting and was dependent with all aspect of mobility. R28's Clinical Diagnosis report printed 12/5/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), pressure areas (an injury to the skin and underlying tissue resulting for prolonged pressure on the skin), neurogenic bladder, (lack of bladder control due to spine or nerve injuries) , constipation, epilepsy (brain disorder that causes recurring, unprovoked involuntary movement), quadriplegia (paralysis that affects all a person ' s limbs and body from the neck down), and colostomy (a surgical procedure that creates an opening in the abdomen to divert stool from the colon to a bag or pouch). R28's Clinical Orders report printed 12/4/24, indicated an order dated 11/20/24 for vancomycin HCL intravenous (IV) solution (antibiotic medication) 1250 milligrams (mg)/250 milliliters (ml) for methicillin-resistant staphylococcus aureus (a bacterial infecion also called MRSA) infection. R28's orders report lacked orders to change the peripherally inserted central catheter (PICC) line dressing, and/or monitoring insertion site for signs and symptoms of infection. R28's Care Plan indicated printed on 12/4/24 indicated R28 had MRSA which required antibiotic therapy. R28's care plan lacked documentation regarding the PICC line and the IV therapy. R28's medication administration record (MAR) and the treatment administration record (TAR) for the months of November and December lacked documentation regarding changing the PICC line dressing and/or monitoring the insertion site for signs and symptoms of infection. R28's progress note dated 11/20/24 at 5:09 a.m. indicated R28 had a PICC inserted in the right upper arm. During observation and interview on 12/4/24 at 10:15 a.m., registered nurse (RN)-F started R28's vancomycin IV infusion via PICC line. R28's PICC line was on the right upper arm. The insertion site was covered with a clear dressing without a date indicating when the dressing was changed. R28 stated nobody has changed the dressing since it was inserted on 11/20/24. RN-F verified the PICC line dressing was separated from the skin around three out of the four sides of the dressing and lacked a date when the dressing was changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 12/4/24 at 10:43 a.m., RN-F verified there were no orders to change the PICC line dressing and/or to monitor insertion the site for signs and symptoms for infection. RN-F stated the nurse manager was responsible to make sure the orders were added to the medication administration record (MAR) and the treatment administration record (TAR). During interview on 12/4/24 at 10:56 a.m., nurse manager, RN-C stated R28 had a PICC line and the PICC line cap and dressing needed to be changed every seven days. RN-C stated when a resident had a PICC line, the nurse manager would add it to the medical record including the orders, MAR and TAR. In addition, the TAR would include the orders to care for the PICC line and to observe the PICC line site for signs or symptoms of infection. RN-C stated any nurse could also enter those orders. RN-C reviewed R28's medical record and verified the lack of orders and/or documentation about changing the PICC line dressing. During interview on 12/5/24 at 9:20 a.m., director of nursing (DON) stated a PICC line dressing needed to be changed every seven days. DON stated if a dressing is not changed it could lead to an infection. A facility's policy on PICC line care was requested, however, none was received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview and document review, the facility failed to comprehensively reassess after repeated refusals of a range of motion (ROM) program and, if needed, develop interventions to reduce the risk of mobility loss for 2 of 3 resident (R9 and R39) reviewed for ROM. Findings include: R9 R9's quarterly Minimum Data Set (MDS) indicated R9 was cognitively intact, had no behaviors and did not refuse personal cares. R9's Clinical Diagnosis Report printed 12/5/24, indicated diagnoses of post-polio syndrome (a condition that causes gradual muscle weakness and atrophy), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), Type 2 diabetes mellitus (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), candidiasis of skin and nails (a fungal infection caused by an imbalance of healthy bacteria and yeast in the body) , functional quadriplegia (a condition that causes a person to be unable to move due to a severe disability from another medical condition), essential hypertension (abnormally high blood pressure that's not the result of a medical condition) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). R9's Therapy Referral for Maintenance Program dated 6/4/24, indicated passive ROM to bilateral hip, knee, and ankle with 10 repetitions once daily. R9's Plan of Care (POC) task documentation printed 12/5/24, indicated R9 had a Nursing Rehabilitation program for passive ROM to bilateral knee and ankle with 10 repetitions daily before getting in a wheelchair. POC documentation from 11/8/24 to 12/5/24, or 28 days, indicated R9 received ROM four times, refused six times, and the report lacked any documentation for a total of 18 days. During observation and interview on 12/2/24 at 1:30 p.m., R9 was seated in his motorized wheelchair. R9 was leaning to the right side, and his left leg was bent and suspended up in the air. R9 stated it's always like that, they say it's contracted. During interview on 12/3/24 at 2:34 p.m., nursing assistant (NA)-C stated R9 had orders for ROM. NA-C stated she usually did R9's ROM in the mornings as ordered but sometimes she stated she was too busy in the mornings to do this task. NA-C stated, today I didn't do it in the morning so I will do it before the end of my shift. During interview on 12/3/24 at 2:43 a.m., the rehabilitation director/physical therapist (PT) stated R9 can't extend his right leg because he had a right hip contracture. PT stated the goal for the Maintenance Program given to the nursing department was to maintain R9's ROM and prevent further contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/3/24 at 2:28 p.m., occupational therapist (OT) indicated, in June 2024 she instructed the facility nursing assistants to do R9's ROM exercises. OT stated she had not received any reports regarding R9's refusal to do his ROM exercises. During interview on 12/4/24 at 12:39 p.m., R9 stated NA-C and NA-E are the only aids that do my exercises. During interview on 12/5/24 at 8:42 a.m., NA- E stated R9 never refused ROM. NA-E stated, this morning it was too busy, and I was not able to do his ROM. NA-E stated, If I am unable to do R9's ROM, I report this to the nurse and document 'not applicable' in POC. During interview on 12/5/24 at 8:44 a.m., nurse manager (RN)-C verified R9's POC lacked documentation of refusals or ROM completion. RN-C stated he had not been notified about R9's refusal to do his ROM. R39 R39's quarterly Minimum Data Set (MDS), dated [DATE], indicated R39 was cognitively intact and had no delusions, no hallucinations, or behaviors. The quarterly MDS indicated R39 was dependent with dressing, toileting, and personal hygiene and R39 needed moderate assist with oral hygiene and was independent eating. R39's Clinical Diagnosis Report printed on 12/5/24, indicated diagnoses of cerebral palsy (a congenital disorder of movement, muscle tone, or posture), essential hypertension, functional quadriplegia and constipation. R39's Clinical Orders Report printed on 12/5/24, indicated the following: NURSING REHAB: Passive Dorsiflexion Stretch. Passively move the ankle into dorsiflexion and hold for 30 seconds, complete 3 sets 1 Times a Day. TOE PROM- FLEXION-EXTENSION: Grasp the subjects' toes, Then, bend and then straighten them. Repeat. Hold for 30 seconds, complete 3 sets, 1 Times a Day. FOOT PROM- PRONATION SUPINATION: Grasp the subject foot. Stabilize the lower half and rotate the upper portion pivoting at the arch of the foot. Rotate each direction and repeat 15 times, hold for 3 seconds, complete 3 sets, perform 1 Times a Day. HIP PROM - FLEXION- EXTENSION: Grasp the subject's leg by holding under the thigh and ankles, then gently bend the knee and hip upward and then return to original position and repeat for 15 times, hold 3 seconds, complete 3 sets, perform 1 Times a Day. HIP PROM- ABDUCTION-ADDUCTION: Grasp the subject's leg by holding under the thigh and ankle, then gently pull leg outwards and return to original position and repeat for 15 Times, hold 3 seconds, complete 3 sets, perform 1 Time a Day. R39's Plan of Care (POC) task documentation report printed 12/5/24 for the 30-day period from 11/6/24 to 12/4/24 documented R39 refused ROM 12 times, participated four days and two days were documented as 0 repetitions. This report lacked any documentation for 14 out of 30 days. During interview on 12/5/24 on 8:33 a.m., R39 stated the nurses did her ROM but sometimes I refused. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/5/24 at 8:46 a.m. NA-E stated R39 often refuses,today she refused. Sometimes she will let us do one repetition to one of her legs, then she is done. NAR-E stated she documented the refusals and reported refusal to the nurse on duty. During interview on 12/5/24 at 9 a.m. nurse manager/RN-C verified R39's POC 30-day report. RN-C stated that he had not been informed and he had not reviewed R39's participation in their ROM programs. During interview on 12/5/24 at 9:20 a.m. director of nursing DON stated the ROM needed to be followed and done. DON stated ROM programs were important to maintain residents' mobility and prevent contractures. DON stated after several refusals in a week, she expected the nurse manager to approach the residents and follow up with therapies to be reassessed. The failure to do this, was not allowing residents to keep their optimal level, and then developing or worsening of contractures. A facility policy on ROM was requested, however, a policy 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** 33925 Based on interview and document review, the facility failed to comprehensively assess and, if needed, develop interventions to promote safety and reduce the risk of injury or impairment for 1 of 1 resident (R16) reviewed who had been attempting to order alcohol from a mobile delivery service (i.e., DoorDash). Findings include: R16's admission Minimum Data Set (MDS), dated [DATE], identified R16 had intact cognition, demonstrated no delusional thinking or hallucinations, and had several medication conditions including asthma, a history of seizure disorder, and diabetes mellitus. R16's progress note, dated [DATE], identified an entry at 9:03 p.m. which read, Someone was here to deliver an order to a resident while in the room . the person who delivered that her card was expired. while [sic] he was on his way out, I observed that he had a bottle of Liquor; I made the order nurse [sic] witness it . will update social services and her to be searched [sic] every shift. In addition, a subsequent note, dated [DATE], identified as, LATE ENTRY, read, Resident ordered Vodka and was delivered here by door dash. Requested the delivering person to leave with the nurse but delcined and stated he has to give [to] the owner. The delivery person decided to take back. Resident has no orders for alcohol. When interviewed on [DATE] at 12:20 p.m., R16 verified she had attempted to order alcohol via DoorDash on multiple occasions adding, I did twice but one didn't come. R16 stated she wanted to drink a Vodka-Squirt but had none currently in her room. R16 stated she ordered multiple things, including food and alcohol, from DoorDash before and would do so again, if wanted, adding aloud, If I want to, yea. R16 stated nobody from the care center had talked with her about ordering the alcohol or what, if any, options were available to get a scheduled alcohol beverages for her while there. R16 stated she was interested in getting the physician to order alcohol allowance if able. R16's care plan, printed [DATE], identified R16 had an activity of daily living (ADL) self-care deficit and was non-ambulatory. The care plan lacked evidence R16 had either a history of past or current substance use (i.e. , marijuana, alcohol); nor any interventions to address such despite the completed progress notes. In addition, R16's Medication Administration Record (MAR), dated ,d+[DATE], identified R16's current physician-ordered medication and treatment regimen, along with spaces to record their administration or refusals. This identified R16 had current orders for multiple medications including anti-depressants, anticoagulants (i.e., blood thinners), insulin injections, and narcotics (i.e., oxycodone). The MAR and Treatment Administration Record (TAR) both lacked any specific interventions or monitoring to be completed if or when R16 was found to be ordered and/or consuming alcohol despite multiple progress notes recording she had attempted to obtain alcohol for use. (continued on next page)

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	245320	A. Building B. Wing	12/05/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on [DATE] at 12:32 p.m., nursing assistant (NA)-E stated they were assigned care for R16 and had worked with her multiple times recently. NA-E stated R16's care needs depend on the day but most often stayed in her room. NA-E stated they were aware R16 often used DoorDash to get food, however, expressed they were unaware R16 had attempted to have alcohol delivered from it adding, No, not that I know. NA-E stated they had not been directed to ask or check any DoorDash deliveries for alcohol or other substances adding, How are we going to know [if they bring alcohol]? NA-E reiterated they were unaware R16 had been trying to get alcohol delivered to herself adding, [Nobody] never told us anything about it. R16's medical record lacked evidence this behavior had been assessed or evaluated to determine what, if any, interventions (i.e., safety checks, vital monitoring) were needed to ensure her safety with ordering or potentially consuming alcohol with or without staff knowledge. When interviewed on [DATE] at 1:05 p.m., registered nurse (RN)-B verified they were currently assigned care for R16. RN-B stated they were unaware R16 had been attempted to order alcohol from DoorDash. RN-B stated if they found R16 to be intoxicated or ordering alcohol then it should be reported to the supervisor adding, They are not supposed to have alcohol. RN-B stated nobody had directed or told them what, if any, actions to take when R16 has a DoorDash delivery or if found with alcohol but reiterated they would report it to the supervisor. RN-B stated they were unsure what, if any, facility' protocols were in place for alcohol consumption (i.e., vitals monitoring, medication holding) adding, I'm not sure of this facility's protocol. On [DATE] at 10:16 a.m., the director of nursing (DON) and registered nurse unit manager (RN)-C were interviewed, and DON verified they had reviewed R16's medical record. DON expressed they were unaware R16 had been attempting to order alcohol from the mobile delivery service so, as a result, just the day prior ([DATE]) the social services team went and visited with R16 about it to review the policies and procedures of alcohol consumption. DON verified the social services team had not followed up on it until [DATE], after the surveyor made them aware of it. DON stated they would evaluate the situation and place some interventions for staff to follow. DON verified the medical record lacked evidence the situation had been assessed or acted upon until the day prior ([DATE]), but acknowledged doing so was important to help make sure she's safe. Further, RN-C stated R16 consuming alcohol could interact with her medications. The facility policy on alcohol consumption or evaluation of thereof was requested, however, none was received.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview and document review the facility failed to comprehensively assess a resident who had significant weight gain at the care facility (37%) in less than 1 year, and failed to care plan appropriate interventions to assist with weight loss goals for 1 of 2 residents (R51) reviewed for nutrition status. Findings include: R51's quarterly Minimum Data Set (MDS), dated [DATE] indicated R51 was admitted to the care facility on 1/29/24, was cognitively intact and independent with most activities of daily living (ADLs). R51's Diagnoses List, dated 1/29/24, indicated R51 had several medical diagnoses including unspecified personality disorder, generalized anxiety disorder and major depressive disorder. The Diagnoses List also indicated a diagnosis of prediabetes, dated 11/12/24. R51's weights documented in the electronic medical record (EMR) indicated R51 was admitted to the care facility weighing 210.6 pounds and his most current weight, dated 11/17/24, was 288.9 pounds, indicating a weight gain of 78.3 pounds (37%) in less than 10 months. R51's dietary progress notes, dated 5/6/24 - 11/29/24, indicated R51 was assessed four times as having significant weight gain. On 5/8/24, 8/7/24, and 11/6/24 dietary progress notes were documented that indicated R51 had significant weight gain but is not on a prescribed weight gain regiment. The note however lacked any interventions to address R51's weight gain or any discussion of education provided to R51. On 10/30/24 a nutrition progress note was documented and indicated R51's weight was trending for significant weight gain for the past 6 months. The note indicated the dietary manager and dietician met with R51 who stated he was snacking often on cookies, eats fast food, eats vending machine pastries. The note further indicated R51 was interesting in loosing weight and anticipate weight loss d/t [due to] zepbound. The note indicated the following recommendations: 1) encourage healthy snack choices, 2) res[ident] stated exercising w[ith]/ therapy and may try reduce cookies to 3 packs/day 2) will monitor monthly at high risk d/t [due to] wt [weight] gain. The note lacked education provided to R51 on healthy choices and any risk versus benefit discussed of weight gain/food preferences. A care conference progress note, dated 11/19/24, indicated R51 reported staff told him that the injection was approved for weight loss. R51's EMR, including his Care Plan, lacked communication of the above recommendations and any ongoing conversation or education provided to R51 on ways to reach his weight loss goals. R51's physician orders lacked any evidence of R51 having an order for any weight loss medications, including injections. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/2/24 at 1:46 p.m., R51 stated since he admitted to the facility he had unwanted weight gain, stating I feel like I have gained 100 pounds. R51 stated he met with the dietician once and the only advice he received was to stop eating cookies. R51 further stated, I am depressed and need help to lose weight. During an interview on 12/4/24 at 10:10 a.m., (RN)-H, who stated she regularly worked with R51, stated she was unaware of any concerns regarding R51's weight or any interventions to assist R51 with his weight loss goals. During an interview on 12/4/24 at 12:20 p.m., nurse manager and RN-D confirmed there were no care planned interventions for R51's weight management. RN-D did state staff had discussed, as an interdisciplinary team, weight loss medication for R51 but he did not believe it had been approved through his insurance. During an interview on 12/5/24 at 10:35 a.m., RN-G and nursing assistant (NA)-C who both stated they worked with R51 regularly, stated they were unaware of any concerns regarding R51's weight or any interventions to assist R51 with his weight loss goals. During an interview on 12/5/24 at 8:30 a.m., the dietary director (DD) stated her, and the dietitian, have only spoken with R51 once, a few weeks ago about his weight because she was worried him getting upset with them talking about his weight, stating he wants to diet but he won't. The DD stated R51 exercises with therapy and I don't know if we will be able to do anything else for him. The DD stated she was aware that when R51 admitted to the care facility he started gaining weight, gaining weight The DD stated that the dietitian is more focused on residents who have significant weight loss. The DD stated R51 would go out to eat with friends, but she did not feel it was her business to ask questions or inquire with R51 about R51's food choices. The DD stated, we will keep working with him, but I don't know what we can do. The DD further stated she was unaware of any discussion of weight loss medication. During an interview on 12/5/24 at 11:41 a.m., the director of nursing (DON) confirmed R51's EMR lacked care planned recommendations for staff to assist with R51's weight loss goals, an assessment of R51's food choices and what R51 would agree to or would not agree to to assist with weight loss, or a discussion of risk versus benefits for food choices and continued weight gain. The DON stated the dietician's recommendations should have been care planned and floor staff should have been educated on interventions to support R51's weight loss goals.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49034 Based on interview and document review, the facility failed to ensure the posted nurse staffing information accurately displayed the total number/actual hours worked by the licensed staff for each shift on a daily basis. This had the potential to affect all 66 residents or visitors who wished to review the information. Findings include: The Daily Staff Postings dated 11/19/24 through 12/2/24, included a row titled LPN [licensed practical nurse] but the row did not include a total number or the actual hours worked by LPNs as it did in the rows titled RN [registered nurse] and CNA [certified nursing assistant]. The facility staffing schedules dated 11/19/24 through 12/2/24 included LPN's working on the following days: 11/19/24, 11/20/24, 11/22/24, 11/23/24, 11/24/24, 11/25/24, 11/26/24, 11/27/24, 11/28/24, 11/29/24, and 11/30/24. During an interview on 12/5/24 at 9:37 a.m., the staffing coordinator (SC) stated she oversaw the staff posting. The SC stated after reviewing the staffing schedules and staff postings it looked like the LPN hours were not being separately categorized as they were supposed to and instead being included in the registered nurse (RN) staffing hours. The SC stated they used a computer program to pull the staffing data for the posting and it must have been pulling the information incorrectly. A policy regarding posted nurse staffing information was not received.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on interview and document review, the facility failed to attempt a gradual dose reduction (GDR) or document a clinical rationale for not attempting for 1 of 5 residents (R51) reviewed for unnecessary medications. Findings include: R51's quarterly Minimum Data Set (MDS), dated [DATE], indicated R51 was admitted to the care facility on 1/29/24, was cognitively intact and independent with most activities of daily living (ADLs). R51's Diagnoses List, dated 1/29/24, indicated R51 had several medical diagnoses including unspecified personality disorder, generalized anxiety disorder and major depressive disorder. R51's Orders, dated 1/29/24, indicated R51 had the following psychotropic medications; aripiprazole (an atypical antipsychotic indicated for schizophrenia, bipolar disorder, major depressive disorder, irritability associated with autism, and Tourette's) 2 milligrams (mg) by mouth one time a day for anxiety depression and duloxetine (an antidepressant medication) 60 mg two times a day for anxiety and depression. R51's Pharmacist Recommendation to Prescriber, dated 2/29/24, indicated a recommendation R51 had an order for Cymbalta [duloxetine]. It appears they [R51] are having some issues with anxiety as well since they have an order for Abilify [aripiprazole] for 'anxiety and depression'. Please be advised that Cymbalta [duloxetine] can cause or at least worsen anxiety due to its mechanism of action. It may be prudent to titrate off Cymbalta and if needed, start an SSRI such as Celexa, Zoloft, or Lexapro [alternative medications to treat depression]. The prescriber responded with a check box of other stating R51 was working with a psychiatrist to adjust medications. Review of R51's medical record lacked evidence this recommendation was forwarded on to R51's psychiatrist. R51's Pharmacist Recommendation to Prescriber, dated 5/31/24, indicated a recommendation R51 had an order for Cymbalta [duloxetine]. It appears they are having some issues with anxiety as well since they have an order for Abilify [aripiprazole] for 'anxiety and depression'. Please be advised that Cymbalta [duloxetine] can cause or at least worsen anxiety due to its mechanism of action. It may be prudent to titrate off Cymbalta and if needed, start an SSRI such as Celexa, Zoloft, or Lexapro. The prescriber responded with a check box of disagree stating R51 refused changes and was followed by psychiatry. Review of R51's medical record lacked a clinical rationale for why a GDR was not attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9:40 a.m., the pharmacist consultant (PC) stated he generally did not think it was a good idea for a resident with anxiety to be on a stimulating antidepressant such as Cymbalta. The CP stated he had issued a request for a gradual dose reduction (GDR) for the Cymbalta twice, but it was initially declined by R51's provider because he was working with telehealth psychiatry. He reissued the GDR about 3 months later, stating R51's physiatrist should have had time to address the GDR request by that time however, R51's provider declined the GDR again, stating R51 himself did not want any changes to his medications. The CP stated he had seen great results in residents with anxiety when switching to a less stimulating antidepressant. During an interview on 12/5/24 at 11:41 a.m., the director of nursing (DON) confirmed there had not a been GDR attempted for R51's psychotropic medications since his admission to the care facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 4 of 4 residents (R5, R15, R32, R112) reviewed for dining. This had the potential to affect 35 residents identified to reside on the units with cold food complaints. Findings include: During an observation on 12/5/24 at 7:45 a.m., tall metal meal carts and a plastic cart were observed in the main kitchen with trays placed to have a small bowl of hot cereal covered with a disposable plastic cover sitting on (approximately) every tray. Cook-A (C)-A was observed plating pancakes and sausage patties to each tray. At 8:06 a.m., the 300/400-unit meal carts left the main kitchen. During an observation and interview at 12/3/24 at 8:10 a.m., after the four meal trays were passed from the plastic cart to residents on the 400 hallway, the pancake was measured to be at 108 degrees Fahrenheit and the oatmeal was measured at 119 degrees Fahrenheit. The tray was sampled with the C-A who stated it was hard to keep the pancakes warm and the cereal was a little on the low side. C-A stated they normally wanted the food to be served at approximately 155 degrees Fahrenheit, but it was hard to get the trays out to the residents fast enough as it was only dietary staff who helped to pass the trays, although the nursing assistances were supposed to help. C-A left to assist with passing the trays on the 300 hallway which were observed to have approximately 14 trays left in the metal cart that was observed with both metal doors open. The last food tray was observed to be passed for the 300/400 units at 8:23 a.m. During an interview on 12/4/24 at 10:14 a.m., the dietary director (DD) stated around 95 percent of their residents ate their breakfast in their room and it had been hard to ensure room trays stayed warm. The DD stated this was especially hard at breakfast time as the nursing assistants were normally too busy assisting with resident cares to assist with passing food trays. The DD stated she expected the food to be served around 165 degrees. 47495 R5's admission Minimum Data Set (MDS), dated [DATE], indicated R5 was admitted to the care facility on 10/4/24 and was cognitively intact. During an interview on 12/2/24 at 5:25 p.m., R5 stated she did not eat breakfast anymore because it was always served to her cold. 33925 R15's quarterly MDS, dated [DATE], identified R15 had moderate cognitive impairment but demonstrated no delusional thinking. When interviewed on 12/2/24 at 2:59 p.m., R15 stated she typically ate meals within her room served on a room-tray. R15 stated the food was not always served warm but she rarely, if ever, asked staff to re-heat it adding, I just eat it. R15 stated she didn't like to ask staff to re-heat it as they seemed annoyed by the ask adding the look on their face made her feel so. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R32's quarterly MDS, dated [DATE], identified R32 had intact cognition and demonstrated no delusional thinking. On 12/2/24 at 5:08 p.m., R32 was interviewed and stated the food served within the care center was not good adding, Most of the time it's cold. R32 stated she ate the lunch meal in the dining room which seemed better, however, most room-trays were still being served cooler. R32 stated she had told staff about it but nothing seemed to change. R32 stated staff would heat it up, if asked, however, the food should be served warm from the start adding, You shouldn't have to do that [heat it up]. On 12/3/24 at 9:21 a.m., R112 was interviewed about the care within the facility. R112 stated they had recently admitted and the food was not served well or warm adding, It's horrible. R112 stated the food seemed to be not cooked right and everything about it was poor adding, It would be nice if that food was warmer. The facility's In-Room Dining policy dated 2/21, indicated hot food must be hot and cold food must be cold when served to residents eating in their room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49034 Based on observation, interview, and document review, the facility failed to ensure monitoring and timely removal of facility food stored in refrigerators and freezers was completed to reduce the risk of foodborne illness. This had the potential to affect approximately 10 residents who regularly consumed deli sandwiches from the facility kitchen. Findings include: During the initial tour with the dietary director (DD) at 12/2/24 at 11:37 a.m., the following foods were found in walk-in cooler in the first-floor kitchen: -Two opened plastic bags of sliced ham dated 11/4/24. -Two opened undated bags of sliced turkey. -An unopened bag of sliced turkey with an expiration date of 11/23/24 that appeared fully thawed. During an interview on 12/2/24 at 11:49 a.m., the DD stated the deli meat was quickly used so she did not expect dietary staff to date it. The DD stated she thought the bag of sliced turkey dated 11/23/24 had come from the freezer and when asked about the process to ensure thawed food was not kept past the date when it was safe to consume, was not able to answer. During a follow-up interview on 12/4/24 at 12:56 p.m., the DD stated the deli meat should have been discarded after 7 days of opening and this was important to prevent residents from getting sick. The DD stated they had about 10 residents in the facility who would normally eat deli sandwiches from the supply listed above. The facility's Food Storage policy dated 3/22, indicated the date marking should be visible on all high-risk foods to indicate the date by which they should be consumed, sold, or discarded.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure staff consistently implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 3 of 4 residents (R4, R12 and R28) whom resided on different wings of the care center. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, . expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities . residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R4 R4's admission Minimum Data Set (MDS), dated [DATE], identified R4 had intact cognition, demonstrated no delusional thinking, and used an indwelling catheter. On 12/4/24 at approximately 7:05 a.m., R4 was observed laying in her bed from the parking lot with her room lights on, and the window blinds pulled up approximately three-quarters (i.e., 3/4) of the window height. R4's window was at ground-floor level and a single female staff member was observed dressed in dark-blue colored scrubs and assisting R4 whose legs and peri-area were exposed and visible from the sidewalk leading up to the main entrance of the care center. The staff member had gloves on and was observed wiping R4 with a cloth on her peri-area. At 7:09 a.m., the surveyor approached R4's room to alert staff of the blinds being raised. R4's room door had an orange-colored sign posted on it which included multiple STOP signs and directions reading, Enhanced Barrier Precautions . Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing briefs or assisting with toileting[,] Device care or use: central line, urinary catheter, feeding tube . Do not wear the same gown and gloves for the care of more than one person. R4's room lacked any visible PPE outside to follow these guidelines. The surveyor knocked and opened R4's room door. R4 remained in bed but was now covered with linens as nursing assistant (NA)-B was observed standing in the room. Next to the bathroom was a clear, hard plastic floor-based container which had blue-colored gowns and gloves inside. However, NA-B then did not have any other PPE on aside from a pair of gloves despite the posted signage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245320	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlyn Heights Healthcare Center	2060 Upper 55th Street East Inver Grove Heights, MN 55077

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Following, at 7:15 a.m., NA-B was interviewed and verified they were the staff providing cares to R4 for the past 15 minutes or so adding R4 had an incontinent stool which needed to be cleaned up. NA-B verified the posted EBP instructions on R4's doorway and stated staff were supposed to use them as R4 had a urinary catheter. NA-B verified they helped R4 with peri-care and personal cares without use of a gown adding R4 had an emergency with the incontinent stool which caused them in a hurry to just assist rather than use the PPE. NA-B stated they had been educated on using the EBP adding it was important to help protect the client. NA-B verified they were assigned care to the other residents on the same hallway adding, I work with all of them. On 12/4/24 at 7:22 a.m., R4 was interviewed while laying in her bed. R4 had a visible catheter drainage bag attached to the bed frame. R4 stated the PPE supplies were just brought inside her room the evening prior (on 12/3/24) by the nurse manager but had been stored outside the door prior to that. R4 stated she was unsure why the supplies were moved inside her room. R4 stated staff use of the PPE was inconsistent during her cares adding aloud, Sometimes they don't use them [gowns]. 48065 R28 R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated R28 was cognitively intact, had no behaviors and did not refuse personal cares. The quarterly MDS indicated R28 needed maximal assistance with showers, dressing, toileting and was dependent with all aspect of mobility. R28's Clinical Diagnosis report printed 12/5/24, indicated diagnoses of multiple sclerosis (a disease in which the immune system eats away the protective covering of nerves, disrupting the communication between the brain and the body), pressure areas (an injury to the skin and underlying tissue resulting for prolonged pressure on the skin), neurogenic bladder, neurogenic bladder (lack of bladder control due to spine or nerve injuries) , constipation, epilepsy (brain disorder that causes recurring, unprovoked involuntary movement), quadriplegia (paralysis that affects all a person ' s limbs and body from the neck down) , and colostomy status (a surgical procedure that creates an opening in the abdomen to divert stool from the colon to a bag or pouch). R28's progress note dated 11/20/24 at 5:09 a.m., indicated R28 had a peripherally inserted central catheter (PICC) line inserted in the right upper arm. R28's Clinical Orders report printed 12/4/24, indicated an order dated 11/20/24 for vancomycin HCL (antibiotic medication) intravenous (IV) solution 1250 milligrams (mg)/250 milliliters (ml) for methicillin-resistant staphylococcus aureus (a blood borne infection or MRSA) infection. R28's Care Plan, printed 12/4/24, indicated R28 had MRSA requiring IV antibiotic therapy. The care plan lacked documentation about R28's PICC line and enhanced barrier precautions (EBP). R28's medication administration record (MAR) and the treatment administration record (TAR) for the months of November and December 2024 lacked information about R28's infection precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 12/4/24 at 10:15 a.m., R28's room door had an orange-colored sign posted on it which included multiple STOP signs and directions reading, Enhanced Barrier Precautions . Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing briefs or assisting with toileting [,] Device care or use: central line, urinary catheter, feeding tube . Do not wear the same gown and gloves for the care of more than one person. a personal protective equipment (PPE) bin containing gloves, disinfectant, and gowns was outside R28's room door. Registered nurse (RN)-F entered R28's room without wearing gloves or a gown. Once in the room RN-F put on gloves and without a gown on proceeded to start R28's IV antibiotic through the PICC line. During interview on 12/4/24 at 10:47 a.m. RN-F stated she failed to follow EBP precautions. RN-F stated I didn't wash my hands before putting on gloves and didn't wear a gown, it's not right. RN-F stated this was a concern due to a possible spread of infection. During interview on 12/4/24 at 10:56 a.m., nurse manager (RN)-C stated the nurses need to put on gloves and gowns when working with EBP resident to prevent infections. 49034 R12 R12's quarterly MDS dated [DATE], indicated R12 had moderately impaired cognition and was diagnosed with heart failure, asthma, and dementia. R12's wound care note dated 11/27/24, indicated R12 had an unstageable pressure ulcer on her coccyx that the wound care team was assessing weekly. The note indicated nursing staff were to cleanse the wound and then cover with Santyl (collagenase enzyme topical medication used in wound healing) and a foam dressing daily. During an observation and interview on 12/3/24 at 8:08 a.m., nursing assistant (NA)-E was observed entering R12's room and was not observed to have on a gown or gloves. R12's room was observed to have a sign on the door indicating staff were to utilize EBP with a cart containing PPE immediately outside the door. NA-C was then observed to room also with gown or gloves. At 8:22 a.m., NA-C stated they had assisted R12 with getting out of bed into her chair. NA-C stated she did not think the EBP sign on R12's door was accurate, so she had not worn a gown when transferring R12. At 8:26 a.m., NA-E was observed exiting R12 room and stated R12 was on EBP for a wound she had. NA-E stated she had not worn a gown while assisting R12 to transferring from the bed to the chair as this was not needed unless they were doing wound care. During an interview on 12/4/24 at 2:02 p.m., the director of nursing (DON) stated staff were expected to follow the EBP signs placed on the door that instructed them on when to utilize additional PPE such as during personal cares. On 12/5/24 at 10:44 a.m., the DON stated she expected PICC line dressings changes to be completed weekly along with a daily cap change. The DON stated the nurse managers were expected to order these when the PICC line was placed so nursing staff could document this in the treatment administration record (TAR). The DON stated she would be confirmed about the PICC line possibly getting infected if these dressing changes were not occurring. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Enhanced Barrier Precautions policy dated 11/13/24, indicated EBP would be utilized for residents with chronic wounds and indwelling medication devices. The policy indicated staff should utilize gowns and gloves during high-contact care activities such as dressing, transferring, and device care (central lines, catheters, etc.) for residents on EBP.