STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245324	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Bloomington LLC	9200 Nicollet Avenue South Bloomington, MN 55420

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation and interview, the facility failed to ensure a comfortable and homelike environment for 2 of 2 residents (R19, R23) who shared a room with a large area of the wall patched but left unfinished, unsanded, and unpainted. Findings include: R19's quarterly Minimum Data Set (MDS) dated [DATE], identified R19 had intact cognition. R23's annual MDS dated [DATE], identified had intact cognition. During observation and interview on 1/27/25 at 6:01 p.m., a shared wall of R19 and R23's room had an area of white joint compound that measured one hundred and three inches long by thirty-seven inches tall spanning most of the wall. The area was not sanded, smoothed out, or painted to match the rest of the wall and room. R23 stated, the wall has been like this since [sic] moved to this room in October of 2024. During interview with registered nurse (RN)-B on 1/28/25 at 10:01 a.m., RN-B stated she was familiar with all the residents. RN-B stated there was an expectation of staff to notify the maintenance staff for repair work through an email request form. All staff can do it. RN-B denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview with nursing assistant (NA)-A on 1/28/25 at 10:25 a.m., NA-A stated she was familiar with all the residents. NA-A stated staff were expected to notify the maintenance staff for repair work, online. If [maintenance director] is not here, I may talk to the nurse manager. NA-A denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview on 1/28/25 at 10:44 a.m., R23's stated, I don't like it because it tells me the place has not been totally taken care of and not necessarily clean. I would never stand for that in my own home. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with NA-B on 1/28/25 at 11:00 a.m., NA-B stated she was familiar with the residents. NA-B stated expectation of staff to notify the maintenance staff for repair work in the computer. NA-B denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During interview with NA-C on 1/28/25 at 11:12 a.m., NA-C stated she was familiar with all the residents. NA-A stated expectation of staff to notify the maintenance staff for repair work through an email request form. NA-C denied noticing the unfinished wall repair in R19 and R23's room or submitting a maintenance request to complete the sanding and painting. During observation and interview on 1/28/25 at 11:26 a.m., LPN-B looked at R19 and R23's shared wall and stated, I don't know when they [maintenance staff] did that work on the wall but it is not finished. It does not look good. I have not noticed that before. At 2:02 p.m., LPN-B stated staff was expected to use a communication system with the maintenance department if a repair was needed, like for painting a hallway or resident room. During observation and interview with the maintenance director (MD) on 1/28/25 at 12:14 p.m., MD looked at R19's and R23's bedroom wall and stated, I have patched this. In order for me to paint, I have to pull everyone out of their rooms, and we have been full lately. And we don't have the colors in here anymore. We don't have rooms to put [R19 and R23] in. If I had extra room to put these residents in while I fix the paint, then I would be able to do something about it. MD stated he could not remember when he patched their wall. MD stated he did not have a work order or documentation of ever working on the wall but that he was aware of it needing to be fixed. During interview with R19 and R23 on 1/30/25 at 9:25 a.m., R19 stated, it [wall patch] has been here since I got here. I think at one point [maintenance] was fixing something on the wall over there [pointing to R23's side of the room] and he did this. Looking at it makes me think it is dirty, not cared for. I don't like it. I would like it painted. R23 stated, I am embarrassed by it. During interview with assistant director of nursing (ADON) on 1/30/25 at 10:50 a.m., ADON stated, the wall should be painted. Don't know how long that is has been there. It is not appealing. Facility policy on building maintenance and repair was requested and not received.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure dental appliances (i.e., dentures) were offered or provided to promote safety and independence with eating for 1 of 4 residents (R60) reviewed for activities of daily living (ADL). Findings include: R60's quarterly Minimum Data Set (MDS), dated [DATE], identified R60 had severe cognitive impairment and demonstrated no rejection of care behaviors. Further, the MDS outlined R60 needed substantial and/or maximum assistance to complete oral hygiene (inc. dentures). R60's most recent MHM (Monarch Healthcare Management) Oral/Dental Evaluation, dated 11/18/24, identified R60's oral cavity had no issues and R60 used an upper and lower denture with their condition being recorded, Good condition. R60 was recorded as edentulous (no natural teeth) and a summary outlined, Resident wears full upper and lower dentures. He denies pain with chewing. He is dependent on staff to perform oral hygiene. No mouth sores noted with oral inspection. The completed evaluation lacked evidence R60 refused to wear his dentures. On 1/27/25 at 1:36 p.m., R60 was observed seated in his wheelchair while in the hallway. R60 stated he was unsure how long he had lived at the care center and often mumbled his speech with responses. R60 had no visible natural teeth or dentures in place at this time. R60 stated his dentures were at the dentist office, however, just mumbled a response when asked if he had issues with chewing his food without them. The following day, on 1/28/25 at 10:36 a.m., R60 was again observed in his wheelchair while in his room. R60 had no visible teeth or dentures in and, when asked, opened his mouth to show edentulous palates. R60 was again asked where his dentures were and responded aloud at the dentist again. R60 stated he would wear them if he had them adding aloud, yea, why not, with a mumbled tone. When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked at the center for a few months and had worked with R60 prior. NA-A described R60 as needing help with transfers and could be restless at times. NA-A stated R60 was typically accepting of cares but added, It depends on the day. NA-A stated R60 would sometimes refuse oral care adding, He doesn't like to be touched too much. NA-A stated R60 did not wear dentures to their recall nor had they ever seen him with any placed adding, I don't think so. NA-A stated dentures, if he had them, would be kept in his room. NA-A and the surveyor then inspected R60's room and found a single, lower denture in his bedside dresser in a pink-colored cup. NA-A stated aloud, I didn't even know that [he had one]. NA-A verified they had helped R60 with his morning cares that day and acknowledged they didn't offer the dentures to R60 due to not knowing about them. NA-A stated resident's with dentures should have them offered and placed before meals as it helps to eat them for the food. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's care plan, printed 1/28/25, identified all of R60's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R60 wore dentures and listed a single intervention which read, Provide mouth care as per ADL personal hygiene. The care plan lacked when or how often to provide R60 his dentures nor evidence R60 refused to wear his dentures prior to 1/28/25. When interviewed on 1/28/25 at 11:02 a.m., registered nurse (RN)-D stated they had worked with R60 prior and we unsure off-hand if he used dentures or not adding aloud, I'd have to check his room or record. RN-D stated R60 consumed a soft diet and had not, at least to their recall, ever voiced complaints about his mouth or eating. RN-D stated if a resident used dentures, they should be offered with morning cares and placed if able. R60's medical record was reviewed and lacked evidence R60 had been offered or refused his dentures on 1/27/25 and 1/28/25 when observed without them. On 1/28/25 at 1:16 p.m., the interim director of nursing (DON) was interviewed, and verified R60 had dentures but expressed he would often refuse to wear them when offered. DON stated staff were expected to offer them to him and expressed refusals were not documented. DON stated it was important to offer and, if able, provide dentures as it helps the resident with their food and it was just good quality care. A provided Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/2023, identified the facility would provide necessary care and services to ensure a resident' abilities in ADLs did not diminish unless unavoidable. The policy included, 3. The facility will provide care and services for the following . d. Dining-eating, including meals and snacks, .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure routine nail care was provided for 1 of 1 resident (R58) reviewed for activities of daily living (ADLs) who needed assistance from staff for nail care. Findings include: R58's quarterly Minimum Data Set (MDS) dated [DATE] indicated, R58 was cognitively intact, had no behaviors and did not refuse cares. MDS indicated R58 was independent with ADLs and needed set up or clean up assistance with showers. R58's Clinical Diagnosis Report printed 1/30/25, indicated diagnoses of gout (a form of arthritis that causes severe pain, swelling, redness and tenderness in joints), generalized muscle weakness, other reduced mobility, need for assistance with personal care, protein calorie malnutrition and failure to thrive. R58's ADLs care plan printed 1/30/25 indicated R58 needed assistance with personal cares. An undated Group Report Sheet used by nursing assistants to know how to care for the residents, indicated R58 needed assistance of one staff for bathing and grooming. R58's Weekly Skin Assessments forms printed on 1/30/25, completed on 1/11/25, 1/18/25, 1/25/15 and 1/26/25, indicated under the Bath and Nail Care, R58's fingernails and toenails did not need to be trimmed. During observation and interview on 1/27/25 at 1:00 p.m., R58 was laying on top of the bed and not wearing socks. R58's fingernails were about half an inch long. His nails were yellow and had dark orange matter underneath most of them. R58's toenails were also about half an inch long and the toenail on his right big toe was cracked with a sharp edge. R58 stated, They don't help me cut my fingernails or toenails; they are like an inch long. When my family or friends come to see me, they said I could do better with my personal care. I would like them to help me cut my nails. The last time they help me was 4 weeks ago. You ask them and they never come back. During observation and interview on 1/28/25 at 11:16 a.m., R58 was in bed watching TV and not wearing socks. R58's nails were still long. During observation and interview on 1/28/25 at 1:13 p.m., nursing assistant (NA)-C stated they cut the residents nails on shower days. If a resident is diabetic, the nurses will cut their nails. NA-C verified R58's fingernails and toenails were long. She said they were, yellow/orange and had stuff underneath the fingernails. NA-C asked R58 if somebody offered to help him. R58 said, No, it's been at least a month since they helped me with my nails. (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 1/29/25 at 8:29 a.m., R58 stated the staff set up the shower room for him, gave him towels, and he was able to shower by himself. R58 said the nurses had not checked his skin or cut his nails. R58 said, This morning, a short nice blonde lady came to cut my fingernails. It feels so good, so much better. R58 toenails were not clipped. R58 was not sure who this person was. During interview on 1/29/25 at 8:49 a.m., the admission coordinator, who is a trained medical assistant and NA-D, stated sometimes she was pulled to help on the floor, and she visited all the residents and offered nail care. NA-D stated, she cut R58's fingernails and said, they were about half an inch long, they were yellow and there was stuff underneath the pinky nails. NA-D added, the podiatrist would cut his toenails that day. During interview on 1/29/25 on 9:31 a.m., nurse manager, a licensed practical nurse (LPN)-B, stated the residents' nails and toenails were trimmed on bath day by the nursing assistants. The nurses were responsible to take care of diabetic residents' nails, while some of the residents were seen by the podiatrist. LPN-B verified the Weekly Skin Assessments forms dated 1/11/25, 1/18/25, 1/25/25 and 1/26/25, under section C, Bath and Nail care, indicated R58's nails did not require trimming. During interview on 1/29/25 at 9:05 a.m., the assistant director of nursing (ADON) stated the expectation was nail care needed to be completed and documented, and if a resident refused nail care, it also needed to be documented. Residents with long nails were a concern because residents could scratch themselves and develop skin problems. Dirty nails are an infection control problem. ADON stated we will need to provide education to the staff and make sure those cares get done. Facility policy title Activities of Daily Living dated 3/31/23, indicated a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to assess and, if needed, develop interventions or refer to contracted therapy services to address poor wheelchair posture for 1 of 2 residents (R60), and failed to provide assessed interventions from occupational therapy to reduce the risk of skin injury or further mobility loss (i.e., contracture worsening) for 1 of 1 resident (R15) reviewed for limited range of motion (ROM). Findings include: R60 R60's quarterly Minimum Data Set (MDS), dated [DATE], identified R60 had severe cognitive impairment and demonstrated no rejection of care behaviors during the review period. Further, the MDS outlined R60 had a functional limitation in range of motion (ROM) to both lower extremities and used a wheelchair for mobility. On 1/27/25 at 1:36 p.m., R60 was observed seated in a standard wheelchair in the hallway. R60 stated he was unsure how long he had lived at the center and presented with mostly mumbled responses which, at times, were non-sensical. R60's feet were flat on the floor while seated and he had a upright posture while seated, however, his arms overhung the wheelchair's armrests despite being seated upright with his arms coming to rest on the top of the wheels. The wheelchair had a visible, thick black cushion on the seat. Further, the wheels of the chair were worn down with a large portion of the gray-colored rubber material being worn away exposing the orange-colored resin below with cracks and crevices on the wheel surface. Later, on 1/27/25 at 2:28 p.m., R60 was again observed while seated in the same wheelchair. R60's posture remain upright with his arm's bent approximately 90-degrees at the elbow; however, again, his arms weren't able to rest on the wheelchair' armrests without him having to hunch up his shoulders. R60 was pushing himself backward down the hallway while seated in the wheelchair, and the wheels of the chair remained in disrepair as had been observed earlier. R60's care plan, printed 1/28/25, identified all of R60's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R60 had an alteration in mobility due to multiple medical diagnoses and listed a goal, Resident will move safely within their environment. The care plan listed several interventions including physical therapy as ordered, assistance with bed mobility and transfers, and a low bed for safety. However, the care plan lacked any information on R60's wheelchair (i.e., type used, positioning interventions). The following day, on 1/28/25 at 10:04 a.m., R60 was observed seated in the same wheelchair as the day prior. R60 was in the commons area for an activity and his positioning while seated remained poor with his arms being bent 90-degrees and remaining down at the side of the wheelchair and at wheel-level when at rest. The armrests of the chair were up between his torso and arms. Later, on 1/28/25 at 10:36 a.m., R60 was asked about his wheelchair, including if it was comfortable to be seated in, and responded aloud, [It] could be tighter. R60 did not elaborate further when asked. The wheel's of the chair were inspected at this time and, again, remained in disrepair with the gray-colored rubber coating being nearly worn off in the middle of the wheel causing cracks and a large circumference divet in the middle of the wheel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked with R60, and described R60 as needing help to transfer adding he could be restless at times. NA-A stated R60 had used the same wheelchair for awhile to their recall and expressed they noticed R60 seemed to be sliding down in it causing poor posture. NA-A stated R60 often slept in a near fetal-position and expressed they were not sure what had been causing R60's posture while seated in his wheelchair adding, I don't think about what's causing it. NA-A stated they tried, at times, to boost R60 up to be more upright sitting, however, acknowledged even with doing such his arms would often remain down past the armrests when seated. NA-A stated they were unsure if OT (occupational therapy) had ever worked with R60 for his positioning or not adding aloud, I don't know When interviewed on 1/28/25 at 11:02 a.m., registered nurse (RN)-D stated they had worked with R60 prior. RN-D explained they felt R60's arm's were typically rested on the armrests when seated, however, mentioned they had noticed he does kind of slouch over adding such posture was typically seen for him. RN-D stated they didn't recall OT working with R60 recently and was unsure if OT had ever addressed R60's positioning in the wheelchair adding aloud, That is a good question. R60's medical record was reviewed and lacked evidence R60 had been evaluated recently for his wheelchair positioning despite having potentially poor, uncomfortable posture and direct care staff being aware of the same observation. When interviewed on 1/28/25 at 12:56 p.m., the director of rehabilitation (i.e., PT, OT) (DOR) stated R60 was last on their service in November 2024 and, at that time, had not been using the wheelchair he was currently seated in. DOR stated R60 had multiple hospitalization s and the chair had potentially been switched out at some point. DOR verified they had just observed R60 while seated in the wheelchair and, from that, placed a referral for the OT to review him adding his posture was not terrible but could be improved. DOR stated the chair's armrests were possibly too tall and expressed they had noticed the wheelchair's wheels in disrepair, so they went and obtained a new wheelchair and cushion which was better fitting. DOR verified nobody from nursing had reported any concerns to them about R60's wheelchair or positioning and expressed if staff saw a concern they could report it to be acted upon. DOR expressed poor posture while seated in a wheelchair could cause skin concerns but also low back tightness or discomfort. On 1/28/25 at 1:16 p.m., the interim director of nursing (DON) was interviewed. DON stated they were notified of the wheelchair concern just prior and were working to get one with a suitable fit and position-wise. DON verified they had observed R60's wheelchair and the wheels were in disrepair, adding it appeared like it had seen a good few thousand miles. DON stated nobody had reported any concerns to them about R60's wheelchair condition or positioning and expressed it should have been reported so it could be addressed. A provided Range of Motion (ROM) and Positioning policy, undated, identified a procedure to ensure proper positioning while seated in a chair including ensuring the patient's buttocks are firmly against the back of the chair and spine is straight; however, lacked further information on how to ensure ongoing concerns are addressed (i.e., referred to therapy). 49034 R15 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's quarterly Minimum Data Set (MDS) dated [DATE], indicated R15 had severely impaired cognition with no rejection of care behaviors. The MDS indicated R15 had highly impaired hearing, had no speech, and was rarely/never able to express her ideas or wants with either verbal or non-verbal expression. The MDS indicated R15 had a limited ROM for all extremities and was dependent on staff for all activities of daily living. R15's care plan dated 7/10/24, indicated R15 had alterations in skin integrity related to dementia, malnutrition, immobility, and contractures of all extremities. The care plan indicated R15 had a history of refusing palm protector use while she was in treatment with therapy. The care plan indicated R15 was to wear palm protectors daily and they were to be removed daily to inspect skin and observe for skin breakdown. The care plan indicated nursing staff were to monitor skin integrity daily during cares and weekly skin inspections were to be completed by the nurse. R15's Weekly Skin Inspection reports dated 12/8/24 through 1/19/25 were reviewed and indicated R15 received a bed bath but fingernail trimming was not necessary, leaving refused unchecked. A Weekly Skin Inspection report for the week of 1/20/25-1/26/25 was not found. R15's occupational therapy note dated 12/11/24, indicated the occupational therapist had assessed the resident and recommended R15 wear palm protectors, and her bilateral elbows be positioned in a slight extension with the use of rolled towels/ a small pillow to maximize function and decrease the risk of skin breakdown. The note indicated R15 had previously not tolerated hand splints related to the severity of her contractures. The note indicated the occupational therapist recommended gentle hand/elbow hygiene daily to protect skin integrity. R15's medication/treatment administration record dated 1/1/25 through 1/28/25, indicated R15 had an order dated 3/30/23 for palm protector application. The order also indicated staff were to remove them once a shift for hand cleaning and skin inspection. The order was documented on every shift with 24/81 shifts documented as on, 53/81 shifts documented as off, and 4/81 shifts not documented on, or documented as 0. The record included an order dated 12/20/24 for positioning of R15's elbows in a slight extension with the use of a rolled towel or small pillow to increase the angle and protect skin integrity was documented as completed (approximately) every shift. R15's medical record was reviewed for this period and did not indicate refusal of palm protectors/alternatives for hand protection or refusal of the towel/pillow for R15's elbow extension. The undated 100 Hallway- Group 1 Report Sheet, indicated R15 was to be turned and repositioned every two to three hours with a pillow placed between her legs but did not include towels/ palm protector application to her hands or towels/pillows between her elbows and body. During an observation on 1/27/25 at 12:40 p.m., R15 was lying in bed with her hands balled into fists with no towels, palm protector, or other device noted in her hands. R15's arms were observed tightly against her body with each hand close to the opposite shoulder with no noted towels or small pillows between her arms and her body. During an observation on 1/28/25 at 8:10 a.m., R15 was lying in bed with her hands balled into fists with no towels, palm protector, or other device noted in her hands. R15's arms were observed tightly against her body with each hand close to the opposite shoulder with no noted towels or small pillows between her arms and her body. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 1/28/25 at 2:02 p.m., R15 was lying in bed with her hands balled into fists with no towels, palm protector, or other device noted in her hands. R15's arms were observed tightly against her body with each hand close to the opposite shoulder with no noted towels or small pillows between her arms and her body. Nursing assistant (NA)-B stated they had just repositioned R15, and pillows were observed between her knees. NA-B stated she was not aware R15 needed a pillow between her body and her elbows, so she had not been placing one when she was working with R15. NA-B stated she did do gentle range of motion with R15's arms and hands every day. NA-B was observed demonstrating this range of motion to R15's arms. NA-B was then observed to do range of motion to R15's hands and a white/ yellow build-up was noted on both of R15's palms as well as four bright pink nail marks on R15's left hand. R15's fingernails were observed over 1/4 of an inch beyond the end of the fingertip with a white build-up noted underneath. NA-B confirmed R15's hands had a strong odor when she opened them. NA-B stated R15's hands looked dirty and thought nursing staff was to clean her hands only on bath days so it should have been cleaned last Sunday (1/26/25) but thought that must not have been completed. During an interview on 1/28/25 at 2:21 p.m., registered nurse (RN)-B stated R15's nails were getting long. RN-B stated nursing staff should cut them every week on her bath day but was unsure if this had been completed. RN-B confirmed she had not attempted to clean R15's hands today and had not assessed her palms. RN-B stated R15 had refused to let her place palm protectors or towels in her hands in the past and she had not attempted to apply either yet today. RN-B stated that R15's palm protectors had gone down to the laundry and had been damaged, so she had informed the former director of nursing but was unsure if new ones were ever ordered. RN-B stated she thought the therapy department had been told of R15's refusal to use the palm protector but was not given a different intervention to try instead and was unsure if the therapy department had been told the palm protectors were damaged. RN-B stated she was not aware pillows/towels needed to be applied between R15's body and her elbows so she had not been ensuring this was completed. During an interview on 1/28/25 at 2:27 p.m., the director of rehabilitation (DOR) stated R15 was last seen by occupational therapy on 12/11/24 when they did an evaluation for the appropriateness of a splint which R15 did not qualify for, so they had recommended palm protectors be applied. The DOR stated they were not aware R15 had been refusing to wear the palm protector. During a follow-up interview on 1/28/25 at 3:01 p.m. with the DOR and occupational therapist (OT)-A, the DOR stated she had checked with nursing that day and thought R15's palm protectors had gone down to the laundry department and were damaged. The DOR stated she was unsure when they had been damaged, but they do have extra palm protectors R15 could have used. OT-A stated if they had been made aware of R15 refusing the palm protectors they would have reassessed her for an appropriate alternative as the palm protectors were important in protecting R15's skin and ensuring contractures did not worsen. OT-A stated applying towels in R15's hands would have been an appropriate intervention to attempt if R15 was refusing the palm protectors. During an observation on 1/29/25 at 9:05 a.m., R15 was in bed with bilateral palm protectors applied with eyes closed and no observed signs of pain such as grimacing, furrowed brow, or agitation. During an observation on 1/30/25 at 10:33 a.m., R15 was in bed with bilateral palm protectors applied with eyes closed and no observed signs of pain such as grimacing, furrowed brow, or agitation. (continued on next page)

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	245324	A. Building B. Wing	01/30/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 11:42 a.m., the interim director of nursing (DON) confirmed that she had reviewed R15's medical record and did not find that staff had documented refusals to applying the palm protectors or alternatives and would expect staff to clean R15's hands every shift when they were assessing her hands for skin breakdown. A policy regarding range of motion, mobility, and palm protector application was requested and an undated Range of Motion and Positioning procedure was received. The procedure indicated staff should reposition a resident as needed, per protocol and written RN instructions but did not when occupational therapy should be reconsulted and address palm protector application.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure an order for an audiology (medical specialty assisting with hearing) referral was acted upon promptly to promote better hearing and quality of life for 1 of 1 residents (R13) reviewed who expressed difficulty with hearing. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had intact cognition with no delusional thinking. The MDS indicated R13 had adequate hearing (i.e., no difficulty in normal conversation) and did not use hearing aids. R13's referral form dated 2/22/24, indicated R13 had an order from her provider for an audiology consult for a diagnosis of hearing loss. R13's provider note dated 7/1/24, indicated R13 had reported worsening hearing loss and as a result, withdraws from social interaction and stays in her room. The note indicated the plan for the resident's hearing loss was to provide an audiology consult. During an interview on 1/27/25 at 1:46 p.m., R13 stated she had needed her ears checked for a while and did not recall anyone offering to help her set up an appointment to see the ear doctor. R13 stated she thought she had told someone that her hearing was getting worse but was unsure who. During an interview on 1/30/25 at 9:03 a.m., the interim director of nursing (DON) stated the health information manager (HIM) oversaw making resident appointments and recommended questions regarding whether resident appointments were scheduled/attended be directed to her. During an interview on 1/30/25 at 10:29 a.m., the HIM stated she oversaw making resident appointments for things such as seeing the audiologist. The HIM confirmed she had reviewed R13's medical and found an order from the provider for R13 to see the audiologist in February of 2024 but did not find that this appointment had ever been made or refused by R13. The HIM stated she would make this appointment now, but it would take about four months for the resident to be seen by an audiologist. A policy regarding audiology services was requested and not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review, the facility failed to ensure an unsecured bed mattress was assessed for correct fit for a resident's bed for 1 of 1 residents (R59) reviewed for safety hazards. Findings include: R59's quarterly Minimum Data Set, dated dated dated [DATE] identified R59 had intact cognition and was independent with most mobility related activities (i.e., dressing, toileting and personal hygiene, and ambulation). In addition, R59 had diagnoses of cellulitis (bacterial infection of the skin that can cause redness, pain and swelling at the site) of left lower extremity, anxiety, and depression. During observation and interview with R59 on 1/27/25 at 1:26 p.m., R59 was observed to be lying in bed which was positioned along the wall with the foot of the bed just inside door to hallway. The bed had no footboard, and the unsecured mattress hung over the foot of the bed frame by about 12 inches. There was no retainer bar at the foot of the bed frame to prevent mattress from sliding down. R59 stated, it is hard to get on and off of it and I have to move my feet to allow roommate and others to open and close the door to the hallway. During observation on 1/28/25 at 8:04 a.m., R59 unsecured mattress continued to hang off the foot of the bed frame by about twelve inches. During observation and interview with nursing assistant (NA)-B on 1/28/25 at 11:00 a.m., NA-B stated she was familiar with R59 and pointed to his bed mattress. [R59] is tall and a big guy. That mattress does not fit him. I haven't noticed it or said anything to anyone about it and I haven't heard anyone saying or doing anything about it. During observation and interview with RN-C on 1/28/25 at 1:10 p.m., RN-C stated she was familiar with R59. RN-C pointed out no footboard. I would expect it to be there. All beds should have headboards and foot boards. I don't know why it is like that. RN-C identified the unsecured mattress as a safety risk. During interview with the maintenance director (MD) on 1/28/25 at 1:21 p.m., MD stated, [R59] should have footboard. He kicked it off. [Facility] don't have bed extenders for these beds. We don't have alternatives, and I haven't looked for any. MD stated he was aware of R59's unsecured mattress sliding down past the bedframe and was not responsible for assessing the appropriateness of the mattress and bedframe. MD stated, no I have not asked [R59] for alternatives or options to the overhanging mattress. During interview with R59 pm 1/28/25 at 1:28 p.m., R59 stated he kicked off the footboard. R59 stated, [mattress] is uncomfortable. I was not told about any alternative to the mattress or bed. R59 stated facility staff were aware of the missing footboard because staff put it in my closet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with licensed practical nurse (LPN)-C on 1/28/25 at 2:06 p.m., LPN-B stated he was also the nurse manager for the resident wing R59 resided on. LPN-B stated he was told that R59's missing footboard and slipping mattress was his preference. The staff removed the foot board. Since then, I did not visit back with him about it. LPN-B stated, I think [R59] would benefit from an extension to the mattress or bed[frame]. He is at risk for pressure ulcers to feet. LPN-B stated the electronic medical record (EMR) failed to address the footboard and his unsecured mattress sliding down past the frame of the bed. During observation and interview with assistant director of nursing (ADON) on 1/28/25 at 2:30 p.m., ADON and surveyor walked to R59's room. ADON stated R59 would rest his feet on top of the footboard and it is not appropriate and [R59] said he likes to hang his feet over it. [R59] did not want the footboard. He slides down in the bed. I don't know if maintenance addressed the mattress or bed. As far as I know, we do have extensions for beds. [R59] is very much alert and oriented and knows what his wants and needs are. ADON stated, it is awkward and facility did not have documentation of assessing [R59's] bed frame and unsecured mattress. During interview with MD on 1/28/25 at 3:10 p.m., MD stated, [facility] do[sic] have extensions and longer mattresses and bed[frames]. I do not document or have anything about offering alternatives for extending the bed frame or mattress. MD stated R59 slides down. During interview with ADON on 1/30/25 at 11:17 a.m., ADON stated, [facility] did not assess and reassess for the mattress to stay secured on the bed frame. The mattress does slide down off the foot of the bed without the foot board and his feet do dangle off the mattress at times. Facility policy on Bed Safety was requested and not received.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure ongoing monitoring of resident oxygen use was completed to reduce the risk of respiratory complications for 1 of 1 residents (R13) reviewed for oxygen use. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had intact cognition and was diagnosed with heart failure, kidney failure, Chronic Obstructive Pulmonary Disease (COPD- incurable lung disease causing breathlessness, frequent coughing, and chest tightness), and respiratory failure. The MDS indicated R13 required setup help with eating and oral hygiene and maximum assistance with dressing. The MDS indicated R13 was on oxygen therapy. R13's care plan dated 9/7/24, indicated R13 had an alteration in respiratory status and would remove her oxygen cannula and adjust her oxygen administration rate herself. R13's care plan indicated oxygen was to be administered as ordered and oxygen saturations were to be monitored. The care plan indicated staff were to monitor and document R13's respiratory status. R13's medication and treatment record dated 1/1/25 through 1/26/25, indicated R13 ' s oxygen saturations were taken (approximately) every shift with values ranging from 92 to 99 percent but did not indicate how many liters per minute (LPM) of oxygen R13 was receiving at the time of the reading. The record included an order dated 3/1/24 to wean oxygen back to baseline of two to three LPM to keep oxygen saturation above 92 percent. This order was documented on (approximately) every shift with oxygen saturation values ranging from 92 to 99 percent but did not indicate how many LPM of oxygen R13 was receiving at the time of the reading. R13's medical record was reviewed and did not include correlating a measurement of the LPM of oxygen used to assist R13 in reaching the oxygen saturations measured. R13's provider note dated 1/10/25, indicated R13 had complained of bouts of shortness of breath so a chest x-ray and labs were ordered on 1/10/25. The note indicated R13's chest x-ray showed lung congestion, so a diuretic was ordered on 1/17/25. The note indicated R13 had a history of acute on chronic respiratory failure with hypercapnia (a condition that can lead to shortness of breath that is caused by a buildup of a waste product that your body gets rid of with exhale) that had led to a prior hospitalization in 8/24. R13's progress note dated 1/28/25 at 2:09 p.m., indicated R13 was sent to the hospital related to shortness of breath. During an interview and observation on 1/27/25 at 4:16 p.m., R13 was observed sitting in a recliner in her room receiving oxygen via a nasal cannula. The oxygen concentrator was observed running at a rate of four LPM. R13 stated she had been feeling very short of breath that day and so her nurse had increased her oxygen. R13 was observed taking breaks between words to take deep breaths before she continued talking. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/28/25 at 8:06 a.m., R13 was observed sitting in a recliner in her room receiving oxygen via a nasal cannula. The oxygen concentrator was observed running at a rate of four LPM. During an interview on 1/28/25 at 12:41 p.m., registered nurse (RN)-C stated the computer system they used did not allow nursing staff to put in how many LPM of oxygen they were administering to the resident so she could only see what oxygen saturation the previously nurse had recorded but not the dosage of oxygen being administered at the time of the measurement. RN-C stated R13 had a history of increasing her oxygen administration level and she thought she had done that this morning, so RN-C had decreased her oxygen to three liters. RN-C stated the previous nurse had not passed along how many LPM of oxygen R13 had needed the previous shift and confirmed she was unable to find this information in the medical record. RN-C stated R13 had been feeling very short of breath that day and if it did not get better, she was going to have to go to the hospital. During an observation on 1/28/25 at 1:53 p.m., R13 was observed telling outside emergency medical personnel she can't breathe and it started about four days ago. During an interview on 1/30/25 at 8:22 a.m., nurse practitioner (NP)-A stated she would expect nursing staff to document how many liters of oxygen were administered when documenting oxygen saturation so the facility could track respiratory status changes. During an interview on 1/30/25 at 11:37 a.m., the interim director of nursing (DON) confirmed she had reviewed R13's medical record and stated the facility usually included an order for recording how many LPM of oxygen was administered to a resident and then it would allow nurses to document how many LPM were being administered, but it had been missed for R13. The DON stated it was important her oxygen flow rate was recorded so changes in respiratory status could be tracked, and interventions could be attempted as needed. A policy regarding oxygen use was requested and not received.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to accurately or comprehensively assess the use of side rails and ensure installed side rails were secured to prevent injury or potential entrapment for 1 of 1 resident (R33) reviewed who used bilateral quarter-sized side rails on their bed. Findings include: R33's admission Minimum Data Set (MDS), dated [DATE], identified R33 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R33 required substantial and/or maximum assistance for bed mobility. On 1/27/25 at 1:14 p.m., R33 was observed lying in bed while in her room. R33 used a standard-size hospital bed and each side had a mounted, affixed metallic one-quarter side rail attached to the frame via a center arm. The rail on the open side of the bed (opposite the wall) was loose when touched and allowed movement of approximately eight to 10 inches back-and-forth towards and away from the bed which increased the spacing between the mattress and rail. R33 stated the rail had been loose since she got the bed and expressed she told staff about it but staff responded, They keep telling me that's OK but I don't know. R33 stated the whole side rail on the open side wiggles like that and she was concerned about falling out when they roll her but staff kept telling her it wasn't an issue as they are standing right there. R33 stated nobody from nursing maintenance had been in to review the side rail despite it being loose adding, Not that I'm aware of anyway. R33 repeated, I think somebody should tighten that up. Further, R33 stated she couldn't recall being offered or told what, if any, other options instead of a side rail were available to help her roll side-to-side in bed adding, I don't know if there are any other options. R33's most recent MHM (Monarch Healthcare Management) Bed Mobility Device Evaluation 7/18, dated 1/3/25, identified a section labeled, What type of bed mobility device does resident/legal representative prefer[?], which was answered, Bilateral grab bars. The evaluation identified R33 or their representative was educated on the risks of such device and R33 had no history of injury using such device, either. A section labeled, Evaluation of Alternatives, listed a radio-button response of, Yes, along with dictation reading, . is an assist of 2-3 with a lift . has been educated on the devised [sic] being used and is aware reason why its being used. However, the evaluation lacked further information what which specific devices had been attempted or discussed with R33 (i.e., smaller grab bar, trapeze). The evaluation continued and identified, Assist/Grab bar(s), would be used along with a summary reading, Resident uses grab bars to assist with turn and repositioning. The evaluation was signed by the interim director of nursing (DON) on 1/7/25. R33's care plan, printed 1/28/25, identified all of R33's current or potential medical or mobility issues along with their corresponding goals and interventions. The care plan outlined R33 was at risk of falls and injury, and had an alteration in mobility due to edema and wounds. The care plan directed to assist R33 with movement in-and-out of bed and use a mechanical lift for transfers. However, the care plan lacked information or direction on R33's use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/28/25 at 10:46 a.m., nursing assistant (NA)-A stated they had worked with R33 prior and described her as needing total assistance with most cares. NA-A stated R33 used a mechanical lift and two people to transfer in-and-out of bed, adding R33 would help with repositioning when in bed by hold[ing] on to the thing on the side of the bed. NA-A verified R33 used the side rails to help with turning and brief changes, indicating she had them attached to the bed when she moved in to their recall. NA-A stated they had noticed the one rail, on the open side of the bed, was loose adding aloud, It wiggles. NA-A stated it had been loose awhile and they were unsure if other alternatives (i.e., grab bar, trapeze) had ever been installed on the bed but reiterated the loose rail needed to be fixed adding, I think it needs to be tightened. NA-A stated staff could notify maintenance to have it done on TELS (the maintenance software system) but expressed they themselves had not completed one as they wasn't [weren't] pay attention that much. On 1/28/25 at 1:10 p.m., the director of maintenance (DOR) was interviewed. DOR stated staff had just brought it up about R33's side rail being loose and, as a result, they were going around to everyone with such device to ensure they were tight and secured. DOR verified nobody had alerted him or completed a 'TELS' about it prior to that day (1/28/25,) and expressed side rails and grab bars should be tight and secured for safety reasons. DOR stated grab bars or side rails were not routinely checked for fit and condition by their department because they felt nursing would let them know if a device was loose. DOR stated a monthly check of the devices moving forward would possibly help the issue. When interviewed on 1/28/25 at 1:22 p.m., the interim director of nursing (DON) verified they had reviewed R33's medical record. DON stated the evaluation (dated 1/7/25,) was completed in error and should have reflected side rail use versus grab bars being installed. DON explained R33's bed was rented and no alternatives were able to be done because of that, adding the usual u-bars wouldn't attach to it. However, DON stated they were unsure if maintenance or an outside person set the bed up. DON stated side rails and bars should be checked just with every day care and, if needed, a 'TELS' should be done so it can be fixed. DON added, [We] put it in TELS right away so we can get it fixed. Further, DON stated a loose side rail could cause falls or entrapment adding, It can cause harm to the patient. A facility' policy on side rail evaluation and maintenance was requested, however, none was received.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were fully addressed or acted upon for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had intact cognition and utilized antipsychotic, antianxiety, and antidepressant medication. R13's diagnostic report dated 7/1/24, indicated R13 was diagnosed with major depressive disorder, bipolar disorder, and an anxiety disorder. R13's Order Summary report dated 1/30/25, included the following orders: -dated 6/2/23 for 200 milligrams (mg) of quetiapine (an antipsychotic medication used to treat bipolar disorder) daily for bipolar disorder. -dated 8/14/23 for 300 mg of bupropion XL (an antidepressant) daily for major depressive disorder. -dated 8/14/23 for 120 mg of duloxetine (an antidepressant) daily for major depressive disorder. -dated 8/14/23 for 400 mg of lamotrigine (an anticonvulsant sometimes used to treat bipolar disorder) daily for a bipolar disorder. -dated 12/29/23 for five mg of aripiprazole (an antipsychotic medication used to treat bipolar disorder) daily for bipolar disorder. -dated 12/29/23 for three mg of melatonin (a dietary supplement used to assist with sleep) daily for insomnia. -dated 1/23/24 for 10 mg of buspirone (an anti-anxiety medication) twice a day for an anxiety disorder. R13's Consultant Pharmacist Recommendation to Physician dated 12/23/24, indicated R13 received psychotic medication including five mg of aripiprazole daily, 10 mg of buspirone twice a day, 400 mg of lamotrigine daily, 300 mg of bupropion XL daily, and 120 mg of duloxetine daily. The pharmacist recommended the prescriber review if R13 was on the lowest effective doses of the medications listed above. The pharmacist indicated if a dose reduction was contraindicated, that the clinical rationale be documented below. The recommendation had a blank for a signature, date, and prescriber response that were left blank. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's Consultant Pharmacist Recommendation to Physician dated 1/27/25, indicated R13 received psychotropic medications including five mg of aripiprazole daily, 10 mg of buspirone twice a day, 400 mg of lamotrigine daily, 300 mg of bupropion XL daily, 120 mg of duloxetine daily, three mg of melatonin daily, and 200 mg of quetiapine daily. The pharmacist recommended the prescriber review if R13 was on the lowest effective doses of the medications listed above. The pharmacist indicated if a dose reduction was contraindicated, that the clinical rationale be documented below. The recommendation had a blank for a signature, date, and prescriber response that were left blank. R13's medical record was reviewed and did not include a provider response to the above pharmacist recommendations. During an interview on 1/30/25 at 9:26 a.m., the consulting pharmacist (CP) stated when she had reviewed R13's medication record she had not found evidence the provider had attempted or declined to attempt a dose reduction of her psychotropic medications in the current quarter. The CP stated she had given a similar recommendation in January as the previous CP had in December, as she could not find that the provider had responded to the recommendation given in December, and it was important that they attempt to reduce psychotropic medication use when possible. During an interview on 1/30/25 at 11:43 a.m., the interim director of nursing (DON) confirmed she had reviewed R13's medical record and could not find that a response was received from the provider regarding the pharmacist's recommendation for a dose reduction. The interim DON stated she thought the recommendation should have been sent to R13's psychiatrist as they managed her psychotropic medications but as R13 had changed psychiatrists recently, was unsure who this was sent to as the previous DON oversaw this task. The interim DON stated she expected these to be faxed to the provider and the response uploaded to the medical record. The facility's Medication Regimen Review policy dated 8/19, indicated the pharmacist would review each resident's medication regimen at least monthly, and the recommendations would be acted upon and documented by facility staff and/or the prescriber. The prescriber would accept and act upon the suggestions or reject the suggestion and give an explanation for disagreeing.

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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** 33925 Based on observation, interview, and document review, the facility failed to ensure acute, potentially distressing psychoactive symptoms were recorded and non-pharmacological interventions were attempted or recorded to ensure efficacy of as-needed (i.e., PRN) psychotropic medication for 1 of 5 residents (R2) reviewed for unnecessary medication use. Findings include: R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 had severe cognitive impairment and continuous inattention, disorganized thinking, and altered consciousness. The MDS recorded R2 having multiple signs of potential depression, including appear or feeling down and being short-tempered, but demonstrated no behaviors (i.e., physical, verbal, other). Further, the MDS identified R2 consumed multiple psychotropic's including both antipsychotic and antianxiety medications. R2's Doctor's Order, dated 1/6/25, identified an order from hospice was received which read, Restart lorazepam concentrate . 0.5 mg [milligrams] (0.25 ml) PO/SL [by mouth] Q4H PRN [every four hours as needed]. The order listed a diagnosis which read, Terminal agitation [a state of extreme restlessness, anxiety, and confusion that can occur in people who are nearing the end of their life]. On 1/27/25 at 1:28 p.m., R2 was observed seated in a geri-chair in the hallway by the nurses' station. R2's eye were open and she was alert as registered nurse (RN)-E held up her right leg and exposed a large, dark area on her right heel. R2 demonstrated no physical signs of pain or anxiousness at this time but had little, if any, verbal response to RN-E or the surveyor. Two days later, on 1/29/25 at 8:45 a.m., R2 was observed lying in bed while in her room. R2 was alert with her eyes open and speaking aloud with I want to tell you something, however, just mumbled a response afterward. R2 appears comfortable and without obvious physical signs of pain or anxiousness at this time. R2's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 1/2025, identified R2's administered medications and treatments for the period. The MAR recorded a total of five (5) administrations of PRN lorazepam including: On 1/9/25 at 7:20 p.m., with the results listed as, E [effective]. A corresponding progress note, dated 1/9/25, identified the medication was given but lacked any recorded symptoms or behaviors which supported use of the medication, nor any non-pharmacological interventions being attempted or done prior to the medication. On 1/13/25 at 9:32 a.m., with the results listed as, E. A corresponding progress note, dated 1/13/25, identified the medication was given but lacked any recorded symptoms or behaviors which supported use of the medication, nor any non-pharmacological interventions being attempted or done prior to the medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 11:07 a.m., with the results listed as, E. A corresponding progress note, dated 1/23/25, identified the medication was given but lacked any recorded symptoms or behaviors which supported use of the medication, nor any non-pharmacological interventions being attempted or done prior to the medication. None of the recorded doses or corresponding notes for the 1/2025 administration(s) contained any recorded symptoms or behaviors which supported use of the PRN psychotropic medication, nor any non-pharmacological interventions being attempted or done prior to the medication. R2's care plan, printed 1/29/25, identified R2's current identified problems, goals, and interventions to help R2 meet those goals. The care plan identified R2 was on hospice care and had an alteration in her mood and behavior related to her medical complications. The care plan outlined, Resident has hx [history] of refusing all cares, meds and food. Resident speaks another language [and] understands a little English. The care plan directed, Monitor and document mood state/behaviors upon occurrence. Further, the care plan identified R2 was at risk for psychotropic medication adverse reactions due to using them daily, and directed staff to update the provider regarding the efficacy of the medications or, if any, adverse reactions noted. When interviewed on 1/29/25 at 8:49 a.m., trained medication aide (TMA)-B stated they had worked with R2 multiple times prior and described her as having good days and bad days with her care needs. TMA-B explained R2 would, at times, help staff complete basic cares like dressing and expressed she (R2) used to have more behaviors, such as hallucinations, but those had subsided adding, [She's] very calm now. TMA-B stated R2 was very loving and often would tell you she loves you to the staff members. TMA-B stated they recalled one episode of R2 being a little anxious a week ago but otherwise had not seen any indications R2 was anxious or distressed. TMA-B stated when they witnessed the episode the week prior, the nurse stepped in and gave R2 medication which made it much better. TMA-B stated R2 seemed to speak in her native language when anxious or upset and, in response, staff just remind her they're not able to understand her and to use English, if able. However, TMA-B verified they had a translator service available and could use it, if needed. R2's medical record was reviewed and lacked evidence what, if any, physical or verbal symptoms were present to warrant use of the medication on each of the administered doses of the PRN lorazepam; nor evidence what, if any, non-pharmacological interventions had been attempted prior to using the medication to see if the behaviors deescalated without medication intervention. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/29/25 at 11:02 a.m., registered nurse (RN)-B stated they had worked with R2 multiple times and described R2 as being total cares. RN-B stated R2 could have very different behaviors including yelling, screaming and, at times, throwing items at the staff. However, RN-B stated then, I think in the last month she's been doing better. RN-B stated it was now mostly outbursts here and there. RN-B stated if R2 had behaviors, they themselves had tried to wheel her around the hallways and noticed R2 seeing other people tended to make her more calm. RN-B verified R2 had an active order for PRN lorazepam and stated they typically gave it to R2 only after non-pharmacological interventions failed. RN-B reviewed R2's completed MAR and associated charting and acknowledged it lacked any recorded symptoms or non-pharmacological interventions prior and expressed staff possibly were just giving it and not recording those things. RN-B stated staff should be attempting to figure out why R2 was agitated or anxious, and expressed behavior monitoring and non-pharmacological interventions were tracked on the TAR. RN-B reviewed R2's TAR and stated aloud, Her's is different here. RN-B verified it did not have the typical order set used to track non-pharmacological interventions and reiterated, [Maybe] it's something they don't put in [interventions] and just give it [medication]. Further, RN-B stated they were unsure if anyone from nursing leadership had ever told them to record symptoms or non-pharmacological interventions with PRN psychotropic medication administration adding aloud, I'm not sure. On 1/29/25 at 11:52 a.m., the regional nurse consultant (RNC)-A was interviewed. RNC-A verified they reviewed R2's medical record and it lacked the behavior monitoring order set which was used to document non-pharmacological interventions on each shift to support medication' use. RNC-A stated it should have been in there as it was used to show resident specific target behaviors and interventions. RNC-A stated staff could have also completed a progress note with such information. RNC-A verified symptoms and non-pharmacological interventions were to be attempted and tracked as doing such helped determine if the medication was actually helping with it [symptoms]. When interviewed on 1/30/25 at 9:29 a.m., the consulting pharmacist (CP) explained specific behavior monitoring was more completed on the nursing end, however, verified witnessed behaviors should be recorded with any PRN medication administration. CP explained non-pharmacological interventions were also to be attempted adding aloud, They definitely should attempt non-[NAME] prior. However, CP reiterated doing such things was, again, more up to the nurses and nursing leadership to ensure it was done. A provided Psychotropic Medication Use policy, dated 11/2024, identified such medications could be considered for resident with symptoms which have been identified by the interdisciplinary team (IDT) and whom have deemed such medications would benefit the resident. The policy directed, Pertinent non-pharmacological interventions must be attempted, unless contraindicated, and documented. Further, the policy outlined, Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44656 Based on observation, interview and document review, the facility failed to ensure community use glucometers (machines to check blood sugar) were properly cleaned and disinfected between patient use, and failed to ensure staff who performed blood glucose checks were knowledgeable of process for cleaning and disinfecting blood glucose devices prior to and after use per manufacturer instructions. This had the potential to affect 9 of 9 (R10, R13, R15, R26, R29, R41, R49, R54, and R118) residents who were diabetic, had orders for blood glucose monitoring, and used a community glucometer. Findings include: The manufacturer's instructions for use of the Arkray Assure Platinum Blood Glucose Monitoring System in Section B: To reduce the chance of infection, the clinician is to, Wash hands thoroughly with soap and water before putting on a new pair of gloves and performing the next patient test. And, prior to obtaining blood sample, Step 1: Wash patient's hands with soap and warm water. Guidelines for cleaning and disinfecting the unit state, To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed. Per the manufacturer's instructions, the clinician is to utilize the approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit after each use. One of the approved wipes is, Super Sani-Cloth Germicidal Disposable Wipes[Saniwipe]. General guidelines for use of the wipe is to Allow treated surface to remain wet for two (2) minutes. Let air dry. The procedure for cleaning and disinfecting the Assure Platinum Blood Glucose Monitoring System is to wear appropriate protective gear such as disposable gloves, wipe the surface of the meter to clean it, and wipe around the test strip port with unit facing down to prevent the disinfectant liquid from entering the meter. Treated surface must remain wet for recommended contact time per the wipes manufacturer's instructions. The product description for Super Sani-Cloth Germicidal Disposable Wipe list the Overall Contact Time (time a cleaner needs to kill germs on a surface or device) as two minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During continuous observation and interview on 1/27/25 at 5:44 p.m., registered nurse (RN)-A stated she was familiar with the residents. RN-A walked to the nursing medication cart and removed a yellow plastic container from the cart with R10's name written on top of it. From the container RN-A removed an Arkray Assure Platinum Blood Glucose Monitoring System glucometer, one lancet, container of test strips, two cotton balls, and two alcohol wipe towelettes. RN-A walked to R10's room with the supplies. RN-A entered R10 room and asked if she could take your blood sugar before you eat? R10 had started to eat dinner and was holding silverware and his wheelchair armrest when RN-A entered room. RN-A sanitized hands and applied gloves, then placed supplies directly on top of bedside table next to dinner tray. There was no barrier used between the supplies and the bedside table. RN-A did not wash R10's fingers with soap and water. RN-A wiped R10's right pointer finger with an alcohol wipe, then inserted a glucometer strip into the machine turning it on. RN-A then used the lancet to the right pointer finger and obtained a sample of blood. RN-A wiped the finger with a cotton swab and then applied a drop of blood to the glucometer strip. RN-A obtained the result, wiped the finger with second alcohol wipe, and removed the strip from glucometer. RN-A then disposed of the lancet in a Sharps container (puncture-resistant waste container), and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-A walked back to medication cart with glucometer after sanitizing hands and placed supplies on top of medication cart to document results on a care sheet. RN-A then obtained a facial tissue from top of medication cart, pumped hand sanitizer onto the tissue, and wiped the entire glucometer. RN-A obtained second facial tissue and immediately wiped the entire glucometer with a dry tissue. RN-A unlocked the medication cart and returned the supplies back into R10's box, closed the lid and placed it back into the medication cart. RN-A did not use an approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit prior to and/or following use. Immediately afterwards at 5:51 p.m., RN-A removed a blue plastic container from the cart with R54's name written on top of it. RN-A obtained an Arkray Assure Platinum Blood Glucose Monitoring System glucometer and supplies and walked to R54's bedroom and knocked on the door before entering the room. RN-A did not clean glucometer prior to use. RN-A asked permission to obtain blood sugar result and then placed supplies directly on top of bedside table next to his dinner tray. There was no barrier used between the supplies and the bedside table. RN-A did not wash R54's fingers with soap and water. RN-A wiped R54's left pointer finger with an alcohol wipe, then inserted glucometer strip into the machine turning it on. RN-A then used the lancet to the left pointer finger and obtained a sample of blood. RN-A wiped the finger with a cotton swab and applied a drop of blood to the glucometer strip. RN-A obtained result and wiped finger with second alcohol wipe and removed the strip from the glucometer. RN-A then disposed of the lancet in a Sharps container, and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-A walked to medication cart, sanitized her hands, applied gloves, and used a facial tissue with hand sanitizer applied to it and then wiped the glucometer and dried it immediately with a dry facial tissue. RN-A then placed R54's glucometer and supplies into the blue container with his name on it and put it in the locked medication cart. RN-A did not use an approved and recommended Environmental Protection Agency (EPA)-registered wipe to cleanse and disinfect the unit it prior to and/or following use. RN-A opened her care sheet and wrote the information on it. RN-A stated, I always clean the glucometer with that sanitizer [pointing to an 8 fl ounce (oz) container of McKessan brand hand sanitizer on the medication cart]. It's what I have always done. (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 and interview with RN-C on 1/28/25 at 7:12 a.m., RN-C obtained communal Arkray Assure Platinum Blood Glucose Monitoring System, used for multiple residents in the facility, and supplies from medication cart and entered R26's room. RN-C did not clean glucometer prior to use. RN-C asked permission to obtain blood sugar result and then placed supplies directly on top of bedside table. There was no barrier used between the supplies and the bedside table. RN-C did not wash R26's fingers with soap and water. RN-C wiped right pointer finger with alcohol wipe, then inserted a glucometer strip into the machine turning it on. RN-C then used the lancet to the left pointer finger and obtained a sample of blood. RN-C wiped the finger with a cotton swab and then applied a drop of blood to the glucometer strip. RN-C obtained result and wiped finger with second alcohol wipe and removed the strip from the glucometer. RN-A then disposed of the lancet in a Sharps container and disposed of the used strip, cotton ball, alcohol towelettes, and gloves into the resident garbage container. RN-C then walked to medication cart and sanitized hands prior to applying gloves. RN-C wiped glucometer with Saniwipe cloth and immediately placed it back into the medication cart. This was not done according to the Saniwipe recommendations. RN-C stated, no hand sanitizer for cleaning glucometer. During interview with licensed practical nurse (LPN)-A on 1/28/25 at 10:54 a.m., LPN-A stated the process for cleaning and disinfecting the glucometer was clean it with the purple Saniwipe for thirty seconds and put on a paper towel and let it dry. LPN-A stated, hand sanitizer would not be ok to clean a glucometer because I think it needs more of the Saniwipe thing, it says two minutes. LPN-A provided surveyor a list of facility residents requiring blood glucose monitoring using the Arkray Assure Platinum Blood Glucose Monitoring System. The list was marked with icons that identified the residents who had personal dedicated glucometers in the locked medication carts and the residents who used the shared glucometers. Personal dedicated glucometers were identified as R10, R13, and R54. Shared glucometers were used for R15, R26, R29, R41, R49, and R118. During interview with LPN-B on 1/28/25 at 11:26 a.m., LPN-B stated glucometer cleaning and disinfecting was done by the nurses. LPN-B stated expectation of glucometer cleaning as, [sic] must use the Saniwipe or the alcohol wipe. LPN-B then opened a locked medication cart and removed an alcohol towelette and showed it to the surveyor. This is what we can use. During interview with registered nurse (RN)-C on 1/29/25 at 7:12 a.m., RN-C removed an Arkay Assure Platinum Blood Glucose Monitoring System glucometer from a medication cart and wiped it with a Saniwipe, then placing it on a facial tissue. RN-C stated, no. [hand] sanitizer does not apply [to cleaning] it. During interview with RN-B on 1/30/25 at 9:31 a.m., RN-B stated the procedure to clean and disinfect the Arkay Assure Platinum Blood Glucose Monitoring System glucometer was to wipe down the machine with one of the [Saniwipe} wipes and to do this procedure before and after use. RN-B stated, I don't not usually wash fingers with soap and water before obtaining result. During interview with trained medication aide (TMA)-A on 1/30/25 at 9:35 a.m., TMA-A stated staff were expected to clean and disinfect the glucometer with a Saniwipe not alcohol wipe or hand sanitizer before resident use. TMA-A also stated, I don't know if the last person cleaned it or not. TMA-A stated, I do not use soap and water to wash [resident] finger before poking finger [obtaining result]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with assistant director of nursing (ADON) who was also the facilitys infection control preventionist on 1/30/25 at 10:43 a.m., ADON stated, we use the purple Saniwipe between glucometer use and allow it sit for three minutes. ADON stated the expectation of nurses was to clean and disinfect the glucometer always before and after use. I expect staff to follow manufacturers guidelines and instructions to wash hands with soap and water before testing and to clean and sanitize the machine with Saniwipe before and after use. ADON stated, alcohol wipes are not the same as a Saniwipe and they are not appropriate to clean a glucometer. Facility policy on cleaning and disinfecting medical equipment was requested and not received.