| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245347 | A. Building<br>B. Wing | 06/05/2025 |

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|---|---|
| Lyngblomsten Care Center | 1415 Almond Avenue<br>Saint Paul, MN 55108 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 1 of 3 residents (R13) reviewed for medication administration.<br><br>Findings include:<br><br>R13's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition and diagnoses of Alzheimer's disease (a progressive neurological disorder affecting a person's memory, thinking, and behavior), heart failure and anxiety. The MDS indicated R13 required partial to moderate assistance for oral hygiene and substantial to maximum assistance for personal hygiene cares.<br><br>R13's self-administration of medication assessment dated [DATE] indicated R13 did not wish to self-administer her medications.<br><br>R13's undated order summary report included the following orders:<br><br>- Resident is not capable of safely self-administering medications, dated 10/31/23.<br><br>- Albuterol Sulfate Inhalation Nebulization Solution (Albuterol Sulfate) 3 milliliters (mL) inhale orally via nebulizer three times a day for cough or difficulty breathing, dated 3/13/25.<br><br>R13's care plan was reviewed on 6/2/25, and revealed a lack of documentation of an assessment she was okay to self-administer medications.<br><br>(continued on next page) |

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

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

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a continuous observation on 6/2/25 starting at 1:23 p.m., a buzzing noise was heard from outside R13's room. At 1:24 p.m., trained medication aide (TMA)-A walked out of R13's room and back to a medication cart, leaving R13's door open. Inside R13's room, a nebulizer treatment machine was observed to be running and causing the buzzing noise heard. There was tubing going from the nebulizer treatment machine to a mask that covered R13's nose and mouth, and connected below the mask was a medicine cup with liquid condensation inside. R13 sat in her wheelchair inside her room facing the nebulizer treatment machine that was plugged into the wall. TMA-A was observed going from the medication cart into other resident rooms and back to the medication cart during this time. At 1:32 p.m., TMA-A returned R13's room and announced, time is up. R13 had removed the mask from her face and was holding it in her lap. R13 stated to TMA-A, I don't want it on. I have had worse colds than this. TMA-A responded, you took it off, and told R13 would need to update the doctor if she did not want the treatment any longer. TMA-A offered a drink of water and attempted to complete the medication pass, however R13 began to cry, spit out her medications and stated she wanted to leave.<br><br>During interview on 6/2/25 at 1:37 p.m., TMA-A stated R13 had been having a cough and was taking a scheduled nebulizer treatment before breakfast and after lunch for the cough. TMA-A stated R13 did not like the afternoon nebulizer treatment but took the morning treatment well. TMA-A confirmed she administered the nebulizer treatment and left R13 in her room unsupervised while she finished her treatment. TMA-A stated she normally kept the mask on but today was not normal for her. TMA-A stated R13 should have an order in her medication administration record (MAR) stating it was okay for her to be left alone (or unsupervised) to finish her nebulizer treatment. TMA-A was unsure about the self-administration assessment but indicated the nursing manager would know. TMA-A expected there to be an order in place indicating R13 could complete her nebulizer treatment on her own. TMA-A reviewed MAR and identified for R13; Albuterol Sulfate Inhalation Nebulization order and opened the administration instructions and stated, it doesn't have all the details in there. TMA-A was unable to locate a provider order indicating R13 was okay to self-administer her nebulizer treatment, however stated the MAR banner or administration instructions was where it should be.<br><br>During interview on 6/2/25 at 1:47 p.m. with registered nurse (RN)-A, indicated a resident who wished to self-administer medications, including complete their nebulizer treatment after set-up unsupervised, would need a provider's order and an assessment. RN-A reviewed R13's orders and identified an order dated 10/31/23, that indicated R13 was not able to self-administer medications. RN-A confirmed this order would include nebulizer treatments. RN-A reviewed R13's electronic health record (EHR), including her MAR, and confirmed staff should stay with R13 for the duration of the nebulizer treatment to ensure she kept the mask on. RN-A explained if a resident wished to self-administer medications, staff were expected to obtain an order and perform an assessment to determine if they could safely do so.<br><br>During interview on 6/5/25 at 8:45 a.m. with RN-B, indicated if a resident had an order to self-administer their medications, it should be in the MAR and/or in the administration instructions for staff to see.<br><br>During interview on 6/5/25 at 9:56 a.m., the director of nursing (DON) expected staff to follow the facility's self-administration policy and procedure.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Facility Self-Administration of Medications policy revised 5/22, indicated the facility would allow residents to self-administer medications and/or treatments if the resident wished AND if the resident was assessed to be capable of safely self-administering medications. The policy directed staff to complete a self-administration of medication assessment and if the resident wished to self-administer and was determined to be safe to do so, to obtain a physician's order to self-administer. Further, the policy guided staff on the specificity of the self-administration order, including any modifications (if any) determined during the assessment. |

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| F 0577<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation, interview and document review, the facility failed to ensure complaint investigation survey results were readily accessible and available for review within the campus. This had potential to affect all 207 residents, visitors, and their families who could wish to review the information.<br><br>Findings Include:<br><br>During the recertification survey on 6/2/25 at 12:21 p.m., a binder labeled survey results hung on the wall to the left of the information board located in a hallway on the 1st floor, adjacent to the front desk and contained the following results:<br><br>Recertification survey dated 3/14/24<br><br>Abbreviated complaint survey results dated 5/21/24.<br><br>The facility binder lacked documentation in the form of a CMS 2567 (Formal investigation documentation required by the Centers for Medicare and Medicaid Services-CMS) for investigations or standard surveys completed during the following dates:<br><br>6/27/24, abbreviated complaint survey results,<br><br>7/29/24, abbreviated complaint survey results,<br><br>8/29/24, abbreviated complaint survey results with F578- cited at J.<br><br>1/17/25, standard abbreviated survey results<br><br>During interview on 6/2/25 at 6:17 p.m., the administrator stated the director of nursing was responsible for maintaining the binder. The director of nursing (DON) entered the office and stated the past survey results will be printed and placed in the binder.<br><br>During an interview on 6/4/25 at 11:00 a.m., R63 stated survey results are not available for residents to review.<br><br>Policies related to survey results were requested, but no policies were received. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>Based on observation, interview and document review, the facility failed to ensure freedom of movement was not restricted for 1 of 1 resident (R143) who was reviewed for physical restraints.<br><br>Findings include:<br><br>R143's quarterly Minimum Data Set (MDS) assessment, dated 4/16/25, identified severely impaired cognition. R143's diagnoses included; Parkinson's disease (a chronic progressive neurological disorder), dementia, and progressive neurological conditions accompanied by a psychotic disorder. R143 required maximum assistance to ambulate ten feet and was fully dependent on others when using the wheelchair. They also needed maximal assistance for transfers, including rolling from side to side, seating, and positioning in bed. A bed alarm was used daily.<br><br>R143's care plan reviewed on 4/10/25, identified interventions for self care deficits, fall risk, and mood enhancement. The interventions included placing the resident in the common area recliner to engage in activities-such as watching the news-and for staff to observe and intervene when R143 attempted to self transfer. Staff were encouraged to keep R143 in public areas whenever not eating or napping. Furthermore, the care plan recognized impaired mobility secondary to impaired balance and unsteady gait. R143 required assistance from two staff members with a walker; one to two staff for bed mobility, repositioning, sitting up, and rolling side to side; and that a mechanical lift was used when R143 became stiff. R143 was able to propel self short distances but needed assistance for longer distances or when off the unit.<br><br>R143's active providers orders last reviewed 5/6/25, identified a pressure alarm and pads but lacked an order for restraints.<br><br>R143's quarterly Interdisciplinary Care Conference report dated 4/28/25, identified family member (FM)-A attended the conference and requested the television on when R143 was in the lounge area and recommended which channels were preferred and suggested R143 held a book for comfort.<br><br>R143's progress notes dated 5/10/25 at 1:55 p.m., indicated R143 had more than one fall in the past three months, had balance and decreased muscular coordination and used medications that placed R143 at moderate risk for falls.<br><br>R143's progress notes dated 5/16/25 at 6:33 p.m., indicated R143 was screened by occupational therapy (OT) post fall, was not a candidate for OT due to the lack of following directions and declined in basic activities of daily living (BADL) and needed extensive assist since admission despite therapy intervention.<br><br>R143's progress notes dated 5/31/25 at 6:12 p.m., indicated R143 self-transferred and was seen walking around his room unassisted and indicated R143 was not stable walking on his own and brought out to the nurse's station for one-on-one cares.<br><br>R143's electronic medical record (EMR) lacked documentation for a medical diagnosis treated by use of the electric recliner. Furthermore, the medical record failed to show an assessment or R143's ability to rise independently out of the chair/recliner.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/2/25 at 12:30 p.m., FM-A stated staff placed R143 in the common area in the chair, reclined, with his feet up because the bed alarm can no longer be used. The recliner was the only place staff could keep him because of the recent falls.<br><br>During an observation on 6/3/25 at 3:52 p.m., R143 was in the common area, in a recliner with both feet up. The recliner remote was hung over the back of the chair. R143's personal paid companion was seated to the right and two other residents were in their wheelchairs. No staff were present.<br><br>During an interview on 6/4/25 at 8:54 a.m., registered nurse (RN)-C stated R143 can't activate the chair, and the wife requested the use of the recliner. RN-C further stated any assessment would be done by OT and was not aware of any completed assessment.<br><br>During an observation on 6/4/25 at 9:54 a.m., R143 was in the recliner in the common area, both feet were up. R143 was awake and looking around the room. The remote was placed arms reach away on the heat register.<br><br>During an interview 6/4/25 at 11:42 a.m., FM-A stated no consent, or waiver was signed that approved the use of the recliner.<br><br>During an interview on 6/4/25 at 11:46 a.m., director of therapy (DOT) stated R143 had been assessed for transfers, but never assessed for a recliner.<br><br>During an interview on 6/4/25 at 11:46 a.m., the director of therapy (DOT) stated R143 was assessed for transfers only and never assessed for safety with the use of an electric recliner. The DOT was not aware of any assessments ever completed for a lift chair or recliner.<br><br>During an Interview on 6/5/25 at 7:09 a.m., the director of nursing (DON) stated he confirmed with the nurse manager on the unit that R143 cannot get up from the recliner, but felt the recliner was a safe intervention and now staff could observe and intervene as he is in the lobby and not in his room.<br><br>During an interview on 6/5/25 at 8:29 a.m., occupational therapy (OT)-A confirmed no referral was received to assess the safety and use of the electric recliner for R143 furthermore, an assessment would be requested for a recliner only if a pressure injury occurred that required a cushion or if a resident had fallen out of a recliner. OT-A was aware of assessments for recliners and completed those at other facilities, then confirmed R143 had not been assessed to use the recliner.<br><br>Restraint Use policy revised 5/21, identified the use of physical restraint was prohibited for discipline or convenience, unnecessarily inhibit a resident's freedom of movement or activity. Convenience was defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest. Freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control. Physical Restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all the following criteria: is attached or adjacent to the resident's body, cannot be removed easily by the resident, restricts the resident's freedom of movement or normal access to his/her body.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Physical Device Evaluations policy revised 6/22, identified evaluations for any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The guidelines identified an atypical method, or device is considered any intervention or equipment that is nonroutine or would not be considered standard or required in the normal delivery of care. Some examples of atypical methods or devices are Geri-chairs, wedge cushion in wheelchairs, bed placed against a wall for purposes other than room décor/style, anti-roll back wheelchairs. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 resident (R200) reviewed for hospitalization.<br><br>Findings include:<br><br>R200's discharge Minimum Data Set (MDS) dated [DATE], indicated R200 admitted to facility on 2/10/25, from a Short-Term General Hospital, and discharged from facility on 3/6/25, discharging to Short-Term General Hospital.<br><br>R200's progress note dated 3/5/25 at 10:00 a.m., indicted R200 discharge home back to [name of assisted living] signed onto hospice so no home services.<br><br>R200's nursing progress note dated 3/6/25 at 11:04 a.m., indicated R200 discharged to [name of assisted living].<br><br>On 6/4/25 at 10:05 a.m., registered nurse (RN)-F, know as a MDS coordinator reviewed R200's MDS dated [DATE], and confirmed the MDS was inaccurately coded and R200 discharged home and not to the hospital. RN-F stated the MDS was expected coded correctly and correction would need to be completed.<br><br>On 6/4/25 at 2:49 p.m., the director of nursing (DON) stated the MDS was expected to be accurate and the MDS coordinators follow the MDS RAI (Resident Assessment Instrument) manual.<br><br>Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual dated 10/24, indicated<br><br>In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident ' s medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident ' s actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to consistently utilize a communication device or provide an interpreter for 1 of 1 resident (176) reviewed who was deaf and used ASL to communicate care needs.<br><br>Findings Include:<br><br>R176's significant change Minimum Data Set (MDS) assessment dated [DATE], identified no cognitive impairment, primary language was American sign language (ASL), and an interpreter was needed to communicate with doctors and health care staff.<br><br>R176's care plan revised on 12/3/24, identified impaired communication. R176's care plan identified methods for communicating such as short, direct simple phrases, visual aids, and indicated please provide me with an ASL interpreter for all significant meetings/interactions such as care conferences, cognitive/mood assessments, etc.<br><br>R176's active provider orders last reviewed 5/5/25, indicated weekly pain and skin assessments, daily ambulation program and a fluid restriction order which could have required staff to communicate with R176.<br><br>During an initial interview on 6/2/25 at 1:11 p.m., R176 wrote on a notebook, some of the staff do not know how to use the iPad to contact the ASL interpreter and wrote on a notebook to communicate. R176 wrote my preference was the ASL interpreter be used with all cares because writing in ASL structure confuses staff that are non-English speaking. An ASL Interpreter was used for the remainder of the interview and through the interpreter R176 expressed concerns that aids and nurses do not understand me and it has always been my preference to use the ASL interpreter.<br><br>During an interview on 6/3/25 at 4:00 p.m., R176 typed on a word document that staff did not use the iPad interpreter with any interactions or cares today and that only the social worker used the iPad interpreter. R176 indicated a concern that registered nurse (RN-D) completed a skin assessment and did not use the interpreter to communicate. R176 was upset and wheeled out to the nurse's station and pointed at RN-D.<br><br>During an interview on 6/4/25 at 9:23 a.m., R176 was asked via typed communication on a computer whether the iPad interpreter in the social worker ' s office had been used for care. R176 responded by shaking their head to indicate no. They continued to communicate through written messages, stating that few staff members knew how to use the iPad interpreter but were unable to specify which staff members.<br><br>During an interview on 6/4/25 at 9:30 a.m., nursing assistant (NA)-E confirmed not having ever used the iPad but was familiar with how it worked and where it was kept.<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/4/25 at 9:40 a.m., trained medical aid (TMA)-B stated does not use the iPad to administer medications or with cares because R176 was able to answer yes or no. TMA-B stated R176 called staff and wrote down messages in a notebook. TMA-B was unaware of R176's preference, and confirmed this was the only way staff communicated with her. TMA-B confirmed not using the iPad, knowing ASL, and R176 was on her assignment sheet for the day.<br><br>During an interview on 6/4/25 at 3:18 p.m., registered nurse (RN)-D stated an iPad would normally be used, but R176's skin was checked with no major concerns, the interaction wasn't a big deal. RN-D confirmed a notebook and pen was used.<br><br>During an interview on 6/5/25 at 7:06 a.m., the director of nursing (DON) stated that the care plan dictated how to communicate with the resident. The DON explained that alternative communication methods were sometimes used, and that the facility had a comprehensive policy in place for serving the deaf community. The expectation was to use the ASL interpreter for all major interactions. The DON agreed that if the resident preferred the interpreter, staff were expected to use the iPad interpreter. The DON noted that a skin assessment might not typically require use of the iPad interpreter, but given R176 ' s stated preference, it should be used.<br><br>During an interview on 6/5/25 at 8:57 a.m., R176 was asked, do you prefer staff to use the iPad with all communication with you? To which R176 replied, yes, they need education, they do not know how to use it, the social worker knows how to use it he is the only one. They think I write they have hard time reading my writing so it best to use iPad ASL it best I have to do it.<br><br>Facility Access for Communication-Impaired Residents/Patients policy reviewed 8/2023, identified an interpreter be used upon request of patient/resident, explaining medication and possible side effects, and obtaining permission for treatment. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 2 of 4 residents (R88 and R143) reviewed for activities.<br><br>Findings include:<br><br>R88's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R88 was admitted to the facility 2/1/25, severe cognitive impairment, sometimes feel lonely or isolated from those around, no rejection of care, wandering occurred four to six days, but less than daily, utilized a walker and wheelchair, required substantial/maximal assistance with dressing, supervision with personal hygiene, sit to lying, sit to stand, and walking, and diagnoses included hip fracture and non-Alzheimer's dementia.<br><br>R88's care plan printed 6/3/25, indicated R88's leisure interests include going to church, listening to music, talking with others and watching TV and interventions included document attendance/refusals, encourage to tell staff of leisure needs, encourage short durations of activities as able, monitor activity setting for safety, place near outside edge of group, place near sound stage, provider current activity calendar.<br><br>R88's Activity/Recreation assessment dated [DATE], therapeutic recreation (TR)-D director indicated activity preferences: discussion/education, food programs (baking/cooking), gardening/plants, music, reading, religious/spiritual programs, socialization, likes to talk about her family and genealogy, likes dogs and cats, family; preference for program style: small groups, 1:1, summary indicated R88 needs interaction and encouragement, visual learner, enjoy being reassured and people interaction with me in a kind way, feel best when doing something, like to laugh and enjoy funny story or joke, love to read and garden, cook, listening to music and love dogs and cats.<br><br>R88's Documentation Report dated 3/1/25-3/31/25, and 4/1/25-4/30/25, indicated no documentation of R88's activities.<br><br>R88's Documentation Report dated 5/1/25-5/31/25, indicated on 5/22/25 at 2:59 p.m., R88 music observed. No other documentation of activities.<br><br>R88's Documentation Report dated 6/1/25-6/30/25, indicated on 6/2/25, the documentation report added 1:1 visits, independent leisure, and spiritual.<br><br>On 6/2/25 at 6:38 p.m., during a telephone interview family member (FM)-E stated concern regarding the lack of available activities in the TCU (transitional care unit). FM-E stated frequent afternoon visits and had not observed R88 participate in activities. FM-E stated the TCU unit did not have activities going on for the residents. FM-E stated R88 enjoyed interaction with others and would likely participate if activities were offered.<br><br>On 6/3/25 at 8:45 a.m., R88 was observed sleeping in bed.<br><br>(continued on next page) |

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| | 245347 | A. Building<br>B. Wing | 06/05/2025 |

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| Lyngblomsten Care Center | 1415 Almond Avenue<br>Saint Paul, MN 55108 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/3/25 at 12:43 p.m., R88 was seated in a wheelchair by the first-floor nursing station and stated she wanted to go home, and further stated she like to be kept busy, specifically mentioning she enjoyed cleaning and having her fingernails painted.<br><br>On 6/3/25 at 1:33 p.m., R88 was seated in a wheelchair in the day room watching television.<br><br>On 6/3/25 at 1:10 p.m., trained medication aide (TMA)-D stated that each resident had an activity calendar in their room. TMA-D stated activities staff were responsible for offering activities to the residents. TMA-D stated occasionally R88 would go to chapel.<br><br>On 6/3/25 at 1:13 p.m., R88's room was observed and both April 2025 and June 2025 activity calendars were found posted, April's near the door and June's behind the bedside table. Nursing Assistant (NA)-D stated that activity staff were responsible for offering activities to residents, including R88, but could not recall if R88 had participated.<br><br>On 6/3/25 at 1:20 p.m., registered nurse (RN)- G stated activities staff were responsible for offering and including R88 in activities.<br><br>On 6/3/25 at 1:39 p.m., TR-D stated she was responsible for first floor resident activities including R88, and stated any staff can offer and include R88 in activities. TR-D confirmed there was no documentation of R88 participating in activities prior to 6/3/25. TR-D acknowledged R88's activities were not consistently offered or documented as expected. TR-D stated she completed R88's activity interest and assessment but could not confirm those preferences were being consistently implemented<br><br>On 6/4/25 at 8:18 a.m., R88 was observed in a wheelchair and self-propelled through the dining room and R88 stated she did not know what she was going to do today.<br><br>On 6/4/25 at 12:58 p.m., during a follow up interview TR-D confirmed R88 was not consistently offered or included in activities and was unsure if other staff had included R88 in activities. TR-D confirmed that she was responsible for the TCU residents' activity planning and should have ensured offers were made based on R88's assessment.<br><br>On 6/4/25 at 2:57 p.m., the administrator stated residents were expected to be offered activities based of interests and specific to each resident and confirmed activities staff were expected to offer and document on R88's activities. The administrator confirmed that activity offerings were expected based on the preferences and activity assessment.<br><br>R143s admission MDS dated [DATE], identified activity preferences were books, pets, news, engaged in favorite activities, attended religious activities and going outdoors.<br><br>R143's quarterly MDS dated [DATE], identified cognitive impairment, diagnoses of Parkinson's disease, dementia with progressive neurological conditions. R143 had clear speech, wore hearing aids, had no impairment to vision, had the ability to understand others, used a walker/wheelchair and was dependent on staff for mobility/transfers.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R143's care plan initiated 4/10/25, identified a care area of activities and had interventions to attend group activities and wanted encouragement to attend group programs for short periods and if unable to stay would be assisted out of the group. R143 would like his activity level monitored and assessed for changes, preferred to pursue independent activities such as having someone read devotions, bring pets to visit, walking, listening to music. The care plan identified R143 would notify activities if he needed independent leisure supplies and for staff to anticipate independent needs and to be reminded and assisted to group activities of interest.<br><br>R143's paper chart that included an activities tab was reviewed but had no activities recorded.<br><br>R143's electronic medical record (EMR) was reviewed but had no attendance to activities recorded.<br><br>An activities assessment dated [DATE], identified R143's family was very involved and visited daily. He had attended some music events and was willing to stay for concerts if family attended. He enjoyed going for walks around the facility and activities of interest were animals, table games, music, singing, concerts, special events, news, devotions and worship services. R143 was a gardener and had an interest in nature groups.<br><br>R143's quarterly therapeutic recreation note dated 1/16/25 and 4/28/25, were reviewed and contained the same note, R143 continued to pursue independent leisure interests daily with assistance setting up as needed and participated or observed group programs as desired/able. R143's family was very involved and often visited daily. Family typically walked R143 around the neighborhood halls on 3rd floor and would at times encourage him to join activities. He had attended some music events- not a fan of polka music but more willing to stay for concerts if family attended with him. R143 used a walker for mobility and required staff/family assistance/supervision. Activities of interest include animals (had dogs), table games (risk, monopoly), music/singing/concerts (Elvis, 50's), special events, keeping up with the news, devotions and worship services (Lutheran). R143 was previously a gardener and has observed flower arrangements/nature groups when walking through the activity room with family. Independent leisure interests consist of watching tv/movies (CNN news, Netflix), visited with family, devotions, music, walking, pets, resting in my room or neighborhood lounge, and snacking as able. He often rests in the neighborhood lounge with peers where they watch tv together/ observe those passing in hallway. R143 responded to conversation and hears with loud tone and used hearing aids. His care plan has been reviewed and remained appropriate.<br><br>During an interview on 6/2/25 at 12:30 p.m., family member (FM)-A stated a calendar of activities was posted in R143's room every month, but the facility doesn't invite him to attend. Most of the activities are over by the time family arrives and felt if family doesn't take him to an activity or to church, R143 sat in his room and FM-A would appreciate if staff would invite him to activities. FM-A stated the few staff that came which was a long time ago, they would ask, but if he didn't respond or shook his head no, they would just leave. FM-A stated the facility had a shortage of staff and felt she needed to visit every day to take R143 out of his room.<br><br>During an observation on 6/3/25 at 9:43 a.m., R143 was in the lounge area, laying in the recliner watching the news.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation and interview on 6/3/25 at 3:52 p.m., R143 was in the lounge area in a recliner. A privately paid companion (FM)-B stated I arrived today at 1:00 p.m., have been with R143 since he lived at home and came every Tuesday since R143 moved to the facility. FM-B stated no one from activities came today to invite R143 but the facility used to invite him to activities when he first came and confirmed no one has invited R143 to activities recently. Activity calendar for 6/3/25 read at 10:15 a.m. included devotions, 11:00 a.m. [NAME] music class, 2:00 p.m., bingo, 6:45 p.m. cloudberry choir concert.<br><br>During an interview on 6/4/25 at 11:45 p.m., activities personnel (A)A stated R143 preferred to watch tv in the lounge with a small group, doesn't like large groups and therefore would not be invited to an activity such as bingo. A-A was aware R143 preferred music events but was unable to sit for long periods, so if staff brought him to an activity, he would come last. A-A acknowledged R143's wife brought him to most activities but stayed to the side. The facility didn't invite R143 as much as they should, confirmed he did not attend the music event yesterday, and that he has not attended any activity by invitation recently. All activities have been with his family the past several months.<br><br>During an interview on 6/4/25 at 1:18 p.m., TR-D stated the facility offered individualized activities such as an art and roving library cart, puzzles, cross words and for residents that are unable to attend large group activities we ask the nursing assistants to turn on the lounge television to view the scheduled program in a smaller group setting. Residents that need more one on one interaction could request a special friend visit or have a book read by volunteer services. Activities are tracked using point click care (computer software), but residents that decline activities were not tracked. The TR-D reviewed all R143's 2025 activity tasks reports in his EMR and confirmed no activities had been recorded.<br><br>Facility Therapeutic Recreation Assessments and Documentation policy dated 5/17, indicated:<br><br>Policy: To provide for official, comprehensive written records of all Resident's interests and involvement in Therapeutic Recreation programs. The Therapeutic Recreation staff are assigned the residents to which they must complete all documentation with in specified time frames.<br><br>1.<br><br>admission Assessment<br><br>a.<br><br>Upon admission sections Band F of the MDS will be completed and serve as the initial assessment for the resident/patient.<br><br>b.<br><br>A progress note which includes details of the assessment will be done<br><br>c.<br><br>Any corresponding raps will be completed for appropriate sections<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2.<br><br>Resident Care Plans<br><br>a.<br><br>The care plan is developed from information that is collected in the initial assessment, observations from the resident and information obtained from their representative.<br><br>b.<br><br>A care plan will be developed for each resident/patient within 21 days<br><br>c.<br><br>Care Plan will be reviewed and updated as needed every 90 days, if a significant change occurs and as needed.<br><br>3.<br><br>Daily Attendance Records<br><br>a.<br><br>Daily attendance will be recorded in POC<br><br>b.<br><br>Review records every 90 days, if a significant change occurs and as needed to ensure any emerging needs for resident / patient reassessments or care plan reviews.<br><br>c.<br><br>File attendance records for a minimum of 5 years<br><br>d.<br><br>Make use of attendance records as data for summary within resident /patient progress notes<br><br>4.<br><br>Quarterly/Annual/ Significant Change Progress Notes<br><br>a.<br><br>Summarize information from activities, care plan and MDS assessments to complete quarterly progress note.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b.<br><br>Do a Therapeutic Recreation Progress note. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess transfers with a mechanical lift or develop and implement policies to ensure the safety and supervision for 1 of 4 residents (R20) reviewed for accidents.<br><br>Findings include:<br><br>R20's annual Minimum Data Set (MDS) assessment dated [DATE], identified severely impaired cognition and had limited function to the right arm and hand, used a wheelchair, required maximal assistance for mobility and was on hospice. R20's diagnoses included cerebral palsy, seizure and psychotic disorders, and post-polio syndrome.<br><br>R20's care plan (CP) created on 6/2/23, identified mobility as an area of concern and indicated one staff assisted with bed mobility, repositioning, and sitting up. Furthermore, the CP identified R20 had a history of compression fractures to the spine and spasticity/hemiparesis of the right hand since birth, was not ambulatory and needed one to two staff for transfers with the mechanical lift (EZ Stand).<br><br>R20's electronic medical record (EMR) contained a completed annual physical device evaluation dated 3/3/25 but failed to reassess R20's transfer needs when a mechanical lift was used.<br><br>During an observation and interview on 6/2/25 at 4:51?p.m., R20 was found in bed with the upper body against the wall, the head resting against the wall at an angle, and the left foot hanging off the bed while calling out for help. Licensed practical nurse (LPN) B entered the room and repositioned R20. R20 was moved into a seated position, a belt was placed around the resident and attached to the mechanical standing lift; both feet were lifted onto the foot plate by the nurse. R20's left hand was placed on the handle and held securely by a nursing assistant (NA)-C. R20's right arm was flaccid and hung down at the side of the body. R20 was observed hanging from the stand, unable to bear weight while being lowered onto the wheelchair. LPN B stated that R20's mode of transfer was by the mechanical standing lift and the criteria to use the lift was to bare weight and at least one hand on the handle, then stated R20 met criteria for a standing lift.<br><br>During an interview on 6/3/25 at 9:15 a.m., NA-A stated I am not comfortable with R20's transfers and called for a second aid. NA-A stated the standing lift was appropriate for R20 because he stood up good and held on to the handle with one hand.<br><br>During an observation and interview on 6/3/25 at 9:25 a.m., NA-A and NA-C assisted R20 transfer using the mechanical standing lift. R20's left hand was secured to the handle, but R20 did not stand up independently, could not bear weight and hung from the lift. NA-A stated R20 supported himself during other transfers and would often stand without hanging on and needed reminders to hang on before the aids would start the transfer.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/3/25 at 1:35 p.m., director of therapy (DOT) stated therapy assessed residents for transfers upon admission, status change, or if a referral was received. The DOT stated R20 was not currently in therapy and was unfamiliar with the transfers. The qualifications to use the EZ Stand (mechanical standing lift) would be to bear weight, moderate to maximal assistant, tolerated standing at least thirty seconds, and to hold on with one hand decently. The DOT stated patients with hemiparesis, for example a stroke patient would not be a candidate for the EZ Stand. The DOT stated resident needed to assist with the stand to use the EZ Stand and confirmed therapy has not received a referral to assess transfers for R20 but would observe a transfer later today.<br><br>During an interview on 6/3/25 at 1:50 p.m., licensed practical nurse (LPN)-A explained the process on how residents are assessed for transfers. It starts with new admissions, physical and occupational therapy (PT, OT) provided guidance, the resident and family's goals and fears are discussed and overall allowed the residents to function at their highest level but remained safe. LPN-A stated if there was a change in transfer abilities a referral was placed to PT for an evaluation and the criteria used for the EZ Stand was to bear weight. If a resident had a stroke, two assistants were required. LPN-A stated the nursing assistants kept the nurse updated on transfers, but ultimately it was the nurse's decision and if there was a concern after the evaluation the resident would use the next level for transfers. LPN-A stated staff were aware of the process.<br><br>During an observation and interview on 6/3/25 at 3:33 p.m., NA-B and NA-C entered R20's room and began to transfer R20 with the standing lift. The DOT observed the transfer. NA-B and NA-C indicated they were familiar with R20 and abilities to transfer. R20's legs were dependent upon staff to lift them on to the foot plate, the belt was attached to R20's waist, left hand placed on the handle, and right arm hung to the side in a flaccid position. The DOT asked how long R20 could stand and then R20's left hand fell from the handle. NA-C asked the DOT if this meant R20 could not safely transfer with the EZ Stand and the DOT nodded yes. The DOT stated EZ Stand transfers needed 20 some seconds of tolerance, but usually 45-60 seconds was needed to transfer to the wheelchair or toilet and then confirmed R20 should no longer use the EZ Stand.<br><br>During an interview on 6/4/25 at 3:52 p.m., the director of nursing (DON) stated the process for transfers was continuous monitoring of care needs and adjusted transfer abilities based on the front-line staff recommendations. Any changes are discussed, care planned, and it was a collaborate effort based on a formal assessment from therapy. The DON stated the staff knew how to transfer resident safely and are saying the correct things but had learned that staff didn't identify unsafe transfers.<br><br>Facility Transfer Procedures policy revised 5/24, identified residents are not suited for standing transfers are unpredictably able to bear weight, unable to hold onto handles/lift frame.<br><br>Facility Physical Device Evaluations policy revised 6/22, identified evaluations for any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The guidelines identified an atypical method, or device is considered any intervention or equipment that is nonroutine or would not be considered standard or required in the normal delivery of care. Some examples of atypical methods or devices are geri-chairs, wedge cushion in wheelchairs, bed placed against a wall for purposes other than room décor/style, anti-roll back wheelchairs. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 6 residents (R115) reviewed for medication administration.<br><br>Findings include:<br><br>R115's face sheet printed 6/5/25, indicated diagnoses of reduced mobility, cardiac pacemaker, personal history of sudden cardiac arrest, Alzheimer's disease, and heart failure.<br><br>R115's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, use of wheelchair, substantial/maximal assistance with personal hygiene, lower body dressing, and bathing.<br><br>R115's care plan printed revised 8/14/24, indicated self-care deficit related to congestive heart failure, pacemaker in left chest, and dementia. Staff crush my pills, mix together in applesauce to aide in swallowing.<br><br>R115's physician's orders printed 6/5/25, indicated an order for metoprolol succinate extended release 50mg tablet (blood pressure medication) daily for high blood pressure. An additional order stated medications may be crushed or given in liquid form unless contraindicated or otherwise.<br><br>During observation on 6/4/25 at 8:30 a.m., trained medication aide (TMA)-C prepared medications for administration to R115. TMA-C crushed acetaminophen 1000mg, metoprolol 50mg extended release, potassium 20meq, torsemide 30mg, and sertraline 100mg for ease of swallowing for R115.<br><br>During interview on 6/4/25 at 8:35 a.m., prior to administration of medication to R115, TMA-C verified she had been crushing R115's metoprolol succinate extended-release tablet for quite some time due to R115's difficulty swallowing multiple pills and intended to administer metoprolol succinate tablet crushed. TMA-C further stated R115 had an order to crush medications so she assumed metoprolol succinate extended release could be crushed. TMA-C stated she did not see the green sticker on the metoprolol succinate extended-release medication card that read: do not crush or chew.<br><br>During interview on 6/4/25 at 8:45 a.m., registered nurse (RN)-E stated R115 had an order to crush medications. RN-E further stated she was unsure if the metoprolol succinate extended-release could be crushed and she would need to call the provider to check. RN-E stated she did not know the metoprolol succinate extended-release medication card included a sticker indicating not to crush or chew the medication.<br><br>During interview on 6/4/25 at 9:15 a.m., RN-E stated she had called nurse practitioner (NP)-D and NP-D stated the metoprolol succinate extended-release could not be crushed. NP-D changed the order to metoprolol tartrate 25mg tablet two times per day.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 6/5/25 at 8:39 a.m. director of nursing (DON) stated he had heard about this medication error yesterday and had informed RN-E that extended-release medications could not be crushed unless specifically ordered by a provider due to them needing to be released in the body over time. DON further stated it was the facility's responsibility to make sure the provider was notified if a medication needed to be changed to a different form to be crushed and he would expect the nurses to do that.<br><br>R115's blood pressure readings were reviewed for one month and ranged from 117/75 to 157/86.<br><br>A facility policy on crushing of medications was requested but not received. |