STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Lynnhurst LLC	471 Lynnhurst Avenue West Saint Paul, MN 55104

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on interview and document review, the facility failed to ensure resident and resident guardian's participation in the development and review of care plans 1 of 1 residents, (R8) reviewed who voiced concerns about care conference participation. Findings include: R8's annual Minimum Data Set (MDS) dated [DATE], identified she could make herself understood, was independent with eating, required supervision with transfers and bed mobility. R8's interview for preferences identified it was very important to choose what clothing to wear and take care of personal belongings. Diagnoses included heart failure, diabetes and dementia. R8's MHM BIMS (Brief Interview of Mental Status) Staff assessment dated [DATE], identified five- minute and long past memory recall was ok and R8 was able to recall the current season, her own room, staff name and faces and that she was in a nursing home. R8 had modified independence with daily decision making. R8's discharge care plan dated 2/19/25, identified resident and family would be invited to care conferences quarterly or as needed. A review of R8's MDS history identified the following: - 2/18/25 annual MDS and corresponding care conference form 3/25/25, not completed. There was no documentation R8 or her guardian were invited or attended. - 11/22/24 quarterly MDS and corresponding care conference form 11/13/24, there was no documentation R8 or her guardian were invited or attended. - 8/30/24 quarterly MDS and corresponding care conference form dated 8/14/24, there was no documentation R8 was invited or attended, nor if her guardian attended. - 6/7/24 quarterly MDS and corresponding care conference form dated 6/27/24, there was no documentation R8 or her guardian were invited or attended. - 3/26/24 significant change MDS lacked a corresponding care conference. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/22/24 admission MDS with corresponding care conference 2/26/24, identified the guardian was not involved in the care conference. R8's care conference progress notes identified: - 8/13/24 at 9:32 a.m., the social worker reached out to guardian and caseworker to schedule a care conference. There was no follow up documentation. The note did not identify if R8 was invited. - 6/27/2024 at 14:42 (2:42 p.m.), care conference scheduled for 7/8/24 at 11:00 a.m. The note did not identify if R8 or guardian were invited or attended. - 3/6/24 at 11:31 a.m., care conference held as scheduled. This is the second care conference for R8 upon admission. The note did not identify if the R8 or guardian were invited or attended. - 2/26/2024 at 14:33 (2:33 p.m.), care conference held on this date. In attendance was R8, LPN (licensed practical nurse) coordinator, OT (occupational therapy), and SS (social services). SS attempted to contact guardian to join the care conference but there was not an answer, voicemail was left. During an interview on 4/7/25 at 6:03 p.m., R8 stated she wanted to know if the facility had care conferences and she was supposed to have a meeting two months ago but it never happened. R8 stated the facility held care conferences but she has not been invited since she had a legal guardian. R8 stated she would like to be part of the meetings because she did not think they knew about her concerns. R8 stated she wanted her purse with a driver licence, social security card. R8 wanted pictures of her kids and grandkids for her room. She wanted hearing aides, new eyeglasses, dentures and diabetic shoes. R8 stated many of the items she wanted had been left behind in her house after she was taken out of her home. During an interview on 4/10/25 at 10:38 a.m., registered nurse (RN)-A stated she could not find documentation of who attended or was invited to R8's care conferences. During an interview on 4/10/25 at 12:59 p.m., the social services designee (SSD) stated care conferences were held based off the MDS schedule: quarterly/comprehensive, annual, and significant change. The SSD would open the care conference form and invite the interdisciplinary team (IDT) to fill in their respective sections. Guardians and residents were invited to attend with the IDT. The SSD reviewed R8's care conference forms and agreed she could not tell if the resident or guardian had been invited or attended. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated the resident and guardian should be invited to participate in care conferences along with the IDT, and it should be documented who was invited and present/participated. A facility policy for care conferences was requested and not provided. The administrator emailed a process on 4/10/25, which identified social services meets with resident within 48 hours of admission, and then completes full care conference within first 48 hours, and then every quarter, annually, PRN (as needed) and significant change.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42586 Based on interview and document review the facility failed to timely provide the required liability and appeal rights notices prior to discharge from Medicare Part A services for 1 of 3 residents (R170) reviewed for beneficiary notices. Findings include: R170's last day of covered Medicare Part A Skilled Services was 1/22/25, as identified on the form CMS-20052 (SNF [skilled nursing facility] Beneficiary Protection Notification Review). R170's Notice of Medicare Non-Coverage (NOMNC, form CMS-10123) was signed by the resident on 1/30/25. R170's Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-10055) was signed by the resident on 1/30/25, and lacked indication of which option (regarding the appeal process) he had chosen. During interview on 4/10/25 at 3:30 p.m., the administrator stated the expectation was to have the residents sign the CMS-10123 and CMS-10055 at least 2 days before the last day of covered Medicare part A Skilled Services and ensure an option regarding the appeal process was indicated. A facility policy regarding BNP notices dated 2/20/23, indicated: When a Last Covered Day (LCD) is determined by the facility or the resident's insurance provider, and there are benefit days remaining, we must issue a denial to the resident/legal responsible party (POA/Guardian). These denials must be given at minimum two days prior to the LCD. Example: LCD is chosen for the 15th of the month, the denials is due no later than the 13th.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure personal privacy was maintained for 1 of 2 residents (R29) who required staff assistance with personal cares. Findings include: R29's admission Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and was dependent on staff assistance for toileting hygiene and required partial to moderate assistance with personal hygiene cares. The MDS reported he was frequently incontinent of urine and bowel. The MDS listed his diagnoses as hemiparesis (one-sided weakness) or hemiplegia (one-sided paralysis), chronic lung disease, and chronic obstructive pulmonary disease (COPD, a chronic restrictive lung and breathing condition). R29's Care Area Assessment (CAA) for functional abilities dated 2/12/25, reported he received limited assistance with rolling left and right in bed, and extensive assist with bathing, upper body dressing. The CAA further identified his dependence on staff for toileting hygiene. R29's care plan dated 2/11/25, identified his self-care deficit and categorized him as a vulnerable adult. The care plan directed staff to provide an assist of 1 with personal hygiene, bathing, and dressing. During observation on 4/7/25 at 2:24 p.m., R29's door was not closed and from the unit hallway reflected through a mirror affixed in the middle of the wall, nursing assistant (NA)-C could be seen standing beside R29's bed on the far end of the shared room. The privacy curtain was not pulled all the way around the bed. The mirror on the wall reflected NA-C removing R29's incontinence brief and his bare genitals were exposed. The mirror reflected NA-C fastening the tabs on the new brief, doffing his gloves, and adjusting the bed to the lowest position. NA-C exited the room and performed hand hygiene at the soiled utility station. During interview on 4/7/25 at 2:27 p.m., NA-C stated staff should first knock then close a resident's door and close the privacy curtain to maintain their dignity and protect their privacy. NA-C stated R29's door was unable to be closed due to resident preference. When asked if R29's curtain could be closed further to maintain his privacy, NA-C first stood where the surveyor made the observation and looked through the mirror at R29's bed. Next, NA-C and the surveyor entered his room and NA-C demonstrated the privacy curtain could close further. Finally, NA-C and the surveyor returned to the hallway and looked through the mirror at R29 and only his ankles and feet were reflected in the mirror. NA-C confirmed the privacy curtain should have been pulled fully closed to provide privacy. Per interview on 4/8/25 at 9:51 a.m., NA-E expected staff to close the door, pull the curtain and ask a resident's permission before starting cares to protect their privacy and dignity. Per interview on 4/10/25 at 10:22 a.m. with registered nurse (RN)-A, staff were expected to knock before entering a resident's room, ask permission, explain the task being performed, pull the privacy curtain, make sure the blinds are closed if that's appropriate, clean up the supplies, and make sure the resident is safe and comfortable before leaving the room. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 4/10/25 at 1:03 p.m. with the director of nursing (DON), staff were expected to close the door and pull the privacy curtain to maintain dignity and privacy for residents. A facility policy pertaining to resident rights and privacy was requested but not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to review and revise the care plan with input from the resident to meet a resident's vision needs for 1 of 1 residents reviewed for reassessment of the care plan. Findings include: R21's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had moderately impaired cognition, did not reject cares, and was usually able to make himself understood and usually able to understand others. The MDS indicated his vision was adequate and he did not wear corrective lenses. The MDS identified diagnoses including aphasia (a condition in which language function is disordered), and cataracts (a progressive disorder of the lens of the eye characterized by a loss of transparency with a white/yellow/brown tinge to the lens). R21's Care Area Assessment (CAA) for visual function dated 6/19/24, was triggered due to his cataracts and indicated he had the potential for impaired visual function related to his diagnosis of bilateral (left and right) age-related cataracts. The CAA indicated the overall objective for care planning this potential problem was to maintain his current level of functioning indicated, per vision exam 3/28/24: Educated patient regarding ocular condition and prognosis. Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA [visual acuity]. Resident has adequate vision with use of reading glasses. Care plan to maintain current level of visual acuity. R21's care plan, last revised 3/4/25, identified his potential for impaired vision related to his diagnosis of age-related cataracts and listed a goal to maintain his current vision. The care plan directed staff to set up ophthalmology appointment as needed. Additionally, the care plan identified his self-care deficit related to his hemiplegia and indicated he had glasses that he wears when he chooses and was able to put on and take off the glasses himself. The care plan directed staff to assist him clean the eyeglasses and ensure they were in good repair. The care plan lacked documentation of any use of multiple pairs of non-prescription glasses. Furthermore, the care plan lacked documentation Patient encounter notes dated 9/28/23, 10/3/24, and 3/28/24, indicated R21 was seen by the Doctor of Optometry (OD) for a cataract evaluation. The encounter notes revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an attempt to improve reduced VA [visual acuity]. Please schedule consultation. A care conference form dated 3/24/25, indicated R21's last eye exam was on 10/3/24 but lacked documentation if he or his representative's input were considered in the care conference or care planning process. R21's EHR was reviewed on 4/8/25 at 2:20 p.m. and lacked documentation that referral to cataract extraction specialist was followed-up on. Furthermore, the EHR lacked documentation his order for consult to optometry for new eyeglasses was followed-up on. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/7/25 at 2:33 p.m., R21 showed surveyor a pair of eyeglasses with a missing left temple (long arm on the side of the frame that fit over the ear). Per interview on 4/8/25 at 3:31 p.m. with R21 via interpreter, his cataracts had been ongoing for approximately one year and he believed there was orange discoloration to his left eye. He stated he had not seen any provider about the cataract extraction. He also endorsed having difficulty seeing without his eyeglasses and stated he needed a new pair. During interview on 4/9/25 at 9:15 a.m., OD verified familiarity with R21 and his vision exams. OD explained the decision to make a referral for a cataract extraction was usually driven by either a resident, family, representative or the primary provider. OD stated the decision to move forward with referral was driven by R21. OD confirmed placing the order for the consult in March 2023 and confirmed, he does have the presence of cataracts and explained once the referral was made, it is up to the facility to get that scheduled. Additionally, OD denied being made aware of R21's need for eyeglasses and stated, at no point have we done a pair of eyeglasses for him or an exam for glasses. OD reviewed R21's progress notes and was unable to find that he presented anytime with a request for eyeglasses. OD stated, typically, the facility would make us aware of the need for repair or the resident brings them with and makes us aware. Per interview on 4/10/25 at 12:58 p.m. with the director of nursing (DON), staff were expected to follow up on appointment referrals. The DON stated resident's preferences and care planned interventions were discussed and reassessed for appropriateness during care conferences. The DON also stated staff had been purchasing over the counter (OTC) non-prescription eyeglasses because there had been many broken pairs but expected there to be documentation of the use of OTC non-prescription eyeglasses. A facility policy title Care Planning last revised 11/24, indicated each resident would have a person-centered care plan developed by the IDT for the purpose of meeting the resident's individual needs. The policy directed the IDT to, in conjunction with the resident and the resident representative, develop and implement a comprehenisve individualized care plan with information gathered from the comprehensive assessment. The policy indicated the care plan should be consistent with resident's rights to identify problem areas and their causes to develop interventions that were targeted and meaningful to the resident. The policy also highlighted that the resident had the right and would be encouraged to participate in the development of his or her care plan, and the care plan should be modified and updated as the condition and care needs of the resident changed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and document review the facility failed to ensure residents were provided incontinence care in a timely manner for 1 of 1 resident (R9) reviewed for activities of daily living (ADL). Findings include: R9's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of chronic obstructive pulmonary disease (COPD), chronic atrial fibrillation (A-fib), and pancreatitis. It further indicated R9 was dependent on staff for toileting and was frequently incontinent of bowel and bladder. R9's care plan dated [DATE], indicated alteration in elimination d/t limited mobility secondary to COPD and alcohol dependence with the following interventions: -Assist of 2 with toileting. -Provide assistance with peri-cares morning (AM), hour of sleep (HS) and as needed (PRN). -Provide incontinent products and assist to change PRN During observation on [DATE] at 3:22 p.m., R9 was sitting in his wheelchair by the door to his room, waiting to go in. He asked nursing assistant (NA)-B to change his brief because he had a bowel movement (BM) and NA-B told him to wait until staff was done with R55's (roommate) wound care. R9 asked how long that would be and registered nurse (RN-B) stated 15 minutes. When the surveyor left the room, (following wound care) at 4:25 p.m., R9 was still waiting outside the room and there was an odor of BM. R9 stated he often had to wait from ,d+[DATE] hours to have his brief changed because his roommate had a wound and if they change him during wound care it could be contagious. He further stated he also had to wait for an hour to be changed so both nursing assistants can go on their breaks. At approximately 4:35 p.m. NA-B assisted NA-E to transfer R9 from his wheelchair to the bed and NA-E proceeded to change his brief. He was wet and urine had soaked through his pants so NA-E removed them and got a new pair stating the weird thing is it didn't go through to your sling (urine). R9 had also had a BM. NA-E cleaned up the BM, applied new pants, and NA-B assisted NA-E to transfer him from his bed back into his wheelchair. During interview on [DATE] at 4:52 p.m. NA-B verified R9 had waited an hour to be changed and stated it was because too many people were in the room and the nurse stated it would only take 15 minutes to complete his roommates wound care. During an interview on [DATE] at 12:08 p.m. the nurse manager registered nurse (RN)-C stated an hour was too long for a resident to be sitting in a soiled brief and R9 should've been able to be changed before they started his roommates wound care, stating it takes longer then 15 minutes to complete wound care and change a wound vacuum (vac). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:52 p.m., the director of nursing (DON) stated when a resident asked to be changed/toileted, it should be done as soon as possible or within ,d+[DATE] minutes (at most) to prevent skin breakdown. If the NA's or nurses are busy the nurse manager can also assist residents to changed/toileted. A facility policy on ADL's dated [DATE], indicated: The facility will provide care and services for the following activities of daily living: a. Hygiene-bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting d. Dining-eating (meals and snacks) e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. 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; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident ' s advance directives.

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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** 42586 Based on interview and document review the facility failed to follow up on 1 of 1 residents (R55) Urology referral. Finding include: R55's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of paraplegia and neuromuscular disfunction of the bladder. It further indicated R55 required substantial assistance with bed mobility, was dependent on staff for transfers, had a catheter, and was always incontinent of bowel. R55's care plan dated 3/25/25, indicated alteration in elimination related to diagnoses of motor vehicle crash, neurogenic bladder, convulsions, etc. Resident admitted with foley catheter 20 French (F) 30 cubic centimeters (cc) for neurogenic bladder and assist of 1 with toileting. It further indicated the following interventions: -Prefers to notify staff when incontinent to have brief changed -Monitor foley catheter output every shift. -Change foley catheter monthly per order. -Foley catheter care per policy. -Monitor BM's as they occur. -Administer bowel medications as ordered. -Introduce resident to other residents with similar interests. -Monitor target behaviors per protocol. R55's hospital discharge orders dated 1/31/25, indicated: the physician had recommended an appointment with HealthPartners Urology for bladder spasms and urine bypassing Foley catheter. During interview on 4/9/25 at 9:28 a.m., the HUC verified there was an order for a urology appointment, and he hadn't followed through on it, stating he doesn't know why it wasn't scheduled and it should have been. During interview on 4/9/25 8:57 a.m., licensed practical nurse (LPN)-B stated when a resident was admitted /readmitted to the facility, the Health Unit Coordinator (HUC) entered the discharge orders in PCC (Point Click Care computer system) before the resident arrived at the facility. Once they arrive 2 nurses were required to compare the paperwork the resident brought with them, to the orders the HUC entered in PCC. If there were any questions or clarifications, the nurses were responsible for calling the provider to clarify. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview 4/9/25 9:17 a.m., the director of nursing (DON) stated when a resident was admitted /readmitted to the facility, they would receive an email with the admitting residents discharge orders and the HUC would enter it into PCC. Once the resident arrived, they should have a paper copy of the orders/discharge summary and the admitting nurse would print off the order and make a copy (so they aren't writing on the original order). Then the admitting nurse would start confirming the orders and a 2nd nurse would compare the orders the HUC entered to the orders the resident brought with them. If there are were any discrepancies or clarifications, it was the nurses responsibility to call the provider to clarify. The DON also verified R55 had an order for a referral to urology and was unable to find the date of his last urology appointment or one scheduled in the future. A facility policy regarding coordination of care was requested but not received.

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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** 49617 Based on observation, interview and document review, the facility failed to follow-up on consults for vision-related appointments for 1 of 3 residents (R21) and failed to provide assistive devices to maintain hearing for 1 of 3 residents (R29) reviewed for communication. Findings include: R21 Glasses and Cataracts Consults R21's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had moderately impaired cognition, did not reject cares, and was usually able to make himself understood and usually able to understand others. The MDS indicated his vision was adequate and he did not wear corrective lenses. The MDS identified diagnoses including aphasia (a condition in which language function is disordered), one-side weakness or one-sided paralysis (hemiparesis or hemiplegia, respectively), anxiety, and cataracts (a progressive disorder of the lens of the eye characterized by a loss of transparency with a white/yellow/brown tinge to the lens). R21's Care Area Assessment (CAA) for visual function dated 6/19/24, was triggered due to his cataracts and indicated he had the potential for impaired visual function related to his diagnosis of bilateral (left and right) age-related cataracts. The CAA indicated the overall objective for care planning this potential problem was to maintain his current level of functioning indicated, per vision exam 3/28/24: Educated patient regarding ocular condition and prognosis. Cataract extraction consultation discussed, and patient elects to proceed with consultation in attempt to improve reduced VA [visual acuity]. Resident has adequate vision with use of reading glasses. Care plan to maintain current level of visual acuity. Furthermore, the CAA revealed health information management (HIM) was notified. R21's order summary report dated 2/28/25, included the following orders: - consult optometry for new glasses, dated 12/14/24. - may see audiologist, dentist, podiatrist, optometrist, psychology as needed (PRN), 1/2/24. - OK for ancillary orders: may see eye care physician if requested by resident or family, dated 12/3/19. A review of R21's electronic health record (EHR) on 4/8/25 at 2:20 p.m., revealed an Ovitsky Vision Care of Minnesota PC order dated 3/1/23 for refer for cataract extraction evaluation with cataract specialist. The order indicated the resident requested the consult to prevent vision decrease and the specialist could be determined by his attending medical doctor (MD) or nurse practitioner (NP). (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's care plan, last revised 3/4/25, identified his potential for impaired vision related to his diagnosis of age-related cataracts and listed a goal to maintain his current vision. The care plan directed staff to set up ophthalmology appointment as needed. Additionally, the care plan identified his self-care deficit related to his hemiplegia and indicated he had glasses that he wears when he chooses and was able to put on and take off the glasses himself. The care plan directed staff to assist him clean the eyeglasses and ensure they were in good repair. A patient encounter note dated 9/28/23, indicated R21 was seen by the Doctor of Optometry (OD) for a cataract evaluation. The encounter note revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an attempt to improve reduced VA [visual acuity]. Please schedule consultation. A patient encounter note dated 10/3/24, indicated R21 was seen by OD for a cataract evaluation. The encounter note revealed the cataract extraction consultation was discussed and R21 elected to proceed with the consultation in an attempt to improve reduced VA [visual acuity]. Please schedule consultation. A patient encounter note dated 3/28/24, indicated R21 was seen by OD for a cataract evaluation. The encounter note revealed the cataract extraction consultation was discussed, and he elected to proceed with the consultation in an attempt to improve reduced VA [visual acuity]. Please schedule consultation. A nursing progress note dated 3/1/23 indicated R21 was seen by OD and received new orders for cataract extraction evaluation with cataract specialist. Resident requests consult secondary to reported vision decrease. A provider progress note dated 11/22/23 indicated under the chief complaint/nature of presenting problem header that R21 took a lens out of his pocket in order to request a new pair of eyeglasses. The provider 's progress note indicated under the plan header, make eye doctor appt [appointment] for new eyeglasses, for the diagnosis impaired vision. A nursing progress note dated 9/28/23 indicated he was seen by OD but lacked documentation on cataract extraction consult. R21's EHR was reviewed on 4/8/25 at 2:20 p.m. and lacked documentation that referral to cataract extraction specialist was followed-up on. Furthermore, the EHR lacked documentation his order for consult to optometry for new eyeglasses was followed-up on. During observation on 4/7/25 at 2:33 p.m., R21 showed surveyor a pair of eyeglasses with a missing left temple (long arm on the side of the frame that fit over the ear). Per interview on 4/8/25 at 3:31 p.m. with R21 via interpreter, his cataracts had been ongoing for approximately one year and he believed there was orange discoloration to his left eye. He stated he had not seen any provider about the cataract extraction. He also endorsed having difficulty seeing without his eyeglasses and stated he needed a new pair. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/9/25 at 9:15 a.m., OD verified familiarity with R21 and his vision exams. OD explained the decision to make a referral for a cataract extraction was usually driven by either a resident, family, representative or the primary provider. OD stated the decision to move forward with referral was driven by R21. OD confirmed placing the order for the consult in March 2023 and confirmed, he does have the presence of cataracts and explained once the referral was made, it is up to the facility to get that scheduled. OD stated cataracts do change a person's vision but once a cataract is removed, the vison is significantly clearer for a person. OD stated any change in vision from cataracts is only temporary. OD explained the symptoms of having a cataract or cataracts could include blurred vision, difficulty reading, loss of ability to perform a specific activity they were doing, glare from lights or difficulty with overhead lighting, or trouble with nighttime driving. OD denied being made aware of R21's need for eyeglasses and stated, at no point have we done a pair of eyeglasses for him or an exam for glasses. OD reviewed R21's progress notes and was unable to find that he presented anytime with a request for eyeglasses. OD stated, typically, the facility would make us aware of the need for repair or the resident brings them with and makes us aware. Per interview on 4/9/25 at 11:00 a.m. with HIM, if an additional referral is made from the vision team for cataract extraction, the vision team would write up the referral and the facility would send that out to the respective clinic. HIM reviewed R21's chart and the vision encounter note dated 10/3/24 and stated, there it is, the consult for the cataract eval. The referral should have been noted and sent out. HIM reviewed the Ovitsky Vision Care of Minnesota PC order dated 3/1/23 and stated the order should have gone to the HIM and then it should have been faxed over and acted upon. HIM stated the facility used an electronic fax and had the capability of seeing if faxes were successfully submitted and if there were not, they should have been re-attempted. HIM stated if there was a reason the referral was not followed up on, there should have been documentation in the progress notes. Per interview on 4/10/25 at 10:06 a.m., licensed practical nurse (LPN)-A stated consults and referrals were entered in the orders and then communicated to HIM. LPN-A stated they received confirmation the consult or referral was followed up on by seeing the resident was scheduled for an appointment. LPN-A stated if HIM was out, its sort of all of us to ensure the consults or referrals were followed up on. During follow-up interview on 4/10/25 at 10:28 p.m., HIM stated if the vision team decided to work with a consult for eyeglasses, they would work with the resident and the facility to complete the consult. HIM reviewed R21's EHR and confirmed the consult to optometry for new eyeglasses dated 12/14/24 and stated, I did see that order, it didn't come to me right away. IT should have been communicated better, and I should have gotten it and forwarded that on to the vision team. HIM explained the normal process would be that the consult be communicated to HIM and then emailed or faxed to the vision team. HIM stated the vision team would confirm receiving the consult by letting the facility know the resident was on the schedule for their next visit at the facility. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per interview on 4/10/25 at 12:58 p.m. with the director of nursing (DON), the health unit coordinator (HUC) was expected to facilitate referrals and consults and should be calling over to get the appointment and the appointment should be entered in PointClickCare (PCC). The DON also stated appointments were discussed during daily interdisciplinary (IDT) standup meetings so we can make any other arrangements necessary to accommodate the resident. The DON indicated the in-house providers sent the facility a list of residents they would see on their visit days and the list was posted on the nurse's station. The DON stated the facility had been purchasing R21 over-the-counter non-prescription glasses because there had been many broken pairs but expected there to be documentation of this use of non-prescription eyeglasses. The DON stated the facility was awaiting insurance approval for his cataract extraction but was unable to provide documentation of the referral being followed-up on in a timely manner. R29 Assistive Hearing Devices R29's admission Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition, had moderate difficulty hearing and utilized a hearing aid or other hearing appliance. The MDS reported he was dependent on staff for toileting hygiene and required partial-to-moderate staff assistance for personal hygiene cares. The MDS identified diagnoses including hemiparesis (one-side weakness) or hemiplegia (one-sided paralysis), asthma (a condition where the airways narrow), and chronic obstructive pulmonary disease (COPD, a chronic restrictive lung and breathing condition) and depression. R29's Care Area Assessment (CAA) for communication dated 2/12/25, identified his hearing problem and indicated he has moderate difficulty hearing when not in quiet setting. The CAA reported a referral was sent to nursing and social services because hospital notes reported he used a pocket talker and questioned if this could be beneficial to him. The CAA directed staff to his care plan. Per progress note dated 3/12/25, admin order a pocket talker for resident as that is what he was using in the hospital. The pocket talker came in today and SS: [sic, social services] gave to the resident. Resident response was what a pleasure it is to hear again. R29's care plan dated 2/11/25 noted his alteration in communication and included goals to have adequate communication and have his needs anticipated and met by staff. The care plan directed staff to use a pocket talker to aid in communication. During observation on 4/07/25 1:41 p.m., R29 was sitting in his bed. There was a black box with a small, round microphone on the one end and headphones connected to the other end sitting on top of the nightstand next to his bed. During observation on 4/7/25 at 2:24 p.m., nursing assistant (NA-C) changed R29's soiled incontinence brief. R29 stated, I am hard of hearing, and NA-C continued changing the brief without offering him the use of the assistive hearing device on the bedside table. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/10/25 at 9:16 a.m., NA-C and NA-D delivered R29's breakfast meal tray to his room. R29 was lying in bed with his eyes closed and appeared to be asleep. NA-C and NA-D attempted to wake him up by calling his name out at the same time, but he did not wake up. They repeated his name again together, but louder and his eyes opened wide. When asked what the black box on the nightstand next to his bed was, NA-D picked it up, the black speaker box in one hand and the headphones in the other and stated, he listens to music out of it. NA-C and NA-D both stated they had assisted him listen to music with the device before. Per interview on 4/10/25 at 10:16 a.m., licensed practical nurse (LPN)-A expected staff to utilize pocket talkers if a resident was hard of hearing. LPN-A was unsure if there was any in-service or training for staff on how to use them, but stated R29 was the only resident using a pocket talker at that time and indicated he knew how to use the device appropriately. Per interview on 4/10/25 at 1:03 p.m. with the director of nursing (DON), staff were expected to use assistive hearing devices, such as a pocket talker with residents who had communication deficits. Policies pertaining to communication devices and vision treatment and/or appointments were requested but not received.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview, and document review, the facility failed to ensure podiatry services were obtained or 1 of 1 resident (R8) reviewed for foot care. Findings include: R8's annual Minimum Data Set (MDS) dated [DATE], identified she could make herself understood, was independent with eating, required supervision with transfers and bed mobility. R8's interview for preferences identified it was very important to choose what clothing to wear and take care of personal belongings. Diagnoses included heart failure, diabetes and dementia. R8's MHM BIMS Staff Assessment (staff assessment of cognition) dated 2/18/25, identified memory recall was ok after five minutes and R8 seemed to recall long past. R8 was able to recall the current season, location of own room, staff name and faces and that they were in a nursing home. R8 required modified independence regarding tasks of daily life. R8's care plan dated 2/19/24, identified she had a self care deficit related to neuropathy and type two diabetes mellitus. R8 preferred to complete ADLs (activities of daily living) independently, would accept assistance PRN (as needed). R8's care plan lacked information about diabetic shoes or podiatry preferences. During an interview on 4/7/25 at 5:58 p.m., R8 stated she was promised diabetic shoes but no one at the facility followed up. R8's in-house podiatry visit note dated 7/8/24, identified a diabetic foot exam was completed and R8 was encouraged to wear appropriate shoe gear that would not impinge or rub on feet. R8 should continue ongoing at-risk foot care to prevent infection and ulceration. Follow up in nine to 12 weeks. R8's medical record was reviewed from 7/8/24 until 4/7/25, and no further podiatry appointments were scheduled. R8's regulatory provider visit dated 9/11/24, identified R8 requested diabetic shoes as she felt her current Crocs (clog style foam footwear) were not supportive and would like a shoe with more support. R8's painful bilateral LE (lower extremity) edema had not improved. A referral to podiatry was requested due to need for diabetic shoes. R8's doctor's order dated 3/10/25, identified to see podiatry for diabetic shoes. R8 had not been seen by podiatry to obtain diabetic shoes for six months since the initial order from 9/11/24. During an observation and interview on 4/10/25 at 10:37 a.m., R8 was in bed with her feet uncovered. Toenails were long and feet had dry skin with some edema. R8 stated her feet hurt and she could not wear her Croc shoes. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/10/25 at 10:47 a.m., registered nurse (RN)-A stated in-house podiatry visited residents at the facility monthly and was not sure why R8 had not been seen after the initial orders on 9/11/24. The health information manager (HIM) typically scheduled appointments. During an interview on 4/10/25 at 10:58 a.m., the HIM stated he thought R8 refused a podiatry visit, however, did not have any documentation. The HIM stated he could schedule podiatry appointments with the in-house provider or at an outside clinic for residents. During an interview on 4/10/25 at 2:52 p.m., the director of nursing (DON) stated typically podiatry referrals could be scheduled within a month of the provider orders. The DON stated R8's previous guardian was supposed to follow up on the podiatry referral, however, a new guardian was assigned and no follow up was processed. A facility policy for referrals was requested and not provided. The administrator emailed a process on 4/10/25, which identified when referrals were received from providers, they are given to the HUC (health unit coordinator)/HIM (health information manager) to follow up and schedule appointments and rides. If escorts were needed, they were provided by the facility. Resident would be made aware when the appointment was confirmed and the day before.

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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** 49617 Based on observation, interview and document review, the facility failed to ensure fall prevention interventions were implemented consistently according to the comprehensive care plan for 1 of 1 residents (47) reviewed for falls. Findings include: R47's quarterly Minimum Data Set (MDS) dated [DATE], indicated he was sometimes able to make himself understood and was able to understand others with clear comprehension. The MDS reported he had severe impairment in his cognitive skills for daily decision making and required substantial to maximal staff assistance with bed mobility but was dependent on staff for transfers. The MDS identified his diagnoses including hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis), stroke, seizure disorder, and malnutrition. R21's Care Area Assessment for falls dated 6/28/24, was triggered due to his fall history and indicated the care plan was ongoing as he was observed for changes in his mobility. A quarterly fall review evaluation dated 9/20/24, indicated the interventions in place included mat placed on floor by bed, bed in lowest position. R21's care plan last reviewed 3/12/25, identified he was at risk for falls related to his right hemiparesis. The care plan indicated he puts himself on the floor mat and the goal was to keep him safe and free from falls. The care plan directed staff to place mattress next to bed. During a continuous observation on 4/9/25 at 8:11 a.m., licensed practical nurse (LPN)-B entered R47's room and told him, I'm going to turn your tube feeding off and flush you. LPN-B moved the mattress that was on the floor next to his bed up and to the side and proceeded to disconnect the tube feed tubing from him and flush his drain before clamping his drain. LPN-B discarded the empty tube feed bottle and tubing in the bathroom garbage can, performed hand hygiene and lowered his bed to the lowest position before exiting his room at 8:20 a.m. LPN-B did not replace the mattress next to his bed before exiting the room. At 8:22 a.m., nursing assistant (NA)-F entered the room carrying a meal tray into the room. NA-F exited the room at 8:23 a.m. and the mattress was not in place next his bed. At 8:28 a.m., social services (SS)-A walked into the room and asked, are you all done? before walking out of the room at 8:29 a.m. with meal trays. The fall mattress was not in place next to his bed. At 8:30 a.m., NA-F walked into his room and walked back out of the room at 8:32 a.m. The fall mattress was not in place next to 47's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:39 a.m., LPN-B and surveyor entered the room together and LPN-B confirmed the fall mattress was not in place and should have been down. LPN-B stated the mattress should be down unless someone was in here with him assisting with his meal. LPN-B explained he used to fall out of bed when he first admitted to the facility, so the mattress was utilized for his protection. LPN-B put the mattress down on the floor next to his bed and ensured the call light and bed remote were within his reach before exiting the room. Per interview on 4/9/25 at 8:56 a.m., NA-F stated fall interventions included ensuring residents have their call lights within reach and educating them on the call light, asking a resident if they feel okay before a transfer, and making sure resident-specific interventions are in place. NA-F stated some residents have recommendations, like fall mats, that staff are expected to put into place for safety. NA-F stated staff are given weekly education by the nurse managers and fall interventions can be located on the care sheets. Per interview on 4/10/25 at 12:39 p.m. with the director of nursing (DON), staff were expected to replace R47's fall mattress when they were finished working with him to prevent fall injuries and it should be in place when he was in bed. Upon subsequent interview on 4/10/25 at 3:41 p.m., the DON confirmed the interdisciplinary team (IDT) had reviewed and reassessed the fall interventions for R47 and stated the IDT discovered despite being positioned in the middle of the bed, he would somehow move himself right over to the edge of the bed. The DON cited this discovery was the reason the fall mattress intervention was still considered appropriate and stated, that is why we kept the intervention in place. Per facility policy titled Fall Prevention and Management last revised 2/24, facility staff would identify interventions related to a resident's specific risks and causes to try to prevent the resident form falling and to minimize complications from falling. The policy directed staff to implement interventions, monitor and document a resident's response to interventions intended to reduce falling or the risks of falling.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42586 Based on interview and document review the facility failed to employ either a full-time registered dietician (RD) or a qualified dietary manager (DM) to carry out the functions of the food and nutrition service since 3/26/24, which had the potential to affect all 65 residents who resided in the facility. During interview on 4/9/25 at 11:30 a.m., the registered dietician (RD) stated she worked full time, overseeing 5 buildings but only worked 8 hours a week at this facility. During interview on 4/9/25 at 11:45 a.m., the Culinary Director (CD) stated he had been working for the facility for almost a year and had been asked about starting training for his Certified Dietary Manager's certificate (CDM) but he wanted to wait a little bit and wasn't ready to start the training yet. During interview on 4/10/25 at 12:44 p.m. the administrator stated he expected the Culinary Director to either have their CDM upon hire or within the first 3 months. He further verified the CD's date of hire was 3/26/24 and he'd been working at the facility for almost over a year.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42586 Based on observation, interview, and document review the facility failed to ensure dietary staff was wearing beard guards when preparing food This had the potential to affect all 65 residents who reside at the facility and consume food from the kitchen. During observation on 10/7/25 at 11:49 a.m. the Culinary Director (CD) was in the kitchen cutting up fruit. He had a beard but was not wearing a beard guard/restraint. During interview on 4/9/25 at 10:41 a.m., the CD verified he was not wearing a beard guard/restraint while prepping food stating it was hard to determine if the facility wanted staff to wear them or not. The CD further stated the facility did not have any beard guards for staff to wear, but he could get some if needed. During interview on 4/10/25 at 12:44 p.m., the administrator stated dietary staff (who had beards) were expected to be wearing beard guards/restraints when preparing food and this was important for infection control purposes. A policy regarding infection control in the kitchen was requested but not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42579 Based on observation, interview and document review the facility failed to ensure proper personal protective equipment (PPE) was utilized for 1 of 2 residents (R14) reviewed for enhanced barrier precautions (EBP). Findings include: R14's quarterly Minimum Data Set (MDS) dated [DATE], identified no behaviors or rejection of care. Dependent on staff for eating, hygiene, toileting hygiene, bathing and dressing. Diagnoses included dementia, seizure disorder, and contractures of right and left hand. R14's care plan dated 4/7/25 identified resident is currently on EBP R/T (related to) wound on coccyx. Resident will remain free from infection. Staff to follow EBP. R14's wound care progress note dated 4/3/25, identified resident was seen for new area of sacrum MASD (moisture associated skin damage). The wound measured 2.9 centimeters (cm) long, 2.2 cm wide, 0.1 cm deep with scant serosanguinous exudate (wound drainage with serous fluid and blood). During an observation and interview on 4/07/25 at 11:59 a.m., R14's name sign next to her room door identified EBP following the name. Trained medication assistant (TMA)-A was asked if the resident was currently on EBP. TMA-A was not able to answer and was shown the name sign with the initials EBP following the name. TMA-A was still not able to answer the question. TMA-A was shown the poster on the door identifying EBP was in place and TMA-A was not able to reply if R14 was on EBP. There was no PPE bin directly outside the room, however, there was one on the other side of the hallway. During an observation on 4/7/25 at 12:46 p.m., nursing assistant (NA)-A was in R14's room, no PPE on. TMA-A entered R14's room and gave R14 her oral medications, no PPE on. TMA-A then brought in the full body lift to assist NA-A to transfer R14 out of bed. NA-A and TMA-A leaned against the bed with scrubs touching the bedding, connected R14 to the sling for the full body lift which. Both staff had direct contact with R14 and her bedding during the transfer process from bed to wheelchair. After R14 was positioned in her wheelchair, the director of nursing (DON) entered at 12:52 p.m., and asked the staff where their EBP PPE was. Staff did not answer the question and continued to provide cares without PPE on. NA-A tucked in a blanket over R14's lap, picked up her feet and positioned them in the wc footrests and applied foam booties to both feet. NA-A stated she was not aware R14 was on EBP. During an interview on 4/10/25 at 10:52 a.m., registered nurse (RN)-A stated the presence of wounds would be a criteria for staff to follow EBP during cares. During an interview on 04/10/25 02:52 PM the DON stated R14 was seen on wound rounds today. All staff were educated on EBP and she expected staff to always follow EBP for infection control. The facility policy dated 4/1/24 titled EBP, identified the use of gown and gloves during high contact (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Lynnhurst LLC	471 Lynnhurst Avenue West Saint Paul, MN 55104

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care activities was required for residents known to be colonized or infected with a MDRO (multidrug-resistant organisms) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure a personal refrigerator was monitored and kept sanitary in a resident's (R47) shared room. Findings include: R47's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had severe impairment in his cognitive skills for daily decision making and required substantial to maximal staff assistance with bed mobility but was dependent on staff for transfers. The MDS identified his diagnoses including hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis), stroke, seizure disorder, and malnutrition. Per observation on [DATE] at 12:50 p.m., of R47's room, there was a black mini refrigerator on a nightstand on his side of the privacy curtain. There was a Record of Refrigerator Temperatures sign posted on the door of the mini refrigerator dated [DATE] and there were temperatures documented for the dates of [DATE] - [DATE]. The other entries were blank. There was a second Record of Refrigerator Temperatures taped underneath that was dated [DATE], and it was completely void of documentation. The contents inside the mini refrigerator included six small plastic water bottles, a small can of Shasta Cola, two dark green-to-brown avocados, five unlabeled and undated resealable plastic sandwich bags with unidentified food items inside, two lumps of rolled up aluminum foil, an unlabeled and undated blue plastic cup with a white liquid inside, a silver-colored mug with a black handle and top, a clear plastic bottle with a dark teal top and handle, three unlabeled and undated plastic containers with unidentified items inside, a tied up grocery bag, an labeled glass jar of Smuckers brand jam, and two unlabeled Chobani brand yogurt beverages. There was a second mini refrigerator in the room located behind the first one. It was empty and unplugged. Per interview on [DATE] at 4:00 p.m., family member (FM)-B was unsure who the refrigerator in R47's room belonged to. FM-B believed it was his roommate's food inside the refrigerated and stated, that is very unsanitary, so who cleans that? It is so dirty there. Per interview on [DATE] at 7:40 a.m. with licensed practical nurse (LPN)-B, the nursing staff were responsible for checking the temperature of the mini refrigerator in R47's room every night and documenting them on the record of temperature log. LPN-B stated when the logs were completed, they were turned into management who kept them. On [DATE] at 11:48 a.m., the administrator was asked to provide personal refrigerator temperature logs for the floor R47 resided on dated ,d+[DATE] - ,d+[DATE]. During interview at 1:17 p.m., the administrator provided logs for 2025 and responded, we got rid of the ones from the prvious [sic] year. The temperature logs dated ,d+[DATE] - ,d+[DATE] were requested but not received. The Record of Refrigerator Temperatures dated ,d+[DATE] - ,d+[DATE] were reviewed and included completed documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on [DATE] at 12:39 p.m., the director of nursing (DON) and surveyor were in R47's room. There was only one mini black refrigerator in the room and the Record of Temperatures was dated [DATE] and included documentation of temperatures from [DATE] - [DATE]. The refrigerator's contents included four small disposable plastic water bottles, one Chobani brand yogurt beverage, one glass jar of Smuckers brand jam, a silver-colored mug with a black handle and top, and a clear plastic bottle with a dark teal top and handle. The DON stated staff were expected to check the temperature every night and document it on the log sheet. Additionally, staff were expected to clean the resident refrigerators out and update the log sheet each month. The DON and surveyor reviewed the photographs of the Record of Refrigerator Temperatures dated ,d+[DATE] and ,d+[DATE] from surveyor's observation on [DATE] as well as the photographs of the contents of the refrigerator from the observation. The DON confirmed the deficient practice and stated staff should have cleaned the refrigerator out prior to [DATE] and should have updated the temperature log before [DATE]. Per an undated facility policy titled Resident's Personal Refrigerator, to assure infection control practices, including refrigerator function, was maintained, cleaning would be done for prevention of food-borne illness. The purpose of the policy was to assure personal refrigerators in resident room's are functioning at the correct temperature and are clean and do not contain expired products that could cause food-borne illness. The policy directed staff to check the temperature of the refrigerator in the room weekly and record the results in the temperature log in the room. Additionally, the policy guided staff to check the temperature, condition of food/beverage, and spoilage on a weekly basis and remove expired perishable food items after notifying the resident. The policy indicated the refrigerator would be cleaned monthly and as needed and would be defrosted as needed.