STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245424	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Homes of Arden Hills	3220 Lake Johanna Boulevard Arden Hills, MN 55112

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to report to the state agency (SA) allegations of potential neglect and verbal abuse for 2 of 3 residents (R30, R37). Findings include: R30's Optional State Assessment (OSA) dated 7/18/24, indicated R30 rarely made self understood, did not have behaviors or reject cares, required extensive assistance for all activities of daily living (ADLs), had aphasia (a language disorder that affects a person's ability to communicate), and hemiplegia or hemiparesis (paralysis or weakness on one side of the body). R30's annual Minimum Data Set (MDS) dated [DATE], indicated R30 had both a long-term and short-term memory problem, was always incontinent of bowel and bladder, was at risk for developing pressure ulcers. R30's care plan dated 8/2/24, indicated R30 had an ADL self-care performance deficit and interventions included, R30 required two staff participation to dress, one staff person assist with personal hygiene, and one assist with eating. R30's care plan dated 8/2/24, indicated R30 required one to two staff assist for bed mobility, and required two assist with a full mechanical lift for transfers. R30's care plan dated 8/2/24, indicated R30 was at risk for abuse and or neglect related to cognitive and functional deficits and interventions directed staff to follow the vulnerable adult policy, keep R30 safe at all times, and refer to resident services as needed. R37 R37's OSA dated 6/6/24, indicated R37 required extensive assistance with eating. R37's quarterly MDS dated [DATE], indicated a short-term and long-term memory problem, did not have behaviors, had a limitation in range of motion on one side of the upper and lower extremities, required setup or clean-up assistance with eating, had dementia, and hemiplegia or hemiparesis. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's Medical Diagnosis form indicated R37 had unspecified dementia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side, anxiety disorder, major depressive disorder, muscle weakness, and dysphagia (difficulty swallowing). R37's care plan dated 9/10/24, indicated R37 had a self-care performance deficit related to dementia, history of stroke with right sided hemiparesis and right hand contracture and required assistance to perform most ADLs. R37's interventions identified R37 required supervision with eating in the dining room during meals with set-up. R37's care plan dated 9/10/24, indicated an alteration in mood or behaviors due to dementia and a history of delusions an unknown person from outside the facility was attempting to kill or harm R37 or R37's family and interventions indicated encouragement to participate in activities of interest, intervene as necessary to protect the rights and safety of others. Approach and speak in a calm manner, divert attention, remove from the situation and take to an alternate location as needed. R37's care plan dated 9/10/24, indicated R37 was at risk for abuse and neglect due to functional limitations and severe impaired cognition and dementia. Interventions directed staff to follow the vulnerable adult policy, keep R37 safe at all times, and refer to resident services specialist as needed. Nursing assistant's (NA)-F's Notice of Termination form indicated NA-F was overheard telling a resident to stop crying or NA-F would stop feeding them and a clinical coordinator informed NA-F they do not talk to residents like that and expected residents be treated with consideration, courtesy, and respect. Further, the form indicated on 8/14/24, NA-F forgot a resident in their room all morning and upon camera review, the resident was discovered at 11:04 a.m., still in bed and unattended to. NA-F took the resident to lunch at 12:10 p.m. The form indicated NA-F got busy and forgot and as a result the resident did not receive breakfast and did not receive morning cares. During interview on 9/12/24 at 9:44 a.m., the director of nursing stated the administrator had the video of the resident who was forgotten and further stated if there was confirmed abuse a staff person was terminated. During interview on 9/12/24 at 10:17 a.m., the administrator stated the resident who NA-F told to stop crying or she would stop feeding in the Notice of Termination form was R37 and further, the resident NA-F forgot was R30. The administrator further stated she spoke with registered nurse (RN)-A who told NA-F she could not do that and stayed with R37 until she was done and helped feed R37 the remainder of the meal. The administrator stated there was no written follow up completed for R30, but RN-A spoke to NA-F to make sure she reported to someone if she was unable to get a resident up in time. The administrator stated she viewed the footage and R30 was not up until about 11:00 a.m., and did not review cameras for R37. The administrator further stated she did not think they followed up with R30 and stated they dropped the ball on that one unless RN-A followed up. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 9/12/24 between 10:35 a.m., and 10:59 a.m., RN-A stated she was standing by the health unit coordinator station completing paperwork and R37 sat at the table and NA-F was feeding R37. RN-A stated R37 was upset that day and was often upset and NA-F stated, if you don't stop, I'm going to stop feeding you. RN-A stated she was standing about 2 or 3 feet away from NA-F and immediately went to NA-F and told her she couldn't speak to R37 like that and went back to where she was standing and continued to do paperwork. RN-A stated she was appalled and stated R37 did not need help eating and stated she stayed with R37 the whole time and added R37 was ok and tended to have behaviors of crying and being agitated. RN-A stated she reported the encounter to NA-F's supervisor, CCHC-G. RN-A stated she felt it was abusive and added you don't talk to someone like that and stated she did not know whether CCHC-G reported the encounter to anyone other than human resources. RN-A stated R30 was non-verbal and stated they have an interdisciplinary team (IDT) meeting from 10:15 a.m., that ends about 11:00 a.m., and RN-A came upstairs and stated a staff person reported R30's food was in the kitchen and was thrown away because it was 11:00 a.m., and they forgot to feet R30. RN-A stated she asked NA-F what had happened and NA-F began to cry and told RN-A she got busy and missed R30. RN-A stated she contacted the director of nursing (DON) and the administrator right away along with CCHC-G and human resources and asked NA-F what she could do to make sure it didn't happen again. RN-A stated she contacted R30's daughter to explain staff forgot to give R30 breakfast and was not aware if any disciplinary action was completed. At 10:51 a.m., RN-A stated R30 did not have any pressure injuries and did not initiate a body audit because it did not make sense. RN-A stated R30 was incontinent and stated NA-F's shift started at 6:00 a.m. and R30 went about 5 hours by the time she got out of IDT R30 was up in the chair and thought it was around 10:30 a.m. RN-A further stated R30 was at risk of developing pressure ulcers and stated they were worried about R30's meal and did not look at the big picture about R30's skin. At 10:59 a.m., RN-A viewed R30's progress notes and verified there was no progress note indicating a skin assessment was completed for R30 on 8/14/24. During interview on 9/12/24 at 11:52 a.m., CCHC-G stated she was NA-F's supervisor and stated RN-A reported NA-F's statement to R37 on the same day it occurred and thought that incident occurred on 6/4/24. CCHC-G stated she had a log in for filing a vulnerable adult report, but stated their process was to call the administrator or DON who would direct staff how to proceed. CCHC-G further stated she started in her role as the CCHC on 6/3/24, but was an administrative intern at the facility prior. CCHC-G stated the administrator was out, but spoke to human resources about R37 if not the same day, the following day and the campus administrator was also involved. CCHC-G stated she received a report R30 did not receive breakfast and did not know if R30 did not get out of bed, but RN-A spoke to NA-F and handled the situation and stated the vulnerable adult report would be under the discretion of the administrator and the DON. During interview on 9/12/24 at 11:43 a.m., RN-A stated she did not notify R37's family and did not complete vulnerable adult reports and would contact the administrator or the DON and thought she notified both CCHC-G and the administrator regarding R37. During interview on 9/12/24 at 12:50 p.m., the administrator stated a vulnerable adult report was not completed for either resident and stated they should have been reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Vulnerable Adult Abuse Prevention Plan, dated January 2023, indicated verbal abuse was the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability, neglect is the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. Once abuse is suspected or identified, the facility will take all appropriate steps to stop the abuse and protect residents from additional abuse immediately. These steps include but are not limited to reporting the alleged violation and investigation within required timeframes, conducting a thorough investigation of the alleged violation, taking appropriate corrective action, revising the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.

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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** 46885 Based on interview, observation, and document review, the facility failed to ensure R30 received a pillow for positioning for prevention of pressure ulcers and that aided in comfort associate with contractures. Findings include: R30's annual MDS dated [DATE], indicated R30 had severely impaired cognitive skills for daily decision making, had an impairment in range of motion to both upper and lower extremities, was dependent on staff for all activities of daily living, was at risk for pressure ulcers and had pressure relieving devices for the chair and bed. R30's Medical Diagnosis form indicated the following diagnoses: hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the right dominant side, vascular dementia, contracture of the right and left hand, abnormal posture, and osteoarthritis of unspecified site, R30's care plan dated 8/2/24, indicated R30 had limited physical mobility related to impaired balance, range of motion, dementia, right and left hand contractures, osteoarthritis and interventions included: R30 had positioning signs located in her room, observe for changes in mobility, contractures forming or worsening. R30's care plan dated 8/2/24, indicated R30 was at risk for impaired skin integrity and interventions included to float elbow on the pillow while in bed, and float elbow on U pillow when in the chair see picture. R30's care sheet dated 9/6/24, indicated float elbow on a pillow while in bed and in the chair. During interview and observation on 9/9/24 between 1:48 p.m., and 1:57 p.m.,R30 was in her black reclining wheelchair and R30's elbow was contracted along with the left wrist and fingers on the left hand were curled shut. Signage was located above the bed that indicated R30 was always supposed to have a pillow under her left elbow, however, R30 did not have a pillow located under her left elbow. At 1:57 p.m., nursing assistant (NA)-E stated R30 had a pink pillow and placed it under R30's right elbow. When asked which elbow the pillow was supposed to go, NA-E placed the pillow under R30's left elbow. R30 did not decline to have the pillow. NA-E stated they liked the pillow put on in bed more than the chair but NA-E placed the pillow when R30 was in either location. During observation on 9/10/24 at 12:14 p.m., R30 was at the dining room table in her wheel chair and staff were assisting R30 with her meal. No pillow was located under R30's elbow. During observation on 9/10/24 at 12:42 p.m., an unidentified staff person brought R30 to her room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 9/10/24, between 12:43 p.m., and 12:55 p.m., NA-C and NA-D assisted R30 into bed with the full body lift. At 12:54 p.m., boots were applied to R30's feet and at 12:55 p.m., a bed pillow was placed under R30's right side and a leg positioning device was placed between R30's legs. NA-C did not apply the pillow under R30's left elbow and did not offer to apply the pillow. NA-C took R30's oxygen tubing out of the room. During interview on 9/10/24 at 1:04 p.m., registered nurse (RN)-B stated R30 was supposed to have a pillow under her elbow and would have expected the pillow to be in place in the chair and stated staff should have offered or placed the pillow under the elbow. RN-B verified after review of R30's care plan staff should have placed the pillow according to the care plan. During interview on 9/10/24 at 1:16 p.m., RN-A stated she thought R30 was supposed to have her elbows floated on any pillow because R30 had a history of pressure injuries and when agitated, tends to dig elbows in. During interview on 9/10/24 at 10:11 a.m., the director of nursing stated staff were not following the plan of care and further, it was important to have the pillows in order to prevent skin issues and the pillow could help with contractures and offloading because R30 had very fragile skin. A policy, Cares-AM and HS, dated September 2020, indicated every resident was to have daily a.m., and bedtime cares completed, being mindful of any resident preferences that may be care planned. The procedure directed staff to review the care plan, nursing assistant assignment sheet for the amount of assistance required to provide care and resident's ability to participate, and complete any other personal cares as requested by the resident or as indicated on the care plan (nursing assistant assignment sheet).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure supplemental oxygen was properly maintained per professional standards for 1 of 1 resident (R30). Findings include: R30's Optional State Assessment (OSA) Minimum Data Set (MDS) dated [DATE], indicated R30 required extensive assist with bed mobility, transfers, eating, and toileting. R30's annual MDS dated [DATE], indicated R30 had severely impaired cognitive skills for daily decision making, did not identify whether R30 utilized oxygen therapy. R30's Medical Diagnoses form indicated the following diagnoses: chronic respiratory failure with hypoxia (low levels of oxygen in body tissues). R30's physician's orders indicated the following order: 1/8/24, Ok to keep oxygen at 1 to 4 liters via nasal cannula (NC) to keep oxygen saturations greater than 88%, change tubing every week. R30's care plan revised 8/2/24, indicated R30 had chronic respiratory failure with hypoxia and R30's goal was to receive oxygen per physician's orders and interventions included to follow facility protocol for care and maintenance of equipment, provide oxygen per nasal cannula see physician orders for liters per minute. During observation on 9/9/24, at 1:52 p.m., R30's oxygen tubing had a sticker that indicated 8/29/24 and the bubbler for the oxygen was dated 8/29/24. During interview and observation on 9/10/24 between 12:43 p.m., and 12:55 p.m., nursing assistant (NA)-C was getting ready to lay R30 down in the bed. R30's oxygen tubing was on the floor along with the cannula portion that goes into the nose and the oxygen was turned on at 2 liters. R30 also had portable oxygen with tubing on the back of the wheelchair, but was not in R30's nose and R30 was not using oxygen. At 12:55 p.m. , NA-C picked up the oxygen tubing that was on the floor and placed the nasal cannula in R30's nose. NA-D stated the date on the humidifier and tubing was August 29th. NA-C stated she did not know the cannula was on the floor and stated she would call the nurse and took the oxygen tubing out of the room after being questioned whether the tubing should be placed on R30 after being on the floor. During interview on 9/10/24 at 1:04 p.m., registered nurse (RN)-B took off the bubbler and stated the humidifier was dated August 29th and added distilled water in the humidifier. RN-B stated oxygen tubing was changed every two weeks but would check to verify this and stated she did not expect staff to put the cannula in R30's nose after being on the floor. RN-B viewed the orders and verified the oxygen tubing should have been changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 9/10/24 at 1:16 p.m., RN-A stated oxygen tubing was changed on a weekly basis and if it falls on the floor and stated if the tubing was dated August 29th, it should have been changed and stated staff should know if oxygen tubing was on the floor, the tubing should be thrown away. During interview on 9/12/24 at 10:11 a.m., the director of nursing (DON) stated she had someone that came weekly to change oxygen tubing, but that person was ill and there wasn't a back up plan. DON further stated they should not apply the cannula if it was on the floor because of infection control. A policy, Oxygen Equipment Care and Maintenance, modified October 2011, indicated tubing was not to touch the floor and tubing was changed and dated weekly. Additionally, the humidifier bottles would be changed and dated weekly.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on inteview and document review the facility failed to identify potential triggers and offer specialized services for 1 of 1 resident (R275) who had a history of trauma. Findings include: R275's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of major depressive and anxiety disorder. It further indicated R275 had a behavior of socially isolating herself, required substantial assistance with toileting and partial assistance with mobility. R275's Long Term Care (LTC) Psychosocial assessment dated [DATE], indicated R275 had a dignoses of major depressive disorder, anxiey, and had a history of trauma. It also indicated R75 had felt numb, detached from others, activities and/or surroundings as a result of that trauma. It lacked documentation that triggers were assessed to prevent re-traumatization. R275's Comprehensive Nursing Assessment Data Collection dated 8/22/24, indicated R275 preferred female caregiver only. It lacked documentation that triggers were assessed to prevent re-traumatization. R275's care plan dated 8/22/24, indicated I have a history of trauma. I was sexually abused for many years at a young age. I tend to isolate myself and can be quite shy due to this. It further indicated the following interventions: -I prefer females for personal cares -refer to resident services as needed -remind me that I am safe here R275's care plan lacked documentation of an assessment for triggers to prevent re-traumatization or other specialized services were offered or refused. R275's medical record lacked documentation ACP or other specialized services were offered or refused. R275's progress notes since admission lacked documentation of an assessment for triggers to prevent re-traumatization or specialized services were offered or refused. During interview on 9/9/24 at 5:35 p.m. R275 stated she had been a long time victim of child abuse and it was hard for her to have a male come in and change her brief, (especially at night) due to her past trauma. She understands they (the facility) may not have enough women (staff) but it seemed to be a problem during the overnight shift. R275 further stated she hadn't been assessed for triggers but her son told the facility about her past history of trauma when she was admitted . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 9/10/24 at 10:23 a.m. R275 stated she hadn't been offered any specialized services (such as associated clinical physcology) to help her cope with past trauma. During interview on 9/11/24 at 12:24 p.m., household coordinator (HC)-A stated when a resident admits to the facility the household coordinators are responsible for completing an assessment titled Long-Term Care (LTC) Psychosocial assessment which included the questions regarding past trauma. The questions specifically assessed for triggers such as if the resident tends to isolate, detach from others and their surroundings, and if they had nightmares. The facility also offered ACP services and it should be documented if it was offered and if the resident accepted or declined it. HC-A further stated they spoke to R275 today, offered ACP services, and made a plan to check in on a quarterly basis to see how things were going. She also asked her about any triggers. HC-A stated ACP was offered at admission but hadn't been documented and added it today (9/11/24) to R275's care plan. During interview on 9/12/24 8:56 a.m., the director of nursing (DON) stated when a resident was admitted to the facility the household coordinators were responsible for completing all the paperwork and if something came up they would complete the assessment for trauma informed care. Once that was completed, it would be added to the residents care plan. The assessment used for trauma informed care was titled LTC Psychosocial assessment for any resident diagnosed with a behavioral health disorder or a history of trauma. The household coordinators should ask the residents about any triggers, unless asking about the trigger may be a trigger. They should be offering services such as ACP and documenting that services were offered and whether the resident accepted or refused the offer. The facility's policy on trauma informed care dated 12/2022, indicated Presbyterian Homes and Services will ensure we assess a resident who displays or is diagnosed with mental disorder or psychological adjustment difficulty, or who has a history of trauma and/or posttraumatic stress disorder and facilitate appropriate treatment and services to manage the assessed problem to attain the highest practicable mental and psychological well-being. The intent of this requirement is to ensure that the facility delivers care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent and account for experiences and preferences and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview, and record review the facility failed to provide medication as ordered by the provider for 1 of 3 residents (R72) observed during medication administration. Findings include: R72's quarterly Minimum Data Set (MDS) dated [DATE], indicated R72 had cognitive impairment and diagnoses of dementia and delusional disorder. R72's provider order dated 1/9/24, indicated R72 required Seroquel (antipsychotic medication used to help treat delusional disorders) 25 milligrams (mg) daily at bedtime. R72's September medication administration record (MAR) indicated R72 did not receive the ordered Seroquel on 9/9/24 as the dose was not available. R72's nursing progress note dated 9/9/24 at 6:52 p.m., indicated R25's Seroquel was not available and follow up with pharmacy was needed. A facility form titled Refill Reorder Form dated 9/1/24, indicated R72's Seroquel was requested to be refilled. A facility form titled Refill Reorder Form dated 9/8/24, indicated R72's Seroquel was requested to be refilled. A facility form titled Refill Reorder Form dated 9/10/24, indicated R72's Seroquel was requested to be refilled. A pharmacy comment on re-order form indicated to send 3 doses to facility and ok to bill to the facility. An observation on 9/9/24 at 6:48 p.m., trained medication assistant (TMA)-A prepared to administer R72 medications. R72's Seroquel was not available for administration. TMA-A had administered R72's other medications however was not able to administer the Seroquel. When interviewed on 9/9/24 at 7:00 p.m., TMA-A stated the last dose of Seroquel was administered yesterday. TMA-A stated they re-ordered it yesterday and it still had not arrived. If a medication was needing to be refilled, a fax was sent to the pharmacy. The latest time of arrival was between 8:00 and 9:00 p.m. TMA-A further explained if the Seroquel was not on that delivery, it would come tomorrow morning. When interviewed on 9/11/24 at 7:58 p.m., registered nurse (RN)-A stated medications should be re-ordered when there was about a week's worth left. The last row of the blister pack was red and should be reordered when taking from that row. Seroquel was not a medication in the emergency kit and if the medication was not available it would be missed. (continued on next page)

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	245424	A. Building B. Wing	09/12/2024

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 9/12/24 at 11:41 p.m., the Director of Nursing (DON) stated when a medication was re-ordered, the hope was for it to be delivered the following day. DON further stated the facility had been working with pharmacy on this process and trying to ensure medications were received timely. When interviewed on 9/12/24 at 1:01 p.m., pharmacist-A stated R72's initial request was sent on 9/1/24, which was too soon to refill. Pharmacist-A stated insurance will not cover if the medication is refilled too soon. The facility was typically notified that the requested medication was too soon to fill via fax. The pharmacy then puts a notation in their system that will prompt pharmacy to fill when able. Pharmacist-A stated R72 had a 30-day supply of Seroquel last sent on 8/15/24 which should be good until 9/15/24. Pharmacist-A stated a refill request for the Seroquel was again sent on 9/8/24 and 9/10/4. On 9/10/24, the facility ok'd to pay for 3 days' worth until the refill could be completed. On 9/10/24, the pharmacy sent 3 days' worth of R72's Seroquel. A follow up interview on 9/12/24 at 1:25 p.m., the DON was asked if there was a process to track or understand why a medication would run out before the ability to refill. The DON stated they would need to look into that and get back however no further information was provided. A facility policy titled Medication ordering and receiving from pharmacy no date, directed staff to reorder medications when a 5-day supply remains to assure delivery can be timely.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and document review the facility failed to ensure medication errors were prevented for 2 of 4 residents (R72, R109) observed during medication administration. This resulted in a medication error rate of 7.69%. Findings include: R72 R72's quarterly Minimum Data Set (MDS) dated [DATE], indicated R72 had cognitive impairment and diagnoses of dementia and delusional disorder. R72's provider order dated 1/9/24, indicated R72 required Seroquel (antipsychotic medication used to help treat delusional disorders) 25 milligrams (mg) daily at bedtime. R72's September medication administration record (MAR) indicated R72 did not receive the ordered Seroquel on 9/9/24 as the dose was not available. R72's nursing progress note dated 9/9/24 at 6:52 p.m., indicated R25's Seroquel was not available and follow up with pharmacy was needed. An observation on 9/9/24 at 6:48 p.m., trained medication assistant (TMA)-A prepared to administer R72 medications. R72's Seroquel was not available for administration. TMA-A had administered R72's other medications however was not able to administer the Seroquel. When interviewed on 9/9/24 at 7:00 p.m., TMA-A stated the last dose of Seroquel was administered yesterday. TMA-A stated they re-ordered it yesterday and it still had not arrived. If a medication was needing to be refilled, a fax was sent to the pharmacy. The latest time of arrival was between 8:00 and 9:00 p.m. TMA-A further explained if the Seroquel was not on that delivery, it would come tomorrow morning. R109 R109's admission MDS dated [DATE], indicated R109 was cognitively intact with diagnoses of Parkinson's disease, and hypothyroid (low thyroid hormone). R109's provider order dated 6/7/24, indicated R109 required levothyroxine 50 micrograms (MCG) daily for hypothyroidism. An observation on 9/10/24 at 8:40 p.m., TMA-B prepared R109's morning medications. R109's (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Synthroid medication pack was observed. There was a label placed that instructed the medication to be taken on an empty stomach. After R109's medications were prepared, TMA-B entered R109's room. R109 was up out of bed seated in a wheelchair finishing breakfast with the assistance of staff. TMA-B waited a few moments until R109 was done with breakfast and then administered R109's morning medications including Synthroid. When interviewed on 9/10/24 at 9:10 a.m., TMA-B acknowledged the Synthroid was given as R109 was finishing up with breakfast and the medication instructions from pharmacy to administer on an empty stomach. TMA-A stated they try to follow the directions; however, it was not always given before breakfast. TMA-B stated the medication was not scheduled at a specific time and was ordered as an 8:00 a.m. medication. Medications ordered at this time had a larger window of administration. TMA-B further stated if it was a priority to be given earlier due to the empty stomach instructions, the Synthroid would be scheduled for 7:00 a.m. When interviewed on 9/11/24 at 7:58 p.m., registered nurse (RN)-A stated medications should be re-ordered when there was about a week's worth left. The last row of the blister pack was red and should be reordered when taking from that row. Seroquel was not a medication in the emergency kit and if the medication was not available it would be missed. RN-A stated the medication order and the medication label on the packet or bottle should match up. If there were further administration instructions from pharmacy listed, they should be followed, and the medication order or schedule should reflect the medication administration instructions. When interviewed on 9/12/24 at 11:41 p.m., the Director of Nursing (DON) stated when a medication was re-ordered, the hope was for it to be delivered the following day. DON further stated the facility had been working with pharmacy on this process and trying to ensure medications were received timely. Furthermore, the DON expected staff to follow medication instructions listed from pharmacy on the medication card. When interviewed on 9/12/24 at 12:44 p.m., the consultant pharmacist (CP) stated Synthroid has a better absorption if given on an empty stomach and if given with meals, it may not be absorbed as well. A facility policy titled Medication Administration revised 5/2021, directed medications ordered to be given on an empty stomach will be administered at least 30 minutes prior to a meal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and document review the facility failed to ensure food was properly disposed of after their best by dates in 2 of 4 serving kitchens and failed to ensure food was properly stored in 2 of 4 of the serving kitchens reviewed. This had the potential to impact residents who reside on the unit the serving kitchen is located. Findings include: An observation on [DATE] at 1:21 p.m., the 3rd floor serving kitchen was reviewed. Server (S)-A was in the serving kitchen cleaning up after lunch. In the cupboard was a box containing 2 individual packets of instant cream of wheat. The top of the box was torn off. There was no use by date on the box. A second un-opened box of cream of wheat was next to the open box. The top of the box included best if used by date of [DATE]. An interview on [DATE] at 1:30, S-A verified there was no best by date on the opened box of cream of wheat and the April date on the unopened box. S-A further stated lead server (LS) who was responsible for checking the dates of food items daily. S-A further stated most of the items were served by the kitchen and the individual items were made for residents by the nursing staff. S-A stated she wasn't sure how it was determined if the opened box was any good and further stated both should have been removed. An observation on [DATE] at 1:43 p.m., the 2nd floor serving kitchen was reviewed. S-B was in the serving kitchen cleaning up after lunch. Upon review of the refrigerator, there were two half-gallon containers of [NAME] skim milk sitting next to each other. One milk container was approximately ,d+[DATE] full and had a best by date of [DATE]. The second milk container was less than ,d+[DATE] of milk left and had a best used by date of [DATE], 6 days prior this observation. The milk had just a small amount left. When interviewed on [DATE] at 1:50 p.m., S-B verified the milk had a best used by date of [DATE] and stated usually LS made rounds on the units to ensure items were stocked, labeled and to check if any food items needed to be removed. S-B further stated she was not sure which jug of milk was used as it was usually the nursing assistants who assist with the beverages. S-B stated everyone should be checking dates and acknowledged they had not as it was so busy and disposed of the milk. An observation on [DATE] at 2:18 p.m., S-C was in the 4 north serving kitchen. Inside the refrigerator was two large trays with multiple glasses of milk and apple juice. The juice and milk were not covered and not dated. When interviewed on [DATE] at 2:25 p.m., S-C verified the uncovered glasses and stated the juice and milk were prepped for evening shift a little while ago. S-C was not aware of the glasses needing to be covered. S-C then started to cover the beverages. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on [DATE] at 2:05 p.m., LS stated she has a process for ensuring items are stocked and when items expire and had a list of items for the main storage and the pantry kitchens (kitchenettes separate from the serving kitchen). Furthermore, LS stated she was responsible for the pantry kitchens on the units however, the servers who worked in the serving kitchens were responsible to review the food items and ensure proper storage. When interviewed on [DATE], the Assistant Dietary Director (ADD) expected those working in the serving kitchen to be checking food items daily to ensure they were used by the best-by dates. If no date was found the items should be thrown. ADD further stated staff were expected to date and cover all items stored or prepped for future use. When interviewed on [DATE] at 11:49 a.m., the administrator expected staff to follow the processes in place to ensure food is stored properly and removed if past the best by date. A facility policy titled Safe Food Storage Policy revised ,d+[DATE], directed staff to label, date and properly cover all food items upon opening of package. The policy directed staff to ensure food is rotated by placing new items behind older items in a first in, first out system, however did not indicate a method of checking dates to ensure food items had not expired.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review, the facility failed to ensure appropriate transmission-based precautions (TBP) were used for 3 of 3 residents (R69, R108, R4) who had COVID-19. Furthermore, the facility failed to ensure proper hand hygiene was used for 1 of 1 residents (R72) observed during personal care. Findings include: R69 significant change Minimum Data Set (MDS) dated [DATE], indicated R69 had severe cognitive impairment and diagnoses of dementia. R69's MDS further indicated R69 was dependent on staff for eating. R69's nursing progress note dated 9/1/24 at 5:07 p.m., indicated R69 had tested positive for COVID-19. R69's nursing order dated 9/1/24, indicated R69 required TBP because of an active infection of a highly transmissible pathogen that had been acquired by physical contact, airborne or droplet transmission. Staff were to assist resident to maintain strict isolation. R108's quarterly MDS dated [DATE], indicated R108 was cognitively intact and had diagnoses of cancer of the spine and diabetes. R108's nursing progress note dated 9/10/24 at 9:22 a.m., indicated R108 tested positive for COVID-19. R108's nursing order dated 9/10/24, indicated R108 required TBP because of an active infection of a highly transmissible pathogen that had been acquired by physical contact, airborne or droplet transmission. Staff were to assist resident to maintain strict isolation. R4's annual MDS dated [DATE], indicated R4 was cognitively intact and had diagnoses of chronic lung disease and diabetes. R4's nursing progress note dated 9/10/24 at 1:23 p.m., indicated R4 tested positive for COVID-19. R4's nursing order dated 9/1024, indicated R4 required TBP because of an active infection of a highly transmissible pathogen that had been acquired by physical contact, airborne or droplet transmission. Staff were to assist resident to maintain strict isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 9/11/24 at 8:25 a.m., R69's room door was closed. On the door was a pink sign directing staff droplet precautions was required. The sign directed staff to have gown, gloves, eye protection and a N-95 respirator on when entering. A white paper sign was also on the door and stated R69 was in quarantine from 9/1/24-9/11/24 and instructed staff a gown was required during all high contact cares such as personal cares and transfers. At 8:29 a.m., nursing assistant (NA)-A delivered breakfast to R69. Before entering R69's room, NA-A performed hand hygiene, removed their surgical mask, and donned a N-95 respirator and gloves. Without donning a gown or eye protection, NA-A entered R69's room and closed the door. Forty minutes later at 9:10 a.m., NA-A exited R69's room wearing an N-95 mask and carrying a bag of trash. NA-A went directly to the soiled utility room to dispose of trash, washed hands and had replaced the N-95 mask with a new surgical mask. When interviewed on 9/11/24 at 9:13, NA-A verified R69 was on TBP for COVID-19 and was assisting R69 with breakfast. R69 acknowledged they had not had a gown on and only had personal eyeglasses onto assist with breakfast. NA-A stated a gown was not needed to help with meals and was only required for close contact such as transferring and personal cares. NA-A stated their personal eyeglasses could be used as eye protection. An observation on 9/11/24 at 11:50 a.m., R108's room door was closed. On the door was a pink sign directing staff droplet precautions was required. The sign directed staff to have gown, gloves, eye protection and a N-95 respirator on when entering. A white paper sign was also on the door and stated R108 was in quarantine from 9/10/24-9/21/24, and instructed staff a gown was required during all high contact cares such as personal cares and transfers. At 11:54 a.m., NA-B delivered lunch to R108's room. Upon entering NA-B performed hand hygiene and donned a gown and gloves. Without donning an N-95 respirator or eye protection, NA-B entered R108's room and left the door open. NA-B talked with R108 as they set up lunch on R108's bedside table. At 11:59 a.m., NA-B removed the gown and gloves and performed hand hygiene upon exit of R108's room. At 12:00 p.m., R4's room door was closed. On the door was a pink sign directing staff droplet precautions was required. The sign directed staff to have gown, gloves, eye protection and a N-95 respirator on when entering. A white paper sign was also on the door and stated R4 was in quarantine from 9/10/24-9/21/24, and instructed staff a gown was required during all high contact cares such as personal cares and transfers. 12:01 p.m., NA-B continued to R4's room to deliver lunch. NA-B performed hand hygiene and donned a gown and gloves. Without donning a N-95 respirator or eye protection, NA-B entered R4's room leaving the door open. At 12:03 p.m., NA-B removed the gown and gloves, performed hand hygiene and exited R108's room. When interviewed on 9/11/24 at 12:15 p.m., NA-B verified R108 and R4 were on TBP due to COVID-19. NA-B acknowledged a N-95 respirator and eye protection was not in place as NA-B was just delivering trays. NA-B further stated eye protection and an N-95 respirator was needed during close contact cares such as helping to the bathroom. Hand Hygiene R46's quarterly MDS dated [DATE], indicated R46 was cognitively intact and had diagnoses of vascular disease and bladder dysfunction. Furthermore, R46 was always incontinent. R46's care plan revised 5/18/24, indicated R46 was incontinent and required assistance of one person for hygiene and incontinent cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 9/11/24 at 12:06 p.m., NA-B entered R46's room to assist with incontinent cares. NA-B performed hand hygiene and donned gloves. NA-B unfastened R46's soiled brief and cleaned the front of R46 with wipes and then tucked the front side of the brief down and underneath R46. R46 was able to turn to the right side. NA-B then wiped R46's backside and removed the soiled brief and placed in the garbage. Without glove exchange or hand hygiene, NA-B took a clean brief and assisted R46 to turn and place the clean brief. NA-B then fastened the brief and removed the soiled gloves. Without hand hygiene NA-B assisted to pull down R46's dress and adjusted R46's sock. NA-A then bagged up the garbage and performed hand hygiene before leaving the room. When interviewed on 9/11/24 at 12:15 p.m., NA-B acknowledged they had not removed gloves or performed hand hygiene after removing R46's soiled brief and placing the new one. NA-B stated they should have performed hand hygiene and exchanged gloves after removing the soiled brief and before assisting with the clean brief and clothing. When interviewed on 9/12/24 at 10:36 a.m., the infection preventionist (IP) stated when a resident is positive for COVID-19, TBP for droplet with N-95 use was initiated right away. IP further stated the dates of quarantine were posted on the resident rooms along with the droplet isolation signs. IP acknowledged the quarantine signs indicated gowns with close contact cares and stated that could cause confusion. IP expected staff to have gowns, gloves, N-95 respirator, and eye protection on every time they enter a room of a resident with COVID-19. IP stated staff were expected to perform hand hygiene when moving from dirty or soiled items to clean items and after each glove removal. This will help minimize risk of spreading bacteria. When interviewed on 9/12/24 at 11:41 a.m., the Director of Nursing (DON) expected staff to perform hand hygiene and exchange gloves when moving from dirty or soiled items to clean items and after any glove removal. Staff were also expected to follow the signage on the doors and wear all the required personal protective equipment every time entering a room for residents on TBP. A facility policy titled COVID-19 revised 8/2023, directed staff to implement TBP when caring for a resident with COVID-19. Staff who enter the room should wear a N-95 mask, gown, gloves and eye protection that covers the front and sides of face. A facility policy titled Infection Control Hand Hygiene dated 2020, directed staff to perform hand hygiene after contact with visibly soiled items, and after removing gloves.