STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catholic Eldercare on Main	817 Main Street Northeast Minneapolis, MN 55413

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation and interview, the facility failed to promote a dignified home-like environment during dining services in 4 of 6 dining rooms reviewed. Finding include: R48's significant change Minimum Data Set (MDS) assessment, dated 8/24/24, indicated R48 had intact cognition with no hallucinations or delusions with an admitted [DATE]. During observation on 10/14/24 at 5:08 p.m., on 2nd floor main dining room residents were seated and had been served their meals. It was observed each resident had a hard plastic tray in front of them which contained a plate of food that was sitting on a plate warmer. The drinks (which ranged from juice to coffee to milk) were also placed on the hard plastic tray along with the silverware. In the middle of the table were hard plastic dome shaped lids (which would have been used to cover the food plates). At 5:12 p.m., a staff member walked up to a resident who was sitting with her head down and prompted her to eat. During observation on 10/14/24 at 5:14 p.m., on 2nd floors smaller dining room, it was observed all residents had been served their meals. One unidentified staff member was seated assisting a resident to eat. It was observed that each resident had a hard plastic tray in front of them which contained a plate of food that was sitting on a plate warmer. The drinks (which ranged from juice to coffee to milk) were also placed on the hard plastic tray along with the silverware. In the middle of the table were hard plastic dome shaped lids, upside down, with disposable plastic lids that had been used to cover the soup bowls and drinks. On 10/15/24 at 11:50 a.m., it was observed that staff were starting to serve resident meals. The staff would take the meals from a lunch cart which was an enclosed cart on wheels with slots, that held hard plastic trays that contained resident meals. The hard plastic trays each contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with a plastic lid and the silverware on the tray was rolled in a napkin. At 11:53 a.m., all residents in the dining room had been served their meal. Each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 12:10 p.m., the dining cart was delivered to the 2nd floor small dining room by dietary aid. The dining cart was an enclosed cart on wheels with slots, that held hard plastic trays that contained resident meals. The cart had a few trays sitting on the top of the cart. The hard plastic trays (both inside and on the top of the cart) contained a paper slip that identified who the meal was intended for, a plate of food that was sitting on a plate warmer and was covered with a hard plastic dome shaped lid. The drinks were covered with a plastic lid and the silverware on the tray was rolled in a napkin. At 12:13 p.m., the first tray was served to a resident. At 12:17 p.m., a dietary aid delivered another dining cart to the floor that contained 5 more trays. At 12:19 p.m., all residents in the dining room have been served. Each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. On 10/16/2024 at 11:46 a.m., the dining cart was delivered to the 2nd floor main dining room. The dining cart observed appeared the same as previous observations. Staff, including administrator, served meals to residents. At 11:51 a.m., all residents in the dining room were served their meal. As previous meals observed, each resident had a hard plastic tray in front them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. On 10/16/2024 12:03 p.m., staff were serving trays to residents in the 2nd floor smaller dining room. Residents had a hard plastic tray in front of them which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. During observation on 10/17/24 at 12:15 p.m., on 1st floor dining room, residents were observed to be eating lunch. Each resident had a hard plastic tray in front them of which contained a plate that sat on a plate warmer, drinks and silverware. The hard plastic dome shaped lids, that were once covering the plates, sat in the middle of the tables and contained the disposable plastic lids that once covered the drinks. During interview on 10/16/24 at 10:39 a.m., R48 stated she has thought of ways to make it feel more like home here, but they don't listen, and further stated, we are in a nursing home. R48 stated she eats her meals in the dining room. R48 indicated she feels that it is probably easier for staff to serve the meals on the trays and indicated this is not her preference. On 10/16/2024 at 1:07 p.m., registered nurse (RN)-D indicated they don't know why the meals in the dining rooms are served on the plastic trays. RN-D indicated there is not really a reason. On 10/16/2024 at 12:48 p.m., when asked about serving resident meals in the dining rooms on the hard plastic trays, administrator indicated no rational for this. Administrator verified this is how all meals are served except on 3rd floor. On 10/17/24 at 12:57 p.m., director of nursing (DON) stated, that will be a dietary question, when asked about serving resident meals on hard plastic trays and declined to further comment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy, Serving Meals and Feeding the Resident, revision date 7/21/16, was provided. The policy lacked indication on how the facility would promote a dignified home-like environment during dining services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure appropriate wheelchair foot supports were provided or, if needed, therapy consulted to promote adequate wheelchair positioning to avoid complication (i.e., pain, edema) for 1 of 1 resident (R51); failed to ensure proactive skin interventions were consistently implemented to reduce the risk of skin tears or bruising for 1 of 1 resident (R110); and failed to assess and revise an insulin administration schedule to promote acceptable diabetes management and improve blood glucose levels for 1 of 1 resident (R161) reviewed for dialysis and who missed multiple doses of insulin related to scheduled dialysis treatments. Findings include: WHEELCHAIR POSITIONING: R51's quarterly Minimum Data Set (MDS), dated [DATE], identified R51 had severe cognitive impairment and demonstrated no rejection of care behaviors during the review period. Further, the MDS outlined R51 had no range of motion limitations in her upper or lower extremities, used a wheelchair for a mobility device, and was dependent on staff for nearly all mobility-related activities (i.e., transfers, bed mobility). On 10/14/24 at 12:37 p.m., R51 was observed seated in a high-back, tilted wheelchair in the hallway on her unit. R51 extended her hand to shake the surveyor' hand and did not verbally respond aloud when asked her name. R51's body was seated upright in the wheelchair, however, there were no attached pedals or platform on the wheelchair and, as a result, her feet dangled downward without touching the floor. Later, on 10/14/24 at 4:47 p.m., R51 was again observed in the same wheelchair while in the dining room waiting for the supper meal. R51 continued to not have any pedals or platform attached to the wheelchair and, again, her feet dangled downward without being able to reach the floor. R51's care plan, dated 6/2023, identified R51 had impaired mobility due to left hip pain, weakness and variable understanding of directions and behaviors. The care plan identified R51 was non-ambulatory and used a Broda wheelchair adding, WHEELCHAIR: total assist of one around obstacles and to get to all destinations. The care plan lacked rationale or instruction on R51's lack of wheelchair pedals or platform. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following day, on 10/15/24 at 8:56 a.m., R51 was again observed seated in the tilted wheelchair while at a small table in the breakfast area. R51 continued to not have any pedals or platforms in place on the chair causing her feet to be unsupported and dangle downward. Later on 10/15/24 at 11:40 a.m., R51 was seated in her same wheelchair in the dining room but now had bilateral foot pedals attached and in place. However, R51's legs were crossed and her feet were positioning behind the affixed pedals dangling downward again. R51 was assisted with eating the noon meal by nursing assistant (NA)-B with no attempts to place R51's feet back onto the pedals observed. When interviewed on 10/15/24 at 12:32 p.m., NA-B stated R51 needed help with eating and most cares. NA-B stated they did not help R51 with morning cares that day and directed the surveyor to NA-C as they were assigned her care. NA-B stated they were unsure if R51 typically used foot pedals or a platform on their wheelchair adding, I wouldn't be able to go into detail like that. NA-B stated they were unsure if there was a reason or rationale why R51 couldn't use pedals and reiterated aloud, I'm not too sure. When interviewed on 10/15/24 at 12:43 p.m., NA-C stated they often worked with R51 and described her as needing whole help with cares. NA-C stated R51 had used the tilting one wheelchair for awhile and expressed she is supposed to use pedals at all times. NA-C stated they did not place the pedals on the wheelchair when they got R51 up and added, Must be my nurse [who did]. NA-C stated placing the pedals must have skipped from the memory adding further, She's supposed to have them on. However, NA-C stated R51 seemed to be just letting her feet dangle behind the pedals and not actually use them more in the past months. NA-C stated R51 used to be on hospice care but was removed from it a few months ago now adding therapy had, at one time, worked with R51 on her wheelchair positioning but it had been a long time ago. NA-C stated they had never reported R51's dangling feet but felt the nurses were aware of R51 dangling her feet more and not using the pedals adding, I think they see it. R51's most recent therapy note, dated 1/22/24, identified R51 was seen by occupational therapy (OT) with dictation, Per RN, resident to be d/cing [discharged] from hospice. Therapy provided 16 tilt-in-space [wheelchair] with standard foam cushion. Therapy to remain available for further needs. The note was authored by certified occupational therapy assistant (COTA)-A. However, R51's medical record was reviewed and lacked evidence therapy had been consulted or R51 had been assessed for wheelchair positioning despite direct care staff seeing R51 not use the provided foot pedals causing her legs to dangle unsupported. On 10/15/24 at 12:55 p.m., COTA-A was interviewed, and verified they are available to see patients in the long-term care units. COTA-A explained therapy places a note into the EMR when patient's are seen, including for wheelchair positioning, and reviewed R51's medical record. COTA-A verified they gave R51 the tilt-in-space wheelchair back in January 2024 and expressed pedals would have been provided at the same time adding, It comes with cushion and foot rest. COTA-A stated if R51's legs were now dangling and not being supported on the pedals, then perhaps a calf pad or rest could be used adding, I can go approach them [nursing] and see if that will work. COTA-A stated they could not recall anyone from nursing reaching out to them about R51's wheelchair positioning and verified if concerns were seen, such as unsupported feet or legs, then someone should consult therapy adding legs left dangling or unsupported could be a safety issue. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 10/15/24 at 2:30 p.m., registered nurse unit manager (RN)-A verified they had reviewed R51's medical record. RN-A explained R51 had been on hospice care prior and they were aware R51 often crossed their legs while seated in the wheelchair, however, they had just then contacted therapy about possibly getting a smaller wheelchair so R51's feet could a a little closer to the ground and better supported. RN-A stated they were unsure why staff had not been using the supplied pedals for R51's chair, as observed on 10/14 and 10/15, and verified the pedals should have been attached so in case [R51] gets tired and want to put your feet down to rest. RN-A stated none of the nursing staff had reported concerns to them about R51's feet often being behind the pedals, when attached, and unsupported and expressed, They [staff] should say something. RN-A verified R51's feet should not be left dangling and unsupported while seated in the wheelchair adding, We agree on that. A facility' policy on wheelchair positioning was requested, however, none was received. SKIN PROTECTION: R110's quarterly Minimum Data Set (MDS), dated [DATE], identified R110 had severe cognitive impairment and demonstrated no rejection of care behaviors. R110's Physician Order Report, dated 9/16/24 to 10/16/24, identified R110's medical conditions along with both her current physician and nursing orders for care. This identified R110 had a history of vitamin deficiency and cellulitis (soft tissue swelling) to the left hand. R110's orders, including both physician orders and nursing orders, were listed with their respective start and, if applicable, stop dates. This included, RISK FOR SKIN INJURY: Bilateral protectors on at all times . Every Shift; Nights, Days, Evenings. The order had a start date listed, 05/13/2021 - Open Ended. On 10/14/24 at 12:34 p.m., R110 was observed seated in wide-back wheelchair by the doorway on the unit with a stuffed animal in her hands. R110 was asked her name and responded aloud, I don't know. R110 hands along with the lower part of her arms and wrists were visible, and her right hand had light brown-colored discoloration present on top of the hand. R110 did not have any visible cloth or other protectors on her arms or hands at this time. On 10/14/24 at 1:15 p.m., R110's family member (FM)-D was interviewed. FM-D stated R110 had poor cognition and often would get bruises on her hands. FM-D stated R110, at times, would have cloth-type protectors on her arms and hands but others times not adding, Sometimes [they] have them on. FM-D stated they believed maybe they were only used when bruises were noticed but was not sure. FM-D stated R110 seemed to bruise pretty easy though. Later on 10/14/24, at 4:52 p.m., R110 was again observed seated in her wheelchair. R110 was placed next to the dining room table and, again, had no visible protectors (i.e., geri-sleeves) on her hands or arms at this time. When observed on 10/15/24 at 11:39 a.m., R110 was again seated at the dining room table in her wheelchair. R110 did not have any visible protectors on her hands or lower arms at this time. R110's skin care plan, dated 3/15/24, identified R110 was at risk for skin breakdown due to limited mobility, moisture exposure and cognitive impairment. The plan listed several interventions for R110 including use of a ROHO cushion in her wheelchair, daily skin checks by the nursing assistant (NA) staff, and elevating her heels off the bed surface. However, the care plan lacked direction or guidance on the ordered protectors. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R110's Treatment Administration History (TAR), dated 10/2024, identified R110's physician and nursing orders along with spaces for staff to record their administration or refusal via initial. The TAR outlined an order which read, RISK FOR SKIN INJURY: Bilateral protectors on at all times, along with a frequency listed, Every Shift. The order was signed off every day within the month period so far as being completed (despite R110 being observed without them on for multiple days). On 10/16/24 at 9:14 a.m., R110 was again observed seated in her wheelchair while at the table. R110's hair was wetted and combed and she was dressed in a long sleeved shirt, however, her hands were visible and both had a tan-colored, cloth protector in place covering the hand' skin. When interviewed on 10/16/24 at 9:21 a.m., NA-D stated they were assigned to R110 and helped her with morning cares. NA-D stated R110 wore geri-sleeves on her hands and arms which were used to protect her skin adding R110 had a couple pairs of them in her room for staff to use. NA-D verified they placed the sleeves on R110 that morning and expressed aloud, She's supposed to have them [on] all the time. NA-D stated application of them was on her care card and the NA staff should be doing it. Further, NA-D reiterated R110 should be using the geri-sleeves at all times as R110 did, at times, get bruises on her hands adding, Yea, sometimes she does. R110's medical record was reviewed and lacked evidence why R110's ordered skin protectors (i.e., geri-sleeves) had not been used as observed on 10/14/24 and 10/15/24. On 10/16/24 at 10:40 a.m., registered nurse unit manager (RN)-A was interviewed. RN-A stated the skin protectors for R110 were there as just like an extra layer of skin and verified the cloth-type protectors seen on R110 that day (10/16/24) are what the provider order referenced adding they were an extra layer of protection. RN-A stated R110 used to be more mobile and would obtain cuts and bruises on her hands which is why they were added. RN-A stated they expected them to be on R110 as ordered or care planned adding, The care plan should be followed. A facility' policy on non-pressure skin management was requested, however, none was received. 47495 DIABETES MANAGEMENT: R161's significant change Minimum Data Set (MDS), dated [DATE], indicated R161 was admitted to the care facility on 8/14/24, was cognitively intact and required supervision for activities of daily living (ADLs). R161's Facesheet, printed 10/17/24, indicated R161 was admitted to the care facility with multiple diagnoses including end stage renal disease and type 2 diabetes mellitus with ketoacidosis (a serious complication of diabetes.) R161's Order History, dated 10/15/24, indicated R161 had an order for Novolog U-100 insulin aspart solution; 100 units per milliliter (ml), administered per sliding scale (amount administered based on current blood glucose reading) three times a day before meals at 8:00 a.m., 12:00 p.m., and 4:00 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R161's care plan, dated 8/29/24, indicated R161 went to dialysis on Mondays, Wednesdays and Fridays with a start time of 11:30 a.m. The care plan further directed staff to monitor/record/report blood glucose per facility schedule and policy and MD [doctor] order. R161's admission provider note, dated 9/5/24, indicated R161 was hospitalized [DATE] - 8/14/24 for diabetic ketoacidosis (a life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to allow blood sugar into cells for energy.) The provider note further indicated R161 was hospitalized a second time on 8/23/24 - 8/31/24 for dialysis initiated due to renal failure. R161's medication administration record (MAR), dated 10/1/24 - 10/15/24, indicated R161 did not receive her noon dose of Novolog insulin on 10 out of 15 days in October, including Mondays, Wednesdays, and Fridays when out at dialysis. The MAR further indicated that R161's blood glucose level was over 200 19 times from 10/1/24 - 10/15/24. During an interview on 10/14/24 at 1:02 p.m., R161 stated she had concerns about the management of her diabetes and blood glucose levels. R161 stated she left the facility around 10:20 a.m., on Mondays, Wednesdays and Fridays for dialysis and took a bag lunch with her but no medications, voicing a concern for missing her noon administration of insulin. During a follow up interview on 10/16/24 at 9:38 a.m., R161 again voiced concerns about her elevated blood glucose levels, stating she needed to keep her blood glucose levels below 200 because she needed surgery for a dialysis fistula, but would be unable to until for hemoglobin A1C (a blood test that measures a person's average blood sugar levels over the past two to three months) dropped from 10% to 8.5%. During an interview on 10/16/24 t 9:16 a.m., registered nurse (RN)-H stated R161 went to dialysis three times a week on Mondays, Wednesdays, and Fridays, and while she was out a dialysis she would not get her 12:00 p.m. blood glucose check and insulin administration if needed. RN-H stated he had not updated R161's provider about her missing the 12:00 p.m. blood glucose check and insulin administration because they could check her blood glucose when she returned (at approximately 4:00 p.m.) and R161 was able to voice her preferences. RN-H stated he did not have any concerns with R161's blood glucose lately, noting the provider would be notified if her blood glucose was above 400 per R161's insulin order. During a follow up interview on 10/16/24 at 11:20 a.m., RN-H stated he had spoke with R161's provider that morning and her insulin administration schedule had been adjusted to accommodate her scheduled dialysis. New blood glucose checks and sliding scale insulin administration times were changed to 6:00 a.m., 10:00 a.m., and 5:00 p.m. During an interview on 10/16/24 t 1:25 p.m., R161's dialysis nurse (DN) stated R161 had voiced concerns to her about her unmanaged blood glucose levels. The DN stated R161 had had really high fluid gains and unmanaged blood glucose levels could have a tremendous affect on her fluid gains and the effects of her dialysis. During an interview on 10/17/24 at 9:58 a.m., R161 stated she had not been told about the change in her insulin administration schedule, stating, Oh, good, that will help so much! (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 47495 Based on observation, interview and document review, the facility failed to comprehensively reassess and, if needed, develop interventions with unsupervised eating to reduce the risk of accidental choking or asphyxiation for 1 of 1 resident (R67) who ate unsupervised in their room and had two documented episodes of choking. This constituted an immediate jeopardy (IJ) situation for R67. The IJ began on 9/14/24 when R67 choked for a second time on oral food, and the facility failed to comprehensively reassess R67's risk of choking, implement any interventions for increased supervision while eating or safe swallowing (i.e., speech therapy), or reeducate R67 and her responsible party on the risks of choking if R67 remained eating unsupervised as she had been despite choking. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 10/17/24 at 4:09 p.m. The IJ was removed on 10/18/24, but noncompliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level D). In addition, based on observation, interview and document review, the facility failed to comprehensively assess for fall risk upon admission and with subsequent, repeated falls to determine what, if any, interventions were needed to ensure safety and reduce the risk of injury for 1 of 3 residents (R107) reviewed for accidents. R107 sustained actual harm when they fell multiple times after admission obtaining a head laceration and fracture hip. However, the facility had implemented corrective measures prior to the onsite survey, so these findings (falls) are being issued as past noncompliance. Findings include: CHOKING: R67's quarterly Minimum Data Set, dated dated [DATE], indicated R67 was admitted to the care facility on 12/9/22, had severe cognitive impairment, no swallowing problems and required partial to moderate assistance with eating and oral care. The MDS further indicated R67 was receiving hospice care. R67's facesheet, printed 10/17/24, indicated R67 had several medical diagnoses including dementia with behavioral disturbances, hemiplegia and hemiparesis following cerebral infarction (stroke), and dysphagia (difficulty swallowing) following cerebral infarction. R67's Orders, printed 10/17/24, indicated R67's diet order was mechanical soft, dated 3/23/24. R67's Progress notes, dated 3/4/24 through 10/17/24, indicated R67 had two choking episodes requiring staff intervention on 3/12/24 and 9/14/24. On 3/12/24 it was documented R67 was found in her room in a semi-Fowlers position, mouth wide open, not talking, trying to cough but couldn't. R67 required the Heimlich maneuver when finally a[n] object jumped out which was a piece of toast. The documented response was diet changed to mechanical soft with choking precautions for residents safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/12/24 it was documented the licensed dietician (LD) met with R67 who did not want to stop eating toast, however it was discussed cutting toast and other foods into small pieces, and alternating food and fluids. Also discussed cutting the crust off the bread. On 9/14/24 it was documented R67 was out in the small dining area when she was noted to be holding her neck and struggling to breathe when staff managed to get the food out that was stuck in resident throat. Approximately 20-30 minutes later, R67 became unresponsive for 5-10 minutes. On 9/16/24 it was documented R67 was visited by speech therapy, however a bedside ST [speech therapy] eval[evaluation] not completed d/t [due to] resident's active hospice status. OK for nursing staff to downgrade solids and liquids as needed for safety. R67's Associated Clinic of Psychology note, dated 3/13/24, indicated it was discussed with R67 that she could continue to eat preferred foods such as toast with a staff member present in her room, however lacked any discussion of the risks of choking or asphyxiation with R67 and her responsible party if R67 continued to eat unsupervised. R67's Care Plan, dated 3/13/24, indicated R67 was at risk for choking resident has no upper teeth, root tips on lower and had Dx [diagnosis)] = dementia, psychosis Res [resident] declines to get up for meals - eat in bed, declines staff sitting in room during meals ok'd [okayed] supervision. Risks and benefits discussed. A dcoument labeled, Approaches, also dated 3/13/24, indicated for staff to check R67's vital signs and lung sounds for 48 hours after a choking episode, to notify family, hospice and R67's nurse practitioner with significant changes, to check on R67 frequently throughout mealtime to ensure R67 is safe and free from choking, and to position R67 in a 90 degree position for each meal. The Care Plan lacked any clarity on what frequently meant or how often it would be expected for staff to check on R67. The Care Plan further lacked any updates after R67 second choking episode on 9/14/24. R67's electronic medical record (EMR) lacked documented evidence a discussion of the risks and benefits of R67 continuing to eat toast and a mechanical soft diet, unsupervised, after a second choking episode was discussed with R67 and her responsible party. R67's EMR further lacked a comprehensive reassessment and if warranted care plan updates were completed after R67's second choking episode. During observation on 10/14/24 at 5:34 p.m., R67 was sitting up in bed, unsupervised, with an over the bed table across her lap with her dinner set up. On her plate was two slider sized buns with sliced meat and multiple tator tots, not cut into small pieces. R67 was alone in her room with staff present in the main dining room area assisting other residents with dinner. During observation and interview on 10/16/24 at 10:16 a.m., nursing assistant (NA)-C brought R67 peanut butter and jelly toast, stating because it was R67's favorite. R67 was sat up in bed and NA-C left the room. During an interview on 10/16/24 at 11:41 a.m., NA-C stated he was aware of R67's choking episode but had been off that day, stating she had choked on a piece of toast. NA-C stated that despite R67 choking on toast, it didn't happen very often so R67 was still given toast to eat unsupervised in her room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/16/24 at 12:05 p.m., speech therapist (ST)-A confirmed she was aware of R67's choking episodes but did not do an evaluation of R67's swallowing on 9/16/24 because she was on hospice, stating if she was not on hospice her choking episode would have warranted a full evaluation. ST-A stated R67 remained on a mechanical soft diet after her choking episode, and it was recommended for the nursing staff to downgrade [R67's] diet [to puree] as needed. During an interview on 10/17/24 at 7:55 a.m., social worker (SW)-A stated she recalled R67's choking episodes back in March but did not remember anything about R67 choking last month. SW-A stated she remembered having a conversation with nurse manager and registered nurse (RN)-A after R67's choking episode back in March and being told they should be offering R67 whatever brings her joy. SW-A confirmed R67 was not evaluated by speech therapy back in March after her first choking episode or last month after her second choking episode, nor by the dietician after her most recent choking episode and was unable to find any documented evidence of a risk versus benefit being competed with R67 for her responsible party regarding offering food choices to R67 that would bring her joy versus safety or what those safer food options would be. During an interview on 10/17/24 at 8:04 a.m., registered nurse (RN)-I stated it was a standing order for all residents that nursing staff could downgrade their diet if needed, meaning if a resident was coughing a lot while eating or drinking, they could downgrade their diet to mechanical soft or puree. RN-I stated they would change the diet and follow up with the doctor. During an interview on 10/17/24 at 2:06 p.m., RN-I stated when R67 was eating in her room, staff would try to check on her every 15-20 minutes. During an interview on 10/17/24 at 2:30 p.m., NA-E stated R67 was independent with eating after she was set up and stated staff would check back every 20-30 minutes to see how well she was eating. NA-E stated R67 loved eating toast for breakfast and was unaware of any choking episodes or problems R67 had with chewing or swallowing, again stating she was independent with eating. NA-E stated each resident had a care sheet hanging in their closet to explain what type of diet they were on and how they transfer and other cares however R67's was missing. During an interview on 10/17/24 at 8:44 a.m., RN-A stated there was a standing order for all residents that nursing staff can downgrade a diet if a resident was coughing, having difficult chewing, or choking on their food, stating nursing staff could change the diet and they would have speech therapy follow up and evaluate. RN-A stated R67 had coughing episodes, stating, I would not really call them choking episodes however agreed that requiring the Heimlich Maneuver and struggling to breathe would be considered a choking incident. RN-A stated after R67 required the Heimlich Maneuver back in March they attempted to change R67's diet to puree but she refused to eat stating they settled on a mechanical soft diet. RN-A stated her goal would be to have R67 out of bed for every meal, but she often refuses to get up and will often refuse to eat if a staff member is in the room with her, stating R67 will eat when she is ready. RN-A stated staff had been educated to ensure R67's head of bed was elevated when she was eating, as much as she [R67] will let us. RN-A stated she had talked with R67's responsible party at her last care conference on 9/11/24 (three days before her second choking episode). RN-A confirmed there was no documented risk versus benefits, no comprehensive reassessment of R67 after her second choking episode, and no changes to her care plan despite current interventions not preventing a second choking episode. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/17/24 at 8:11 a.m., R67's hospice nurse (HN) stated she was on call when R67 choked last month stating she received a call that R67 choked on a piece of bread and stated R67 didn't require the Heimlich Maneuver but at one point couldn't breathe and went into a state of unresponsiveness. HN stated the day after the choking incident R67 did not eat or take any of her medications, stating I think she was afraid to choke again. The HN stated because it was an isolated event and R67 was on hospice, a speech evaluation was not done and further stated at a care conference back in March they had discussed R67's diet and the risks associated with it but had not discussed it since her most recent choking episode. During an interview on 10/17/24 at 11:53 a.m., the director of nursing (DON) stated he could not recall R67's choking incident which happened last month and stated he would have expected the dietician to be involved, hospice to be notified and a speech therapy evaluation to be completed, even with R67 on hospice, confirming the dietician did not evaluation R67 nor was a speech therapy evaluation done after the choking episode in September. The DON further stated he would have expected a comprehensive assessment of what R67 would be willing to do/eat and what she wouldn't, along with the risk associated, and stated this should all have been documented in the EMR. The DON further stated he would have expected for a new plan to be developed since the current interventions in place did not prevent a second choking episode. During an interview on 10/17/24 at 12:08 p.m., R67's responsible party and family member (FM)-A stated she was not aware that R67 was still eating toast for breakfast and thought R67 was on a pureed diet. FM-A stated, I guess she can't have toast anymore and they would have to determine what else R67 would be willing to eat for breakfast. FM-A stated she did not believe that R67 would logically be able to make the decision on her own regarding the risks versus benefits of continuing to eat toast and other non-pureed foods. FM-A further confirmed the risks of potentially choking to death were not discussed with her and while she acknowledged R67 was on hospice she did not want her to die in a horrific manner from choking. During a follow-up interview on 10/17/24 at 2:35 p.m., nurse manager and RN-A stated they had tried cutting up R67's toast and cutting the crust off per the dietician's March note but R67 would not eat it that way. RN-A stated there was not a time frame for how often to check on R67 when she was eating, and stated she tires easily when she eats so staff were not sure when she would be eating or sleeping. RN-A further stated they had not documented the attempts to cut R67's crust off her toast and she had not discussed the choking episodes with R67's provider but believed the floor nurses had updated the provider. During an interview on 10/18/24 at 10:55 a.m., the medical director (MD) stated he was not made aware of R67's choking episodes until today. The medical director stated he would have advised to change her diet to puree and recommended that she eat in a supervised environment, even with a pureed diet, stating it was an issue with personal preference but also safety. The MD Further stated there was no reason R67 could not have a speech therapy evaluation. The immediate jeopardy that began on 9/14/24, was removed on 10/18/24, when the facility comprehensively reassessed R67, changed her diet to puree, documented discussing the risks of eating unsupervised with R67's responsible party, and educated staff on the care plan changes for R67, but the noncompliance remained at the lower scope and severity because of the continued risk for potential harm with R67 continuing to eat unsupervised. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	33925 FALLS (past noncompliance): R107's admission Minimum Data Set (MDS), dated [DATE], identified R107 admitted to the care center from the acute hospital. The MDS outlined R107 had severe cognitive impairment, demonstrated no physical or verbal behaviors, and had no rejection of care episodes. The MDS continued and listed a section labeled, Section J - Health Conditions, which identified R107 did not have a terminal prognosis along with several questions related to R107's fall history (i.e., falls in the month(s) prior to admission), however, these were all answered with, 9. Unable to determine. However, after admission to the care center, the MDS recorded R107 had sustained one fall without injury. The MDS corresponding CAA (Care Area Assessment) Summary Report, completed 8/1/24, identified the various triggered CAAs for R107 which included one labeled, CAA 11. Falls. This identified R107 was at risk for falls related to impaired cognition, pain, and impaired mobility. The CAA recorded, One fall during look back without injuries with a matt [sic] placed on the floor next to his bed when he is in bed for safety/injuries. Receives supervision assist with bed mobility, toileting, and transfers currently in therapy, plan is for short term care per wife . Staff to place call light within his reach at all times when in his room and encourage him to use. Fall risk assessments per facility protocol. The CAA directed care planning would be completed adding, Proceed to care planning for fall and injury prevention. On 10/14/24 at 1:50 p.m., R107 was observed seated in a standard wheelchair in the commons area of the locked unit (i.e., memory care) with good posture and no leaning or slouching. R107 had a tan-colored bandage on his right hand and stated he had scratched it but was unsure how. R107 was unable to recall how long he had been at the care center and abruptly replied, I don't live here. R107 stated he was unsure what, if any, lunch meal they had that day, either. R107's current care plan, dated 8/26/24, identified R107's assessed problems, respective goals, and subsequent interventions to meet those goals. A total of three sections were labeled, Category: FALLS, and each outlined R107's various rationale for fall risk including but not limited to a history of falling, gait/balance problems, self-transfer attempts. All these sections were recorded as still in effect (i.e., not resolved) and these problem statements and interventions in chronological order outlined: Problem Start Date: 07/20/2024, outlined R107 as being at risk for falls and was last edited on 10/1/24, and a goal was listed which read, Will remain free from falls and fall-related injuries, with a goal date recorded, 11/21/2025. The section included multiple interventions to help R107 meet the goal including staff to do hourly well-checks to ensure safety, offer toileting or food if persistently self-transferring, and a low bed for safety. However, all the interventions listed within this section listed a start date of 8/21/24 or later. The problem statement and interventions were all initiated by registered nurse unit manager (RN)-A. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Problem Start Date: 07/22/2024, outlined R107 as being at risk for falls and was last edited on 7/22/24, and a goal was listed which read, Will remain free from falls and fall-related injuries, with a goal date recorded, 10/22/2025. The section included multiple interventions to help R107 meet the goal including pharmacy consults per protocol, promoting scheduled rest periods, reinforcement to request assistance, not leaving unattended while in the bathroom, safety checks on shoes, monitoring for foot pain, ensuring proper lighting, providing non-skid material in the wheelchair and, When falls occur investigate root cause through IDT [interdisciplinary team] meeting protocol, and, When falls occur nursing to monitor using CEOM [Catholic Eldercare on Main] fall protocol. All the interventions listed had a start date recorded, 07/22/2024. R107's progress note, dated 7/19/24, identified R107 admitted to the care center locked unit on 7/19/24 for long term care placement. R107 was recorded as having a history of alcohol-induced dementia, chronic obstructive pulmonary disease (COPD), and prior stroke. The note outlined, Resident alert, memory is impaired with poor insight and judgement . has Foley Catheter . He is totally dependent on staff for ADL including dressing, grooming, bathing, and transferring. A subsequent note, dated 7/21/24, identified R107 was alert with impaired memory and poor insight. The note added, He attempt to self transfer with out adequate or calling for help [sic]. He is easy to redirect . is totally dependent on staff for ADL . Later, on 7/21/24, another note identified a bed rail was added to his bed to promote increased independence with mobility adding, Bed rail necessary for use as mobility device, and Nurse manager updated. On 7/22/24, the notes outlined R107's Foley catheter was removed, and routine bladder scans were started. On 7/23/24, R107 was found with bloody urine adding, When this writer arrived patient was standing in the middle of his room, urinating and his urine and mixed [sic] with large amount of blood. VS WNL [vital signs stable] . Further, another progress note, dated 7/24/24, was recorded with R107 now being COVID-19 positive with symptoms of nasal drainage and emesis. R107's 'SBAR [situation, background, assessment, response]' progress note, dated 7/26/24 at 5:36 p.m., identified R107 sustained a fall without injury. The note outlined, [nursing assistant] approached this staff at [3:00 p.m.] to say pt [patient] was on the floor in his room. This staff found pt laying on the floor near his bed. Pt denied pain. This staff noted that pt didn't have one of his gripper socks on . stated that he was self-transferring. Neuro's intact X1, ROM [range of motion] X4 . R [response]: This staff informed the Evening Supervisor, the Nurse Triage line, the POA [power of attorney]. This staff placed a floor mat in pt's room next to pt's bed. This staff updated pt's care plan to the fall. R107's corresponding Event Report, dated 7/26/24 but closed 8/21/24, identified R107 had sustained a fall without injury in his room adding, Pt found on the floor near his bed by the NAR. R107 was recorded as lying in bed just prior to the fall and the fall itself was unwitnessed. R107 demonstrated no pain from the fall and the section provided to record what, if any, injury was obtained answered, N/A. A section labeled, Possible Contributing Factors, identified R107's impaired cognition and infection (COVID-19) with a checkmark placed next to each, respectively. R107 was recorded as being on an antibiotic and a subsequent section was labeled, Interventions - Immediate measures taken, which had a checkmark placed next to, Rest, and Other - Floor mat to floor next to bed. The report included multiple follow-up progress notes which outlined R107 was at baseline. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	However, R107's medical record lacked recorded evidence the IDT had reviewed this incident or what, if any, interventions aside from a mat on the floor were considered or implemented. Further, the record lacked any completed comprehensive fall evaluations or assessments upon admission to the care center (on 7/19/24), including with all potential risk factors and what, if any, immediate interventions were assessed as needed despite R107 being recorded in the progress notes as having cognitive impairment with poor insight, needing total assistance with ADLs, and being found standing up in the middle of the room after his Foley catheter was removed (i.e., self-transfer). R107's SBAR progress note, dated 8/19/24 at 6:54 p.m., identified R107 sustained an unwitnessed fall with injury. The note outlined, . was found in room on the floor with his wheel chair upside down. He had a cut over his left eye and blood on the floor. Resident was assessed and transferred to chair, pressure applied to site and bleeding stopped . ROM is intact, he was able to move all extremities, a neuro assessment and vitals started. Resident spouse was notified and along with [medical provider]. There was no corresponding Event Report for this incident identified in the medical record. A series of subsequent progress notes, dated 8/20/24 through 8/23/24, reiterated the fall had occurred along with nearly all of them having outlined R107 had returned to baseline, and with a dressing in place over his left eye now adding a purple discoloration was present, too. However, a note dated 8/21/24 at 4:44 p.m., had R107 recorded as having some delusional thinking. The note outlined, . pt wanted this staff to close the garage door and get his wife. However, again, R107's medical record lacked documented evidence the IDT had reviewed this incident for any root-cause analysis review nor what, if any, other interventions were considered or implemented by the IDT. Further, the medical record continued to lack any completed comprehensive fall evaluations or assessments despite R107 having sustained two falls and demonstrating delusional thinking during similar evening hours (i.e., 4:00 to 7:00 p.m.). There was no evidence documented to provide rationale for what, if any, comprehensive causative factors were considered or evaluated to ensure effective, proactive interventions to reduce his fall risk despite the care plan being updated on 8/21/24 with interventions (i.e., low bed) which were not documented as being a factor in the progress note about the fall with injury. R107's SBAR progress note, dated 8/26/24 at 5:30 a.m., identified R107 sustained a fall due to self-transferring. The note outlined, Resident was found on the floor when aide notified nurse around 0523 when he was being check on [sic]. Resident was found in the supine position at the foot of his bed . incontinent of bowel; and bladder when he was found . bed was in lowest position when he was found on the floor with w/c [wheelchair] in the middle of the room . showed no signs of having pain at the time . was resistive to care at the time he was being assisted . Will report to AM staff to notify [medical provider], family, and continue to monitor. However, a subsequent note dated 8/26/24 at 7:10 a.m. (little over 90 minutes later), identified R107 was found sitting up in bed at 0640 and complaining of right hip pain. The note outlined, . [R107] had grimacing on his face and notified staff his right hip/side is in excruciating pain . complained of pain to touch and with ROM on his right hip . cognition is impaired with primary DX [diagnosis] of dementia and history of fall. The note identified the medical provider was updated, and an order for pain medication and an x-ray obtained. A subsequent note, dated 8/26/24 at 2:38 p.m., identified R107 was being transferred to the hospital with . Right femoral intertrochanteric fracture possibly post fall. A subsequent note, also dated 8/26/24, identified R107 had dementia adding, Pt has a dx of Dementia and fell today this am, fracturing his right femur . Pt's [family] talked with MD at the hospital and plans on pt having surgery to fix his right femur. R107 was readmitted to the care center from the hospital on 8/30/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R107's corresponding North Memorial Health Admission History and Physical, dated 8/26/24, identified R107 who presented to the hospital . after an unwitnessed fall with right hip pain, found to have a hip fracture. He has bruising scattered throughout his body but only c/o [complains] pain in his right leg. Denies other concerns, though he is not oriented. A series of imaging was obtained, including an x-ray of the femur, which identified, Acute fracture of the proximal femur. R107 was recorded as preparing for surgery intervention to preserve quality of life and needed to be hospitalized for surgical management. R107's John Hopkins Fall Risk Assessment Tool, dated 8/31/24, was completed after R107 returned from the hospital and included multiple questions answered to help determine a risk-based score for falls such as previous number of falls and changes in condition. This assessment tool scored R107 as 23.0 which outlined, High Fall Risk. This evaluation was the first one completed as identified within the medical record. When interviewed on 10/16/24 at 1:21 p.m., NA-D stated they had worked with R107 multiple times at the care center and described him as needing total assist with cares. NA-D stated staff often have to use encouragement to get him to allow cares and verified R107 was no longer ambulatory since he fractured his femur adding, He used to [walk[but not anymore. NA-D stated staff tried to just keep checking on him often since he returned from the hospital, and explained R107 used to try to self-transfer more often which caused his falls. NA-D stated R107 had used a low bed since he admitted to the care center and obtained the bedside mat after one of his falls adding, Not everybody get floor mat. NA-D stated if a fall happens, they report to the nurse who then must evaluate them before staff can get them up adding any new interventions or care following a fall would be communicated to the NA staff using shift-to-shift verbal report and the care card. NA-D stated these were kept both in the room and on the computer for the NA to reference on how to care for each resident adding it was our responsibility to view them each shift. NA-D stated R107 currently used a low bed, mat on floor and was being routinely checked on adding he was less mobile than prior. On 10/16/24 at 1:36 p.m., licensed practical nurse (LPN)-A was interviewed, and explained when a resident admits they are assessed for their fall risk using a John Hopkins tool which then helps develop the care plan. LPN-A verified the floor nurses are responsible to do the tool. LPN-A stated if a fall happens after admission, the nurses will check the resident' vital signs, assist them up, and initiate neurological checks if the fall was unwitnessed. LPN-A stated any immediate interventions to help prevent further falls would be dependent on what the situation is adding every fall is kind of different. LPN-A explained the nurse should be updating the medical provider along with doing three items post-fall which included starting a short-term fall care plan, stating an event, and completing the paper-based data collection tool. LPN-A explained the paper-based tool was used to record initial data adding it was kind of brief with not too many lines to do before it gets routed to the nurse manager who, from there, takes the data and meets with IDT where they talk about it. LPN-A explained the event and short-term care plan were like a template which could help guide the nurses on actions or possible interventions. LPN-A recalled R107 having sustained a fall and explained he now used a low bed along with a bedside mat to prevent injury adding they can't remember off hand when each intervention was added. LPN-A stated staff always try to keep an eye on him and ensure the call light was in reach, too, as R107 still, at times, could be a busy man and try to move around. LPN-A stated R107's mobility since the femur fracture had decreased a little bit and he was no longer ambulatory. Further, LPN-A stated any root-cause analysis of the falls, including potential proactive intervention development, would be the nurse managers to do with IDT as they do their analysis and determine the cause. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/17/24 at 10:06 a.m., registered nurse unit manager (RN)-A and the director of nursing (DON) were interviewed, and R107's medical record was reviewed. DON explained, upon admission, the nurse was responsible to complete the fall risk assessment on each resident which DON verified was the John Hopkins tool. The completed tool is then reviewed by the MDS nurse or unit manager, and the evaluation is then repeated quarterly thereafter with the fall risk care plan being developed from it. DON verified the care plan and fall risk assessment were the only two items used within the medical record to demonstrate the facility' comprehensive fall risk evaluation process. DON verified the fall risk assessment was not completed upon admission and should have been, however, attributed the development of a care plan (dated 7/20/24, 7/22/24) as belief someone had done an evaluation. RN-A stated they likely initiated the care plan for R107 on 7/20/24 but added, I don't remember. RN-A explained they initiated the 7/22/24 falls care plan for R107 but expressed they didn't recall if they reviewed any completed fall risk evaluations or not with it. RN-A stated the main reason they initiated it was R107 had a history of falls adding the interventions placed on both the initial care plans, dated 7/20/24 and 7/22/24, were placed while we [got] to know him as the team didn't know him right away. RN-A and DON both verified the first completed John Hopkins fall risk evaluation was completed upon R107's return from the hospital after he sustained a broken femur and DON added, I think there was a miss there. DON stated they felt a possible Internet global failure around the same time may have contributed to it being missed for so long but were unsure. RN-A explained R107 had used a low bed from day one as R107's family was insistent of it. The interview continued with DON and RN-A who reviewed R107's falls. On 7/26/24, R107 sustained a fall without injury and the incident information was provided. R107's Catholic Eldercare Resident Incident Report, dated 7/26/24, identified R107 was found on the floor near his bed by the NA. R107's vital signs were stable, and he denied pain with no injury apparent. The form identified a temporary care plan and event were initiated per protocol; and the use of a blue mat at bedside was added to the care plan immediately after the fall. DON acknowledged the form and explained the temporary care plans were used then typically resolved after 72 hours. DON stated they attempted to locate the temporary care plan for R107's fall on 7/26/24 but, so far, had been unable to find it. When questioned on the IDT review process, DON stated the IDT review could be completed solely by the nurse

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on interview and document review, the facility failed to consistently assess a resident's pain level prior administration of an as-need narcotic pain medication, in addition, the facility failed to assess for and implement if requested non-pharmacological pain interventions for 1 of 2 residents (R106) reviewed for pain management. Findings include: R106's quarterly Minimum Data Set (MDS), dated [DATE], indicated R106 had intact cognition with no hallucinations or delusions. R106's diagnoses included polyneuropathy (damage or disease affecting nerves in roughly the same areas on both sides of the body), muscle weakness, radiculopathy (the pinching of the nerves at the root), other symptoms and signs involving the musculoskeletal system-wheelchair dependent and alcohol dependence with withdrawal. and required, at least, substantial/maximal assistance with dressing, sitting up or transferring. Further, under Section J - Health Conditions, the MDS identified R106 consumed no scheduled pain medication but received as-needed (i.e., PRN) pain medication along with non-medication intervention for pain; furthermore, R106 reported pain on a frequent basis which occasionally effected sleep, rarely or not at all interfered with day-to-day activities with a verbal descriptor scale of moderate pain. R106's face sheet, printed 10/17/24, indicated R106's diagnoses included: chronic pain, history of neuralgia (nerve damage or irritation that causes sharp, shock-like pain) and neuritis (inflammation of nerves that can cause pain), insomnia (inability to sleep), other osteoporosis without current pathologic fracture left foot (condition which causes bones to become weak and brittle), urinary incontinence (loss of bladder control), and adult failure to thrive (a syndrome that describes a general decline in health in older adults). R106's care plan, printed 10/17/24, included the following interventions: -[R106] has complaints of chronic pain R/T [related to] polyneuropathy of lower extremities with the following approaches: acknowledge to the resident that her pain is unique and believable; assess effects of pain on the resident (disturbances in sleep, activity, self-care, appetites, psychosocial, etc.); assess past effective and ineffective pain relief measure; caution resident against using unproven cures such as alcohol consumption; handle gently and try to eliminate any environmental stimuli; monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors; monitor and record any non-verbal signs of pain: (e.g., crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc.). -Pain with alteration in comfort r/t site: broken toe on left foot r/t to fall; neuropathic pain to bilateral lower extremities (from the knees down); chronic pain; pancreatitis r/t alcohol abuse with the following approaches: review pain interventions-implement or adjust interventions as needed, pharmacological-scheduled and PRN analgesics [medications that treat pain], non-pharmacological; rate pain before and after receiving PRN. Document any refusal of pain medications (PRN or scheduled) (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Will offer activities that resident will find intriguing and of interest and make sure to invite her to those. Offer M technique hand massage, aromatherapy, and/or healing touch for physical psychosocial comfort. During interview on 10/15/24 at 8:47 a.m., R106 was observed lying in bed. She stated she doesn't sleep well due to the constant pain she is in. R106 indicated she has pain from her toes to the middle of her back and in her hands. R106 indicated she gets half a tab of oxy, and it doesn't treat my pain but keeps me going. R106 indicated the facility don't do anything for my pain .nobody does anything about it. R106 indicated she did physical therapy previously but that doesn't help with nerve pain. R106 stated she might be interested in therapy again, so she doesn't lose any more strength as she feels she has lost a lot. R106 became upset during interview and talking about pain and continued to state, they don't do anything they want me like this. R106's October Medication Administration Record (MAR/TAR), printed 10/16/24, included the following orders and administrations: - acetaminophen [Tylenol] (pain reliever) tablet 325 milligrams (mg) tablet administer 650 mg oral [by mouth] every 6 hours PRN. DX [diagnosis]: other chronic pain. Started 7/2/24. -No administration or refusals documented in the month of October - tizanidine (muscle relaxer) 2 mg capsule administer 2 mg oral three times a day PRN. DX: neuralgia and neuritis. Started 7/16/24. -No administration or refusals documented in the month of October - Offer lavender aromatherapy patch (found in the aromatherapy drawer at the nursing station). Apply one patch on the clothing or clean dry skin daily twice a day PRN. Started 9/24/24. -No administration or refusal documented in the month of October - oxycodone (narcotic pain medication) 5 mg tablet administer 1/2 oral every 12 hours PRN. DX: other chronic pain. Started 7/10/24. -Administered two times a day for the month of October except for 3 days when it was given one time a day. Of those administrations, 5/26 had a pain scale and 2/26 had a location of pain listed. The remaining administrations, 21/26 administrations, did not have a pain scale listed and 24/26 administrations did not have a location of pain listed. - Monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors every shift. Started on 10/23/24. -all marked as completed, -A review of the full medical record lacked any additional information related to the of the pain, such as, location, frequency, effect on function, intensity, alleviating factors, aggravating factors despite being marked completed on every shift in October. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R106's Pain Assessment Observation Details completed from 10/1/24-10/15/24 revealed the following; No Pain Assessment Observation Detail completed for R106 on 10/15/24. R106's Pain Assessment Observation Detail, dated, 10/14/24 at 8:37 p.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: no The rest of the assessment was left blank. R106's Pain Assessment Observation Detail, dated, 10/13/24 at 9:43 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply Pain location: left blank Pain interference with day-to-day activities: occasionally Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/11/24 and 10/12/24. R106's Pain Assessment Observation Detail, dated, 10/10/24 at 10:10 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply. Pain location: bilateral lower extremities Pain interference with day-to-day activities: occasionally (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/8/24 and 10/9/24. R106's Pain Assessment Observation Detail, dated, 10/7/24 at 11:29 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply. Pain location: n/a [not applicable] Pain interference with day-to-day activities: almost always Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/6/24. R106's Pain Assessment Observation Detail, dated, 10/5/24 at 9:39 p.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: almost constantly Pain effect on sleep: frequently Pain interference with therapy activities: almost constantly Pain location: generalized pain Pain interference with day-to-day activities: almost always Verbal scale rating: moderate R106's Pain Assessment Observation Detail, dated, 10/4/24 at 11:10 a.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pain frequency: almost constantly Pain effect on sleep: occasionally Pain interference with therapy activities: almost constantly Pain location: BLA Pain interference with day-to-day activities: almost always Verbal scale rating: moderate No Pain Assessment Observation Detail completed for R106 on 10/3/24. R106's Pain Assessment Observation Detail, dated, 10/2/24 at 8:26 p.m., Pain Assessment Interview: questions are answered with radio-button answers: Presence of pain: yes Pain frequency: occasionally Pain effect on sleep: occasionally Pain interference with therapy activities: does not apply. Pain location: bilateral toes Pain interference with day-to-day activities: left blank Verbal scale rating: left blank A review of the Pain Assessment Observation Details completed for October lacked indication of non-pharmacological interventions offered or discussed. The documents further lacked coordination of the timing of administration of PRN oxycodone and other medications being offered prior to administration of narcotic medication. R106's Permission Form for the use of Healing Touch, dated 10/24/23, was signed by R106. R106'2 Consent for the use of Aromatherapy, dated 5/21/24, was signed by R106. Progress notes reviewed from 9/1/24 to 10/17/24 identified the following: -10/1/24: note indicated resident rated her pain at 8/10. The note lacked indication of any intervention offered. -9/23/24: resident had 2.5 mg oxycodone at 11:00pm. The note lacked indication of reason for medication, pain level or location, or non-pharmacological interventions offered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9/20/24: administer PRN oxycodone. The note lacked indication of reason for medication, pain level or location, or non-pharmacological interventions offered. -9/17/24: Returned to res's room at 1250 to administer PRN oxycodone . The note lacked indication of reason for medication, pain level or location, or non-pharmacological interventions offered. -9/9/24: resident reported she is unable to complete shower due to pain in lower legs. PRN Oxycodone administered. The note lacked indicated of pain level or non-pharmacological interventions offered. The progress notes, dated 9/1/24 to 10/17/24, lacked documentation of Healing Touch, aromatherapy or other non-pharmacological interventions being offered or declined during the period reviewed. Furthermore, the notes lacked evidence of a discussion with R106 of preferences of non-pharmacological interventions being offered. R106'2 Quarterly care conference note, dated 9/12/24, reviewed care for the last quarter. The note lacked evidence of discussion of R106's pain. Furthermore, it lacked evidence of discussion of pain interventions of non-pharmacological interventions. During an interview on 10/16/2024 at 11:14 a.m., registered nurse (RN)-E stated that residents pain level is measured on a pain scale. RN-E stated the pain level should be documented in the comment section on the medication administration record when a pain medication is administered. RN-E stated the pain level can also be documented in a progress note along with any non-pharmacological interventions offered. During an interview on 10/16/2024 at 12:33 p.m., RN-F indicated they are familiar with R106. RN-F verified that a pain level should be assessed prior to giving as needed pain medication. RN-F verified other interventions should be attempted prior to giving as needed pain medications. RN-F verified that non-pharmacological intervention would be documented on the medication/treatment administration record (MAR/TAR) and the pain level would be documented in the comment section in the MAR when giving the medication. On 10/16/2024 at 12:54 p.m., RN-D stated the expectation was that prior to administration of pain medication that an assessment should be completed. The assessment includes the type of pain, location of pain, pain scale, non-pharmacological interventions offered, effectiveness of the non-pharmacological interventions and then offer a PRN (as needed) pain medication. RN-D stated it is also important to follow-up to see if the PRN medication was effective. RN-D stated it is expected the pain scale to be documented in the comment section when administering R106's PRN oxycodone medication. RN-D did not answer regarding non-pharmacological intervention documentation when asked. RN-D reviewed administration of last 14 days (10/2/24 to 10/16/24) and verified a pain scale was entered 5 times out of 26 times PRN oxycodone was administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 10/17/24 at 9:54 a.m., nurse practitioner (NP)-A stated that a pain assessment and non-pharmacological interventions should be offered prior to administration of pain medications. NP-A stated a pain scale should be completed, documented, and then to attempt and document non-pharmacological interventions prior to administration of pain medications. NP-A stated residents can refuse non-pharmacological interventions, but it is important we are asking and documenting. NP-A indicated it is important we are assessing and re-assessing pain to see what is working and not working and should be documenting all of it. NP-A indicated that pharmacists can be a good resource also for suggestions. During interview on 10/17/24 at 10:37 a.m., pharmacist consultant (PC)-A indicated that it is important for non-pharmacological to be offered and documented on prior to giving as needed pain medication. PC-A stated it is important that pain levels are monitored prior to administration of a pain medication along with after administration of the pain medication. During a follow-up interview on 10/17/24 at 11:28 a.m., RN-D verified there was no PRN use or documented refusal of lavender aromatherapy in October. RN-D verified tizanidine PRN was not administered in October. During interview on 10/17/24 at 12:52 p.m., director of nursing (DON) verified the expectation is that non-pharmacological interventions are offered prior to administration of PRN pain medication along with assessing the residents' pain which includes a pain scale. DON verified this had not been done for R106. DON verified the order was not entered correctly as the order should prompt to enter a pain scale when it is clicked on for administration. DON stated he was going to follow up on this. DON stated the care plan may indicate any non-pharmacological interventions and they might be documented in progress notes. DON stated they were going to follow up and provide further information if available. No further information was provided. A facility policy Pain Management, dated 11/20/20, indicated non-pharmacological interventions for pain management will include distracting activities such as preferred music, watching a chosen show, 1:1 for calming, heat or cold as indicated, orders for PT or OT, healing touch and other non med modalities as resident indicates interest. Furthermore, the daily IDT meeting will be used to discuss residents who have pain that is not easily managed. Documentation will be entered into the EHR when these reviews take place.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview and document review the facility failed to monitor for resident specific target behaviors related to antipsychotic medications use for 1 of 5 residents (R105) reviewed for unnecessary medications. Findings include: R105's quarterly Minimum Data Set (MDS), dated [DATE], indicated R105 had moderately impaired cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others or behavioral symptoms not directed toward others. Further, it indicated R105 had received an antipsychotic medication during the seven-day look back period. R105's Physician Order Report, dated 10/16/24, included the following orders: -quetiapine (antipsychotic medication used to treat mental/mood disorders) tablet 25 milligrams (mg) take 12. 5 mg one time a day at 8:00 a.m. for delusional disorder with a start date of 2/28/24 -quetiapine tablet 25 mg take one tablet by mouth once in the evening at 8:00 p.m. for delusional disorder with a start date of 2/28/24 The Physician Order Report lacked documentation of an direction to monitor target behaviors or identification of target behaviors. R105's care plan, printed 10/15/24, identified R105's orthostatic blood pressure to be monitored monthly while on anti-psychotic medications and side effect monitoring for antipsychotic medication. The document lacked mention of target behaviors for antipsychotic use or identification of what, if any, target behaviors R105 exhibited. R105's Medications Administration Record (MAR/TAR), printed 10/17/24, for October was reviewed. The document verified R105 received quetiapine. The document indicated an entry for Target Behavior Monitoring: increased anxiety fears; unrealistic fears/concerns; delusions; hallucinations with a start date of 10/17/24. The document lacked evidence of target behavior monitoring prior to 10/17/24. On 10/14/24 at 2:24 p.m., R105 was observed sitting in her room. R105 was calm, pleasant and pinning her clothes getting them ready to sew. R105 stated how much she enjoys sewing. On 10/15/24 at 12:21 p.m., R105 was observed sitting in her room in her rocking chair eating lunch. R105 reports she was enjoying her lunch and really liked her desert. At 2:32 p.m., R105 was sitting in her rocking chair and sewing/pinning an item of clothing. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:30 a.m., R105 was observed sleeping in her rocking chair in her room with her sewing items in her lap. No behaviors such as agitation, aggression or paranoia observed. At 2:15 p.m., R105 was observed sitting in her chair in her room sewing. R105 stated she was having a good day and denied any concerns. On 10/17/24 at 9:24 a.m., R105 was observed in her room. R105 would take an item of clothing out of her closet, lay it on her bed and then hang it back up. R105 was observed smiling throughout this time. R105 stated she was having a good day and getting ready to pin some things. On 10/17/24 at 9:52 a.m., nurse practitioner (NP)-A verified that target behaviors should be monitored if a resident is prescribed an antipsychotic medication. NP-A stated this is important in determining many things such as: if the medication is effective, if the medication is needed, should it be scheduled, do they need a PRN (as needed medication). On 10/17/24 at 10:37 a.m., pharmacist consultant (PC)-A verified that if a resident is prescribed antipsychotic medications, target behaviors (along with other things) should be monitored. PC-A stated target behaviors should be monitored because we want to monitor the effectiveness of the medication to why she is receiving it. PC-A verified the monitoring of target behaviors was added to the MAR/TAR on 10/17/24. On 10/17/24 at 11:36 a.m., registered nurse (RN)-D indicated it was important for antipsychotic medications to be monitored. RN-D verified this included monitoring of target behaviors. RN-D stated this is helpful because then you know the reason for the medications, if they are having side effects and if it is effective. On 10/17/24 at 12:36 p.m., director of nursing (DON) verified antipsychotic medications absolutely need to be monitored. DON verified that it is important target behaviors are monitored with antipsychotic medications as this helps determine the effectiveness of the medication. DON verified monitoring target behaviors also helps with gradual dose reductions. DON verified there was no target behavior monitoring for R105's quetiapine before today and the behavior monitoring was added today. DON stated it was previously on the TAR but must have fallen off at some point. A facility policy titled Psychotropic Medication, dated 1/1/24, The document has a procedure for the facility to follow when a resident has an order for psychotropic medication. Number 4 identified Add problem to care plan listing behavior to be treated. List measurable goal in the care plan. The document further indicated Initiate a psychotropic drug monitoring graph. List the specific behavior(s). Each shift is to document frequently of behavior. This information is used to monitor effectiveness of drug.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245439	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catholic Eldercare on Main	817 Main Street Northeast Minneapolis, MN 55413

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49339 Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication (i.e., cavities, oral pain) for 1 of 1 residents (R88) reviewed for dental care and services. Findings include: R88's quarterly Minimum Data Set (MDS), dated [DATE], indicated R88 had intact cognition with no hallucinations or delusions with an admitted [DATE]. Further, R88's face sheet, printed 10/17/24, identified R88's primary payer as, Medicaid. R88's care plan, printed 11/5/23, identified R88 has natural teeth and may require assistance with oral care r/t [related to] Parkinson disease [a disease that affects the central nervous system that affects both motor and non-motor systems of the body], impaired mobility with a goal of adequate oral hygiene will be maintained. The care plan listed several interventions to help R88 meet this goal which included, assess condition of oral cavity, teeth, tongue, lips and set-up/supervision and cueing for mouth care and hygiene. The care plan lacked identification of coordination with dental appointments, or identification of missing teeth. During interview on 10/14/24 at 2:12 p.m., R88 indicated that she sees the dentist that provides in-house services at the facility. R88 stated she has not seen them in 5 or 6 months and was supposed to have a follow up visit with them as she is missing 2 or 3 teeth on the right side of her mouth. R88 stated she is waiting for either implants or a partial [denture] on that side. R88 indicated that she does not have pain and is able to chew on the opposite side of her mouth, but the facility hasn't updated her on when her appointment is or if was arranged. R88 indicated she was sure she was supposed to have the appointment by now and stated she asked a staff about it but unsure when that was or who it was. R88's Chart Progress Note from her dental appointment, dated 4/19/24, indicated R88 had an appointment on 4/19/24 for a dental appointment. The note indicated on a previous visit R88 had a tooth extracted (removed). During 4/19/24, R88 had a cavity filled along with routine teeth cleaning. The note recommended that R88 to be seen in 3 months by the dentist for follow up. R88's Progress notes, dated 3/17/24 to 10/17/24, were reviewed and revealed the following: -4/22/24: Dentist: S: Seen by Dentist with no new orders. Progress notes, dated 3/17/24 to 10/17/24, lacked indication of any coordination on follow up on dental appointment. During interview on 10/16/24 at 11:00 a.m., nursing assistant (NA)-A indicated that if they notice any dental concerns with a resident, they notify the nurse for further assessment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 11:14 a.m., registered nurse (RN)-E indicated that dental appointments could vary depending on a residents insurance. RN-E indicated that they are not sure about this as the HUC (Health Unit Coordinator) manages the appointments. RN-E stated that if a dental concern gets reported to a nurse, the nurse assesses the concern and if an appointment needs to be made then the HUC sets up the appointment. RN-E stated she is not aware of any dental pain with R88. RN-E verified that R88's last dental appointment was 4/19/24 and the recommendation was a follow-up in 3 months. On 10/17/24 at 9:30 a.m., health unit coordinator (HUC)-A verified that they are responsible for setting up dental appointments. HUC-A stated when a resident moves in, consents are signed, and that information gets faxed to the dental provider that comes to the facility (in-house dental provider). The dental provider adds the resident to the calendar and updates the facility on when they are coming. HUC-A stated after a dental visit, the after-visit summary (AVS) is reviewed by nursing to see if there are any new orders and then they upload the document into the electronic medical record (EMR). HUC-A stated the nurse will initial the AVS after reviewing it. HUC-A stated that once a resident is seen by the in-house dental provider, the dental provider manages the resident's dental schedule. HUC-A verified she does not track routine or follow up dental appointment for residents seen by the in-house dental provider and she only gets them initially set up and if they need to be seen for an urgent reason. HUC-A stated she was not sure why R88 was not seen as the dental provider manages that schedule. During follow-up interview with HUC-A on 10/17/24 at 10:24 a.m., HUC-A stated she called the in-house dental provider and verified the last visit with R88 was 4/19/24. HUC-A verified she was over-due for the appointment. HUC-A stated the dental provider added her to the schedule and will hopefully be seen the next time they are at the facility or in December. During interview on 10/17/24 at 11:37 a.m., RN-D verified that she oversees the schedule for dental appointments along with the HUC. RN-D stated the dental provider sends a list of residents that will be seen to review prior to arrival. RN-D stated that all after visit summaries from dental appointments are reviewed by nursing to help ensure if it is recommended that they are seen in 3 months for follow up then the resident is. RN-D stated she does not have a tracking system to track when residents should be seen for routine or follow up appointments by the dental provider. RN-D stated she does not know why R88 has not been seen since 4/19/24 if the recommendation was to be seen in 3 months. RN-D stated I don't have access to the system. During interview on 10/17/24 at 12:38 p.m., director of nursing (DON) indicated that a resident family can always take the resident to an outside dental appointment and should be documented in progress notes or care conferences. DON indicated that the after-visit summaries are reviewed by nursing and then go to the HUC to be uploaded. DON verified that if it is recommended to be seen in 3 months for a follow up dental appointment, then a resident should be seen in 3 months. DON stated she was going to look for documentation on another dental appointment. No additional documentation was received. A policy on dental appointments was requested and not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48065 Based on observation, interview, and document review the facility failed to ensure residents clothing was covered during storage and delivery to the residents. The uncovered linen had the potential to affect all residents. Findings include: During observation and interview on 10/14/24 at 1:13 p.m. laundry aide (H)-C was observed pushing a large metal uncovered laundry cart down a resident hallway on the first floor containing various cleaned resident clothing items. H-C stated she had worked at the facility as a laundry aide for a long time and they had never covered the personal laundry carts. During observation and interview on 10/15/24 at 1:28 p.m. H-A verified she was delivering cleaned personal linen on the second floor in an uncovered cart. H-A stated the carts used to deliver personal clothing were never covered. During interview on 10/15/24 at 1:34 p.m. the director of environmental services-housekeeping and laundry, (H)-B, stated he had been in his position since 2016, and they had never covered the carts used to deliver personal clothing. H-B added, we only cover the cart use the bed linen and towels. It's the process we have. During interview on 10/17/24 at 1:27 a.m., the director of nursing (DON) stated the personal clothing carts should be covered to minimize possible cross contamination. Facility policy titled Laundering Linen and Resident Clothing, revised on 9/2/16, indicated all linen and resident clothing was cleaned and handled in such manner that prevents contamination and decreased the risk of spreading infection. The policy also indicated, clean linen and clothing will be sorted and folded in laundry and placed on covered shelves or racks for transport to nursing stations.