STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245460	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jones Harrison Residence	3700 Cedar Lake Avenue Minneapolis, MN 55416

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review the facility failed to ensure a sanitary and homelike environment for 1 of 1 residents (R55) who had dried feeding tube-like substance on their feeding tube pole, dresser, bed, and floor. Findings include: R55's quarterly Minimum Data Set (MDS) dated [DATE], indicated R55 had intact cognition and depended on staff for assistance with dressing, transferring, and bed mobility. The MDS indicated R55 received over 50 percent of her total calories through a feeding tube. R55's medication administration record (MAR) dated 11/1/24 indicated received daily feedings from 9 p.m. to 11 a.m. During an observation on 11/12/24 at 11:20 a.m., R55 was observed lying in bed on the left side of the room with a feeding pump attached to a pole to her right. To the right of the pole was a dresser and in front of the pole was a bedside table. The dresser had splatters of a light brown/yellow substance scattered over the side and front of the dresser. The light brown/yellow substance was also observed scattered over the bottom one-fourth of the feeding pump pole, the carpet on the right side of the bed, and the right bed rail/frame of R55's bed. During an observation and interview on 11/13/24 at 11:02 a.m., the light brown/yellow substance was again observed in R55's room as described above. R55 stated she did not like that the brown substance was on her furniture and floor and at home she would have cleaned it up immediately. R55 stated she had family visit her at least a few days ago, and they noticed the brown substance on the furniture and floor, and it bothered her that her room was not clean especially when she had visitors. R55 stated she assumed the brown substance was tube feeding solution. R55 stated staff cleaned it up whenever they feel like it and most of her furniture hadn't been cleaned for several months. During an interview on 11/13/24 at 11:19 a.m., registered nurse (RN)-A stated she was the nurse in charge of R55's care and had stopped her tube feeding this morning. RN-A stated she was unsure how long the tube feeding had been on R55's furniture and floor. RN-A stated it should have been cleaned by either housekeeping or nursing staff but looked like it had not been. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 11:51 a.m., the unit nurse manager (RN)-B stated she expected nursing staff to clean the resident furniture and tube feeding pole as the spills occurred and housekeeping should have been called if nursing staff was unable to clean the spill. RN-B stated staff should have cleaned the dried tube feeding to ensure R55's had a home-like environment and infection control measures were practiced. A policy regarding resident room cleaning was requested and not received.

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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** 49034 Based on observation, interview and document review, the facility failed to ensure care plan interventions were followed and new interventions were implemented in a timely manner when resident pain goals were not met for 1 of 1 residents (R44) to ensure comfort and reduce the risk of complications. Findings include: R44's quarterly Minimum Data Set (MDS) dated [DATE], indicated R44 had intact cognition. The MDS indicated R44 was on a scheduled and as-needed (PRN) pain medication regimen and received non-pharmocological interventions for pain. The MDS indicated R44 had pain almost constantly over the past five days and it made it hard for R44 to sleep constantly and occasionally limited day-to-day activities. R44's care plan dated 6/5/24, indicated R44 had pain related to multiple factors including lumbar spinal stenosis (narrowing of the spinal canal causing pressure on the nerves) with radiculopathy (a pinched nerve), osteoarthritis (a joint disease that can cause pain stiffness or swelling), osteoporosis (weak and brittle bones), and failed back surgery syndrome (pain following back surgery). The care plan indicated staff should give pain medications per schedule to maintain therapeutic levels, offer non-pharmacological interventions, and notify the provider of inadequate pain relief. R44's pain interview and evaluation dated 9/23/24, indicated R44 rated her pain at a seven out of ten and had non-verbal signs of pain such as moaning and grimacing. The assessment indicated R44's pain goal was zero out of ten. The assessment indicated R44's pain management plan included diclofenac gel (pain gel) and 1000 milligrams (mg) of Tylenol three times a day. R44's provider progress note dated 10/8/24, indicated R44 had a left arm fracture requiring surgery with ongoing discomfort to the left elbow area. The note indicated R44 currently had 50 mg of Tramadol (a narcotic pain medication) available every eight hours PRN but R44 stated her pain was not well-controlled with this schedule. The provider agreed to increase the medication to every six hours PRN. The note also indicated R44 had lumbar spinal stenosis (narrowing of the spinal canal causing pressure on the nerves) with radiculopathy (a pinched nerve). R44's medication administration record (MAR) dated 10/1/24 through 11/11/24, indicated R44 had orders for the following medications: - 1000 mg of Tylenol three times a day dated 1/15/24 - 400 mg of gabapentin daily at bedtime dated 5/3/24 - two lidocaine patches (pain patch) daily dated 7/23/24 - 100 mg of gabapentin (medication used for nerve pain) two times a day dated 8/15/24 - one percent diclofenac gel available every eight hours PRN dated 8/26/24 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 0.2596 mg total daily dose of hydromorphone (narcotic pain medication) through an implanted pain pump dated 9/3/24 - 50 mg of PRN tramadol available every eight hours dated 9/17/24 through 10/8/24 - 50 mg of PRN tramadol available every six hours dated 10/8/24. - 30 mg daily (10/19/24-10/24/24), 20 mg daily (10/25/24-10/27/24), and 10 mg (10/28/24-10/30/24) of prednisone (a steroid) ordered for gout (a form of arthritis that can cause severe pain, swelling, and joint tenderness) R44's progress notes, order administration notes, pain scores, and MAR dated 10/27/24 through 11/11/24 were reviewed and indicated: - On 10/27/24 at 2:24 a.m., tramadol was given for six out of ten pain. A follow-up pain score was assessed at 7:01 a.m., an eight out of ten and the medication was documented as being ineffective. The note did not include what new pain interventions were implemented and if needed, the provider was notified. - On 10/27/24 at 10:13 a.m., tramadol was given for eight out of ten pain. At 12:43 p.m., left elbow elevation, and a cold compress were applied to the left elbow for swelling, pain, and slight warmth. The note indicated this information would be reported to the oncoming nurse. A follow-up pain score was assessed at 1:17 p.m., at eight out of ten and the medication was documented as being ineffective. The note did not include what further pain interventions were completed at that time or if the provider had been notified. - On 10/27/24 at 4:36 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 5:19 p.m., at seven out of ten and the medication was documented as being effective. - On 10/28/24 at 1:24 p.m., tramadol was given for seven out of ten left elbow pain. A follow-up pain score was assessed at 2:07 p.m., at five out of ten and the medication was documented as being effective. - On 10/29/24 at 9:56 a.m., R44 requested a physical therapy evaluation as she thought that might help with her pain, so the nurse left a message for the nurse practitioner. At 10:58 a.m., the nurse left a message for nurse practitioner who was in the building, but the note did not indicate what the message was regarding. - On 10/30/24 at 8:03 a.m., tramadol was given for six out of ten left leg pain. A follow-up pain score was assessed at 1:01 p.m., at eight out of ten and the medication was documented as being ineffective. The note did not include what further pain interventions were completed at that time or if the provider had been notified. - On 10/30/24 at 8:06 p.m.,tramadol was given for eight out of ten left leg pain. A follow-up pain score was not documented. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 11/1/24 at 9:19 a.m., tramadol was given for eight out of ten left elbow pain. A follow-up pain score was assessed at 10:12 a.m., at four out of ten and the medication was documented as being effective. - On 11/2/24 at 8:58 a.m., tramadol was given for eight out of ten left elbow pain. A follow-up pain score was assessed at 9:40 a.m., at four out of ten and the medication was documented as being effective. - On 11/4/24 at 9:30 p.m., tramadol was given for seven out of ten pain. A follow-up pain score was not documented. - On 11/6/24 at 2:04 p.m., the nurse stated she had talked to the nurse practitioner, and she was working on the order. - On 11/8/24 at 7:43 a.m., tramadol was given for seven out of ten pain. A follow-up pain score was not assessed until 12:55 p.m., and was seven out of ten and the medication was documented as being ineffective. - On 11/8/24 at 1:12 p.m., tramadol was given for seven out of ten pain. A follow-up pain score was assessed at 3:22 p.m., at six out of ten and the medication was documented as being effective. - On 11/9/24 at 6:09 a.m., tramadol was given for eight out of ten pain. A follow-up pain score was not assessed until 1:16 p.m., and was eight out of ten and the medication was documented as being ineffective. - On 11/9/24 at 1:16 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 7:28 p.m., at six out of ten and the medication was documented as being effective. - On 11/9/24 at 7:28 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 8:39 p.m., at six out of ten and the medication was documented as being effective. - On 11/10/24 at 8:00 a.m., tramadol was given for eight out of ten pain. A follow-up pain score was not assessed until 12:55 p.m., and was seven out of ten and the medication was documented as being ineffective. The note indicated the resident stated this medication only helps a bit. - On 11/10/24 at 4:43 p.m., tramadol was given for eight out of ten pain. A follow-up pain score was assessed at 7:09 p.m., at six out of ten and the medication was documented as being effective. - On 11/11/24 at 8:23 a.m., tramadol was given for eight out of ten in the left elbow pain. A follow-up pain score was assessed at 10:09 a.m., and was five out of ten. The medication was documented as being ineffective and an ice pack was offered. The note did not indicate if a pain follow-up assessment was completed to ensure the non-pharmacological intervention was effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 8:51 a.m., nurse practitioner (NP)-A stated she was R44's primary care provider and managed her pain plan. NP-A stated R44 had pain related to a broken elbow that did not heal correctly and chronic back pain. NP-A stated she had not gotten any reports in the last few weeks from nursing staff indicating the current pain plan was not effectively managing her pain. NP-A stated she had gotten a report and had worked on orders regarding getting R44 physical therapy per her request but R44 had not qualified for this. NP-A stated if she had gotten a report from nursing staff indicating R44's pain was inadequately managed, she would have followed up with R44 to evaluate possible interventions but stated she doubted her pain would ever be under a seven out of ten. During an interview on 11/14/24 at 10:21 a.m., R44 stated she did not feel like her pain was well controlled and would like her pain at a maximum of 3 out of 10. R44 stated her pain was usually in her back or her left elbow and lately had been sitting at a seven or eight out of ten. R44 stated she did not feel like the staff believed her pain was as bad as it felt to her and were not providing adequate pain interventions even when she was telling them her pain was still higher than what was tolerable for her. R44 stated she feels like the facility does not listen to her when she tells them she still has pain and the pain interventions that have been attempted didn't help. During an interview on 11/14/24 at 10:28 a.m., registered nurse (RN)-C stated the trained medication aides (TMA) were responsible for asking residents what their pain levels were and then following up later to ensure the medication was effective. RN-C stated he thought R44's pain goal was zero out of ten. RN-C stated if a resident did not meet their pain goal after a PRN medication was given, then the TMA would offer a non-pharmacological intervention. RN-C stated he expected the TMA to complete this follow up assessment to determine if the residents pain goal was met after administering PRN pain medications or non-pharmacological interventions. RN-C stated if the pain goal was not met, he expected to be notified and then he would call the NP to determine what further interventions could be attempted and then that would be documented in the progress notes. During an interview on 11/14/24 at 10:58 a.m., RN-D, the unit nurse manager, stated she would expect the TMA to alert the nurse if the resident is reporting pain so the nurse could assess the resident and determine appropriate interventions. RN-D stated she would expect the nurse to follow up with the resident to determine if the resident's pain goal had been met after the pain intervention had been implemented. RN-D stated if they had already attempted the PRN medications available as well as non-pharmacological interventions she would expect nursing staff to notify the NP that the resident's pain goal was not being met so they can see if pain medication regimen needs to be updated, such as scheduling pain medications, ensuring they are using the right medication and it is being dosed effectively. RN-D stated she was unsure what the expectation was for how long after a pain medication was given, nursing staff should re-evaluate pain levels, but thought it would be around an hour. A policy regarding resident pain management was requested and not received.

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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** 49654 Based on observation, interview and document review the facility failed to comprehensively assess past trauma and develop a comprehensive person-centered care plan with goals and interventions utilizing a trauma-informed approach including monitoring of post traumatic stress disorder (PTSD) for 1 of 1 residents (R79) reviewed for trauma-informed care. Findings include: R79's quarterly Minimum Data Set (MDS) dated [DATE], indicated R79 was [AGE] years old, was cognitively intact and the MDS further indicated R79 was widowed, suffered from feelings of depression or hopelessness several days a week, and always socially isolated. R79's diagnoses sheet, dated [DATE], indicated the following diagnoses: post-polio syndrome (a condition that causes gradual muscle weakness and atrophy), hypertension (high blood pressure), hemiplegia (paralysis or weakness on one side of the body), and schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and altered mental status. An Associated Clinic of Psychology (ACP) progress note dated [DATE], indicated R79's social history included an alcoholic father, had lost two siblings, had suffered the loss two sons who died as infants, and was the victim of an abusive partner. It further indicated R79 suffered from flashbacks of her traumatic experiences. ACP progress note dated [DATE], indicated R79 exhibited behavioral and emotional symptoms that affect functioning, was paranoid and lacked trust in others. R79's facility Psychosocial/History assessment dated [DATE], indicated resident had experienced life threatening or traumatic events that included: polio as a child, her first husband died at age 35, her second husband committed suicide, loss of two children in infancy, and had history of a stroke. The assessment further indicated R79 had been intimidated, hurt, manipulated, or controlled by her second husband who was verbally and physically abusive towards her. R79's care plan printed [DATE], at 12:05 p.m. lacked any information on trauma informed care or trauma triggers. A care plan printed on [DATE], at 2:15 p.m. indicated R79's care plan had been updated to include trauma informed care with an initiation date of [DATE], three days after survey entrance. During interview on [DATE], at 1:09 p.m. certified nursing assistant (CNA)-A stated he was familar with R79 and worked with her frequently. CNA-A stated he did not now if R79 was a trauma survivor but did have behavioral issues. CNA-A stated he did some online education for trauma-based care but nothing specific to R79. During interview on [DATE], at 1:21 p.m. registered nurse (RN)-F stated she was familiar with R79 and worked with her frequently. RN-F stated she would occasionally take R79 outside if she was exhibiting behavioral issues but could not identify any specific trauma informed care-based interventions for R79. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 1:35 p.m. transitional care unit charge nurse (TCU-CN) stated when a resident is assessed by social workers the information is shared with staff, used to create the plan of care, and discussed in interdisciplinary meetings. TCU-CN went on to say the facility meets with ACP providers weekly to discuss resident care and will reach out to them for instruction, assistance, or guidance on how to treat residents with history of trauma. During interview on [DATE] at 2:40 p.m. director of nursing (DON), stated she was familiar with R79, and she required total care and assistance. DON stated R79 had trauma history including emotional and physical abuse, death of children and dealing with law enforcement. She went on to say R79 would frequently isolate herself, exhibited fear of the government and it was difficult to identify what was trauma and what was delusion. DON stated she would expect any resident who had experienced trauma would have trauma informed care addressed on their care plan and it should identify what the trauma was and how to minimize risk of retraumatizing. DON confirmed R79's care plan did not previously include trauma informed care, did not include trauma triggers or interventions but had been updated on [DATE], three days after survey entrance, to include trauma informed care, triggers and interventions. DON stated it was important to know and understand a residents trauma history to avoid re-traumatization.

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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** 47263 Based on interview and document review the facility failed to ensure orders for PRN (as needed) psychotropic medication (mood altering medications) were time limited to 14 days. In addition, the facility failed to ensure provider assessment and documentation of rationale and duration of continuation of a psychotropic PRN medication beyond 14 days occurred for two of six residents (R70 and R40) reviewed for PRN psychotropic medication use. The facility further failed to ensure an indication for use was present for one of six residents (R40) reviewed for psychotropic medication. Findings include: R70 R70's significant change Minimum Data Set (MDS) dated [DATE], indicated R70 was moderately cognitively impaired with the diagnoses of cancer. Section O. indicated R70 was receiving hospice services at the facility. The Current Order Summary dated November 2024, included the order: lorazepam (medication which act on the brain and nerves to produce a calming effect) oral concentrate 2 milligrams per milliliter (mg/ml) Give 0.5 mg by mouth every 2 hours as needed for anxiety, sleep, severe nausea. The stop date was listed as indefinite. R70's provider order for lorazepam documented, lorazepam oral concentrate mg/ml, give 0.5 mg by mouth every 2 hours as needed for anxiety, sleep, severe nausea. provider order did not document it was time limited to 14 days or less. R70's medication administration record showed that R70 had not received a dose of the ordered lorazepam between the dates of 9/6/24 to 11/13/24. Provider notes between 9/1/24 and 11/14/24 lacked evidence to show a provider had reviewed R70's lorazepam order for discontinuation or order renewal every 14 days. The Consultant Pharmacist's Medication Review dated 9/17/24, identified R70 had been prescribed lorazepam since 9/3/20 [error lorazapam was started ordered on 9/6/24] and indicated: there was not a stop date or duration listed in the order. Written review included: Per updated CMS regulations, all new prn psychotropic medications orders must be re-evaluated within 14 days of initiation and then at routine intervals thereafter. Provider note must specify rationale for renewal of medication. During an interview on 11/14/24 at 12:17 p.m., the director of nursing (DON) stated all the prn antipsychotic/psychotropic medications such as lorazepam ordered as a PRN medication should be reviewed and evaluated every 14 days for renewal or discontinuation and they should not be ordered with a stop date of indefinitely. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Policy Psychopharmacologic Drug use dated 7/8/2024, number 11. As needed (PRN) orders subpart b. included: PRN orders for psychotropic drugs are limited to 14 days except if the provider or prescribing practitioner believes the order period should be extended. They must document in the medical record the duration of and the rationale for extension of the order. The provider must directly examine the resident to determine if the PRN is still needed. 47495 R40's quarterly MDS, dated [DATE], indicated R40 was admitted to the care facility on 2/6/23 and was cognitively intact. R40's diagnoses list, printed 11/14/24, indicated R40 had several medical diagnoses including bipolar disorder, anxiety disorder, depression, and insomnia. R40's Physician Orders contained an order, dated 10/23/24, for Compazine (an antipsychotic medication) 5 milligrams (mg) by mouth every 8 hours as needed for nausea. The order however lacked an end date or a rationale of why the medication should be continued beyond 14 days. R40's Physician Orders also contained an order, dated 6/19/24, for Trazadone (an antidepressant and sedative medication) 25 mg by mouth at bedtime. The order however lacked an indication for use (i.e. depression or insomnia). During an interview on 11/14/24 at 8:22 a.m., licensed practical nurse (LPN)-B was unable to confirm if R40 received Trazodone for depression or insomnia, stating it was for bedtime. During an interview on 11/14/24 at 9:13 a.m., assistant nurse manager and registered nurse (RN)-E stated it would be expected that an indication for use would be noted on R40's Trazodone order to ensure staff knew why they were giving the medication, stating she was usually notified when a medication was missing an indication for use. During an interview on 11/14/24 at 1:42 p.m., the director of nursing (DON) confirmed all antipsychotics should always have a 14-day end date. The DON further stated it would be expected the Trazodone order had an indication of use, stating if staff did not know what they were giving the medication for they would not be able to assess the medication's effectiveness.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48065 Based on observation, interview and record review, the facility failed to test the levels of chemicals used on the three compartments sink to sanitize the pots used for meal preparation; failed to ensure dry goods removed from original packaging were stored in a manner to reduce the risk for cross contamination; and failed to properly monitor food temperatures before serving food to residents. These findings had the potential to affect all 102 residents, staff, and visitors, who consumed food prepared from the main production kitchen. Findings include: During observation and interview on 11/12/24 at 8:20 a.m., an initial kitchen tour was completed with culinary coordinator (CC) and the following items were identified: 1. A series of two white colored plastic bins were on the floor (wheeled) adjacent to the baking area. These were labeled for flour and sugar. However, the bin labeled for flour was approximately half full and a plastic, blue-colored scoop was present inside the bin and touching the flour. The handle was pointed upward from the product. CC opened the flour container and stated, that shouldn't be there. 2. The three compartments sink was filled with water. The water in two of the compartments was clear, and the third one was tinted blue. A testing log of the chemical used on this sink was not available upon request. During interview on 11/13/24 at 10:25 a.m., CC and company regional kitchen manager (RKM) confirmed the facility used a chemical sanitization process for cleaning pot and pans and stated the staff had not been testing the chemical levels used in the three-compartment sink. CC stated the pots used to prepared food were washed in the three compartments sink and the pots were never washed in the dishwasher. RKM stated a testing log was implemented that morning. During observation on 11/13/24 at 11:36 a.m., dietary staff were dishing food from a steam located next to the main cooking area. A black binder was on top of the steam table and contained daily temperature logs for the month of November. Daily logs included breakfast, lunch, and dinner. Temperature documentation of meals were as follows: 11/01/24 - Breakfast and dinner temperatures were documented. 11/02/24 - No temperatures were documented 11/03/24 - Breakfast and dinner temperatures were documented. 11/04/24 - Breakfast, lunch, and dinner temperatures were documented 11/05/24 - Breakfast and dinner temperatures were documented. (continued on next page)

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	245460	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jones Harrison Residence	3700 Cedar Lake Avenue Minneapolis, MN 55416

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/06/24 - Breakfast and lunch temperatures were documented. 11/07/24 - Breakfast and dinner temperatures were documented. 11/08/24 - Breakfast and lunch temperatures were documented. 11/09/24 - Breakfast and lunch temperatures were documented. 11/10/24 - Breakfast and lunch temperatures were documented. 11/11/24 - Breakfast, lunch, and dinner temperatures were documented 11/12/24 - Breakfast and lunch temperatures were documented. 11/13/24 - Breakfast and lunch temperatures were documented. During interview on 11/13/24 at 12:20 p.m., CC and RKM verified the daily temperature logs for the steam table were incomplete. CC stated the cooks used a blue colored binder to document the food temperatures when they were preparing the food, and before the food was transferred to the kitchen's steam table. CC was unable to locate the cook's binder used to log temperatures at the point of food preparation and stated she was going to contact the weekend cook and ask where the binder was. During interview on 11/14/24 at 7:20 a.m., CC stated the binder used by the cooks to document the food temperature was not found. During interview on 11/14/24 at 7:25 a.m., cook (CA) stated he did not temp or document the breakfast or lunch temperatures on 11/12 or 11/13 before he transferred the food from the kitchen to the steam table because the dietary aide checks the food temperature at the steam table. During interview on 11/14/24 at 8:32 a.m., RKM stated having two binders to document temperatures was not functional, and probably the cook and the kitchen aid were relying on each other to check the temperature. RKM stated starting immediately a single temperature log will be used by the kitchen staff. RKM stated the food temperatures needed to be monitored to assure the quality of the food, meet regulations, and prevent foodborne illnesses. Further, RKM stated leaving a scoop inside a container was a concern for cross contamination, and the chemical levels of the three-compartments sink should be tested to assure pots are properly sanitized. During interview on 11/14/24 at 1:58 p.m., the administrator stated the expectation was to check the temperature of food before it's served, scoops are not left inside food containers to prevent cross contamination, and testing of the chemicals used to sanitize kitchen equipment was done to assure proper sanitation. Facility Policy titled Meal Program, dated 03/2023, indicated the purpose of this policy was to offer a comprehensive and attractive meal program that meets the United States Department of Agriculture guidelines for the nutritional needs of the elderly and ensures compliance with 144G.41 and 144G.91. Policy also indicated the food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. Further, policy indicated temperatures will be taken by cook after transfer any item to the steam table prior to beginning of service and logged. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Policy titled Food Labeling and Storage dated 11/2023 indicated the director of food and nutrition services will be responsible for providing safe foods for all individuals and knows to store food to prevent cross contamination. Facility Policy titled Food Safety and Sanitation dated 05/2024 indicated the staff will complete all necessary tasks regarding regulations for service and preparation in healthcare environment. Policy included the proper procedure to set up three-compartment sink and test water for PPM ((200-4500) for quart and (500-700) for sink and surface, record and initial in log.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and document review the facility failed to ensure 2 of 5 residents (R25, R85) were offered, educated and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC), who were reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R25's annual Minimum Data Set (MDS) dated [DATE] indicated R25 was [AGE] years old, was admitted to the facility on [DATE], was severely cognitively impaired, and had the following diagnoses: peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (high blood pressure), Alzheimer's disease, and dementia. R25's Point Click Care Immunization, updated 11/14/24, indicated R25 had received pneumococcal vaccine (PCV23) on 4/26/17. The record did not indicate a refusal or if R25 had been offered/educated on the benefit of receiving an additional pneumococcal vaccinations. R85's quarterly MDS dated [DATE] indicated R85 was [AGE] years old, admitted on [DATE], was severely cognitively impaired, and had the following diagnoses: heart failure, diabetes mellitus (a chronic disease where the body is unable to properly regulate blood sugar levels), hyperlipidemia (high blood lipid levels), Alzheimer's disease, and dementia. R85's Point Click Care Immunization tab, updated 11/24/24, indicated R85 received PCV13 on 7/13/15 and PCV23 on 01/11/07. The record did not indicate a refusal of PCV20, or if if R85 had been offered/educated on the benefit of receiving an additional pneumococcal vaccinations. During interview on 11/14/24, at 1:40 p.m. infection preventionist (IP) stated she used the Minnesota Immunization Information Connection (MIIC) and admission paperwork to determine residents' vaccination status. IP stated R25, and R85's medical records lacked documentation of receiving the PCV20 vaccination. During interview on 11/14/24, at 1:44 p.m. director of nursing (DON) stated R25 and R85 were eligible to receive the PCV20 vaccination. DON confirmed R25 and R85 had not been offered nor had they received the PCV20 vaccination. DON stated her expectation was all residents would be educated on the risks and benefits of receiving vaccinations, as well as offered any eligible vaccinations. DON stated it is important to receive vaccinations to promote good health. A vaccination policy was requested but not provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and document review, the facility failed to ensure the Coronavirus Disease (COVID-19) vaccination was offered and/or provided to reduce the risk of severe illness to 1 of 5 residents (R58) reviewed for immunizations. Findings include: Center of Disease Control and Prevention (CDC) Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States reviewed 4/4/24, directed the following guidance: For people [AGE] years or older who are not moderately or severely immunocompromised: -unvaccinated= 1 dose of an updated (2023-2024 Formula) mRNA COVID-19 vaccine OR 2 doses of updated Novavax vaccine. -Previously received 1 or more Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of Original monovalent Novavax vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of [NAME] vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine or Original monovalent Novavax doses= 1 dose of any updated COVID-19 vaccine. -Special situation for people ages [AGE] years and order= People ages [AGE] year and older should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months following the previous dose of updated COVID-19 vaccine. For initial vaccination with updated Novavax COVID-19 vaccine, the 2-dose series should be completed before administration of the additional dose. For people [AGE] years or older who are moderately or severely immunocompromised: -Unvaccinated= 3 homologous (i.e., from the same manufacturer) updated (2023-2024 Formula) mRNA vaccine doses OR 2 updated Novavax vaccine doses. -Previously received 1 or 2 Original monovalent or bivalent mRNA vaccine doses= Complete the 3-dose series with 2 or 1 homologous updated mRNA vaccine doses, respectively. -Previously received a combined total of 3 or more Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Previously received 1 or more Original monovalent Novavax vaccine doses, alone or in combination with any Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of [NAME] vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine or Original monovalent Novavax doses= 1 dose of any updated COVID-19 vaccine. -People ages 12-[AGE] year may receive 1 or more additional doses of any updated COVID-19 vaccine. -People ages [AGE] years and older should receive 1 additional dose and may receive further additional doses of any updated COVID-19 vaccine. R58's quarterly Minimum Data Set (MDS) dated [DATE], indicated R58 was admitted on [DATE], was cognitively intact, and had the following diagnoses: anemia (low red blood cells and hemoglobin in blood), hypertension (high blood pressure), hyperlipidemia (high levels of fat in the blood) and anxiety disorder(a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). R58's Point Click Care Immunizations tab lacked any documentation for COVID 19 vaccination. During an interview on 11/14/24, at 1:40 p.m. infection preventionist (IP) stated she had reviewed R58's admission medical record and the Minnesota Immunization Information Connection (MIIC) website to obtain R58's vaccination status. IP stated R58 was eligible to receive the COVID-19 vaccination but had not been offered, nor had she refused the vaccination. During an interview on 11/14/24, at 1:44 p.m. director of nursing (DON) confirmed R58 had not been offered nor received the COVID 19 vaccination. DON stated her expectation was all residents would be educated on the risks and benefits of receiving vaccinations, as well as offered any eligible vaccinations. DON stated it is important to receive vaccinations to promote good health. A vaccination policy was requested but not provided.