STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245507	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 Southbend Avenue Mankato, MN 56001

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R16) who was observed to have medications in his room, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R16's facesheet printed on 6/13/24, indicated history of a stroke. R16's annual Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, clear speech, could usually understand and be understood. R16 was dependent upon staff for activities of daily living. R16's physician orders included: 1. Calcipotriene external ointment 0.005 %, apply to affected area on right leg topically two times a day every Saturday and Sunday for psoriasis, dated 10/25/23. 2. Aspercreme arthritis pain external gel 1 % (diclofenac sodium topical), apply to left hand and finger joints topically every morning and at bedtime for contracture pain, dated 4/18/24. 3. Systane solution 0.4-0.3 %; instill 1 drop in both eyes every morning and at bedtime for dry eyes, dated 3/24/23. 4. Latanoprost solution 0.005 %; instill 1 drop in both eyes at bedtime related to dry eye syndrome, dated 8/6/22. R16's care plan dated 7/2/15, indicated R16 was inappropriate for self-medication administration except for Icy Hot balm at bedside for wife to administer prn (as needed). During an observation on 6/10/24 at 1:44 p.m., in R16's room, observed two bottles of eye drops on top of a dorm-size fridge: Latanoprost 2.5 ml (milliliters) and Systane 15 ml. On the dresser were tubes of prescription diclofenac gel and calcipotriene ointment. R16 did not have a self-administrator order nor did his care plan indicate R16 could self-administer medications. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/11/24 at 10:40 a.m., the eye drop bottles were no longer visible in R16's room; the ointment and gel remained on the dresser. During an interview on 6/12/24 at 7:06 a.m., family member (FM)-C in room with R16, stated she administered eye drops and ointments to R16. FM-C stated the medications belonged to the facility. During an interview on 6/12/24 at 10:02 a.m., trained medication aide (TMA)-A stated R16 did not have a self-administration order for eye drops, ointment and cream and stated R16 would not be capable to self-administer medications either. TMA-A was informed of finding medications in R16's room and stated she had heard FM-C came in the morning to give R16 his medications as R16 was resistant to staff giving him medications. TMA-A stated FM-C may be putting his eye drops in too; that a nurse may have dropped them off in his room and had not gone back to pick them up. TMA-A stated medications can only be left in a resident's room if the resident had a self-administration of medication order. TMA-A opened the medication cart and R16's eye drops were in the cart. During an interview on 6/12/24 at 12:09 p.m., the director of nursing (DON) was informed of findings with eye drops, ointment, and a cream in R16's room. The DON was unaware of this and stated if a resident did not have a self-administration order, they were not able to keep medications in their room. The DON stated she would remove the ointment and gel from R16's room. The DON was aware FM-C assisted in giving R16's his medications but admitted FM-C had not been evaluated for safe administration of medications for R16. During an interview on 6/13/24 at 9:36 a.m., registered nurse (RN)-A stated R16 was resistant to staff giving him his medications and wanted FM-C to give them, therefore staff brought in the eye drops for FM-C to administer to R16. RN-A stated she was aware the ointment and cream were left in his room. RN-A stated R16 could get aggressive when cares were provided, which was why FM-C provided some of R16's cares. The facility Self-Administration of Medication policy dated 2/2024, indicated: Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on observation, interview and record review, the facility failed to update the care plan and the Kardex with behavioral interventions for 1 of 1 resident (R39) reviewed for care plans. Findings include: R39's facesheet printed on 6/13/24, included diagnoses of metabolic encephalopathy (a chemical imbalance in the brain which can lead to personality changes), bilateral below the knee amputations, and depression. R39's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R39 was cognitively intact, had clear speech, could understand and be understood, was independent with eating and toileting, refused oral care and bathing. Due to bilateral below the knee amputation, R39 used a wheelchair. R39's physician orders dated 8/22/23, and 3/20/24, included psychotropic, antipsychotic, and anti-depressant medication monitoring for side effects. Orders did not include mood and behavior monitoring. R39's care plan dated 6/2/22, indicated the potential for alteration in mood and behavior related to diagnoses of bilateral below the knee amputations and major depressive disorder. Interventions included: be alert to mood and behavioral changes and monitor and document mood state/behaviors upon occurrence. The care plan failed to include interventions for behaviors and how staff were to address them. R39's Kardex (separate from the care plan; an abbreviated reference commonly utilized by nursing assistants [NA's]), printed on 6/12/24, included, under the section titled Behavior included: R39 enjoyed collecting trading cards, animal movies, shows on TV. Independent activities and will chose when would like to socialize. The Kardex failed to include interventions for behaviors and how staff were to address them. Under a section titled Grooming - the Kardex failed to indicate interventions for refusing showers and oral care. R39's progress notes from January 2023, to current, indicated a pattern of behaviors including being argumentative, rude, yelling at staff, refusals to listen to staff, refusals of medical care including dressing changes, refusals of weights, oral care, bathing; spitting nicotine chew on the floor, refusing to allow housekeeping to clean his room, and inability to redirect R39. During an interview on 6/11/24, at 1:55 p.m., the director of nursing (DON) stated R39 was his own worst enemy; he was affecting other residents with body odor and smell emanating from his room. R39 was discussed at morning IDT (interdisciplinary team meetings) but admitted tactics and interventions discussed regarding behaviors were not always added to the care plan or Kardex. During several conversations with R39 on 6/12/24, in and outside of his room, R39 was open to talking and expressing feelings; was pleasant and articulate during the conversations. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24, at 1:50 p.m., licensed practical nurse (LPN)-A who was also the nurse manager for the unit on which R39 resided, stated R39 refused a lot of cares and would cuss, swear, and scream at staff. Together in her office, reviewed R39's care plan. While several types of refusals were care planned, the care plan lacked tactics and intervention to guide staff when R39 refused cares or exhibited behaviors. When asked how current staff, new staff and agency staff would know about R39's behaviors (argumentative, cussing, swearing, screaming and refusals) prior to caring for R39 and what interventions to deploy, LPN-A stated it was okay for staff to care for R39 without being informed of his behaviors because there were always other employed staff they could ask if they had concerns. LPN-A stated R39 would tell staff to get out of his room and staff just needed to get out and not engage with him. Further, there was nothing in R39's Kardex about R39's behaviors and interventions. LPN-A stated she had not been a nurse manager very long and when she had reviewed R39's care plan, thought it looked okay, and had not identified behaviors were missing. LPN-A stated updates to a care plan were generally done when changes were made to the MAR (medication administrator record) or TAR (treatment administration record), or when a new therapy order was received. LPN-A stated care plans were also updated after quarterly care conferences. LPN-A stated R39's care plan and Kardex should address mood and behaviors with interventions to guide the staff, and admitted they did not. During an interview on 6/12/24 at 2:20 p.m., the DON stated she would expect to see mood and behavior identified on a resident's care plan and that nurse managers and social services would add behaviors and interventions to a care plan. The DON stated licensed nurses utilized a care plan to guide them in a resident's care and NA's used a Kardex. The DON was informed R39's care plan and Kardex didn't address his behaviors and outbursts, or how to manage them. The DON admitted that information would be important for staff to know how to effectively approach R39 and should include de-escalation tactics. The DON admitted R39's behaviors should be care planed so that communication was the same among all staff, including agency. During an interview on 6/13/24 at 10:43 a.m., the administrator stated her understanding of a care plan was to ensure staff were doing resident checks that were needed, to help with communication for staff and family, and to guide the staff in providing care to residents. The administrator was informed of R39's care plan and Kardex lacking identification of mood and behavior, and interventions to guide the staff. The administrator was aware of R39's behaviors - they were discussed at IDT - and stated they had tried multiple staff talking to him and it had been a struggle to find what works for him. During an interview on 6/13/24 at 11:10 a.m., the DON stated the purpose of a care plan was to tell the residents story and to identify their specific needs as each resident was different. The DON stated R39's care plan and Kardex could be improved; how to approach, what to do with refusals such as refusing a shower - what are alternatives options. The facility Care Planning policy dated 1/6/22, indicated residents would have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 2 residents (R42) who was dependent upon staff for assistance with activities of daily living (ADL). Findings include: R42's Face Sheet printed 6/13/24, included diagnoses of disorientation, malnutrition, Parkinson's disease (progressive disorder that affects the nervous system and parts of the body controlled by the nerves), and epilepsy (seizures). R42's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R42 had a moderate cognitive impairment, inattention behavior continuously present, and behaviors including rejection of care that occurred 4-6 days out of 7. Activities of daily living (ADL's) included R42 uses a wheelchair and dependent on staff to wheel 50 feet, has impairment on both side of lower extremities for range of motion and requires substantial to maximal assist for transfers, bed mobility, toileting and personal hygiene. Eating requires setup or clean up assist. R42's Care Area Assessment indicated R42 is at high risk for skin breakdown and requires staff assist for transfers and ADL's. Staff offer toileting and repositioning per plan of care. R42's Braden Scale for Predicting Pressure Sore Risk dated 1/16/24 had a score of 17 indicating R42 is at risk for skin breakdown. R42's care plan dated 2/7/22, indicated R42 had a self-care deficit related to impaired mobility, generalized weakness, and decline in cognition. Interventions included please assist with all ADL's, staff to complete pericare after each elimination/incontinent episode every shift. If resistive with cares, leave and return in 10 minutes. Another care plan included alteration in mobility related to generalized weakness and decline in cognition dated 1/19/22. Interventions included; use EZ stand and assist of 1 to 2 for transfers. Encourage and assist with repositioning for pain. No more than 2 hours in wheelchair no matter tilting, repositioning. A separate plan of care dated 1/19/22, indicated alteration in elimination related to urinary tract symptoms and obstructive and reflux uropathy (blockage of urine flow). Interventions included monitor Foley catheter output, and assist of one with toileting every 2 hours and as needed using the EZ stand. May use assist of 2 as needed. Pads/briefs in use to aid in keeping skin dry. During observation on 6/10/24 at 2:48 p.m., urine smell noted in room with wet brief on the floor next to the garbage can and window. During observation on 6/10/24 at 5:04 p.m., R42's soiled brief remains on the floor with urine smell noted in room. During interview on 6/10/24 at 7:06 p.m., family member (FM)-G indicated she has found R42 in wet pants, smelling like urine when she arrives for visits. FM-G stated he should not be leaking from his urinary catheter and plans to schedule a care conference to find out why the catheter is leaking. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R42 was continually observed on 6/11/24: 12:34 p.m., R42 was transferred from his recliner to wheelchair and taken to the dining room for lunch. Staff did not check brief for incontinence during this time. 1:02 p.m., R42 remains at table with meal in front of him. Ate 25% of meal and drank a can of Pepsi. 1:32 p.m., Remains at table in the living room area. At 1:46 p.m., remains at table, watching television and occasionally putting his head down. 2:00 p.m., activities staff pushed him into dining room to play bingo. 2:30 p.m., continues in dining room, playing bingo with other residents. 3:03 p.m., bingo finished and R42 pushed himself from the back away from the table but stayed in the dining room. Staff assisting other residents to their rooms. 3:11 p.m., R42 remains in the same place in the dining room. All other residents have left the area. R42 attempting to move self using his arms to propel wheelchair, but ending up going in a circle. 3:21 p.m., R42 continues to attempt to move himself in his wheelchair. R42 is going the opposite direction of his room and has made it approximately 10 feet towards exit to another hallway. 3:31 p.m., R42 continues to attempt to move himself in his wheelchair and stated he is going to his room because his lower back hurts and he wants to go back to his room. 3:44 p.m., staff still have not approached R42 so staff were informed R42 requested to go back to his room. R42 throughout continual observation was never approached by nursing staff, or offered to be toileted or assisted to be repositioned or taken back to his room. During interview on 6/12/24 at 9:25 a.m., nursing assistant (NA)-A indicated R42 sometimes leaks around his catheter and doesn't always let staff know if he has had a bowel movement so R42's pad should be checked every few hours to ensure he is dry and clean. During interview on 6/12/24 at 1:38 p.m., licensed practical nurse (LPN)-A, also identified as care coordinator, indicated R42 is a high risk for skin breakdown and should be offered to be repositioned every two hours. LPN-A stated I was not aware that wasn't done yesterday. During interview on 6/12/24 at 1:40 p.m., registered nurse (RN)-B indicated R42 has a urinary catheter but has leaked around tubing, plus he is high risk for skin breakdown so should be repositioned and checked to ensure he is dry and clean every two hours. During interview 6/13/24 at 8:14 a.m., the director of nursing (DON) indicated R42 does have a catheter but he still needs to be repositioned and checked to make sure he is clean and dry every 2 hours per plan of care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Activities of Daily Living (ADLs)/Maintain Abilities policy dated 5/9/24 included: - It is the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident ' s quality of life by ensuring all staff, across all shifts and departments, understand the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided are person-centered, and honor and support each resident ' s preferences, choices, values and beliefs.- -The facility will provide care and services for the following activities of daily living: a. Hygiene -bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. -A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R42) who was dependent upon staff for repositioning and high risk for pressure ulcers. Findings include: R42's Face Sheet printed 6/13/24, included diagnoses of disorientation, malnutrition, Parkinson's disease (progressive disorder that affects the nervous system and parts of the body controlled by the nerves), and epilepsy (seizures). R42's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R42 had a moderate cognitive impairment, inattention behavior continuously present, and behaviors including rejection of care that occurred 4-6 days out of 7. Activities of daily living (ADL's) included R42 uses a wheelchair and dependent on staff to wheel 50 feet, has impairment on both side of lower extremities for range of motion and requires substantial to maximal assist for transfers, bed mobility, toileting and personal hygiene. R42 is at high risk for pressure ulcers, has pressure reducing device for bed and chair and has no current pressure ulcers. R42's Care Area Assessment indicated R42 is at high risk for skin breakdown and requires staff assist for transfers and ADL's. Staff offer toileting and repositioning per plan of care. R42's Braden Scale for Predicting Pressure Sore Risk dated 1/16/24 had a score of 17 indicating R42 is at risk for skin breakdown. R42's care plan dated 2/7/22, indicated R42 had a self-care deficit related to impaired mobility, generalized weakness, and decline in cognition. Interventions included please assist with all ADL's, staff to complete pericare after each elimination/incontinent episode every shift. If resistive with cares, leave and return in 10 minutes. Another care plan included alteration in mobility related to generalized weakness and decline in cognition dated 1/19/22. Interventions included; use EZ stand and assist of 1 to 2 for transfers. Encourage and assist with repositioning for pain. No more than 2 hours in wheelchair no matter tilting, repositioning. A plan of care dated 2/7/22 indicated R42 has a potential for skin breakdown related to impaired mobility and generalized weakness. Interventions included call bell within reach, answer promptly, turn and reposition resident every 2 hours and as needed. A separate plan of care dated 1/19/22, indicated alteration in elimination related to urinary tract symptoms and obstructive and reflux uropathy (blockage of urine flow). Interventions included monitor Foley catheter output, and assist of one with toileting every 2 hours and as needed using the EZ stand. May use assist of 2 as needed. Pads/briefs in use to aid in keeping skin dry. R42 was continually observed on 6/11/24: 12:34 p.m., R42 was transferred from his recliner to wheelchair and taken to the dining room for lunch. Staff did not check brief for incontinence or reposition during this time. 1:02 p.m., R42 remains at table with meal in front of him. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:32 p.m., Remains at table in the living room area. 1:46 p.m., remains at table, watching television and occasionally putting his head down. 2:00 p.m., activities staff pushed him into dining room to play bingo. 2:30 p.m., continues in dining room, playing bingo with other residents. 3:03 p.m., bingo finished and R42 pushed himself from the back away from the table but stayed in the dining room. Staff assisting other residents to their rooms. 3:11 p.m., R42 remains in the same place in the dining room. All other residents have left the area. R42 attempting to move self using his arms to propel wheelchair, but ending up going in a circle. 3:31 p.m., R42 continues to attempt to move himself in his wheelchair and stated he is going to his room because his lower back hurts and he wants to go back to his room. 3:44 p.m., staff still have not approached R42 so staff were informed R42 requested to go back to his room. R42 throughout continual observation was never approached by nursing staff, or offered to be toileted or assisted to be repositioned or taken back to his room. During interview on 6/12/24 at 9:25 a.m., nursing assistant (NA)-A indicated R42 sometimes leaks around his catheter and doesn't always let staff know if he has had a bowel movement so R42's pad should be checked every few hours to ensure he is dry and clean. NA-A indicated R42 does not have any bed sores currently but is at high risk. During interview on 6/12/24 at 1:38 p.m., licensed practical nurse (LPN)-A, also identified as care coordinator, indicated R42 is a high risk for skin breakdown and should be offered to be repositioned every two hours. LPN-A stated I was not aware that wasn't done yesterday. During interview on 6/12/24 at 1:40 p.m., registered nurse (RN)-B indicated R42 has a urinary catheter but has leaked around tubing, plus he is high risk for skin breakdown so should be repositioned and checked to ensure he is dry and clean every two hours. During interview 6/13/24 at 8:14 a.m., the director of nursing (DON) indicated R42 does have a catheter but he still needs to be repositioned and checked to make sure he is clean and dry and doesn't develop any pressure ulcers minimally every 2 hours per plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview, and document review, the facility failed to ensure staff were educated and following the fall risk interventions for 1 of 2 residents (R42) identified at risk for falls to prevent further falls. Findings include: R42's Face Sheet printed 6/13/24, indicated R42 had diagnoses of age related cognitive decline, disorientation, obstructive and reflux uropathy (blockage of urine flow), Epilepsy (seizures) and Parkinson's disease (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). R42's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R42 had a moderate cognitive impairment, had inattention behavior continuously present, and behaviors of rejection of care that occurred 4-6 days out of 7. Activities of daily living (ADL's) included R42 uses a wheelchair and dependent on staff to wheel 50 feet, has impairment on both side of lower extremities for range of motion and requires substantial to maximal assist for transfers, bed mobility, toileting and personal hygiene. Eating requires setup or clean up assist. R42's Care Area assessment dated [DATE], indicated R42 was at risk for falls. See plan of care for fall interventions. Fall assessment last completed 1/16/24, identified R42 was at risk for falls and has had 3 falls since last assessment. R42's plan of care last updated 4/17/24, indicated R42 was at risk for falls related to generalized weakness, impaired mobility and decline in cognition. Interventions included; clip call light to overbed light to prevent resident from needing to reach over bed for the cord, Dycem in recliner, grabber (reacher mechanical tool used to increase the range of a persons reach and grasp objects) for use when reaching items, hourly checks when in recliner, offer to lay down in the afternoon as resident allows, place garbage can next to recliner, call light within reach, proper footwear to be worn at all times and monitor and document on safety. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Facility Incident Review and Analysis dated 4/17/24, indicated R42 experienced a fall from chair at 8:00 p.m Incident Analysis included resident slid from recliner and stated he was throwing something away and slid. Contributing factors included R42 not always able to realize limitations. Possible interventions was left blank with implementation of interventions including staff education if applicable, intervention care planned and appropriate assessments completed. Signed by licensed practical nurse (LPN)-A. A progress note dated 4/16/24 at 11:18 p.m., by registered nurse (RN)-C included R42 slid out of his recliner at 8:00 p.m. R42 stated he was throwing plastic cup away and slid. No injuries noted. Transported from the floor to bed via hoyer lift by 2 staff. Sister notified. (continued on next page)

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	245507	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 Southbend Avenue Mankato, MN 56001

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Incident Review and Analysis dated 4/29/24 at 4:40 p.m., indicated R42 had a fall from chair. Causal factor included patient was on the ground laying anterior attempting to get himself up from the ground. Patient stated that he was trying to reach for something and slipped out of his chair. R42 denied hitting his head or being hurt. R42 stated his shoes were slippery which might have caused him to fall from his chair. Follow up interventions included resident was given a grabber with instruction on how to use it. Implementation of interventions included staff education if applicable and interventions were care planned. Signed by LPN-B. Facility Incident Review and Analysis dated 4/29/24, at 11:40 p.m., indicated R42 had a fall from the bed. Casual factor included nursing assistant (NA), unidentified, found resident on the floor in his room on his knees with arms on bed. R42 was calling out and stated he just wanted to get up. R42 was assessed for injury and transferred to his bed. Follow up interventions included checked his report for bowel movements (BM) as R42 stated he hasn't pooped for 7 days. Intervention added to care plan to check BM list to make sure resident has BM. Encourage fluids. Provider to review bowel medications. Implementation of interventions included staff education if applicable, interventions care planned, interventions to resident care lists and appropriate assessments completed. Signed by LPN-B. A progress note by LPN-C dated 4/30/24 at 1:55 a.m., indicated R42 was found by aide, kneeling on the floor with his hands over his bed at 11:40 p.m. He stated not hitting his head and did not have injury noted to head. He wasn't able to say exactly why he was getting up, just stated he wanted to get out of bed. He was visually agitated and was having verbal outbursts, not like his baseline. Writer looked back at when resident had his last BM, it stated 7 days prior was the last time. Writer had offered Senna (stool softener), Milk Of Magnesium (laxative), and suppository (small solid objects used to deliver medicine). He had refused all at first but around 12:10 a.m., agreed to a suppository. He had medium results, BM was hardened. He became restless during the night, trying to get out of bed several times. Stated he needed to use the commode again around 2:15 a.m.,with small BM results. Resident had fall earlier during evening shift. Found on body was bruises to his left forearm, an old bruise to right hand. Both knees were reddened due to him being on them. No other injuries noted at time. Intervention put in place is to check and see if resident has had a BM every shift. Also, put in provider book for either MiraLAX (laxative solution that increases the amount of water in intestinal tract to stimulate BM's) scheduled or suppositories. He has been refusing his medications, which includes his Senna (stool softener), making it harder for him to have a BM. Facility Incident Review and Analysis dated 5/27/24, indicated R42 was found on the floor at 8:30 p.m. Causal factors included R42 was attempting to put the foot of his recliner down and slid out of his recliner. Follow up interventions included clip call light to overbed light, Dycem (nonskid pad) in recliner, grabber for use to reach items, lay resident down in the afternoon. Implementation of interventions included care planned, and appropriate assessments completed. Additional notes indicated the incident has been reviewed and will continue with the current plan of care. Signed by LPN-A. A progress note dated 5/27/24 at 10:01 p.m. by LPN-D included family member was notified of incident and no injuries. R42 was continually observed on 6/11/24: 12:34 p.m., R42 was transferred from his recliner to wheelchair and taken to a table in living area for lunch. Staff did not check brief for incontinence during this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:03 p.m., bingo finished and R42 pushed himself back from the table. Staff assisting other residents to their rooms. 3:31 p.m., R42 continues to attempt to move himself in his wheelchair and stated he is going to his room because his lower back hurts and he wants to go back to his room. 3:44 p.m., staff still have not approached R42. Staff were informed R42 requested to go back to his room. Throughout continuous observation, staff failed to approach R42 and offer to toilet, assist him to his room, offer to lay him down or place him in his chair in his room. During observation on 6/12/24 at 7:11 a.m., R23 was in his bed. Call light was laying on the floor next to his bed. During observation and interview on 6/12/24 at 8:09 a.m., trained medication assistant (TMA)-B indicated R42 sleeps in some days and other days he is up and about by 7:30 a.m. TMA-B indicated staff will check on R42 periodically but unsure how often and deferred that to NA-A working today. TMA-B indicated R42 will holler out sometimes when he is ready to get up. TMA-B picked call light up off the floor and attached to the bed prior to leaving the room at 8:17 a.m. During observation and interview on 6/12/24 at 9:25 a.m., NA-A and NA-C went into R42's room and provided ADL care. R42 was taken out to breakfast. R42 stated he is tired this morning. During observation on 6/12/24 at 11:45 a.m., R42 is in his room in his chair. No reacher/grabber or garbage can is present next to his chair. During observation and interview on 6/13/24 at 9:02 a.m., R42 was in his chair in room and stated he is not sure where his grabbing deal (reacher) is, but thought it was around his room someplace. NA-A indicated he hasn't seen R42's grabber since he moved to wing a few weeks ago. NA-A was asked what R42's fall prevention interventions included and he stated Dycem to the chair, Velcro material on the floor and no skid shoes. When questioned about grabber in reach and garbage can next to chair, NA-A stated he wasn't aware of those interventions. NA-A looked around room and indicated he is unsure where the second garbage can is and the one by the door needs to stay there as R42 is on enhanced barrier precautions. During interview on 6/13/24 at 9:05 a.m., NA-D stated she was not aware the garbage can or grabber were current interventions for fall prevention for R42. During interview on 6/13/24 at 9:06 a.m., TMA-B indicated she was unsure of what R42's fall preventions are currently but can find out. TMA-B indicated NA's should be following the current plan of care that was observed with LPN-A to be on the back of R42's door dated 4/17/24, with current interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/13/24 at 9:13 a.m., LPN-A indicated R42 has had his grabber since he moved to this unit. LPN-A indicated all staff including NA's should be aware of all fall interventions in place and should be ensuring they are completed. LPN-A stated R42's grabber should be with him and his garbage can by him when he is in the chair as care planned. LPN-A indicated new interventions put into place is generally shared at shift hand offs and reports. The care plan is also posted on the back of resident's room door. During interview on 6/13/24 at 10:14 a.m., the director of nursing (DON), indicated she would expect the care plan including fall interventions in place be followed. The DON indicated R42 has had more recent confusion so he was moved to another wing for closer observation. The DON indicated R42 should be checked on every hour. During observation on 6/13/24 at 11:20 a.m., R42 was in his room in recliner with chair reclined back. Garbage can remains next to the door and not next to recliner and no grabber present. The facility Fall Prevention and Management policy dated 2/2024, included; -Facility staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. -Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. -Staff will monitor and document each resident ' s response to interventions intended to reduce falling or the risks of falling. -The interdisciplinary team will review falls daily at morning meeting. -The staff will continue to collect and evaluate information until they either identify the cause of falling or determine that the cause cannot be found.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on interview, observation, and document review the facility failed to ensure activities of daily living (ADLs) including timely assistance with toileting and changing soiled clothing were provided for 1 of 1 resident (R57) who needed assistance with toileting and hygiene. Findings include: R57's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R57 had moderately impaired cognition, no rejection of care, required supervision or touching assistance with transfers, was independent with personal hygiene and toilet hygiene, did not use a wheelchair, and was occasionally incontinent of bladder. Diagnoses included non-Alzheimer's dementia (vascular dementia) and unsteadiness on feet. R57's Care Area Assessment (CAA) dated [DATE], indicated the need for assistance with toilet use. R57's care plan printed [DATE], indicated R57 had an ADL self-care deficit related to vascular dementia without behavioral and psychotic disturbance, muscle weakness, history of falling, and osteoarthritis of knee and interventions included; assist with personal hygiene with assist of one staff, transfer with front wheeled walker with assist of one staff. R57's care plan also identified an alteration in elimination and interventions included assist of 1 staff with toileting, offer toileting every two hours and as needed, and provide assistance with personal hygiene every morning and evening. R57's document titled Visual/Bedside Kardex Report printed [DATE], indicated R57 required assist with personal hygiene, transfers, and toileting with assistance of one staff, offer toileting every two hours and as needed, monitor closet for soiled clothing/linens. On [DATE] at 10:08 a.m., R57 was observed seated on his bed in his room. R57 transferred from his bed into his wheelchair and used the bathroom in his room independently. R57 exited the bathroom with pants that were visibly soiled in front and down both legs. R57's pants were light tan in color and the soiled areas were wet with darker tan coloring indicating the wet areas. On [DATE] at 11:15 a.m., R57 was observed seated near the dining room in his wheelchair with visibly soiled light tan pants. The soiled areas were darker tan and appeared wet and covered the front of the pants and extended down both legs and there was a strong smell of urine near R57. On [DATE] at 11:25 a.m., R57 was served food in the dining room. R57 was seated in his wheelchair at the dining room table. R57's soiled pants no long appeared visibly wet and the spots that were previously darker appeared to have dried and matched the initial tan color of the pants. On [DATE] at 12:44 p.m., R57 was observed using the bathroom in his room and transferring to his wheelchair independently with visibly soiled pants in the front and down both legs. R57's light tan pants were visibly soiled in the front groin area and down both legs to a darker tan color and appeared wet. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:18 p.m., R57 was seated in his wheelchair in the day room waiting to play bingo and remained in the same soiled pants, which appeared to have dried and had turned light tan in color again. On [DATE] at 2:32 p.m., R57 was observed playing bingo in the dining room. A strong odor of urine was noted in the area of the dining room where R57 was seated. On [DATE] at 3:16 p.m., R57 was observed sitting in the day room in the same pants. R57's pants appeared visibly soiled in the front and down the legs again. The pants were again a darker tan color in the front. On [DATE] during continuous observation from 7:07 a.m. to 10:40 a.m., no offers of assistance with toilet use or personal hygiene were observed. At 7:07 a.m., R57 was observed seated in his wheelchair at a table in the dining room wearing the same soiled pants, which appeared dry and were light tan in color. A strong smell of urine was present in the dining room area near R57. At 8:01 a.m., R57 used the bathroom in his room and transferred to bed independently. At 9:08 a.m., R57 used the bathroom in his room and transferred to a wheelchair independently. Pants were again visibly soiled in front and down both legs, with the soiled areas appearing dark tan and wet. At 9:53 a.m., R57 was seated in his wheelchair in the day room with visibly soiled pants. A strong odor of urine was noted in the area. At 10:35 a.m., R57 used the bathroom in his room independently and exited the bathroom with soiled pants. R57 entered the hall to return to the day room. While in the hallway, registered nurse (RN)-B asked nursing assistant (NA)-A if R57 had been offered toileting that morning and NA-B confirmed no toileting had been offered. Trained medication aide (TMA)-B noticed the soiled pants and offered to assist R57 with changing clothes. R57 agreed and TMA-B assisted R57 into clean clothing. During an interview on [DATE] at 12:48 p.m., NA-B stated R57's room had an odor of urine due to incontinence and R57 required assistance with getting dressed in the morning but was independent with everything during the day. NA-B further stated R57 rarely used the call light and would require assistance with finding clean clothing if clothing were soiled and with personal hygiene. During interview on [DATE] at 1:12 p.m., RN-B stated the urine odor in the 500 hallway comes from R57's bathroom and clothing. RN-B stated R57 urinates on the floor in his bathroom, does not allow cares, and requires the assistance of one person for toilet use. RN-B further stated staff should be attempting to toilet him during the day and he should not be using the toilet independently. RN-B's expectation would be that the staff are offering toileting every two hours, even with refusals and indicated staff should at least be trying to assist R57. RN-B would expect staff to try different approaches and ask other staff to try to assist R57 with his toileting and hygiene needs. A sign on the back of R57's door indicates assistance of one for toilet use. During interview on [DATE] at 2:31 p.m., NA-G stated that there is a strong odor of urine coming from R57's room. NA-G stated R57 requires the assistance of one person for toilet use and does not use the call light. NA-G further stated that if R57 does not use the call light, staff should ask every two hours to see if the bathroom is needed and indicated R57 refuses assistance but should still be offered assistance every two hours. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 7:41 a.m., NA-A stated that the urine smell comes from both the bathroom and from R57. NA-A further stated R57 requires assistance of one staff for toilet use and hygiene. NA-A stated they know this because of the Kardex on the back of the door in R57's room. NA-A stated toilet use should be offered every two hours and soiled clothing should be changed immediately. NA-A indicated R57 is hesitant with assistance, but usually allows help if offered. During interview on [DATE] at 10:50 a.m., licensed practical nurse (LPN)-A also known as nurse manager stated that she would expect refusals of care to be documented and would expect staff to offer assistance with toileting and hygiene every two hours. LPA-A further stated if R57 would continue to refuse, staff should notify the nurse and if clothing were soiled, staff should offer to change it immediately. During interview on [DATE] at 11:05 a.m., the director of nursing (DON) stated R57 required the assistance of one person for transfers and toilet use, has no scheduled toileting plan, but should be offered toilet use every two hours. DON stated R57 takes himself to the bathroom frequently and refusals of care are documented on a paper form. DON further stated she expects that staff reapproach three different times with offers of assistance and if not successful, notify the nurse. In addition, DON stated if R57's clothing were soiled, staff should approach R57 immediately and attempt multiple strategies to assist with hygiene and changing clothes. DON stated she would expect R57 to be clean, dry, and presentable. The facility Activities of Daily Living (ADLs)/Maintain Abilities policy updated [DATE] states: The facility will provide care and services for the following activities of daily living: a. Hygiene - bathing, dressing, grooming, and oral care, b. Mobility-transfer and ambulation, including walking, c. Elimination-toileting, d. Dining-eating, including meals and snacks, e. Communication, including: i. Speech, ii. Language, and iii. Other functional communication systems. It also states: A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and basic life support, including CPR, when the resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation and interview the facility failed to ensure a mechanical transfer lift was cleaned after resident use for 3 of 3 residents (R9, R45, R26) and that appropriate sanitizer was used to clean the lift observed for infection control practices. Findings Include: R9's Face Sheet printed 6/13/24, included diagnoses of obesity, bipolar disorder, difficulty in walking and unsteadiness on feet. R9's significant change Minimum Data Set (MDS) dated [DATE], indicated R9 was dependent on staff for all transfers and required assist of 2 and a lift. During observation on 6/11/24 at 3:36 p.m., nursing assistant (NA)-E and NA-F with the assist of a mechanical lift (device utilized for transfer) transferred R9 from her bed to her wheelchair. NA-F removed the lift from the room and moved it to another hallway and parked it in room [ROOM NUMBER]. NA-F left the room. NA-F confirmed he did not clean the lift and should have. During observation on 6/13/24 at 8:39 a.m., NA-A was observed in R45's room cleaning a hoyer lift. NA-A was observed using Mckessen Stay Dry disposable washcloths. NA-A confirmed he was using resident wipes and should have been using disinfectant wipes. NA-A indicated they were told not to use bleach wipes anymore as it was staining residents clothing and all he could not find anything but bleach wipes. 50761 R26's MDS dated [DATE], included diagnoses for traumatic brain injury, dementia, and hip fracture. MDS indicated R26 used wheelchair. MDS indicated R26 was dependent on staff for transfers. During observation on 6/12/24 at 8:03 a.m., NA-A exited R26's room with a mechanical lift. NA-A placed the lift in an empty room and failed to disinfect the lift. On 6/12/24 at 8:05 a.m., NA-A confirmed the lift was not disinfected and stated the lift was expected to be cleaned after use. NA-A stated he was not aware of the policy for cleaning resident lifts. NA-A stated the lift was used for multiple residents and that's why we should be cleaning it. During interview on 6/13/24 at 8:18 a.m., the director of nursing (DON) confirmed lifts should be cleaned after use and before placing them in a hallway or empty room. The DON confirmed resident wipes are not sanitizing wipes and are not appropriate for cleaning a patient lift. The DON indicated they had just completed training with staff to talk about bleach and non-bleach wipes and necessary contact time. The facility Infection Prevention and Control Program policy dated 3/13/23 included: - Important facets of infection prevention include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Identifying possible infections or potential complications of existing infections; -instituting measures to avoid complications or dissemination; -enhancing screening for possible significant pathogens; -immunizing residents and staff to try to prevent illness; -implementing appropriate isolation precautions, when necessary; -following established [NAME] and disease-specific guidelines such as those of the Centers for Disease Control.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 40614 Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any residents who had infections requiring antibiotic use. Findings include: When interviewed on 6/13/24 at 8:10 a.m., the director of nursing (DON), also identified as infection preventionist, indicated the facility uses McGeer's criteria but staff are not always completing that in the medical record and stated it is a team effort to monitor symptoms between nurse managers and herself. The DON indicated she has been doing infection prevention for the past year and when she started, they didn't even have a tracking form. The DON stated she is using the Minnesota Department of Health (MDH) Infection Control Assessment and Response (ICAR) form for documentation for infections and antibiotic use. The interim DON indicated from the ICAR report, she is able to share quarterly data at quality assurance and performance improvement (QAPI) meetings, which includes the medical director and consulting pharmacist. The ICAR form included resident name, infection type, symptoms, onset date, diagnostic test performed, results, antibiotic resistant organism (yes, no), antibiotic name, dose, start and end date, transmission based precautions and date symptoms resolved. Upon review of the ICAR form for January through May 2024 the following were found incomplete: - January 2024: 27 entries present with 18 receiving antibiotics. Symptoms were present on 13 of the 27 entries. Test, type of test, results (organism and colony counts for urine) included 12 entries for rapid nasal Covid test and all 18 receiving antibiotics was blank (5 of which were urinary tract infections {UTI}). Date symptoms resolved were documented 0 of 27 entries. - February 2024: 35 entries present with 16 receiving antibiotics. Symptoms were present on 18 of 35 entries. Test, type of test, results included 15 Covid-19 rapid nasal swabs and all 16 of those receiving antibiotics was blank (2 were UTI). Date symptoms resolved were all blank. - March 2024: 36 entries present, 17 of which received antibiotics. Symptoms were present on 1 entry. Test, type of test, results included 9 entries that included RSV (respiratory syncytial virus) and influenza (flu). Of the 17 receiving antibiotics, 1 test type included culture with organism identified as staphylococcus. The other 16 were blank. Date symptoms resolved was documented on 3 of 36 entries. -April 2024: 13 entries with all receiving antibiotics. Symptoms were documented on 11 of 12 possibilities. Test type, specimen source and results were documented on 5 of 12 possibilities. Date symptoms resolved was left blank on all 13 entries. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care & Rehabilitation Center	714 Southbend Avenue Mankato, MN 56001

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-May 2024: 21 entries, 3 of which were prophylaxis use and 20 receiving antibiotics. Symptoms were present on 17 of 18 entries. Test type, specimen source and results were documented on 12 of 17 possibilities with 4 of those documented as results not available. 8 of these were UTI's with no colony counts present. Date symptoms resolved was blank on all 21 entries. During interview on 6/13/24 at 8:30 a.m., the DON indicated nursing staff monitor resident's culture reports to make sure resident's prescribed antibiotics are the correct medication if tests are done at the facility. The DON stated she has not gotten access to the hospital electronic medical record go look up culture results for residents that were hospitalized or had testing in the emergency department. The DON confirmed she needs to follow up on all culture results to ensure the residents are on the correct antibiotic but has not currently been completing this. The DON indicated she is getting used to the ICAR documentation form and is trying to document all necessary items including symptoms resolution. The DON stated she is educating herself to bring the infection and antibiotic stewardship program to a higher level. The facility Antibiotic Stewardship Program dated 3/13/23, included: - Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. this policy is aligned with the CDC core elements of antibiotic stewardship that includes, leadership, accountability, drug expertise, action, tracking, reporting and education. -Prior to calling provider to communicate a suspected infection, the nurse will obtain and have the following information available: Signs and symptoms of suspected infection, history of present illness, current medication list, allergies, and all pertinent lab, imaging or rest results. -If a resident is admitted to the facility with orders for antibiotic therapy, the orders will be reviewed for appropriateness and completeness. Any pertinent supporting document will be reviewed and obtained for the medical record. -Appropriate indications for antibiotic use include: Criteria met for clinical definition of active infection or suspected sepsis; pathogen susceptibility, based on culture and sensitivity to antimicrobial (or treatment begun while culture is pending) and -The infection preventionist or designee will review all antibiotic orders to determine if treatment is appropriate. Treatment is appropriate if the organism is not susceptible to the antibiotic chosen. The organism is susceptible to a narrower spectrum antibiotic. Therapy was ordered for prolonged surgical prophylaxis. Therapy was started awaiting culture but not organism was isolation after 72 hours. -The provider will be notified of the review findings and recommendations and a response will be documented in the resident's medical record.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation and interview, the facility failed to ensure 4 of 5 vents in the 400 hallway, and 5 of 5 vents in 500 hallway were clean when they had a black substance present on the 3 tiered vents. This deficient practice had the potential to affect all residents, staff, and visitors on the 400 and 500 wings. In addition, the facility failed to ensure resident rooms were maintained in a clean, sanitary manner for 13 of 60 residents (R7, R163, R16, R29, R39, R57, R2, R4, R162, R260, R37, R45, R22) whose rooms and/or bathrooms lacked upkeep, and who were reviewed for environment. Findings include: Hallway Vents During an observation on 6/10/24 at 3:29 p.m., the 500 unit hallway was observed to have five vents that had a black substance present on the rungs of the 3 tired vents. The maintenance director (MD)-A indicated it appears like dust buildup and the vents need to be taken down and cleaned. MD-A added it likely due to moisture after starting the air conditioning units causing the dirt to stick. MD-A indicated housekeeping staff are responsible to clean the vents using a duster which he thought was weekly. MD-A indicated he has not taken down and cleaned the vents since he started at this facility a few years ago. During interview and observation 6/10/24 at 4:06 p.m., MD-B indicated the vents have dirt and dust present and was not sure if it was mold or not. During interview on 6/10/24 at 3:45 p.m., environmental services director (EVSD)-E indicated the vents are very dirty and and when questioned if it could possibly be mold she stated yes. On 6/10/24 at 3:46 p.m., the director of nursing (DON), also identified as infection preventionist, indicated she thought the vents were covered in dirt but couldn't say for sure if it was dirt or mold. The DON indicated she would have to go ask some questions for further information. During observation and interview on 6/10/24 at 4:30 p.m., MD-A had one of the vents in hallway 500 down and was cleaning the vent with bleach. MD-A indicated the administrator instructed him to clean them. MD-A when asked if it was possible mold stated he didn't think so as it easily wiped off. During interview on 6/10/24 at 4:34 p.m., the administrator indicated maintenance staff had looked at the vents and didn't believe it was mold so she instructed them to clean the vents. The administrator indicated they have had similar issues in the past with black debris on the vents and it was determined at that time it wasn't mold. The administrator indicated she has not had any complaints of odor of mold down the hallway from staff members or residents. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 6/10/24 at 5:18 p.m., MD-A indicated he looked into the air conditioning vents when taking down the vents and stated everything was clean and dry. Both MD-A and MD-B indicated the dirt/grime washed off easily and it has been likely years since the vents were taken down and cleaned. MD-B indicated housekeeping takes a dust mop to get some of the dirt off weekly, but apparently aren't getting the top tiers of the vents. During interview on 6/11/24 at 10:01 a.m., the maintenance director for the corporation (MDC)-C indicated he had looked at the vents today with MD-A and was told it was just dirt and grime present. MDC-C indicated the dust mops stir up dirt and it sticks to the vents. MDC-C indicated with mold you can't wash off with soap and water. MDC-C indicated he is 100% certain it was dirt and not mold present. During interview and observation on 6/11/24 at 11:30 a.m., EVSD-E showed dusting tool used to clean the vents. The tool had a long handle and fuzzy end that is designed to trap dirt. EVSD-E indicated the staff have a difficult time reaching the vents even with this dusting tool. Review of hallway vent cleaning schedule received 6/11/24, indicated 400 and 500 wing vents were last cleaned 1/16/24 by housekeeping. During observation on 6/13/24, down the 400 hallway, 4 of 5 vents were covered with a black substance on the top tiers of the vents. The bottom of the vents were clean. The facility Daily Cleaning Procedure undated, indicated housekeeping would empty trash, dust all high surfaces including vents and all corners, disinfect flat surfaces and high touch items, spot clean walls, clean restroom including high dust and toilet; and dust mop and damp mop the entire floor. 42073 Resident Rooms/Bathrooms/Hallways During an observation on 6/10/24 at 12:29 p.m., R7's room smelled of urine. Observed a small wastebasket next to the bed with soiled briefs open/overflowing. R7 who was lying in bed, stated she could smell the urine too and had not noticed the wastebasket with soiled briefs in it. R7 stated NA's usually removed the trash when they left the room. During an observation on 6/10/24 at 1:27 p.m., R163's toilet was heavily soiled with dark brown streaks of rust coming from under the rim and a rusty toilet bowl. During an observation on 6/10/24 at 1:49 p.m., in R16's room, the floor was dull and appeared dirty with scuff marks and shoe prints, small white paper debris on the floor, and dusty floor underneath the bed. The overbed table had gray paper stuck to it which appeared to be the bottom of a tissue box that was initially stuck to the surface and then removed, leaving gray paper residue behind. A small wastebasket was observed with soiled briefs open/overflowing. During a second observation on 6/12/24 at 2:30 p.m., R16's room was unchanged from the initial observation on 6/10/24 at 1:49 p.m., except the small wastebasket was empty. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 6/10/24 at 5:11 p.m., family member (FM)-D expressed concerned about cleanliness of R29's room and pointed out dead ants on the windowsill - stating they had been there for weeks. FM-D stated the floor generally wasn't clean, the bed wasn't moved to clean under it, and a small fan in the room was usually dusty. During an observation on 6/11/24 at 8:30 a.m., in R39's room, observed three full urinals sitting on an overbed table with strong smell of urine permeating the room. Multiple white tissues on the floor, small brown piles of tobacco chew/spit on the floor, empty beverage bottles and food containers observed on flat surfaces. The floor was dull and appeared dirty with many dark scuff marks. During an observation on 6/11/24 at 10:03 a.m., while standing in the hallway near R57's room with the door ajar about three inches, the stench of urine permeated the hallway. During an observation on 6/11/24 at 10:14 a.m., R57's floor was sticky. Surveyor shoes were tacky when walking in or near R57's room. A strong odor of urine permeated room R57's room; bed linens were stained yellow/brown when R57 got out of bed. During an observation on 6/12/24 at 7:09 a.m., on the wall of a short hallway leading to the resident shower room on the 200 wing, were multiple, horizontal areas above and below the chair railing where paint had been scraped off. Further, below the chair rail -- the wall appeared darker with dirt or dust, and had other small nicks of paint. During an observation on 6/12/24 at 07:37 a.m., observed the call light above R39's room was missing the white cover over the light on the outside of the door, above the door frame. The cover helps to illuminate he light to see it from a distance. During an observation on 6/12/24 at 9:45 a.m., observed a potential trip hazard on the floor near the main entrance reception desk. Metal strips were between flooring types, and the middle of the three metal strips, each about three feet long and about four inches wide -- was lifting on both ends. During an interview on 6/12/24 at 10:27 a.m., R39 stated he notified nursing assistants (NAs) when his urinals were full as they were too busy to empty them after each use. R39 stated housekeeping had tried to get the scuff marks off his floor the day before. R39 stated the facility was short housekeepers so he only had them clean his room once a week. During observations on 6/13/24 at 8:15 a.m., observed rusty toilet bowls in the following rooms: --R2, toilet bowl was stained rust colored and the ceiling exhaust vent had thick, gray debris on the slats. --R4, toilet bowl was stained rust colored and ceiling exhaust vent in the bathroom had fuzzy gray debris on the slats. During an observation on 6/13/24 at 9:44 a.m., the following rooms had approximately eight inches by five inch sections of the wall where a previous wall-mounted hand sanitizer dispenser had been, which were unpatched and unpainted: R260, R27, R45, R35, R39, R22, and R57. INTERVIEWS (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/24 at 10:57 a.m., with environmental services director (EVSD)-E (who had oversight over several long-term care facilities in the city) and corporate director of operations (DOO)-F for EVS, EVSD-E stated a housekeeper was expected to clean every resident room, every day. If not able to get to all the rooms, housekeepers let EVSD-E know and if she was not able to get to those rooms, housekeeping staff would do those rooms first thing the next day. EVSD-E stated the expectations of a housekeeper included cleaning the bathroom, walls, mirror, restock paper towels, empty trash, move beds and clean underneath; everything should be clean and odor-free. EVSD-E stated in a perfect world, three full-time and two part-time housekeepers would be able to accomplish cleaning every room, every day, but the facility was short two housekeepers. EVSD-E stated they had been interviewing and hiring -- looking at pay and offering a bonus. Some potential candidates scheduled for an interview had not shown up; some new hires started but quit right away. EVSD-D stated one resident in particular -- R39 -- would only allow housekeeping into his room once a week. EVSD-E stated R39's room took a good 20 minutes to clean . housekeeping had to clean up chew/spit off the floor; that R39 didn't bathe, and his room smelled awful. EVSD-E was informed of rusty toilets in various rooms in the facility and stated she was aware of it and aware some had been approved for replacement. During an interview on 6/11/24 at 11:59 a.m., NA-B stated when NA's changed a residents brief, they were to place the soiled brief in the wastebasket and then remove the garbage bag from the room upon exiting. NA-B stated staff were expected to do this even if there was only one soiled brief in the wastebasket. NA-B stated staff removed soiled briefs right away so rooms wouldn't smell of urine or feces. During an interview on 6/11/24 at 2:56 p.m., EVSD-E stated two EVS directors from other facilities were coming 6/12/24, to help catch up with resident room cleaning. During an interview on 6/12/24 at 7:33 a.m., EVSD-E, stated once she was informed of the condition of some resident room, started cleaning rooms herself on 6/11/24. EVSD-E stated due to workload, she had not been able to monitor the performance of the housekeepers and stated in the past, managers had been assigned to monitor cleanliness of rooms, but that was no longer the case. During an interview on 6/12/24 at 1:09 p.m., EVSD-E stated she will have a meeting with her staff to talk about expectations, adding, I thought they were doing better. During an interview on 6/13/24 at 8:28 p.m., with maintenance director (MD)-A, MD-A was aware of the rust-stained toilet in room [ROOM NUMBER] and stated it was on his list to replace. MD-A was aware of rust stains in toilet bowls of other resident toilets and stated he had started to replace some on them on the 200 wing. MD-A was reminded rusty toilets had been cited two years ago but MD-A was not able to say what the plan had been at that time to improve the condition of resident toilets. With MD-A, looked at the metal floor strip that was lifting by the main reception desk, and the missing call light cover outside of R39's room MD-A had not noticed the metal strip lifting and would fix that. MD-A stated he had ordered call light covers and would replace it. Together, looked at resident rooms where patching and painting had not been completed after changing hand hygiene dispensers. MD-A stated he was not working the day the dispensers were switched out and couldn't recall how long ago it had been done. Together also looked at the areas of scraped paint in the short hallway on the 200 wing and MD-A stated he was aware of that. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 at 10:06 a.m., with MD-B, asked about the facility plan after the State survey two years ago for improving the condition of resident toilets. MD-B stated MD-A had a list of toilets to be replaced; she didn't know where the list was and stated they do what they can, when they can -- there was no set schedule to replace the rust-stained toilets. MD-B stated, 100% - the toilets look terrible. MD-B did not recall how long ago hand sanitizer dispensers had been changed out -- that the maintenance department had started to patch and paint, then heard all the rooms were going to be repainted eventually, so didn't continue. During an interview on 6/13/24 at 10:43 a.m., the administrator stated lack of staff was prohibiting them from adequately cleaning resident rooms and added they have had performance issues with some housekeepers. The administrator stated managers used to do room cleanliness audits, but that stopped and they would be taking a different approach to doing that. The administrator was informed of other findings including rusty toilets, paint missing from walls in resident rooms and a hallway, and the condition R36's room. The administrator was aware of R36 refusing to allow staff to clean his room and stated they have tried having various staff talk to him -- adding, it has been a struggle finding what would work for him. Facility policy on room repair and maintenance was requested and the administrator indicated there was no policy. The facility Daily Cleaning Procedure undated, indicated housekeeping would empty trash, dust all high surfaces including vents and all corners, disinfect flat surfaces and high touch items, spot clean walls, clean restroom including high dust and toilet; and dust mop and damp mop the entire floor.