STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sholom Home West	3620 Phillips Parkway South Saint Louis Park, MN 55426

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48583 Based on observation, interview and document review, the facility failed to ensure grievance forms and procedures were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously if desired for 4 of 4 residents (R26, R35, R102 and R104) reviewed for grievances. Findings include: On 1/7/25 at 1:37 p.m., a resident council meeting was held with four residents which included R26 R26, R35, R102 and R104. During the resident council meeting, all four residents indicated they were not aware how to file a grievance form. R35 stated she thought there was a form at the front door that could be filled out and turned into a nurse. R35 further stated she did not think the form could be filled out without the help of a nurse. During an observation on 1/7/25 at 4:36 p.m., the 340 wing had a slot for grievance forms but no forms were present. During an observation/Interview on 1/7/25 at 4:43 p.m., registered nurse (RN)-F stated grievance forms are not kept on the 340 wing. RN-F further stated the forms were down stairs and residents could ask for them if they wanted to fill them out. During an interview on 1/8/25 at 8:29 a.m., guest services (GS) stated residents could grab a grievance form (concern form) from the box on the first floor by the guest services desk or they could ask a nurse to grab one for them. GS further stated when the form was filled out the resident could give the grievance form to a nurse to give to social services. GS revealed forms have always been given to her to give to social services. GS states puts them in the social services directors mail box. During an interview on 1/8/25 at 11:45 a.m., social services director (SSD) indicated grievance forms are put into her mailbox or handed to her directly after they are filled out. SSD further indicated a resident would need to hand the paper copy of the grievance form to someone as there was no box or any other additional place the form could be placed anonymously. SSD stated nurses could also take the form and fill it out online on the facilities intranet. SSD further stated online forms were not accessible to residents and/or family representatives. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/25 at 12:35 p.m., administrator indicated residents would give the paper grievance form to a nursing staff or social worker. Administrator further indicated a form could be left in the dining room or on the nurses station but there were no boxes for the grievance forms to be submitted anonymously. Review of facility form titled Concern Form, dated 6/22, states when complete, please return this form to Guest Services for Director of Social Services. The facility Grievance policy updated 4/17, lacked documentation grievances could be filed anonymously.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50764 Based on interview and document review the facility failed to complete a level II preadmission screening and resident review (PASARR) for 1 of 2 residents (R95) reviewed with a new mental illness diagnosis. Findings include: R95's facesheet printed on 1/8/25, indicated R95's original admitted was 12/16/22, and diagnoses at the time of admission included malnutrition, failure to thrive, anxiety, and repeated falls. Further review of the diagnosis listed on face sheet, indicated R95 was diagnosed with delusional disorders, major depressive disorder, and borderline personality disorder on 7/16/24. R95's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R95 had moderately impaired cognition, felt depressed half or more of the days and felt bad about himself nearly every day. R95's current physician orders printed 1/8/25, included risperidone 0.5mg tablet at bedtime for delusional disorders and citalopram 20mg tablet daily for psychosis. Record review of R95's PASARR screen completed on 8/31/23, indicated negative level 1 screening, level 2 screening not needed at time. Record review indicated R95 had new mental health diagnoses on 7/16/24 with no PASARR screen completed with the new diagnoses. During interview on 1/8/25 at 12:45 p.m., social services (SS)-C stated R95 did not have a PASARR completed at the time of new mental health diagnoses and was not sure who was supposed to complete that, but it should have been done. During interview on 1/8/25 at 12:49 p.m., administrator stated there was a gap in the system for having new PASARR screenings completed and the admissions team took care of making sure residents had a preadmission screening at the time of admission, but a process was lacking for ensuring a new one was completed with a new mental health diagnosis. The facility PASRR Screening policy dated 5/23/18, directed Sholom will comply with DHS regulations regarding screening and necessary updates for persons with developmental or intellectual disorders and those with mental illness. The policy further stated reasons people who have not previously been identified as needing Level II Resident Review includes the addition of or significant increase in antipsychotic or psychotropic medications.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and document review, the facility failed to hold care conference meetings with the resident and/or their representative to allow the resident and/or representative the opportunity to review and participate in the revision of the care plan for 5 of 5 residents (R14, R105, R6, R74,R97) reviewed for care planning. Findings include: R14's facesheet printed on 1/8/25, included diagnoses of Alzheimer's disease, dementia, depression, chronic kidney disease, diabetes, and congestive heart failure (heart doesn't pump as it should). R14's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R14 was cognitively intact, had clear speech, could understand and be understood. R14 was independent with activities of daily living (ADL) and with ambulation. R14's care plan dated 4/14/23, indicated R14's wishes would be respected, and her wishes would be reviewed at quarterly care conferences. Care plan dated 8/2/24, indicated R14's code status would be reviewed with each care conference. During an interview on 1/7/25 at 2:53 p.m., licensed practical nurse (LPN)-B who was also a nurse manager, stated R14's pain was discussed at her care conference today, as was the condition of her room (cluttered). Upon review of care conference notes in the electronic medical record (EMR), R14's last documented care conference was on 7/25/23 - 18 months prior. During an interview on 1/7/25 at 4:10 p.m., social services (SS)-A looked at R14's care conference notes in the EMR and verified that prior to today's care conference (which had not been documented yet), R14's last care conference had been on 7/25/23. SS-A could not explain why this was, as she had only been employed in her role since August 2024. SS-A was aware prior to her, there had been social workers working in a temporary capacity. During an interview on 1/8/25 at 9:48 a.m., the director of nursing (DON) stated she expected care conferences to be conducted every 90 days (or quarterly). The DON reviewed R14's care conference documentation in the EMR and verified the last documented care conference for R14 was on 7/25/23. The DON was not aware until yesterday (1/7/25), when nurse managers brought it to her attention, that care conferences had not been conducted timely. The DON stated social workers were responsible for scheduling, facilitating and documenting resident care conferences. R105's facesheet printed on 1/8/25, included hemiplegia (weakness or paralysis on one side of the body) following cerebral infarction (stroke), depression and anxiety. R105's quarterly MDS assessment dated [DATE], indicated R105 was cognitively intact, had clear speech, could understand and be understood. R105 needed assistance with ADL's including walking. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R105's care plan dated 1/10/24, indicated R105's wishes would be respected, and his wishes reviewed at quarterly care conferences. Care plan dated 6/25/24, indicated R105's code status would be reviewed with each care conference. During an interview on 1/6/25 at 6:46 p.m., R105 mentioned discussing provider visits at a care conference, but could not recall the approximate date. Review of care conference notes in the EMR indicated R105's last care conference had been documented on 5/28/24 - eight months prior. During an interview on 1/7/25 at 4:08 p.m., SS-A stated she just documented R105's care conference note from 9/19/24, today. SS-A said she had been confused about where the care conference note should be documented. During an interview on 1/8/25 at 9:46 a.m., the DON was informed of R105's last two care conference dates - 5/28/24, and 9/19/24, with the notes for 9/19/24, having been documented today. The DON reviewed R105's care conference notes in the EMR and verified the dates as reported. The DON that late entries for documentation should be identified as such. (The 9/19/24, care conference note documented on 1/8/25, did not indicate it was a late entry). The DON stated she expected care conferences to be conducted according to regulation. The DON stated she would discuss with SS-A and report back. During an interview on 1/8/25 at 12:56 p.m., the DON stated she spoke to SS-A and no rationale had been determined as to why care conferences for R14 and R105 had not been conducted. 50764 R6's quarterly MDS assessment dated [DATE], indicated R6 had moderately impaired cognition, behavior not directed towards others, required substantial assistance with eating, and substantial assistance with personal hygiene, utilized a wheelchair, diagnoses included renal (kidney) failure, arthritis, and malnutrition. R6's care plan edited 1/2/25, indicated nutrition concern related to inadequate oral intake related to decreased appetite as evidenced by non-significant weight loss, history of behaviors including yelling out rather than using call light, and frequent requests for therapy services. During interview on 1/6/25 at 12:34 p.m., R6 stated she had not had a recent care conference to make her needs known and could not recall when her last care conference was held. Record review of facility electronic health record (EHR) indicated R6 had a quarterly care conference on 3/8/24 and did not have another care conference until 10/9/24. During interview on 1/8/25 at 12:24 p.m., social services (SS)-C stated she missed R6's care conference around 5/24 or 6/24, and further stated it must have been a busy month. SS-C stated she should have had a care conference for R6 every 90 days. 44630 R74's quarterly MDS assessment dated [DATE], indicated R74 had severe cognitive impairment, required substantial/maximal assistance with activities of daily living (ADL's) and utilized a wheelchair, diagnoses included heart failure, diabetes, depression, and end stage kidney disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R74's electronic medical record (EMR) indicated the most current care conference was documented on 8/9/24. On 1/6/25 at 7:12 p.m., family member (FM)-A stated R74 had only one care conference she had been aware of, and stated she called social services (SS)-A about four or five times for the last two weeks and left voicemail's asking for a care conference and had not received a phone call back. On 1/7/25 at 9:23 a.m., SS-A stated it was her role to schedule resident care conferences, and care conferences were expected at admission, quarterly and if a resident had a change in condition. SS-A stated she would reach out to the resident's family (representative) via phone call and email with a date and time for the care conference and ensure staff and family were aware. SS-A stated R74's last care conference was 8/9/24, and she placed a phone call to R74's daughter on 11/19/24 to offer a care conference and had not received a call back. SS-A confirmed R74 did not have a care conference quarterly as expected. On 1/7/25 at 10:03 a.m., licensed practical nurse (LPN)-B, known as the nurse manager for second floor north, confirmed R74 had not had a care conference since the documented care conference on 8/9/24. RN-A further stated regular care conferences were important to keep families up to date on how the resident was doing. R97's quarterly MDS assessment dated [DATE], indicated R74 was admitted on [DATE], preferred language was Spanish and needed/wanted an interpreter to communicate with a doctor or health care staff, moderate cognitive impairment, required partial/moderate assistance with toileting hygiene, upper body dressing, personal hygiene, and utilized a wheelchair, diagnoses included dementia, anxiety, and depression. On 1/6/25 at 4:32 p.m., during a interview using a Spanish interpreter (via telephone) R74 stated he does not have care conferences at the facility. On 1/6/25 at 9:35 a.m., SS-A stated she met with R74 frequently and used an interpreter phone and stated she had informal care conferences with R74 and stated she had not had a formal care conference with R74. SS-A stated R74's last documented care conference was 6/8/24 and stated R74 was expected to have had a care conference after that. SS-A stated residents were expected to have care conferences every 90 days and with significant changes. On 1/7/25 at 2:48 p.m., SS-B, known as the director of social services, stated residents were expected care conferences every 90 days, with a significant change in condition, and if requested. SS-B stated residents and families were expected to be invited to the care conferences. SS-B stated she was not aware R74 and R97's care conferences had not been completed every 90 days and expected the care conferences completed and documented in the EMR. On 1/7/25 at 3:28 p.m., the administrator confirmed via email R74 did not have formally documented care conference notes On 1/7/25 at 3:53 p.m., the DON stated the social services arranged care conferences and residents were expected to have a care conference every 90 days and stated she was not aware care conferences were not completed for R74 and R97 every 90 days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy on Care Conferences was requested and not received.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44630 Based on observation, interview and document review, the facility failed to ensure a resident's preferred activities for individual entertainment were offered for 1 of 1 resident (R97) reviewed for activities. Findings include: R97's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R74 was admitted on [DATE], preferred language was Spanish and needed/wanted an interpreter to communicate with a doctor or health care staff, moderate cognitive impairment, required partial/moderate assistance with toileting hygiene, upper body dressing, personal hygiene, and utilized a wheelchair, diagnoses included dementia, anxiety, and depression and no rejection of care. R97's annual MDS assessment dated [DATE], indicated it was somewhat important to participate in favorite activities, listen to music, and to go outside and get fresh air when the weather is good. R97's progress note dated 9/16/23 at 1:05 p.m., therapeutic recreation (TR)-A indicated R97 often fatigued/sleeping, pleasant and sometimes interested in snack being distributed, but prefers to stay close to his room/bed, isn't interested in group programming. R97's care plan dated 12/5/24, indicated R97 was able to self-ambulate, enjoys walking, visits from friends, going outside when weather is nice, weakness: confusion, language barrier (Spanish speaking), will invite or ask Spanish speaking TR (therapeutic recreation) to invite to programs of interest, will respect right to refuse programming, The record lacked documentation of activities R97 was offered, participated or refused. On 1/6/25 at 4:32 p.m., during an interview with R97 and the assistance of the Language line, R97 stated he spoke Spanish, and did not understand English. R97 was lying in bed with the television on in Spanish. R97 stated he did not understand the staff who did not speak Spanish. R97 stated he felt like a bird in a cage and stated the facility did not provide him activities, and just sits in his room all day and watched TV. R97 stated he wished there were activities to do and people to talk with. R97 stated he doesn't get to do activities often, because he speaks Spanish. On 1/7/25 at 10:00 a.m., licensed practical nurse (LPN)-C stated R97s spoke and understood only Spanish. LPN-C stated R97 did not attend activities. On 1/7/25 at 10:20 a.m., LPN-B stated TR staff were expected to offer and invite R97 to activities and was unaware if R97 attended activities. LPN-B stated the facility did not offer activities in Spanish and confirmed R97 spoke and understood only Spanish. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 11:11 a.m., TR-B known as the director of TR, stated an activity interest and preference was expected for all residents and confirmed prior to today (1/7/25), an individualized preference for activities was not completed for R97. TR-B confirmed there was not documentation R97 had refused or was offered activities. TR-B stated residents were assessed for their activity preferences quarterly, annually, and with significant changes. TR-B stated expectation of therapeutic recreation staff to communicate with R97 using the interpreter phone and offer R97 activities based off preferences. On 1/7/25 at 11:25 a.m., R97 was in bed sleeping. On 1/7/25 at 2:06 p.m., R97 was self propelling in wheelchair in the hallway and had a ice cream cup in his hand. On 1/7/25 at 11:35 a.m., TR-A and TR-C, stated the facility had planned activities for all residents. TR-C confirmed R97 was not asked daily to attend activities, and was not sure when the last time R97 was asked to attend an activity. TR-A and TR-C confirmed the facility did not have any activities offered in Spanish and stated a reason R97 may not attend activities could be because of the language barrier. TR-C confirmed activities were expected documented in the EMR and stated R97 had no activities documented or refused. TR-A and TR-C were not able to identify how R97's preferences were assessed for one-to-one visits given that she was known to not attend group activities or how individualized activities were being offered. On 1/7/25 at 2:42 p.m., social services (SS)-B, known as the director of social services, stated TR staff were expected to invite R97 to activities daily and would expect the facility to implement activities and programs specific to each resident and have Spanish speaking activities individualized for R97. On 1/7/25 at 3:53 p.m., the director of nursing (DON) stated TR staff were expected to offer activities to all residents daily and documenting refusals in the EMR. On 1/8/25 at 8:12 a.m., the administrator indicated she was unable to find documentation about R97's activities beyond the information on the MDS. The facility Life Enrichment Activities policy dated 10/18/22, indicated: Life Enrichment systems and programs are designed to serve the total person and incorporate ALL disciplines. Resident engagement is grounded in honoring the person and their individual purpose through all the wellness dimensions: spiritual, social, physical, intellectual, environmental, emotional and vocational. Meaningful activities are designed to promote life-skills, quality of life and to encourage involvement. Residents participate in self-care, structured recreational programming, and leisure activities. A member of the Recreation team completes a Resident Assessment by interviewing the resident, family or significant other regarding the residents leisure activities , cultural needs, values and choices. The assessor will seek to understand the residents past roles in order to incorporate them into the present daily life. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a variety of engaging resident programs designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community Incorporate resident preferences into the calendar Identify based on assessment barriers or preferences related to group size variety based on resident needs provide resource for independent resident interests and hobbies incorporate referrals to the Interdisciplinary team (spiritual care, fitness, culinary, volunteers) Assist as assessed with development of calendar participation(daily, weekly and/or monthly) Identify individual program needs: rooms/set up/supplies/dietary & volunteer requests Encouraging resident participation Personal invites as appropriate

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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 (R58) who was dependent upon staff for repositioning and high risk for pressure ulcers. Findings include: R58's facesheet received 1/8/25, included diagnoses of dementia, aphasia (the ability to use or comprehend language is lost or impaired), diabetes mellitus, history of falling and chronic kidney disease. R58's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R58 had severely impaired cognition, and no behaviors. Activities of daily living (ADL's) included R58 uses a wheelchair and is dependent on staff for transfers, bed mobility and locomotion. R58 is able to feed self after setup. R58 has a an unhealed pressure injury that is unstageable with slough and or eschar (dead tissue that impedes healing of wounds) present. R58's Care Area Assessment indicated R58 has an unstageable pressure ulcer on right heel which is covered by slough. R58 has been identified as being at risk for pressure ulcers related to impaired mobility and bowel incontinence. R58 requires assistance with all ADL's. Skin is monitored with daily cares and weekly shower. Wound is improving. R58 has a pressure relieving cushion in his wheelchair and pressure relieving mattress on his bed. R58's Braden Scale for Predicting Pressure Sore Risk dated 10/30/24, had a score of 16 indicating R58 is at risk for skin breakdown. R58's care plan dated 1/6/25, indicated R58 was identified at risk for skin breakdown related to history of right hip and arm fracture, incontinence, and immobility. On 10/2/24, pressure area noted to right heel from hospital stay. Interventions included wound team to assess, apply house lotion as needed to dry skin areas, conduct a skin observation daily by nursing assistants (NA) and weekly by a nurse. Incontinence care every 2-3 hours and as needed. Pressure reducing mattress on bed, cushion in wheelchair, and staff assist of 2 to off load resident every 2 hours. R58 was identified as having an alternation in mobility related to history of right hip and arm fracture and the need for assistance with transfer and locomotion by wheelchair daily. R58 at risk for falls, and impaired skin integrity. Interventions included turn and reposition in bed every 2 hours and as needed with total assist of 2 staff. On observation 1/6/25 at 7:05 p.m., R58 was seated in his Broda chair (positioning wheelchair) in his room watching television. R58 had vascular boots on both lower legs and a cushion in his Broda chair. No air mattress was present on his bed. R58 only laughed when asked how he was doing. No verbal response was received other than that. On observation 1/7/25 at 2:22 p.m., R58 was sitting in his Broda chair in his room watching television. Vascular boots present on both lower legs and chair cushion present. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On observation 1/7/25 at 4:15 p.m., R58 continued sitting in his Broda chair in his room watching television. Continuous observation was started at 1/8/25 at 7:11 a.m.: 7:11 a.m. - R58 was dressed for the day had on his vascular boots, was sitting in his Broda chair in room which was slanted back at 10 degrees and was watching television. 7:30 a.m. - registered nurse (RN)-E, and registered nurse (RN)-D completed wound care on R58's heel. Wound is open to air with vascular boots on. Measurements were completed 3.5 x 2.5 cm's with edges lifting and no drainage or redness present. Eschar present. Lotion was applied to both lower legs and feet and heels and vascular boots reapplied. There was no position changes completed on R58. 7:46 a.m. - Wound care completed as above and staff left the room. 7:56 a.m. - R58 remains seated in his Broda chair and no staff entered room. 8:13 a.m. - R58 remains seated in his Broda chair and no staff entered the room. 8:30 a.m. - RN-C entered room and administered insulin, and oral medications. No position changes completed. 8:41 a.m. - NA-B entered room and transported R58 to dining room for breakfast. Did not reposition R58. 8:53 a.m. - R58 remains in dining room waiting for his breakfast. 8:57 a.m. - R58 was served breakfast and fed himself after staff set up his meal. 9:07 a.m. - R58 remains in dining room eating. 9:28 a.m. - NA-B brought R58 back to his room in his Broda chair. Chair remains tipped back at 10 degrees. No position changes or incontinence pad check completed. 9:46 a.m. - No change in position. No staff in room. 9:56 a.m. - No change in position. No staff in room. 10:15 a.m., No change in position. No staff in room. On interview 1/8/25 at 10:23 a.m., NA-B stated R58 should be repositioned every 2-3 hours and he is due at 10:00 a.m. to be repositioned. NA-B confirmed there has been no position changes since putting R58 in his chair around 7:00 a.m. this morning. NA-B indicated she would get assistance to reposition him. (continued on next page)

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	245574	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sholom Home West	3620 Phillips Parkway South Saint Louis Park, MN 55426

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview and observation 1/8/25 at 10:28 a.m., NA-B and NA-C entered R58's room and using a mechanical lift to transfer R58 to his bed. R58 was rolled side to side and incontinence pad was removed with scant amount of stool present. NA-B and NA-C indicated there is some redness present around rectal area extending outwards, but that is R58's normal. NA-B indicated the purple area on right buttock was a previous pressure ulcer that has heeled. Requested NA-B push on skin and blanchable areas were present on left buttock, with no blanching noted on right buttock. Red area extended up and down 2 inches from the rectal area and outwards approximately 3-4 inches each direction. R58 was positioned with head of bed at 30 degrees and pillow under lower legs. On interview 1/8/25 at 10:57 a.m., RN-D reviewed R58's NA care sheet and stated R58 should be repositioning every 2-3 hours and as needed. RN-D then reviewed R58's plan of care and stated the care plan directs repositioning every 2 hours so they are not matching. RN-D confirmed the care plan is what should be followed and R58 should be repositioned every 2 hours. On interview 1/8/25 at 12:56 p.m., the director of nursing (DON) stated she would expect the NA's to follow the care plan and reposition R58 every 2 hours. The facility Skin Integrity Management policy last updated 4/2/21, included: Identification of Risk: The first step in prevention of pressure ulcer/ injuries is the identification of the resident at risk for developing pressure ulcer/ injuries (any skin impairment caused by pressure i.e. friction, shearing, direct pressure, etc.). This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of interventions. Comprehensive Skin Risk Observation: Risk factors and potential cause(s) will be reviewed, addressed in the analysis and interventions implemented. Examples of risk factors include but are not limited to: Impaired/decreased mobility and decreased functional ability. Based upon the findings of the Comprehensive Skin Risk Observation which includes the Braden Assessment, the consideration of current interventions and resident preferences; a comprehensive analysis will be completed to guide the care plan process. Changes and implementation of interventions will be documented in the care plan. Establish an individualized turning and repositioning schedule if the resident is immobile.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42073 Based on interview, observation and document review, the facility failed to provide a process by which residents could make their own food selections for meals for 6 of 6 residents (R241, R73, R6, R23, R104, R35) reviewed for food. Findings include: R241's facesheet printed on 1/8/25, included diagnoses of chronic kidney disease and congestive heart failure (heart doesn't pump as it should). R241's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R241 was cognitively intact, had clear speech, could understand and be understood. R241 required supervision for most activities of daily living (ADL) and could eat independently after set-up help. R241's orders dated 12/17/24, indicated a heart healthy diet. R241's care plan dated 12/20/24, indicated R241's preferences would be honored during her stay. Staff responsible for this included nursing and nutritional services. During an interview on 1/6/25 at 3:49 p.m., R241 stated she had been at the facility since 12/17/24, and had not been given a choice of what to eat, adding, if you get started on something, like oatmeal, you get it every day. R241 presented several diet slips and stated, this is what you get -- no options. No weekly menu or alternative menu was visible in R241's room nor was she aware of them. During an interview on 1/7/25 at 9:39 a.m., in the dining room, nursing assistant (NA)-D stated when a resident was admitted , a dietician met with him/her to find out likes/dislikes, and each resident had a diet ordered by a doctor. NA-D presented an electronically generated diet slip with a resident's name, diet order and a list of food items for that meal. NA-D stated if a resident didn't like what they were given, they could tell staff at the time of meal service and request something else. NA-D stated residents did not get a menu ahead of time to make their own food selections. From a window ledge (window looking out into the nurse's station) in the dining room, NA-D obtained a paper week-at-a-glance menu for the current week. Listed for each meal, three times a day, was a main entree and below that another meal option. NA-D also presented a paper Bistro Menu indicating alterative food items for lunch and dinner. NA-D stated she did not know if residents received a copy of either menu. Neither was posted or visible in the dining room for residents. During an interview on 1/7/25 at 10:46 a.m., in the dining room, dietary aide, (DA)-A stated after a meal tray was placed in front of a resident in the dining room, he/she could tell a NA if he/she did not like or want that meal. DA-A stated then the NA would bring the tray back to her, she would discard the food, and obtain what the resident wanted. When asked about an alternative menu, DA-A went to binders on the steam table to look for one and did not find one. DA-A acknowledged there was not a weekly menu or an alternate menu posted in the dining room for residents to see. DA-A stated residents were supposed to have menus in their room and thought her manager took them around to resident rooms. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/25 at 1:51 p.m., at the resident council meeting, R104 stated whatever was on their diet slip was what they received at meal time; they did not get an opportunity to select something different ahead of time. R104 stated often, residents didn't even know what the meal was as they did not receive a menu prior to meal services. R104 stated the foods we like and dislike were noted on their diet slips, but that was the extent of their food choices. R104 was not aware of an alternative menu. R35 stated she had heard of an alternate menu but didn't know where to find it. Further, R35 stated it was like scratching off a lottery ticket when staff lifted the cover off their plate of food in the dining room --- meaning the meal was a surprise to them. -- R104: quarterly MDS dated [DATE], indicated intact cognition, clear speech, could understand and be understood, and eat independently after set up help. -- R35: quarterly MDS dated [DATE], indicated intact cognition, clear speech, could understand and be understood, and eat independently after set up help. 44630 R73's significant change MDS assessment dated [DATE], indicated R73 had moderately impaired cognition, no behaviors, required setup or clean-up assistance with eating, and substantial assistance with personal hygiene, utilized a wheelchair, diagnoses included non-Alzheimer's dementia, depression, R73's care plan edited 1/8/24, indicated potential for change in nutrition status related to the need for a therapeutic diet and a BMI (body mass index) that classifies as obese likes egg salad/tuna salad, please offer alternatives at meals if I dislike the daily menu offerings, likes egg salad, tuna salad, PBJ sandwiches on wheat, like to receive less fish at lunch, no rice, no soups with rice/pasta, no orange juice, no bread/rolls with lunch and dinner, provided small portion of starch at lunch and dinner meals would like a salad at lunch and dinner, to receive Mrs Dash and pepper packets with meal, dislike broccoli. On 1/7/25 at 9:08 a.m., R73 stated he did not get a choice of meals and stated he never knew what he was going to eat. R73 stated the facility brings him his meal to his room and it was always a surprise and was not given options and was not aware of menu. On 1/7/25 at 9:46 a.m., NA-E stated residents were not given a choice of food choices, the residents were served food from a generated meal ticked. NA-E stated if the resident did not like what was served the staff would have to call the main kitchen and request another option. NA-E stated there were snacks on the floor however there were not main food options. NA-E stated the menu was expected posted outside the dining room, NA-E was observed outside the second floor north dining room and confirmed a menu was not posted. NA-E stated the residents had lots of complaints regarding food and not liking what was served to them. On 1/7/25 at 10:13 a.m.,, licensed practical nurse (LPN)-A, stated upon admission the dietician assessed residents for preferences, and stated the preferences are entered into the computer and the resident was served food based off those preferences. LPN-A stated there residents were not offered daily choices. 50764 (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's quarterly MDS assessment dated [DATE], indicated R6 had moderately impaired cognition, behavior not directed towards others, required substantial assistance with eating, and substantial assistance with personal hygiene, utilized a wheelchair, diagnoses included renal (kidney) failure, arthritis, and malnutrition. R6's care plan edited 1/2/25, indicated nutrition concern related to inadequate oral intake related to decreased appetite as evidenced by non-significant weight loss. During interview on 1/7/25 at 9:15 a.m., R6 stated staff always brought her tray and dropped it off, she didn't get a choice and would have liked to have some choices. She further stated nobody came to ask what she wanted for meals and she didn't know where she would get a menu. R23's annual MDS assessment date 12/26/24, indicated R23 had intact cognition, no behaviors, required setup assistance for eating, substantial assistance for personal hygiene, utilized a wheelchair, diagnoses included seizure disorder and depression. R23's care plan printed 1/8/25, indicated R23 would maintain her current weight, consume 50% of meals, and will remain able to make needs known through next review date. During interview on 1/8/25 at 10:04 a.m., R23 stated she did not get to choose her meals and would have liked to have had choices. R23 further stated she used to be able to make choices by selecting on a piece of paper but had not done that for over a year. R23 stated she would have liked to choose her meal ahead of time. On 1/8/25 at 10:37 a.m., an interview was conducted with three members of the survey team, the administrator, director of nursing (DON), registered dietician (RD-E), dining services director (DSD)-C, and chef (C)-D regarding food service concerns. C-D was asked to describe the process by which residents made food selections for each meal. C-D stated on admission, the dietician met with residents to determine preferences, likes and dislikes. RD-E stated this information was then entered into meal-tracker software. The administrator stated it weeded out a resident's dislikes and automatically made food substitutions. In addition, RD-E stated residents were asked upon admission if they wanted a weekly menu and bistro menu (alternate menu). During this interview, the group did not describe a process which allowed residents to have a choice in what foods they were served at meals. DSD-C stated menus should be posted in each dining area. The group was informed menus had not been visible in dining rooms or resident rooms, that residents were not aware of an alternate menu, and felt they had no choice in what foods were served to them. Based on interviews from residents and staff, the group was informed of the meal process described to the survey team: a resident at the table in the dining room would receive a plate of food. That would be the first time residents became aware of what their meal would be. At that point, if a resident didn't like that meal, or didn't feel up to eating that meal, he/she would inform staff in the dining room who would remove the plate of food, discard it and either get something else from the steam table or the kitchen. The group was asked if that was accurate, and C-D stated it was. DSD-C stated residents did not select food prior to meal service but were instead given what was electronically printed on their diet slip based upon the menu for that meal, their likes and dislikes. If they wanted something else, dietary staff could make something different for them at that point. DSD-C stated they could not make different meals for that many residents -- they would be short order cooks, and there wasn't time for that - so it worked better to give residents what was on the menu first, then if a resident didn't want that, something else would be made for him/her. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy on food preferences, how residents select their food/meals, alternate menu was requested. Facility Dining and Food Preferences policy with revised date 10/2022, was received. The policy indicated individual dining, food and beverage preferences were identified for all residents. Dining services director, or designee would interview the resident or resident representative to complete a food preference interview within 72 hours of admission. The purpose would be to identify preferences for dining location, meal times, food and beverage preferences. An individual tray assembly ticket would identify all food items appropriate for the resident based on diet order, allergies, intolerances, and preferences. Upon meal services, any resident with expressed or observed refusal of food would be offered an alternate selection of comparable nutrition value.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40614 Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms (R19 and R1), and failed to follow enhanced barrier precautions (EBP) for 1 of 1 resident (R58) who had an indwelling device present. Findings include: R41's facesheet received 1/7/25, included diagnoses including chronic kidney disease, diabetes mellitus, and dementia. A Event Report for R41 for infection control included a start date of 1/3/25 at 9:09 a.m., indicating on 1/2/25 at 10:09 p.m., R41 had 3 loose stools, poor appetite and was placed on isolation with testing completed for RSV (respiratory syncytial virus) and influenza. R41 was negative for Covid-19. A note dated 1/4/25 at 10:36 p.m., indicated R41 remained in isolation and R41 tested positive for Influenza type A. R1's Resident Face sheet received 1/7/25, included diagnoses of dementia, type 2 diabetes mellitus, and paranoid schizophrenia. R1's progress note dated 1/6/25, included R1 had an emesis and was placed in transmission based precautions (TBP) with Covid-19 test negative and RSV and Influenza tests completed and awaiting results. During observation and interview on 1/6/25 at 12:45 p.m., R19's door was closed with a sign that indicated enhanced respiratory precautions. A stop sign was present that directed please see nurse before you enter the room. PPE cart was present outside the door and a garbage can that had discarded gowns, gloves and masks was outside of the room. R1, 2 doors away from R41's room also had a closed door with a stop sign directing Stop, please remain in your room and an enhanced respiratory precautions sign on the door. PPE was present and a trash bin outside of the room with discarded gowns, gloves and masks. Licensed practice nurse (LPN)-A indicated R19 was diagnosed with Influenza A a few days ago and R1 had an emesis this morning and has been tested for Influenza A, Covid-19 and RSV so both are on isolation currently. On observation 1/7/25 at 9:23 a.m., nursing assistant (NA)-A donned gown, gloves, N95 mask and face shield (PPE) and entered R41's room. Upon exit of the room NA-A was wearing the same PPE she entered room in and doffed her PPE and discarded into wastebasket in hallway next to R41's room. NA-A then donned PPE and entered R1's room and upon exit continued to wear PPE donned prior to entering the room. NA-A doffed her gown, gloves, face mask and face shield after exiting the room and disposed of in garbage can outside of R1's room. On observation 1/8/25 at 7:05 a.m., R1 and R41's garbage cans were no longer outside of their rooms. PPE remained present outside the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview 1/8/25 at 10:17 a.m., NA-A indicated she doffs wherever the garbage cans are located. NA-A stated yesterday morning they were outside of the rooms but have since been moved to inside the rooms. On interview 1/7/25 at 3:36 p.m., registered nurse (RN)-B, also identified as infection preventionist and the director of nursing stated garbage cans were expected to be inside the room for EBP and isolation rooms and staff are expected to remove PPE prior to exiting the room. R58's Resident Face Sheet, received on 1/8/25, included diagnoses of dementia, paranoid schizophrenia, type 2 diabetes mellitus, and benign prostatic hyperplasia (non cancerous enlarged prostate) with lower urinary tract symptoms. R58's plan of care last edited 12/13/24, included resident requires enhanced barrier due to indwelling medical device; urinary catheter. Interventions included a sign on residents door to alert staff and visitors regarding EBP and follow CDC recommendations wearing PPE with high-contact resident care activities with gloves and gown to be worn prior to the high contact care activity. On observation and interview 1/8/25 at 8:30 a.m., R58 had an EBP sign outside of his room, along with a cart with PPE present. Registered nurse (RN)-C entered R58's room wearing gloves but did not wear a gown. RN-C checked R58's blood sugar and administered insulin in R58's abdomen, discarded her gloves and performed hand hygiene. R58 then gave oral medications mixed in pudding via a spoon to R58 without gloves on. RN-C then exited the room and performed hand hygiene. RN-C indicated they gown if giving personal cares like bathing, toileting, but did not think it was required to gown for medication administration that was completed. On observation and interview 1/8/25 at 10:45 a.m., NA-B and NA-C entered R58's room with a lift after completing hand hygiene and donning gloves only. The lift harness was placed behind and under R58's legs and R58 was placed in his bed. R58 was rolled side to side with pad changed with scant amount of old stool present. Wipes were used to clean R58's rectal area and new pad was placed. R58 was positioned in his bed with pillow under his lower legs and head of bed elevated at 30 degrees. NA-B and NA-C removed gloves and completed hand hygiene upon exit. NA-B stated they only wear gowns when doing catheter or wound care. NA-B stated gowns are not required for type of care provided and NA-C agreed. On interview 1/8/25 at 10:57 a.m., RN-D, also identified as interim care manager, stated she would expect staff to gown and glove with any direct patient care if the resident is on EBP. On interview 1/8/25 at 1:45 p.m., the DON stated staff are expected to gown and glove for EBP patients when providing high contact direct patient care. The facility Isolation - Categories of Transmission-Based Precautions policy last updated 7/12/22, included: - Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug- resistant organisms (MDROs) in the facility. Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for resident known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (i.e. residents with wounds or indwelling medical devices (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Enhanced barrier precautions will be used for residents with indwelling medical devices or wounds who do not otherwise meet the criteria for contact precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. - High-contact resident care activities include: Dressing Bathing/ showering Transferring Providing hygiene: i.e. brushing teeth, combing hair, and shaving Changing linens Changing briefs or assisting with toileting Device care or use: any device fully embedded in the body without components that communicate with the outside i.e. central line, urinary catheter, nephrostomy tubes, feeding tube, tracheostomy/ ventilator. Pacemakers would not be considered an indication for enhanced barrier precautions Wound care: any skin opening requiring a dressing - Contact Precautions: Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment. Staff and visitors will wear gloves when entering the room. Gloves will be removed and hand hygiene performed before leaving the room. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.

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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** 48583 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R24, R25, and R124) received pneumococcal vaccinations based on shared clinical decision-making in accordance with the Center for Disease Control (CDC) recommendations reviewed for immunizations. Findings include: Review of the current CDC recommendations 4/2024, revealed The CDC identified Adults [AGE] years of age or older received the (PPSV23) or (PCV13) at any age and who have not received the Pneumo 20-valent conjugate Vaccine (PCV20) should receive a dose of the PCV20 at least one year after the most recent PPSV23 or PCV13 vaccine. In addition, the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 at age 65 and older, based on shared clinical decision-making with the patient and the provider one dose of PCV20 at least five years after the last pneumococcal vaccine dose. Review of R24's facesheet identified R24, age 83 was admitted to the facility on [DATE]. Review of R24's Minnesota Immunization Information Connection (MIIC) record undated, identified R24 received the PPSV23 on 12/17/2004 and 11/18/2019, and received the PCV13 on 12/15/2014. R24's medical record lacked documentation R24 had been offered or received the PCV20 based on shared clinical decision-making. Review of R25's facesheet identified R25, age 84 was admitted to the facility on [DATE]. Review of R25's MIIC record undated, identified R25 received the PCV13 on 4/11/15. R25's medical record lacked documentation R25 had been offered or received the PCV20 based on shared clinical decision-making. Review of R124's facesheet identified R124, age 83 was admitted to the facility on [DATE]. Review of R124's MIIC record undated, identified R124 received the PCV13 on 11/24/15. R124's medical record lacked documentation R124 had been offered or received the PCV20 based on shared clinical decision-making. During an interview on 1/7/25 at 4:14 p.m., infection preventionist (IP) confirmed the above findings and indicated the facility follows the CDC guidelines for pneumococcal immunizations. Director of nursing (DON) stated her expectations were that residents receive immunizations following the CDC guidelines. The facility Pneumococcal Immunizations, Adult policy dated 5/16/24, the facility will reduce the incident of pneumococcal disease by offering and providing pneumococcal vaccinations to residents. Residents will be offered the pneumococcal vaccinations and administered, according to the MDH and CDC recommended interval for the vaccines, unless contraindicated, already immunized, or the resident and/or responsible party declines the vaccine.