STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	45 West 10th Street Saint Paul, MN 55102

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure dignity was maintained during cares for 1 of 2 residents (R35) reviewed for dignity. Findings include: R35's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was dependent on staff for toileting and personal hygiene cares as well as mobility and transfers. The MDS identified R35's diagnoses of dementia and indicated she was unable to complete the mental status assessment interview. R35's care plan dated 2/5/25, identified impaired cognitive function or impaired thought processes related to dementia. Furthermore, the care plan indicated R35 had a communication problem related to finding the right words to say and directed staff to anticipate and meet R35's needs. Finally, the care plan identified activities of daily living (ADL) self-deficit related to dementia (a loss of memory, language, problem-solving and other thinking abilities) diagnosis and indicated R35 required staff assistance for dressing, personal hygiene, and toilet use. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continuous observation of evening cares on 2/26/25 between 5:56 p.m. and 6:26 p.m., nursing assistant (NA)-C and NA-D used a mechanical body lift to assist R35 into the bed at 5:58 p.m. and assisted to lay down. R35 began to call out, get out of here repetitively while NA-C pulled her pants down, removed her socks and unfastened the front tabs of her incontinence brief. NA-C told R35 they would be quick while they cleaned her up and NA-D held R35's hand and told her, It's okay. At 6:00 p.m., R35 was uncovered and exposed from the waist down and the NAs worked together to remove her top. NA-C turned her back towards NA-D and R35 and turned on the water at the sink and let the water run while R35 was completely nude and exposed on the bed. At 6:01 p.m., NA-C returned to the bedside. NA-D pulled R35's legs apart while she continued to call out, get out of here assholes. NA-C first washed her face, then they assisted R35 to turn onto her right side and began to wash her backside. NA-C stated, she's just going and she used cleansing wipes to clean feces from R35's buttocks. R35 continued to call out, get out of here. NA-C reported a new area to R35's buttock to the surveyor, calling the surveyor over to assess. NA-C changed soiled gloves and R35 remained nude, and her exposed backside faced the door. At 6:08 p.m., there was a knock at the door and registered nurse (RN)-C opened the door to R35's fully exposed buttocks. RN-C walked over to the bedside and draped the hospital gown over R35's neck, covering her front side and began to rub her back gently. RN-C stated this was done to promote her dignity and they wouldn't want their family members to be laying like that naked. RN-C expected staff to protect a resident's dignity during cares by covering them up with blankets or clothing when it would not impede cares. RN-C also stated it may help provide comfort since being naked might make the resident cold. During interview on 2/26/25 at 6:37 p.m., NA-C verified they had not provided for R35's dignity during cares. NA-C stated it was something they didn't think about and was grateful to be reminded especially for those residents who cannot speak for themselves. NA-C stated covering her also may have provided warmth, which could have promoted comfort during their cares. Per interview on 2/27/25 at 2:22 p.m., RN-D expected staff to only expose what needs to be exposed during cares. RN-D provided the example of covering the chest if perform peri-cares and keeping a resident's bottom covered if performing upper body cares. Per interview on 2/27/25 at 3:13 p.m., the director of nursing (DON) expected staff to try and maintain dignity to the highest level as possible during cares. The DON stated staff should shut the door, pull a privacy curtain if able, explain the task they are about to perform, and ask the resident how they could keep them comfortable. The DON stated staff should maintain privacy as much as they are able to in order to promote a resident's dignity. A policy pertaining to dignity was requested but not received.

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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 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** 49617 Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed to allow residents to safely administer their own medications for 1 of 1 residents (R44) observed with medications at bedside. Findings include: R44's annual Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition, was dependent on staff for personal hygiene and mobility, and required setup or clean-up assistance with eating. The MDS reported diagnoses of a stroke (when blood flow to a part of the brain is disrupted, causing a lack of oxygen and brain cell death), aphasia (a language disorder affecting a person's ability to communicate), dementia (loss of memory, language, problem-solving and other thinking abilities), and hemiplegia or hemiparesis (one-sided muscle weakness or paralysis). Additionally, the MDS identified he had a mechanically altered diet and did not exhibit signs or symptoms of a possible swallowing disorder. R44's order summary report dated 12/25/24, were reviewed on 2/24/25 and lacked documentation of an order for self-administration of medications. Additionally, his order summary report lacked an order for Tums, an antacid medication. R44's medication administration record (MAR) dated 2/2525, was reviewed on 2/24/25 and lacked documentation of an order for self-administration of medications as well as an order for Tums. R44's electronic health record (EHR) was reviewed on 2/24/25 at 9:19 a.m. and lacked documentation of an assessment to self-administer medications. During observation on 2/24/25 at 9:19 a.m., R44 was in bed with his bedside table over the bed, and on the bedside table was a bottle with the label Smoothies-flavored Tums. During observation on 2/25/25 at 10:05 a.m., the bottle of Tums remained unchanged on the bedside table. During observation on 2/27/25 at 10:02 a.m., the bottle of Tums remained unchanged on the bedside table. During interview on 2/27/25 at 10:08 a.m., registered nurse (RN)-C stated a resident wishing to administer their own medications should have an assessment for self-administration. RN-C stated the assessments were completed by nursing staff and then the provider would be updated. RN-C reviewed R44's EHR and confirmed he did not have a self-administration assessment or an order to self-administer medications. RN-C stated we did see it; we were asking our manager about the medications noted at his bedside table, and stated he has very high anxiety, he would get really upset about it if staff took the bottle away from him. RN-C walked into R44's room and confirmed there was a bottle of Tums on his bedside table and asked him where it came from. He responded, my family, and RN-C told him the bottle would not be removed right now but it would be discussed with the nurse manager. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/27/25 at 10:16 a.m., licensed practical nurse (LPN)-B reviewed R44's physician orders and confirmed he did not have an order for Tums or a generic equivalent. LPN-B further verified he should have a self-administration assessment and order to have the Tums at his bedside and stated, I feel like he would be able to self-administer the Tums because of his pureed diet and the Tums being chewable or dissolvable. LPN-B stated, I will update the provider and the nurse manager. Per interview on 2/27/25 at 2:39 p.m., RN-D expected staff to complete a self-administration assessment first, then get an order from the provider with the okay to self-administer medications. RN-D also expected staff to remove medications from a resident's room the second someone noticed it. RN-D stated the risks could include possible medication contraindications or interactions, indications for use, safety implications and stated, we need to get the provider involved to make that decision. Per interview on 2/27/25 at 3:34 p.m., the director of nursing (DON) expected staff complete a self-administration assessment and obtain a provider order. The DON stated if a family member brought in a medication from home, staff should question why there was a need for that medication and get the provider involved. The DON indicated the risks included polypharmacy and interactions with other medications. Per facility policy titled Self Administration of Medications (SAM) revised 9/24, a self-administration of medications assessment would be completed for any resident requesting to administer any medication without the direct supervision of a nurse and the interdisciplinary team would review the recommendation to determine if the resident was safe to do so. The resident's physician would need to write an order for the resident to self-administer medications and only the medications permitted for self-administration would be left at the bedside. The resident's care plan should be updated to reflect self-administration of medications.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on interview and document review, the facility failed to ensure an allegation of potential harm was reported to the State Agency (SA) in the required timeframe for 1 of 1 residents (R23) reviewed for anaphylactic reaction. Findings include: R23's admission Minimum Data Set (MDS) dated [DATE], indicated R23 was cognitively intact and required setup assistance for eating. R23's diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and [NAME]-[NAME] syndrome [a condition affecting appetite and causing one to always feel hungry). R23's diet order/dietary communication dated 11/29/24, indicated food allergies, ginger, bee pollen. R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, insurance does not cover. -12/18/24 at 3:19 p.m. resume, ordered per provider. -Date received-12/23/24, on hand. During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having anaphylactic reaction and requested epinephrine. R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (e-kit). Review of facility week 2 menu for Saturday was Honey Ginger chicken thighs and Asian Stir fry vegetable mix. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's progress note dated 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23 having a stick [sic] throat, and does not feel well. R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their file. R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter. The AVS instructed, You were seen today for an allergic reaction. Your symptoms improved after an epi pen. Return to the emergency department with any new or worsening symptoms. Review of facility risk management lacked evidence facility completed an investigation or safety incident report for R23's anaphylactic reaction event. During interview on 2/27/25 at 2:29 p/m., director of nursing stated expectation for staff to initiate a safety event or risk management entry, both process include the required report of the event to the administrator and DON regardless of date, time or shift. DON stated either herself or the administrator would then file a report with the SA and initiate an investigation. DON confirmed that this did not happen following R23's anaphylactic reaction. During interview on 2/27/25 at 3:13 p.m., administrator stated expectation of any adverse event would be reported via a group text which included herself, the DON, unit managers and the manager on call. Administrator stated either herself or DON would submit a report to the SA and initiate an investigation. Administrator confirmed that the event involving R23's anaphylactic reaction that occurred on 12/14/24, was not reported to the SA until 2/26/25. Facility policy Incident/Accident Reports dated 1/24, indicated, When the incident/accident involves a resident, nursing is responsible for notation in the medical record Risk Management and progress note describing the incident /accident, as well as, prompt follow-up action, intervention and notification of family and physician. The policy further indicated, DON or designee would review and ensure documentation was complete and when appropriate ensure incidents were reported in accordance with state and federal law. Facility policy Vulnerable Adult-Abuse Prohibition Plan dated 10/24, indicated all incidents involving abuse, neglect, exploitation or mistreatment would be reported immediately to the SA. The policy defined neglect as the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further indicated, All incidents requiring medical intervention or follow-up are documented in the resident record and DON, Administrator or other designee would immediately institute an internal investigation of the reported allegation or incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on interview and document review, the facility failed to investigate an incident of anaphylactice reaction and need for emergency services for 1 of 1 residents (R23) reviewed for anaphylactic reaction. Findings include: R23's admission Minimum Data Set (MDS) dated [DATE], indicated R23 was cognitively intact and required setup assistance for eating. R23's diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and [NAME]-[NAME] syndrome [a condition affecting appetite and causing one to always feel hungry). R23's diet order/dietary communication dated 11/29/24, indicated food allergies, ginger, bee pollen. R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, insurance does not cover. -12/18/24 at 3:19 p.m. resume, ordered per provider. -Date received-12/23/24, on hand. During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having anaphylactic reaction and requested epinephrine. R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (e-kit). Review of facility week 2 menu for Saturday was Honey Ginger chicken thighs and Asian Stir fry vegetable mix. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's progress note dated 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23 having a stick [sic] throat, and does not feel well. R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their file. R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter. The AVS instructed, You were seen today for an allergic reaction. Your symptoms improved after an epi pen. Return to the emergency department with any new or worsening symptoms. Review of facility risk management lacked evidence facility completed an investigation or safety incident report for R23's anaphylactic reaction event. During interview on 2/27/25 at 2:29 p/m., director of nursing stated expectation for staff to initiate a safety event or risk management entry, both process include the required report of the event to the administrator and DON regardless of date, time or shift. DON stated either herself or the administrator would then file a report with the SA and initiate an investigation. DON confirmed that this did not happen following R23's anaphylactic reaction. During interview on 2/27/25 at 3:13 p.m., administrator stated expectation of any adverse event would be reported via a group text which included herself, the DON, unit managers and the manager on call. Administrator stated either herself or DON would submit a report to the SA and initiate an investigation. Administrator confirmed that the event involving R23's anaphylactic reaction that occurred on 12/14/24, was not reported to the SA until 2/26/25. Facility policy Incident/Accident Reports dated 1/24, indicated, When the incident/accident involves a resident, nursing is responsible for notation in the medical record Risk Management and progress note describing the incident /accident, as well as, prompt follow-up action, intervention and notification of family and physician. The policy further indicated, DON or designee would review and ensure documentation was complete and when appropriate ensure incidents were reported in accordance with state and federal law. The policy further indicated, Designated staff member [designated by the administrator or DON] will initiate an internal investigation as needed to determine the root cause of the incident. Facility policy Vulnerable Adult-Abuse Prohibition Plan dated 10/24, indicated all incidents involving abuse, neglect, exploitation or mistreatment would be reported immediately to the SA. The policy defined neglect as the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further indicated, All incidents requiring medical intervention or follow-up are documented in the resident record and DON, Administrator or other designee would immediately institute an internal investigation of the reported allegation or incident. The policy indictated the investigation may include but not limited to the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interviews and written statements with staff and any witnesses -Resident and resident representative interviews -Care observations -Environmental review -Resident health status and medical record review.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to notify the physician of a change in condition for 1 of 1 resident with congestive heart failure (CHF) and a significant weight gain. The facility further failed to ensure appropriate wound care orders were followed for 1 of 1 resident (R35) reviewed for wound care. Findings include: R40 R40's discharge Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of CHF, acute and chronic respiratory failure with hypoxia, acute kidney disease, and fluid overload. It further indicated R40 required partial/moderate assistance with most activities of daily living (ADL) and mobility. R40's physician's orders dated 1/20/2025, indicated daily weights and to update the provider of a weight gain of 2 pounds (lbs.) in one day and/or 5 lbs. in one week, every shift. R40's care plan dated 1/3/25, indicated R40 had CHF, peripheral heart disease (PAD), and hyperlipidemia (HLD). Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. Notify provider of abnormalities. It further indicated the following interventions: -Daily weights, call medical doctor (MD)/nurse practioner (NP) for weight gain of more than 2 pounds per day and/or 5 pounds per week. -Encourage adequate nutrition. Offer small frequent feedings. -Give cardiac medications as ordered. -Monitor lab work; potassium (K+), sodium (NA), blood urea nitrogen (BUN), and creatinine. -Monitor/document sleeping pattern. Inform physician of any insomnia or anxiety. Give sedatives as ordered. Monitor/document/report (as needed) any signs or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. Report to provider as indicated. R40's treatment administration record (TAR) for January and February of 2025 indicated, during the week of 1/20/25-1/26/25 R40 had a weight gain of 11.4 lbs., from 1/25/25-1/26/25 a weight gain of 8.8 lbs., and from 2/6/25-2/27/25 a weight gain of 13 lbs. as evidenced by the weights below: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/20/25 443.4 lbs. -1/24/25 443.8 lbs. -1/25/25 446.0 lbs. -1/26/25 454.8 lbs. -1/27/25 445.6 lbs. -2/6/25 433.0 lbs. -2/7/25 446.0 lbs. -2/10/25 442.0 lbs. -2/11/25 448.0 lbs. R40's progress notes for the month of January and February of 2025, lacked any indication the doctor had been notified of a change in condition regarding weight gain During interview on 2/26/25 at 4:40 p.m., RN-F verified R40's weights on her January and February TAR were more than 2 lbs. in one day and 5 lbs. in one week (as referenced above) and stated the physician should have been notified and documentation should have occurred. During interview on 2/26/25 at 4:46 p.m., RN-G verified R40's weight gain of more than 2 lbs. in one day and 5 lbs. in one week (as referenced above) and stated the nurses were responsible for calling the provider and documenting in the progress notes. RN-G further stated if a resident needed to be re-weighed, they should document it in the progress notes. During interview on 2/27/25 at 9:45 a.m. the nurse practioner (NP) stated the only time she had been notified of R40's weight gain was when she sent her to the hospital for hypervolemia on 2/12/25. The NP further stated she was in the facility 4 days per week and reviewed the weights of the patients she planned to see that day. She didn't see every resident every time she was there, therefore the order indicated to notify the physician and that's what the nursing staff were expected to do. The nurses were responsible for re-weighing a resident if there was an issue with the weight. The NP also verified the order was intended to be for a 7 day period typically from Monday to Sunday. During interview on 2/27/25 at 12:45 p.m. the director of nursing (DON) stated the nurses were responsible for notifying the provider of a change in condition and the provider should have been notified regarding R40's weight gain. This was important because R40 had CHF and was at risk for fluid overload which could have negative effects on her cardiac health. The facility's policy regarding weight and height dated 10/2021, indicated to document resident weight in PCC and update the provider of weight increases or decreases as needed and per physician's orders. 49617 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	45 West 10th Street Saint Paul, MN 55102

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35 R35's quarterly Minimum Data Set (MDS) dated [DATE], indicated she was dependent on staff for toileting and personal hygiene cares as well as mobility and transfers. The MDS identified R35's diagnoses of dementia (a loss of memory, language, problem-solving and other thinking abilities) and indicated she was unable to complete the mental status assessment interview. Additionally, the MDS identified she was at risk for developing a pressure injury and had moisture-associated skin damage (MASD, or skin irritation or breakdown caused by prolonged exposure to moisture such as urine, saliva, sweat, or wound drainage). R35's Care Area Assessment (CAA) for pressure ulcer/injury dated 10/31/24, identified her MASD to left gluteal fold with treatment. The CAA directed staff to the care plan for goals and interventions. R35's care plan revised on 2/5/25, identified her impaired skin integrity and risk for further breakdown as evidenced by MSAD to her buttocks. The care plan directed staff to provide treatment and wound care as ordered. R35's signed order summary dated 1/6/25, included the wound order: - wound care 1. Facility staff to perform every other day and as needed 2. Cleanse open areas to buttocks and upper thigh. Allow to dry. Apply Mepilex over open areas every day shift every other day for MASD, dated 12/17/24. R35's TAR dated 2/25, reflected the following wound care orders: - wound care to buttocks: cleanse open areas with wound cleanser. Pat dry. Cover with Mepilex dressing, change every evening shift every other day for MASD, dated 2/26/25 at 7:08 p.m. - wound care for left heel: cleanse with wound cleanser. Pat dry. Apply Medihoney and cover with Mepilex dressing. Change daily and PRN (as needed) every evening shift, dated 1/23/25. During observation on 2/26/25 at 6:14 p.m., registered nurse (RN)-C and RN-D were at R35's bedside during evening cares. RN-D stood at the head of the bed and talked to R35 while RN-C performed wound cares. RN-C sprayed a wound cleanser over R35's buttocks to cleanse the area before patting it dry with gauze. RN-C applied a dark, honey-colored gel from a tube to her gloved fingertips and dabbed it onto each of the opened and red areas on her buttocks, and then applied more from the tube to her fingertips and dabbed it onto the fluid-filled sacs on R35's buttocks. RN-C then applied foam dressings to cover the areas and dated each dressing. During interview on 2/26/25 at 6:42 p.m., RN-C reviewed R35's wound care orders and TAR dated 2/25 and was unable to find current or active wound treatment orders for her. RN-C verified the wound treatment orders for R35's pressure ulcer to her left heel, which included Medihoney, and confirmed applying it to R35's buttock during wound cares. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/27/25 at 2:26 p.m., RN-D verified the MSAD treatment order should have been cleanse with a wound cleanser, pat dry with gauze and cover with a Mepilex. RN-D confirmed witnessing RN-C applying the Medihoney to R35's MSAD on her buttocks and stated, I thought I saw RN-C doing that. RN-D expected staff to verify and double check orders before applying treatments if staff were unsure. Per interview on 2/27/25 at 3:13 p.m. with the director of nursing (DON), staff were expected to review treatment orders if they were unsure of an order before administering the treatment or order. Per facility policy titled Management of Skin Alterations dated 9/11/24, residents with wounds would have at minimum weekly monitoring for appropriateness of treatment/care plan, signs of healing and would report to the provider as needed. Education would be provided to staff as needed on alterations in skin integrity.

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42584 Based on observation, interview, and document review, the facility failed to ensure residents with food allergies received the appropriate tray for 1 of 1 resident (R23) reviewed who had a listed anaphylactic reaction (a severe, potentially life threatening allergic response) to ginger. This resulted in an immediate jeopardy (IJ). The IJ began on 12/14/24, when R23 was served a meal tray which included honey ginger chicken and after a few bites experienced an anaphylactic reaction. R23 had an order for epinephrine to be used in the case of an anaphylactic reaction however, R23 was not given the epinephrine. This resulted in R23 requiring transfer to the emergency department for treatment. The administrator and director of nursing (DON) were informed of the IJ on 2/25/25 at 3:46 p.m. The facility implemented corrective action and the IJ was removed on 2/26/25 at 7:20 p.m. However, non-compliance remained at the lower scope and severity of D, isolated, no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R23's admission Minimum Data Set (MDS) dated [DATE], indicated R23 was cognitively intact and required setup assistance for eating. R23's diagnoses included acute ischemia of small intestine (decrease in blood flow), type 2 diabetes, and [NAME]-[NAME] syndrome [a condition affecting appetite and causing one to always feel hungry). R23's care plan dated 12/9/24, indicated set up assistance to eat, diet as ordered, monitor food intake at meals, and offer alternatives for meals if refusing. R23's care plan lacked evidence of any food allergies. R23's diet order/dietary communication dated 11/29/24, indicated food allergies, ginger, bee pollen. R23's allergy list printed 2/25/25, indicated the following food allergens: ginger, bee pollen/royal jelly. R23's admission nutrition assessment dated [DATE], indicated, Allergies .Diclofenac, metformin, Bee pollen/royal jelly, Ginger. R23's physician order history indicated the following: -Epinephrine injection solution auto-injector 0.3mg/0.3ml. Inject 0.3 mg intramuscularly as needed for anaphylaxis, allergy to ginger, daily - start date 11/29/24 at 5:00 p.m. -11/29/24 at 9:29 p.m. on hold, insurance does not cover. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-12/18/24 at 3:19 p.m. resume, ordered per provider. -Date received-12/23/24, on hand. R23's December 2024 medication administration record (MAR) indicated, EPINEPHrine Injection Solution Auto-Injector 0.3 MG/0.3ML (Epinephrine [Anaphylaxis] Inject 0.3 mg intramuscularly as needed for anaphylaxis, Allergy to ginger. Daily - Order Date- 07/27/2014 .-Hold Date-from 12/01/2024 .to 12/18/2024. R23's MAR indicated H from 12/1/24 through 12/17/24, and did not indicate any epinephrine administration. During interview on 2/24/25 at 11:51 a.m., R23 stated a few months ago she was provided a meal consisting of a piece of chicken and stir fry vegetables. R23 stated her meal ticket did not indicate chicken; therefore, did not know what type of chicken was provided. R23 asked several unidentified staff members if the food items contained ginger, and all said no. After a couple bites, R23 stated she thought she bit into a piece of ginger and within a few seconds her lips started tingling and she felt her throat beginning to tighten. R23 notified staff she was having an anaphylactic reaction and requested epinephrine. R23 was told her epinephrine order was on hold due to insurance not covering it and staff did not have epinephrine in the emergency medication kit (E-kit). Review of facility week 2 menu for Saturday was honey ginger chicken thighs and Asian stir fry vegetable mix. R23's progress note dated (Saturday) 12/14/24 at 10:56 p.m., indicated R23 reported to staff of having a food allergy after eating part of her dinner and on assessment discovered R23 having a stick [sic] throat, and does not feel well. R23 started having shortness of breath and was put on oxygen at 4 liters/min. Resident had an order for epinephrine but it was on hold and the medication was not available. Staff called 911 and resident was sent to the hospital. R23's progress noted dated 12/14/24 at 11:05 p.m., indicated, This writer re email [sic] resident diet order to kitchen because one of the dietary stated that they don't have the food allergy in their file. R23's emergency department after visit summary (AVS) dated 12/14/24, indicated, Reason for Visit ALLERGIC REACTION Diagnoses -Shortness of breath - Anaphylaxis, initial encounter. The AVS instructed, You were seen today for an allergic reaction. Your symptoms improved after an epi pen. Return to the emergency department with any new or worsening symptoms. During observation on 2/25/25 at 9:00 a.m., R23's meal tray ticket lacked evidence of any food allergies. During interview on 2/25/25 at 9:21 a.m., dietary staff (DS)-A stated each resident had diet orders and allergies uploaded to the nutrition program. DS-A stated dietary staff would go room to room and enter residents' requests for all three meals for the following day. The nutrition program would identify a contraindication due to an allergy and would not allow the specific food item to be ordered. DS-A further stated resident allergies should also print out on the meal tray ticket and staff should check ticket prior to providing resident their meal. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on 2/25/25 at 9:41 a.m., licensed practical nurse (LPN)-A stated all resident allergies should be listed in the nutrition program and should display on the resident's meal tray ticket. LPN-A further stated epinephrine was stocked in the E-kit and available to be used in emergency situations. LPN-A further stated if a resident had epinephrine ordered for an anaphylactic reaction and did not have the medication available in their medications, the epinephrine in the E-kit should be used in the case of an allergic reaction. During interview on 2/25/25 at 10:06 a.m., kitchen manager (KM) and director of nutrition services (DNS) stated nursing communicates diet orders and allergies to dietary services using a specific communication form which was completed then scanned and emailed to nutrition. KM stated the information was then uploaded into the nutrition program (Healthtouch) and the system had safety measures built in to not allow a resident to order a food item that was listed as an allergy. During interview on 2/25/25 at 10:34 a.m., registered nurse (RN)-A stated would expect dietary services would have the correct allergy information for each resident and that they would not provide a meal containing food that a resident was allergic to. RN-A stated each resident's meal tray ticket should indicate any food allergies. RN-A further stated if a resident had an order for an emergency medication and it was not covered by insurance, that the facility would purchase the medication within 24 hours of denial and preferably before their first meal in the case of a food allergen. During follow up interview on 2/25/25 at 11:37 a.m., DNS provided list of all available allergies in the nutrition program and confirmed ginger was not included. DNS stated an undefined allergy could be added to the comments area but that did not display on the meal tray ticket. During interview on 2/25/25 at 10:55 a.m., director of nursing (DON) stated expectation that the process would correctly identify a resident's food allergies, and that information would be communicated to nutrition services. DON stated the food allergy should print on the meal tray ticket. DON further stated in a situation of a non-covered emergency medication the facility would purchase the medication to have on hand. DON stated the facility E-kit does contain epinephrine, but was not sure it was the corrected dosage. DON could not explain why there was not a change of condition, safety event or risk management completed on this event and stated lack of such report did not allow for proper follow up, education or resolution. During interview on 2/25/25 at 11:25 a.m., consultant pharmacist (CP) stated epinephrine was stocked in the facility E-kit and was unaware of any shortage around 12/14/24. CP stated if a resident was experiencing an anaphylactic reaction due to a food allergen ingestion, should be given epinephrine if ordered as anaphylaxis is a medical emergency. CP stated a resident in anaphylaxis who does not receive epinephrine could experience inability to breathe and would need emergency services. Facility policy Patient Meal Service Procedure dated 8/8/23, indicated, food allergies would be entered appropriately into HealthTouch and HealthTouch computer system will automatically omit designated allergens from the patient's menu choices. All foods listed as allergen in the HealthTouch system will not be served to the patient .If the patient has an allergy that is not identifiable in Health Touch the menu will be hand checked by the diet clerk or designee. The policy further indicated, A designated Nutrition Aide will check each meal tray for accuracy before the tray leaves the department. This check includes, but it [sic] not limited to: confirming all items are in place and all quality standards are met. (continued on next page)

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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy that began on 12/14/24, was removed on 2/26/25 at 7:20 p.m., when it could be verified through observation and interview that the facility had implemented a process to ensure residents would receive appropriate food items and not receive identified food allergens. A whole house audit was conducted by nutrition services and verified all residents' allergies listed in the medical record was accurately listed in the nutrition system and that those allergies would accurately print on the residents' meal tray ticket. Meal service observation identified staff confirmed the meal served matched the meal tray ticket and any food allergies listed on the meal ticket were not served. In addition, R23's orders and stocked medication included epinephrine. The E-kit contents were reviewed and included epinephrine as well. Nutrition staff education started on 2/25/25 included allergy information communication and entry into the nutrition system, meal service, meal ticket and allergy review and tray assembly. Nursing staff education started on 2/25/25 included verification that the meal delivered matched the tray ticket and did not contain any food allergens. Nursing education further included E-kit contents, use of epinephrine via a vial, standing house orders, signs and symptoms of anaphylactic reaction, procedure for allergic and anaphylactic reactions, and incident reporting. The plan was to educate all staff prior to their next shift. Continued compliance monitored via meal service audits completed daily for two weeks, then weekly for four weeks and monthly thereafter. Audit results would be reviewed by the quality committee.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to ensure adaptive equipment was used for 1 of 1 residents reviewed for adaptive equipment. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated R9 had cognitive impairment and diagnoses of dementia, stroke, and dysphasia (difficulties swallowing). R9 had was dependent for eating, had difficulty swallowing and required a mechanically altered diet. R9's nutritional assessment dated [DATE], indicated R9 required varying level of assistance with meals and required a nosey cup for drink. R9's Kardex printed 2/25/25, indicated R9 required honey thick liquids and adaptive equipment of a nosey cup. (cup that assists resident with drinking fluids) R9's care plan revised 12/13/24, indicated R9 had severe nutrition deficit related to demean, dysphasia and history of weight loss. Interventions included honey thick liquids and use of nosey cup. R9's meal tickets dated 2/24/25 and 2/26/25, directed staff to provide a nosey cup with meals. An observation on 2/24/25 at 11:47 a.m., lunch started to be served. R9's tray had three cups of juice, however did not have a nosey cup. Nursing assistant (NA)-B placed R9's tray in front of him and set it up before delivering other resident trays. R9 was able feed self with spoon a few bites of pureed diet. R9 reached for cup, but did not pick up. After delivering trays, NA-B sat down and assisted R9 with lunch. NA-B assisted with the juice and NA-B had not obtained a nosey cup. R9 was not able to tip head back to drink all the juice and NA-B poured juices together. When interviewed on 2/24/25 at 12:24 p.m., NA-B stated R9 was dependent with eating and was not able to do eat or drink on their own. NA-B verified R9's meal ticket indicated R9 required a nosey cup however R9 liked to hold the normal cup and sometimes refused it. The cup would be sent up from the kitchen and NA-B stated there were not any on the unit. When interviewed on 2/24/25 at 12:24 p.m., dietary aide (DA)-A verified if adaptive equipment was listed on the ticket, the kitchen would send it up on the tray. When observed on 2/26/25 at 12:16 p.m., NA-E assisted R9 with lunch. R9's tray did not have a nosey cup. When interviewed on 2/26/25 at 12:30 p.m., NA-E verified R9's meal ticket indicated R9 required a nosey cup, however, did not use one during lunch. NA-E stated the cups do not always come on the trays from the kitchen. When the cup was not available, NA-E would see how R9 was doing with drinking out of a normal cup and if there was not a lot of coughing, then the normal cup would be used. If R9 wasn't doing well with the normal cup, then the kitchen would be notified to bring a nosey cup. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/27/25 at 8:30 a.m., kitchen manager (KM)-B expected adaptive equipment that was included on the meal ticket to be sent with the residents tray. KM-B further stated if it was not, nursing staff should reach out. When interviewed on 2/27/25 at 10:55 a.m., registered nurse (RN)-D stated if adaptive equipment was needed, it should be available and used. RN-D stated the nosey cup was needed to assist with fluid intake and make it easier to swallow. When interviewed on 2/27/25 at 11:55 a.m., the Director of Nursing (DON) expected resident adaptive equipment to be provided by the dietary staff. If the equipment was not provided, nursing staff should reach out to the kitchen to obtain what was needed. A facility policy titled Adaptive Equipment effective 4/5/23, directed staff to assure all residents were assessed and provided the special equipment necessary for them to reach their highest level of functioning.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647 Based on observation, interview and record review the facility failed to ensure hand hygiene was completed during incontinent cares for 2 of 4 residents (R31 and R9) who were observed for cares. Furthermore, the facility failed to ensure urine was cleaned in a manner to prevent infection for 1 of 1 residents (R31) reviewed for clean environment. Findings include: R31 R31's quarterly Minimum Data Set (MDS) dated [DATE], indicated R31 had cognitive impairment and diagnoses of dementia and heart failure. R31's care plan revised 11/27/24, indicated R31 was had bladder incontinence and tended to void in available garbage cans or receptacles. R31 requires assist of one staff to find the bathroom and assist with incontinent cares. Furthermore R31's care plan indicated R31 would urinate in inappropriate places. An observation on 2/25/25, at 7:07 a.m., R31's door was open with the commode moved away from the wall and placed in front of the R31's door. R31 was laying in bed and then started getting up from bed. R31 walked to the bathroom doorway, stood there for a moment before returning to bed. At 7:33 a.m., nursing assistant (NA)-B entered the room and asked R31 if wanted to go down for breakfast. R31 declined. NA-B then took the commode bucket out of the commode and went into the bathroom and rinsed it out. NA-B then took the commode bucket, now filled with soap and water and poured the soapy water onto R31's floor. NA-B placed the commode bucket back into the commode and then took towels and using their feet, wiped up the soapy water from the floor. A disposable pad and towel were placed on the floor and NA-B then put the commode on top of them. At 7:42 a.m., writer entered the room as R31 was now getting out of bed. Without glove exchange or hand hygiene, NA-B assisted R31 by the arm to the bathroom to urinate NA-B stated the floor may be wet as R31 goes all over the place. After R31 urinated, NA-B obtained a wipe and wiped the toilet seat as R31 walked back to the room. NA-B moved clean towels from the sink in R31's room to his bed and asked R31 to come to the sink. Still without removing gloves or performing hand hygiene, NA-B took R31's toothbrush, added toothpaste and prompted R31 to brush their teeth. When R31 was done, NA-B took the toothbrush and rinsed it off in the sink, using a gloved thumb to rub the bristles. NA-B prompted R31 to wash their hands while NA-B took some clean towels from the bed and placed them back onto the sink. Without hand hygiene or glove exchange, NA-B placed body soap on the towel and got it wet. Assisted resident to wash face. NA-B placed towel in garbage bag. NA-B then lowered R31's soiled pants and took a clean towel placed soap on it and got it wet. NA-B cleaned R31's front groin side and with the same towel wiped down R31's legs to the knees before coming back up to wipe the backside. The wet towel was placed in the garbage bag before NA-B opened a drawer to obtain a dry towel and dried off R31. R31 sat down on the bed. Without hand hygiene or glove exchange, NA-B went to R31's closet and obtained clean clothing. NA-B assisted R31 with a clean sweatshirt and clean pants. R31 put on shoes and NA-B prompted R31 to walk down for breakfast. NA-B finished up with collecting the dirty linens and clothes before removing gloves and performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/25/25 at 8:05 a.m., NA-B verified hand hygiene and glove exchange was not completed after handling soiled towels and the commode bucket and before working with R31. NA-B further acknowledged hand hygiene and glove exchange was not completed in between cleaning soiled areas and working with clean areas. NA-B explained R31 would just get up an urinate anywhere in the room. NA-B used the soapy water from the commode bucket to help keep the smell of urine out of the room. NA-B verified the soap used in the water was a Dial men's 3 in 1 soap. When interviewed on 2/25/25 at 2:02 p.m., universal services staff (USS) stated all resident rooms were cleaned daily. USS stated they just started at one end to the next end. USS stated staff had not informed them of any room needing cleaning due to urine being spilled. USS stated they had not cleaned R31's room yet and left that one for last. USS said R31 urinates on the floor often so that room was saved for last as rooms were completed only once a day. When interviewed on 2/27/25 at 8:33 a.m., universal services manager stated nursing staff should clean up any bodily fluids and then environmental staff should be notified to sanitize the floor. It was expected the USS would clean the floor right away and after each occurrence. Furthermore, body soap would not properly disinfect the floor and would not be used and should not be dumped from a commode bucket. R9 R9's quarterly MDS dated [DATE], indicated R9 had cognitive impairment and diagnoses of dementia, stroke, and dysphagia (difficulties swallowing). Furthermore, R9 was dependent on staff for toileting and bed mobility. R9's care plan revised 12/19/24, indicated R9 was incontinent of bowel and bladder and dependent on staff for toileting. An observation on 2/26/25 at 3:45 p.m., nursing assistant (NA)-E and NA- B assisted R9 back to bed with a lift. R9's was assisted with turning back and forth in bed to remove sling and pull down pants to change brief. NA-A tucked in the left side of brief and then turned R9 to the right. R9 has a small bowel movement. NA-E used a wipe to clean R9 and removed the soiled brief. NA-E then placed the soiled brief on the floor. NA-E then looked at their gloves and took an incontinent wipe and wiped their soiled gloved hands. Without hand hygiene or glove exchange, NA-E assisted with placing R9's clean brief. NA-E and NA-A then assisted with R9's pants. NA-E lowered R9's bed and placed the call light within reach. NA-E moved R9's wheelchair and then picked up R9's soiled brief from the floor and placed in the garbage. NA-E doffed the gloves, tied up the garbage and took to the soiled utility room where hand hygiene was then completed. When interviewed on 2/26/25 at 1:00 p.m., NA-E verified she had not performed hand hygiene or changed gloves after handling R9's soiled brief. NA-E stated since R9's brief was only a little dirty, glove change was not needed. NA-E further verified the soiled brief should not have been on the floor and should have been placed in the garbage right away. (continued on next page)

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	245587	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ebenezer Integrated Care & Rehab	45 West 10th Street Saint Paul, MN 55102

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 2/27/25 at 10:00 a.m., the infection preventionist (IP) stated hand hygiene and glove exchange was required after handling soiled or potentially dirty items and moving to clean areas during resident cares. IP further stated nursing staff were responsible to clean up any bodily fluids that were on the floor and notify the universal workers to come disinfect the floor. The floors can be cleaned as often as needed. When interviewed on 2/27/25 at 11:49 a.m., the Director of Nursing (DON) expected staff to change gloves and perform hand hygiene when moving from soiled cares to clean cares. Dirty briefs should not be placed on the floor and should be placed in the garbage right away. DON further expected staff to clean up any bodily fluids from the floors and then seek out environmental services to clean or disinfect the floor. All of these were important to prevent infection. A facility policy titled Environmental Cleaning revised 3/2024, was received and did not outline cleaning procedures for bodily fluids. A facility policy for hand hygiene was requested however not received.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to ensure 4 of 4 residents (R15, R33, R54, R110) were offered and/or provided updated vaccinations for pneumococcal disease and 2 of 5 residents (R33, R110) for influenza in accordance with the Centers for Disease Control (CDC) vaccinations. Findings include: R15 R15's discharge Minimum Data Set (MDS) dated [DATE], indicated R15 was admitted on [DATE], was currently [AGE] years old, had intact cognition and diagnosis of diabetes which puts him at higher risk for pneumococcal diseases. R15's Minnesota Immunization report dated 2/7/25, indicated R15 received the pneumococcal polysaccharide vaccine (PPSV23) on 7/17/12 and the pneumococcal conjugate vaccine (PCV13) on 4/26/19. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R15's age and vaccine history: Give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. R15's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal vaccination. R33 R33's admission Minimum Data Set (MDS) dated [DATE], indicated R33 was admitted on [DATE], was currently [AGE] years old, had intact cognition and diagnosis of diabetes which puts her at higher risk for pneumococcal diseases. It further indicated her pneumococcal vaccinations were up to date. R33's Minnesota Immunization report dated 1/10/25, indicated R33 received the pneumococcal polysaccharide vaccine (PPSV23) on 10/10/19 and the pneumococcal conjugate vaccine (PCV13) on 11/211/16. It further indicated R33's most recent influenza vaccination was administered on 10/1/2020. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R33's age and vaccine history: though the vaccines were considered complete, based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or 21 is administered, their pneumococcal vaccinations are complete. R33's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal and/or influenza vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R54 R54's quarterly Minimum Data Set (MDS) dated [DATE], indicated R54 was admitted on [DATE], was currently [AGE] years old, had intact cognition and diagnosis of intracerebral hemorrhage (brain bleed). R54's Minnesota Immunization report dated 11/20/24, indicated R54 received the pneumococcal polysaccharide vaccine (PPSV23) on 9/19/19 and the pneumococcal conjugate vaccine (PCV13) on 10/28/15. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R54's age and vaccine history: though the vaccines were considered complete, based on shared or clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Regardless of whether PCV20 or PCV21 was administered, their pneumococcal vaccinations are complete. R54's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal vaccination. R110 R110's discharge Minimum Data Set (MDS) dated [DATE], indicated R15 was admitted on [DATE], was currently [AGE] years old, had moderately impaired cognition and of diagnosis of hepatic encephalopathy and alcoholic cirrohosis of the liver (with ascites). It further indicated his pneumococcal vaccinations were up to date. R110's Minnesota Immunization report dated 2/20/25, indicated R110 received the pneumococcal conjugate vaccine (PCV13) on 4/30/1997. It further indicated R110's last influenza vaccine was administered on 4/30/1956. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/26/25, identified based on R110's age and vaccine history: Give one dose of PCV15, PCV20 or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising conditions, cochlear implants, or cerebrospinal fluid leaks. R110's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. It further lacked a declination or documentation of risk and benefits regarding the pneumococcal and/or influenza vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/27/25 at 10:00 a.m. the infection preventionist (IP) stated the process regarding vaccinations for new admissions was to print of their Minnesota Immunization Information Connection report (MIIC) in order to determine what vaccinations the resident had already received and which ones they needed. Then the facility would ask the resident if they are interested in receiving those vaccines and give them a Vaccine Information Sheet (VIS), and request a physician's order. If the resident refused, they sign a declination form, were educated on the risk versus (vs) benefits, and it was documented in their medical record. The facility offered COVID, influenza, RSV, and pneumococcal vaccinations. The IP verified R15, R33, R54, R110 lacked documentation of vaccines being offered, refused, or educated on risk vs. benefits and was still following up on those residents. The nursing staff try to offer the residents vaccinations in the first day or two following admission. The IP also stated influenza vaccinations are offered from October 1st-March 31st each year. During interview on 2/27/25 at 12:49 p.m., the director of nursing (DON) stated when there was a new admission, the nursing staff were responsible for putting in an order set which would populate the vaccinations and schedule a Tuberculin blood test at the lab. Then the results would be documented. The nursing staff and IP were responsible for following up and ensuring the residents were offered and/or received the vaccinations. Documentation for refusals was not put in Point Click Care (computer program) it was tracked internally. The facility's policy regarding influenza (11/7/24) and pneumococcal vaccinations (11/5/24) indicated, all patients including those admitted during the influenza season, will be offered an influenza immunization, September 1st through March 31st annually, unless the immunization is medically contraindicated, or the resident had already been immunized during this time period. All residents or resident representative will receive information regarding the benefits and potential side effects of immunization prior to a vaccine being offered. In the case of a refusal, staff will discuss the risk and benefits of the influenza vaccine and return later to re-offer, preferably having another nurse offer, and if the resident refuses, document the refusal in the medical record. In regards to the pneumococcal vaccination the policy indicated all residents are encouraged to receive a pneumococcal vaccine as defined by the Minnesota Department of Health or CDC unless medically contraindicated, refused, or already immunized or due to circumstances outside the facility's control. The resident will be give the opportunity to refuse the vaccine and refusals will be documented in the medical record. All residents or legal representatives will receive information regarding the benefits and potential side effects of the immunization prior to a vaccine being offered. In the case of a refusal, the staff will discuss risks and benefits of the pneumococcal vaccine, return later to re-offer (preferably having another nurse offer), if the resident refuses, it will then be documented in the resident's medical record.