STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 Sarazin Street Shakopee, MN 55379

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to assess and determine what, if any, options were available to help facilitate bathing method preference (i.e., showers) for 1 of 1 resident (R33) who voiced feeling unsafe being transported for distance while seated in the shower chair. Findings include: R33's quarterly Minimum Data Set (MDS), dated [DATE], indicated R33 was admitted to the care facility on 11/23/22, had moderate cognitive impairment and required substantial to maximum assistance with most activities of daily living (ADLs) including bathing. R33's care plan, edited 4/8/24, indicated R33 had a self-care and mobility deficit with the following activities of daily living; bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder. The care plan further indicated R33 required a mechanical lift for all transfers but did not indicate how or how often R33 preferred to bathe. R33's Preferences for Customary Routine and Activities, dated 1/23/23, indicated it was very important for R33 to choose between a tub bath, shower, or bed bath. R33's Preferences for Customary Routine and Activities, dated 1/10/24, lacked an assessment of how important it would be for R33 to choose his method for bathing. R33's Hospital Discharge Summary, dated 7/14/23, indicated R33 underwent a right below knee amputation on 3/2/23 and a left below knee amputation on 4/20/23. R33's electronic medical record (EMR) lacked evidence that post double amputation R33 was reassessed to determine what, if any, options were available to help facilitate R33 with continuing to get showers in the care facility. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/24 at 2:21 p.m., R33 stated he was receiving a bed bath weekly but would prefer a shower, however felt uncomfortable and unsafe in the shower chair the facility provided. R33 stated there was a communal shower room and in order to use the shower staff would transfer him to a shower chair in his room and transport him to the shower room through the public space of the unit in the shower chair. R33 stated he felt uncomfortable being wheeled unclothed through the public space despite being covered up and further felt unsafe being transported in the shower chair due to his bilateral amputee status. R33 further stated when he was first admitted to the care facility he would get showers and stated the transitional care unit, where he was first admitted to, had a shower in his room that he was able to use without having to transfer via a shower chair in a public space. During an interview on 10/30/24 at 10:36 a.m., nursing assistant (NA)-B stated he had offered R33 a shower a few times but R33 refused, stating he had never asked, and R33 had never shared, why he didn't want a shower. NA-B stated they usually transferred R33 via a ceiling lift in his room but the facility also had a stand-alone mechanical lift that could be used in the bathroom. During an interview on 10/30/24 at 12:13 p.m., unit manager and licensed practical nurse (LPN)-B stated when R33 was first admitted to the facility he was able to pivot transfer prior to his amputations, however since his second amputation R33 had stated he did not feel comfortable in the shower chair. LPN-B stated she did not assess why R33 felt uncomfortable in the shower chair to determine if there were any options for showering that would make R33 feel safe and stated, I didn't think it was my place to ask for more information. LPN-B stated there were a couple flooring changes from R33's room to the bathroom that could cause bumps and potentially make the shower chair feel unstable. LPN-B stated the facility did have mechanical lifts that could be used in the bathroom with a sling designed for residents with amputations. During an interview on 10/31/24 at 11:43 a.m., the director of nursing stated she would expect R33 be assessed on why he did not feel safe with showers in order to offer choices to help facilitate R33's bathing preference.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 51379 Based on observation and interview, the facility failed to ensure residents had access to all the survey results for the past 3 years along with the plan of correction (POC), without having to ask, for the most recent survey of the facility. This had the potential to affect all 88 residents, families, and visitors who may wish to view these. Findings include: On 10/28/24 at 1:05 p.m., the main entrance area of the care center was observed. The entrance had a reception desk present and on the right side of the desk sat a white-colored binder labeled, St Gertrude's State Survey Results. Upon review of the binder, the binder lacked survey results and the POC from the recertification survey exited on 12/14/23. On 10/28/24 at 4:25 p.m., receptionist (RE)-A, stated that the administrator kept the survey results up to date in the survey results binder that was located at the reception desk. RE-A declined to answer any additional questions and stated they were going to get the administrator. On 10/28/24 at 4:28 p.m., administrator verified that she was responsible for keeping survey results in binder up to date. Administrator verified the survey results for the annual survey from December 2023 were not located in the survey binder that contains the survey results for the past 3 years that was located at the front reception desk. Administrator indicated there was another survey results binder around the corner that contains survey results from the past year. Upon reviewing the binder, administrator verified this binder did not contain the survey results from December 2023. Administrator verified, I must have missed that and acknowledged 3 years of survey results must be available for residents, families and visitors to review. A facility policy on posting survey results was not received.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure routine grooming was offered or provided to promote good hygiene for 2 of 2 residents (R1, R25) reviewed for activities of daily living (ADLs) and who were dependent on staff for their cares. Findings include: R1 R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 with impaired cognition, and diagnoses of heart disease, diabetes, anxiety, depression, and psychotic disorder. Also, the MDS documented R1 on hospice cares and dependent on staff for personal hygiene, bathing, dressing, and transfers from bed to chair. R1's care plan identified, Problem: I have a self deficit with the following activities of daily living; grooming, oral cares, ambulation, transferring, and mobility dated 12/13/21. During observation of R1 and interview with R1's emergency contact/son/family member (FM)-B on 10/28/24 at 2:01 p.m., R1 was observed with multiple white colored hairs on her lower chin. R1 was unable to answer questions. FM-B stated, she [R1] generally isn't OK with them [chin hairs]. FM-B stated the facility, should have them [razors]. During interview with nursing assistant (NA)-A on 10/30/24 at 10:07 a.m., NA-A stated, personal cares involve offering to shave, assisting as needed with dressing, oral care, and personal cares are offered twice per day and as needed. NA-A stated, I would feel like as a woman it should be addressed. During observation on 10/30/24 at 11:13 a.m., R1 was observed self-propelling wheelchair down hallway in front of nursing station. R1 was dressed and had multiple half inch white hairs visible on her chin. During interview with NA-C on 10/30/24 at 11:15 a.m., NA-C stated, no I haven't asked her [R1] to shave her. Every morning, we should be at least asking her when she is getting up and dressed. It takes no time to trim those chin hairs. Looks like those chin hairs [on R1] have not been trimmed for at least a couple weeks. We are all are responsible from trimming or shaving the residents. Also, Women don't like having chin or neck hairs. During interview with NA-B on 10/30/24 at 11:22 a.m., NA-B stated personal cares include, help with hygiene and shaving should be done or offered daily at least. NA-B stated, long chin hairs on a woman like two inches [sic] would be concerning to me [due to] a dignity concern. And I would hate it if my mom had hairs on her face. That is not something most women would like. NA-B stated, [R1's] chin hairs look like they have not been shaved or trimmed for at least a couple weeks. R25 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's admission MDS dated [DATE], identified R25 with admission to facility on 7/23/24, had intact cognition and required partial to moderate assistance with personal hygiene. In addition, R25 was documented with diagnoses of diabetes, end stage renal disease requiring hemodialysis (procedure where a device filters wastes, salts and fluid from blood when kidneys are no longer healthy enough to do this work adequately), anemia (low red blood cell level), and a stroke resulting in partial paralysis of her upper body. R25's care plan dated 7/24/24 identified, Problem: ADLs Functional Status/Rehabilitation Potential. I have a self deficit with the following activities of daily living; bathing, grooming, transferring, mobility. Bowel and bladder. During observation and interview with R25 on 10/29/24 at 8:18 a.m., R25 was observed with multiple two-inch white hairs extending from throat. R25 stated, I want to shave it off. I want them gone. Last time I shaved it was when I was home before I was admitted here [7/23/24]. R25 stated no one from facility ever asked her about the hairs and offered to trim or shave them even on weekly shower days. I have never been asked about it. During observation and interview on 10/30/24 at 10:59 a.m., R25 was observed with multiple two-inch-long white hairs extending from throat. R25 stated facility had never offered to shave or trim her throat hairs and that, they bother me. During interview with FM-C on 10/31/24 at 7:40 a.m., FM-C stated, R25 always trimmed or shave the little hairs that grow out of her neck. In the past, it did bother her when she could notice the hairs. It is frustrating for a woman to have those pesky hairs. I don't know if the nursing home trims or shave her chin or neck hairs, but I totally expect them to offer to do it and to at least trim it. No woman that I know wants one-to-two-inch hairs growing from their face. During observation and interview with licensed practical nurse (LPN)-A on 10/30/24 at 12:54 p.m., LPN-A stated she was very familiar with residents on R25's unit. LPN-A stated, no one on this floor requires shaving. Then LPN-A walked with surveyor to R25's room and observed the throat hairs. LPN-A stated, I do see them. They should be shaved. They are really long. [sic] that looks like it has been missed. We should offer to take care of that for her. During interview with director of nursing (DON) on 10/30/24 at 1:05 p.m., DON stated personal hygiene care should be done at least twice per day and as needed. Shaving would done with personal cares. DON stated, women should be shaved or offered at least. Undated facility policy titled Activities of Daily Living (ADL) identify, Residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility.

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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 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** 33925 Based on interview and document review, the facility failed to ensure complaints of potential constipation were acted upon and assessed to determine what, if any, interventions were needed to promote appropriate bowel management and reduce the risk of complication (i.e., fecal impaction) for 1 of 2 residents (R59) reviewed for bowel management. Findings include: R59's Clinical Documentation (Admission), dated 4/19/24, identified R59 had a section to record R59's mental status with both long and short-term memory being marked, Memory OK. Further, the evaluation listed a section labeled, Bowel and Bladder, which outlined R59 as occasionally incontinent of bowel with a question reading, Constipation present? This was answered, Yes. In addition, R59's most recent quarterly Minimum Data Set (MDS), dated [DATE], identified R59 had moderate cognitive impairment but demonstrated no delusional thinking. Further, the MDS marked R59 as being frequently incontinent of bowel and not being on a bowel-related toileting program, but the question to answer if constipation present (i.e., H0600) was not answered. On 10/28/24 at 4:15 p.m., R59 was interviewed while in his room. R59 stated he had ongoing issues with constipation despite taking medications for it adding most of the time he ended up going three or four days between bowel movements. R59 stated he used to go more regularly and expressed staff had never asked him about what, if any, options were available for a more proactive bowel management program (i.e., increased fiber, medications) adding, Not really, I don't think so. R59 stated he had a history of colon polyps and expressed staff were aware of his concerns with constipation as he had reported it multiple times while staff provide medications adding, They know about it. R59's most recent Elimination - Bowel (evaluation), dated 6/21/24, identified R59 used no bowel-related appliances (i.e., ostomy) and was always continent of bowel. However, the remainder of the evaluation, which included sections to review R59's medication use, pertinent medical conditions and treatment options for bowel status, was left blank and not completed. R59's Medication Administration Record (MAR), dated 10/2024, identified R59's current physician-ordered medications and treatments with spaces for staff to record their administration or refusals, if needed. This identified R59 consumed multiple medications, including multiple bowel-related medications, such as Miralax (a laxative) 17 grams (gm) by mouth every day and Senna-S (a laxative) 8.6-50 milligrams (mg) two tablets by mouth daily. These each had a listed start date, 9/11/24 - Open Ended. The Miralax had four total listed refusals or non-administrations recorded on 10/5/24, 10/6/24, 10/8/24 and 10/20/24. The Senna had five total listed refusals or non-administrations recorded on 10/8/24, 10/12/24, 10/19/24, 10/22/24, and 10/26/24. In addition, an order was listed which read, Bowel Assessment (Review), which listed a one time frequency scheduled for 10/11/24. This was recorded as completed on 10/12/24 with dictation reading, Late Administration: Charted late. The note or order lacked further information on what, if any, actions were taken when it was completed despite the evaluation being left nearly blank; nor did the MAR outline any additional interventions or actions (i.e., as-needed medication) for bowel management during the month period. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 10/29/24 at 12:59 p.m., nursing assistant (NA)-B stated they had worked with R59 multiple times and described him as needing staff help with toileting. NA-B stated they had heard R59 complain about constipation, including as recently as like last week, which NA-B reported to the nurse. NA-B added, I told the nurse about it. NA-B stated the nurses were responsible to then address it adding R59's stools were hard, like really hard and even, at times, needed to be broken up before they'd flush down the toilet. NA-B stated they chart residents' bowel movements in the computer and it should be done every shift. R59's medical record was reviewed and lacked evidence R59 had been comprehensively assessed for what, if any, proactive bowel management interventions were needed to promote more regular bowel movements despite R59 having a history of constipation as marked on the admission evaluation and having ongoing complaints to staff about the issue. On 10/29/24 at 1:44 p.m., registered nurse (RN)-B was interviewed and asked about the facility bowel assessment process. RN-A turned to the surveyor and made a slight sweeping motion away from their body with their hands adding aloud, This place needs to get their [explicative whispered] together [with them]. RN-A stated they were unable to answer those questions and directed the surveyor to licensed practical nurse unit manager (LPN)-B adding, I can't safely answer that question. LPN-B was present and interviewed. They explained each resident had standing orders which could be followed if the resident went so many days without a bowel movement. R59's were provided and listed multiple options which performing a rectal check to determine if impaction was present, encouraging fluid intake, consulting the dietician for recommendations and medications like a suppository or enema. LPN-B verified if a nurse did any of these actions, then they should be charted in the MAR. LPN-B stated residents' bowel movements were charted in the computer system and tracked with the night nurse printing a report for the oncoming shift to review and, if needed, act upon. The unit Resident Bowel Management Report, dated 10/23/24 to 10/29/24, identified R59's name along with corresponding bowel movements. This outlined R59 had a large bowel movement on 10/23/24, a small bowel movement on 10/25/24, and none recorded since then (four days prior). LPN-B verified R59 being on fourth day without a bowel movement and RN-B stated nobody had alerted them to R59 being on the fourth day, either. LPN-B stated the nurses were responsible to assess and, if needed, act on bowel status or potential constipation adding repeated episodes of going multiple days without stool could be a problem as well. LPN-B verified the Elimination-Bowel tool was used to demonstrate the assessment of a residents' bowel status and the MAR order, dated 10/11/24, was used to prompt the nurse working to review it and ensure it was accurate and updated. LPN-B reviewed R59's completed evaluation, dated 6/21/24, and verified it was nearly blank adding aloud, That's not good. LPN-B stated nobody had reported R59 as having ongoing issues with his bowel or potential constipation to them otherwise they would have visited with him and completed an evaluation. LPN-B added, Nobody's told me that though. LPN-B verified it should have been reported adding it was important to ensure residents' were not constipated saying aloud, Constipation is horrible, it's painful. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 2:22 p.m., the director of nursing (DON) was interviewed. DON verified they had reviewed R59's medical record and expressed R59 did end up having a large stool the day prior (10/29/24) after the surveyor interviewed staff. DON stated bowel status was evaluated upon admission and with the MDS cycle (i.e., quarterly) and verified the Elimination-Bowel tool was used to demonstrate this process in the medical record. DON verified the last completed evaluation, dated 6/21/24, was left nearly blank and stated they expected it to be completed accurately and fully. DON stated if staff were hearing concerns from R59 about his bowels, then a discussion and evaluation of his bowel sounds should have been done and recorded in the progress notes. DON verified the record lacked evidence this happened along with evidence the standing orders had been enacted or charted. DON verified it was important to ensure bowel complications were assessed and acted upon to reduce the risk of impaction. A facility policy on bowel management was requested, however, none was received.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review the facility failed to assess for removal of an indwelling urinary catheter as soon as possible to restore urinary continence for 1 of 1 residents (R27), reviewed for catheter care. Findings include: R27's quarterly Minimum Data Set (MDS) dated [DATE], identified R27 was admitted to the facility on [DATE], had intact cognition, had an indwelling catheter and required substantial assistance with toileting and lower body dressing. The MDS documented R27 with diagnoses of polyneuropathy (nerve disease), enlarged prostate, obstructive (swelling) and reflux uropathy (urine flows back up into the kidneys), and urinary retention (incomplete emptying of the bladder). In addition, the facility did not attempt to implement a toileting program (e.g., schedule toileting, prompted voiding, or bladder training). R27's facility nurse practitioner admissions progress note (PN) dated 4/19/24, documented R27 had a fall at home resulting in an ankle fracture on 4/13/24, surgery on 4/14/24, and was hospitalized until 4/18/24. PN stated Foley catheter present since approximately last fall. PN plan stated, Foley catheter cares, follow-up with urology as directed. R27's physician orders (PO), care plan (CP), and progress notes (PN) lacked evidence of a urology consult and discussion with R27 and his spouse regarding a toileting program to determine appropriateness of continued catheter use or justification of continued use. During interview with R27 on 10/29/24 at 1:09 p.m., R27 stated his catheter was in place, off and on since last fall [2023] because I couldn't urinate properly. R27 stated he was admitted to facility in April [2024] and no one from the facility assessed him for removal of the catheter or tried alternatives to having the catheter in place. R27 stated the facility never offered to schedule a urology appointment during his stay. R27 stated, my long-term goal is to have it removed so I can go home. During interview with health unit coordinator (HUC)-A on 10/30/24 at 10:23 a.m., the HUC-A stated her role was to ensure all forms of provider orders including facsimile, voicemails, email, physical written forms, and electronic forms are placed in the resident electronic medical record (EMR) and consults are scheduled. HUC-A reviewed R27's electronic medical record (EMR) and hard chart and stated, I can't find the order for a urology consult. During interview with R27's legal representative/spouse/family member (FM)-A on 10/20/24 at 10:40 a.m., FM-A stated R27 has had a catheter since last fall [2023] due to retention of urine. FM-A stated, facility has not talked to us about setting up a urology consult or follow up and there was no discussion on how long it was to be in. FM-A stated, we do not think the catheter should be in forever and would appreciate a discussion or at least an appointment to get [to the urologist]. FM-A stated, nothing has been brought up by staff here at all and no one has discussed with us any other options or alternatives to having the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with director of nursing (DON) on 10/30/24 at 1:11 p.m., DON stated the facility failed to pursue a urology consult for R27 since his admission to the facility on [DATE]. In addition, DON stated the facility did not assess or evaluate R27 for a bladder rehabilitation program with R27's goal of removing the catheter as soon as possible. DON also stated R27's EMR failed to document a discussion and review with R27 and FM-A about how long the catheter was expected to be in place. An undated facility policy titled Prevention of Catheter-Associated Urinary Tract Infections (CAUTI) stated, indwelling urinary catheters are eliminated whenever possible. In addition, An indwelling catheter is used only after alternative methods have failed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on the interview and document review, the facility failed to ensure the consulting pharmacist's recommendations were fully addressed or acted upon for 1 of 5 residents (R66) who were reviewed for unnecessary medication use. Findings include: R66's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R66 had no cognitive impairment, hallucinations, delusions, or behaviors noted during the seven-day look-back period. Further, the MDS indicated R66 was diagnosed with dementia, general anxiety disorder (GAD), and depression. R66's Consultant Pharmacist Recommendation to Physician dated 7/23/24, identified R66's medication regimen had been reviewed by the consulting pharmacist (CP)-A, and listed, Staff are reporting the resident has been crabby and very behavioral since the discontinuation of the Zoloft in June (was started on mirtazapine at the same time). Further stated, I'm not sure why the Zoloft was discontinued but consider restarting it. If she was having side effects to it consider a different SSRI such as Lexapro. The nurse practitioner (NP)-A acknowledged and signed the recommendation on 7/26/24 and documented Zoloft was stopped due to hyponatremia, recently hospitalized for psychic behaviors, meds were adjusted. No changes at this time. R66's Consultant Pharmacist Recommendation to Physician dated 8/18/24, identified R66's medication regimen had been reviewed by the consulting pharmacist (CP)-A, and listed, Staff are reporting the resident has been crabby and very behavioral since the discontinuation of the Zoloft in June (was started on mirtazapine at the same time). Further stated, I'm not sure why the Zoloft was discontinued but consider restarting it. If she was having side effects to it consider a different SSRI such as Lexapro. The report did not include a provider response. R66's Consultant Pharmacist Recommendation to Physician dated 9/26/24, identified R66's medication regimen had been reviewed by the consulting pharmacist (CP)-A, and listed, Staff are reporting the resident has been crabby and very behavioral since the discontinuation of the Zoloft in June (was started on mirtazapine at the same time). Further stated, I'm not sure why the Zoloft was discontinued but consider restarting it. If she was having side effects to it consider a different SSRI such as Lexapro. The nurse practitioner (NP)-A acknowledged and signed the recommendation on 9/30/24 and documented Zoloft was stopped due to hyponatremia, will review at next visit. R66's care plan dated 9/26/24, indicated R66 received psychotropic medication and directed staff to monitor for target behaviors daily. Further, the staff was directed to observe and report the efficacy of interventions along with a monthly medication record review by the pharmacist. R66's provider visit note, dated 10/3/24, included a list of R66's current medications and indicated continue current medications and treatments. R66's medical record was reviewed and did not include the documented rationale for not acting upon the pharmacist's recommendation to begin Lexapro if a different SSRI could not be used. (continued on next page)

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	245610	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 Sarazin Street Shakopee, MN 55379

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R66's Consultant Pharmacist Recommendation to Physician dated 10/23/24, identified R66's medication regimen had been reviewed by the consulting pharmacist (CP)-A, and listed, Staff are reporting the resident has been crabby and very behavioral since the discontinuation of the Zoloft in June (was started on mirtazapine at the same time). Further stated, I'm not sure why the Zoloft was discontinued but consider restarting it. If she was having side effects to it consider a different SSRI such as Lexapro. The report did not include a provider response. R66's Physician Order Sheet dated 10/30/24, identified R66's current medication regimen and included an order for Lexapro (a treatment for depression and GAD) five milligrams (mg) by mouth once a day. This medication was started on 10/30/24, with no evidence of revision or adjustment since then. An order for Remeron (a medication for the treatment of depression) 15 mg at bedtime daily was started on 7/15/24 with no evidence of revision or adjustment since then. When interviewed on 10/31/24 at 10:59 a.m., RN-D stated R66 was having target behaviors of refusing care and medication and could be more withdrawn at times. When interviewed on 10/31/24 at 11:07 a.m., licensed practical nurse (LPN)-B stated R66 was still experiencing behaviors after stopping Zoloft (a treatment for depression and GAD). These behaviors included yelling at staff and refusing care; R66 had experienced these behaviors in the past. Further stating, the Lexapro was started as R66 was experiencing behaviors. When interviewed on 10/31/2024 at 11:22 a.m., the director of nursing (DON) stated R66 was evaluated by a provider on 10/3/24 and the provider recommended R66 to continue current medication and treatments but did not include further rationale regarding not acting upon the pharmacist's recommendation for Lexapro. The DON stated she was unable to locate evidence in the medical record that the provider had reviewed the August pharmacy recommendation and acted upon it. When interviewed on 10/31/24 at 11:34 a.m., nurse practitioner (NP)-A stated he could not recall R66's mental health history and target behaviors as he did not have a computer available. NP-A stated he last evaluated R66 on 10/3/24 but did not recall the recommendations he made or if recommendations were made regarding possible Lexapro use. NP-A stated he started the Lexapro on 10/30/24 as he had received more communications than usual from the facility care team that indicated R66 was having symptoms of anxiety and depression. When interviewed on 10/31/24 at 12:39 p.m., consultant pharmacist (CP)-A stated the process for completing medication reviews for every resident was done monthly. CP-A stated when pharmacy recommendations were made, he expected a response with a rationale from the provider by the next month's pharmacy review. Further, if he received no response or communication within 60 days, CP-A would increase the priority level. CP-A stated he had not reviewed or noted in the medical record a documented rationale from the provider for disregarding the August and September pharmacy recommendations. When interviewed on 10/31/24 at 12:44 p.m., the DON stated she expected the pharmacy recommendations to be followed up on the next month during pharmacy review by the care team. The DON verified this process was not followed for R66. The DON stated nursing staff should have reviewed the pharmacy recommendations and ensured NP-A had reviewed the need for Lexapro on the next visit, but it looked like that had not occurred. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Consultant Pharmacist Services Provider Requirements dated 12/17, indicated Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings relating to medication therapy orders including recommendations for changes in medication therapy and monitoring of medication therapy as well as regulatory compliance issues.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 33925 Based on observation, interview and document review, the facility failed to ensure medications were available in a timely manner to be provided in accordance with physician orders for 1 of 6 residents (R302) reviewed for medication administration. This resulted in multiple omitted doses and constituted two (2) errors from 27 opportunities for a facility' error rate of 7.14% (percent). Findings include: R302's Hospitalist Discharge Summary, dated 10/29/24, identified R302 was discharged from the acute care hospital to the care center on 10/28/24, with a principal diagnosis listed, Orthostatic hypotension [condition of low blood pressure which happens when standing up from sitting/lying]. R302's corresponding After Discharge Orders, signed 10/28/24, outlined a section labeled, Discharge Medications, which listed the medications for R302 at the care center. These included droxidopa (used to treat low blood pressure) 100 milligrams (mg) orally three times a day, and metronidazole (an antibiotic) 500 mg orally three times a day for seven (7) days. On 10/30/24 at 8:59 a.m., medication administration with licensed practical nurse (LPN)-C was observed and R302's medications were prepared at a mobile cart. LPN-C removed multiple medications and compared them to the Medication Administration Record (MAR). The MAR included the orders for droxidopa and metronidazole, however, there was no supply of the medications in the cart. LPN-C stated they were unable to locate the medications and pointed to the MAR dictation which included a section, Last Given: NA 10/29/24 . Reason: Drug/Item Unavailable. LPN-C reviewed the MAR and stated it seemed as multiple doses have not been given despite R302 admitting two days prior (10/28/24) adding, I don't have it today [either]. LPN-C stated medications could be re-ordered using the MAR and clicking on the Resupply button adding most medications are delivered the same day ordered or, at worst, the following day. LPN-C stated they had worked with R302 the day prior, on 10/29/24, and the medications were not available then, either, from their recall. LPN-C stated they did not update the unit manager (i.e., RN-A) about the lack of medications for R302 but added, I think somebody did. LPN-C stated they would contact the pharmacy and follow-up on it. LPN-C then entered R302's room to provide the rest of the prepared medications. Following the administration, R302 was interviewed and stated they came to the care center a few days ago from the hospital. R302 stated they vaguely recalled being on the two medications but were unsure if they had been getting them or updated about not getting them since admitting to the care center adding aloud, I don't recall. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following, on 10/30/24 at 12:09 p.m., registered nurse unit manager (RN)-A was interviewed and verified R302 admitted to the care center on 10/28/24 from the hospital. RN-A explained physician orders are typically entered into the medical record and then sent to pharmacy for filling adding most medications generally come that night or are available within the Alixa machine (medication dispensing system). RN-A provided R302's MAR for review which outlined some missed and administered doses. RN-A stated they followed up with the nurse who had been working and verified the pharmacy was not contacted about the lack of medications adding they were unsure to the exact reason the medications were not provided (i.e., Alixa error, machine error). RN-A verified the nurse working should have called the pharmacy to ensure the medications were delivered adding the nurse was a brand-new nurse and likely had not been a part of the last completed education on it back in the summer months. RN-A stated they had just updated the medical provider about the situation and obtained new orders adding there seemed to be no negative outcome to R302 due to the missed doses. RN-A stated if there had been a negative outcome, then they would consider the multiple omitted doses an error but added they typically pulled a report each weekday on 'missed doses' and felt they'd have soon caught the issue. However, RN-A acknowledged medications should be provided, as ordered, adding it was important so residents don't miss doses of anything and have a negative outcome. R302's MAR, dated 10/2024, identified R302's administered medication record while at the care center. This outlined the order for droxidopa with only one of the five dose opportunities being recorded as administered. The remaining four doses, all recorded as not given, had corresponding dictation which included, Not Administered: Drug-Item unavailable . The order for metronidazole was also outlined, however, again, only one of the five dose opportunities was recorded as administered. The remaining four doses, all recorded as not given, had corresponding dictation which included, Not Administered: Drug-Item unavailable . On 10/30/24 at 1:32 p.m., the consulting pharmacist (CP)-A was interviewed, and explained they were not affiliated with the dispensing pharmacy. CP-A reviewed R302's medication, and he stated droxidopa was a rare med and used to treat low blood pressure while metronidazole was extremely common and readily available so it should be on-hand adding, There's some mix up going on. CP-A stated the dispensing pharmacy would likely have more input but expressed multiple omitted doses would absolutely be considered an error. Following, on 10/30/24 at 2:09 p.m., the dispensing pharmacy technician (DPT) was interviewed via telephone. DPT reviewed the dispensing pharmacy' record and verified the patient listed as R302. DPT stated the pharmacy had no record of those two orders adding, We did not receive those two orders. DPT stated the last order for metronidazole they had on file was from 10/22 and discontinued on 10/28, with only a single dose being dispensed. DPT reiterated they had no record of a droxidopa order and verified they had never dispensed any according to their record adding, No, we have not. DPT verified both medications, if ordered, would likely be deliverable to the nursing home campus the same day or following. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 2:29 p.m., the director of nursing (DON) was interviewed. DON explained when a patient admits to the center that the health unit coordinator (HUC) was responsible to fax the orders (i.e. After Discharge Orders) to the pharmacy whom then sends the medication supply to the campus. DON reviewed R302's orders and verified both medications omitted were listed with the rest of the orders, so they were unsure how it got missed. DON stated they expected the floor nurses to call pharmacy right away if missed doses are happening along with updating the medical provider. Further, DON stated a medication error would be considered if the medication was available (i.e., onsite) and not given but added the situation with R302's omitted doses potentially could be an error, too. DON added, It's important to follow those provider orders. A facility provided Administering Medications policy, dated 8/2023, identified a process to administer medications to a resident which included the right resident, right dose and right time. The policy added, Medications are administered in accordance with the orders, and, The person preparing or administered the medication will contact the provider if there are questions or concerns regarding the medication. However, the policy lacked any definitions on what constituted an error (i.e., omitted dose) or actions to take with a lack of medication supply.