STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245615	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gables of Boutwells Landing	13575 58th Street North Oak Park Heights, MN 55082

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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	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** 42579 Based on observation, interview, and document review, the facility failed to ensure the provider documented a clear clinical rationale for actions taken or not taken; including risks and benefits to justify the continued use of medications identified to put the resident at risk for falls and adverse effects for 1 of 1 resident (R83) reviewed for requests for clinical rationale. Findings include: R83's admission Minimum Data Set (MDS) dated [DATE], identified a fall occurred in the past two to six months prior to admission. No behaviors or rejection of care occurred, and the mood interview indicated no depression. R83's corresponding Care Area Assessments (CAA), undated, identified falls was triggered related to history of falls, impaired mobility, cognition, hearing, pain, incontinence, anticipated decline, and medication side effects and care planning was in place to minimize risks and provide symptom relief or palliative measures. Additionally, psychotropic medication use was triggered related to high risk drugs taken (antipsychotic and antidepressant). Care planning was in place to minimize risks and provide symptom relief or palliative measures. R83's quarterly MDS dated [DATE], identified intact cognition, and no behaviors or rejection of care. The mood interview identified minimal depression. Diagnoses included metabolic encephalopathy (brain dysfunction), Alzheimer's disease, depression, and anxiety. No falls had occurred since the prior admission assessment. Impairments to upper or lower extremities were present, and a wheelchair was used for mobility. Hospice services were in place. High risk drugs used included antipsychotic, antianxiety, antidepressant, and opioid; and a gradual dosage reduction had not been attempted nor documented by a physician as clinically contraindicated. R83's anticonvulsant care plan dated 2/7/24, identified brain activity could be affected. Interventions to administer medications as ordered, monitor for side effects, inform the resident, family or caregivers about risks, benefits, side effects of medications, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. (continued on next page)

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

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R83's pain care plan dated 2/7/24, identified a risk for pain related to impaired mobility and cognition, history of falls, skin impairments and anticipated decline. Interventions included pain would be assessed, medications would be administered as ordered, non-pharmacological interventions as needed, and hospice consulted as needed. R83's antipsychotic care plan dated 2/8/24, identified diagnoses of delirium, agitation, anxiety and hospice care. Interventions to administer medications as ordered, monitor for side effects, inform the resident, family or caregivers about risks, benefits, side effects of medications, consult with pharmacy and physician to consider dosage reduction when clinically appropriate. R83's mood and behavioral care plan dated 5/21/24, identified diagnosis of depression and anxiety. Interventions included provide encouragement to participate in activities and demonstrate effective coping skills. Non-pharmacological interventions included: tell resident to take a breath, ask resident if she was in pain, talk to me about the North Shore, turn on TV (likes Greys Anatomy, music channel), encourage resident to be out of her room (tends to self-isolate). Target behaviors included: sadness or crying, anxiety related to where family members were, decreased appetite, self-isolation and paranoia. R83's pain ratings dated 2/7/24 through 6/27/24, identified consistent pain ratings of zero. R83's behavior tracking dated 5/11/24 through 7/10/24, identified no behaviors or mood concerns occurred. R83's Order Summary Report dated 7/10/24, identified the following active medications: 1. Start date 2/7/24, methocarbamol (central muscle relaxant) give 500 milligrams (mg) by mouth two times a day for muscle spasms. 2. Start date 2/7/24, tramadol (opioid agonist produces similar pain relief effects as morphine and other opioids) give 100 mg by mouth three times a day for pain. 3. Start date 2/7/24, C-morphine (opioid) give 5 mg sublingually every one hour as needed (PRN) for pain or dyspnea (difficulty breathing). 4. Start date 2/7/24 gabapentin (anticonvulsant) give 300 mg by mouth three times a day for nerve pain. 5. Start date 2/13/24, Seroquel (an antipsychotic) give 12.5 mg by mouth at bedtime for delirium, agitation, anxiety. 6. Start date 2/16/24, venlafaxine (Effexor, an antidepressant) give 37.5 mg by mouth one time a day for depression take in addition to the 150 mg tablet for a total daily dose of 187.5 mg. 7. Start date 2/16/24, Effexor give 150 mg by mouth one time a day for depression take in addition with 37.5 tablet for a total dose of 187.5 mg. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Start date 7/2/24, lorazepam (benzodiazepine) give 0.5 mg by mouth every 2 hours as needed for Anxiety for 14 days (renewed). R83's Medication Administration Records (MAR) dated 5/1/24 through 7/10/24, identified PRN morphine was never given. PRN lorazepam was given once, on 5/12/24 and marked as effective. All other medications listed above were taken routinely since their start date. R83's Consultant Pharmacist (CP) Communication to Physician dated 3/30/24, identified since a recent fall occurred, the resident was at risk for falls, and the above medications (1 through 7, specifically) might increase the risk of falls; an assessment for ongoing use was requested. Additionally, methocarbamol was strongly urged to avoid use in the elderly - strong correlation with falls. Also, the new guidelines from American Geriatric Society (AGS) Beers list (criteria for potentially inappropriate medications) strongly recommended avoiding three or more central nervous system (CNS)-active drugs as they can increase the risk of falls. CNS-active drugs included antidepressants, antipsychotics, benzodiazepines, and opioids. Lastly, a combination of some CNS medications could cause serotonin syndrome and the risk of QT prolongation (heart rhythm disorder which can be life threatening), as well as additional sedative, CNS and/or respiratory-depressant effects. The CP requested an assessment by the provider of the above medications to determine appropriateness of reducing the dose or frequency. Options provided were: - Discontinue (DC). - Reduce. - No changes because the medications are necessary, benefits outweigh the potential risks, and are required to maintain functional status. - Other. The box for other was checked and hospice was written next to it. The form was signed by nurse practitioner (NP)-A on 4/2/24. The form lacked documentation from the provider of clear clinical rationales including risks and benefits; to justify the continued use of medications identified to put the resident at risk for falls and adverse effects. R83's provider progress notes dated 3/20/24 and 6/17/24, lacked documentation of clear clinical rationales including risks and benefits; to justify the continued use of medications identified to put the resident at risk for falls and adverse effects. During an observation and interview on 7/8/24 at 5:13 p.m., R83 was in her wheelchair, self-propelling around her room, well-groomed and conversational. She stated she had no pain at the time, had good support and was happy with her hospice services. R83 stated her doctor and hospice managed her medications and she would go along with what they decided to do. During an interview on 7/10/24 at 9:55 a.m., nursing assistant (NA)-A stated she worked at the facility for over one year and R83 was alert with intermittent confusion, and she had not noticed any recent behaviors. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/24 at 9:57 a.m., NA-B stated she had worked routinely with R83 for about one month and mood was very stable, no delusions, agitation. R83 attended activities and could self-propel after being set up. During an interview on 7/10/24 at 10:07 a.m., registered nurse (RN)-C stated she had observed R83 transfer this morning with the NA and her transfer was steady. RN-C stated R83's mood and behavior and health were stable for the past couple of months. During an interview on 7/10/24 at 12:17 p.m., hospice RN-D stated they had not received a request to review R83's CNS-active medications for ongoing use, and that would typically be reviewed by the facility primary care providers. RN-D reviewed R83's hospice chart and stated it appeared she had been stable. Interviews with NP-A were attempted on 7/10/24 at 11:43 a.m., and 1:02 p.m. NP-A was out of the office and unable to provide information on the response to the CP communication form. During an interview on 7/10/24 at 12:45 p.m., the CP stated unless otherwise identified on the form, a response was expected by the next primary care provider visit, or about two months. The CP stated he would expect if the provider wanted no changes then to document the benefits outweighed the risk, and the medications were the least restrictive measures. The CP stated the 4/2/24, response of hospice on R83's communication form was not a clear rationale nor assessment of risks and benefits of ongoing use. During an interview on 7/10/24 at 1:49 p.m., the director of nursing (DON) stated if the CP requested an assessment on an identified medication irregularity for R83, it would be deferred to the facility primary care providers. The DON stated she thought hospice was an adequate rationale. The DON stated unless they saw a negative impact she would not expect further documentation from the provider. The facility's undated policy titled CP Reports identified recommendations would be acted upon and documented by the facility staff and/or the prescriber. If the prescriber had not responded the medical director would be contacted.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50762 Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 7.41% with 2 errors out of 27 opportunities for errors involving 2 of 7 residents (R25 and R34) who were observed during the medication pass. Findings Include: R25 R25's quarterly minimum data set (MDS) dated [DATE], identified R25 was cognitively intact and required staff assistance with most activities of daily living. The MDS indicated R25 had diabetes mellitus (DM) and received insulin daily in the 7-day lookback period. R25's care plan revised 5/14/24, identified a risk for alteration in blood glucose levels related to the diagnosis of diabetes and tasked staff with providing medications per orders. R25's provider order dated 6/28/24 indicated, HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro). Inject as per sliding scale: if 141-180 = 2 units give before meals, anything above 400 gives 14 units. May sub Admelog, or Novolog based on insurance.; 181 - 220 = 4 units, 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 340 = 10 units; 341 - 400 = 12 units; 401 - 999 = 14 units, subcutaneously before meals for T2 DM give before meals, anything above 400 give 14 units. R25's July 2024 Medication Administration Record (MAR), indicated R25 received Humalog three times a day. During observation on 7/9/24 at 11:58 a.m., registered nurse (RN)-A obtained R25's Humalog KwikPen. RN-A cleansed the tip of the pen with an alcohol wipe and applied a sterile needle. The pen was dialed to the ordered dose, 4 units. RN-A had not primed the needle prior to administering the medication to R25. R34 R34 admission MDS dated [DATE], identified R34 with moderate cognitive impairment and required staff assistance with most activities of daily living. The MDS indicated R34 had DM and received insulin daily in the 7-day lookback period. R34 care plan dated 6/3/24, indicated R34 at risk for alteration in blood glucose levels related to their diagnosis of diabetes and tasked staff with providing medications per orders. R34 provider order dated 7/8/24 indicated, HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro). Inject 5 unit subcutaneously with meals for Type 2 Diabetes. R34's Medication Administration Record printed 7/10/24, indicated R34 received Humalog three times a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/9/24 at 12:19 p.m., RN-A obtained R34's Humalog KwikPen. RN-A cleansed the tip of the pen with an alcohol wipe prior to attaching a sterile needle. The pen was dialed to the ordered dose, 5 units. RN-A had not primed the needle prior to administrating the medication to R34. RN-A stated the needle did not need to be primed unless it was a new pen. During a follow up interview on 7/9/24 at 1:27 p.m., RN-A stated, I made a mistake, it should be primed. During an interview on 7/10/24 at 10:26 a.m., RN-B stated that insulin pens should be primed prior to administration because it could give a lesser dose of insulin. During an interview on 7/10/24 at 11:00 a.m., the director of nursing (DON) stated that insulin KwikPens should be primed prior to administration to ensure the correct dose was given to not cause an error. Manufacturers instructions regarding Humalog Kwikpen dated 8/23, indicated to first dial up to two units to prime the needle, turn pen with needle pointing up, tap pen gently to move air bubbles to the top, push the dose knob until it stops, and ensure insulin is visible at the tip of the needle.

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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** 50762 Based on observation, interview, and document review, the facility failed to ensure proper infection control practices were followed when staff failed to utilize enhanced barrier precautions (EBP) and proper hand hygiene for 1 of 1 resident (R20) observed during wound care. Findings include: R20's admission minimum data set (MDS) dated [DATE], identified R20 was cognitively intact, required partial to substantial staff assistance in most activities of daily living, and at risk for developing pressure ulcers. Diagnoses included debility (general weakness), chronic obstructive pulmonary disease (COPD), and oxygen therapy. R20's care plan (CP) dated 6/18/24, identified EBP was placed due to a wound. The CP directed staff to follow EBP, in addition to standard precautions, by wearing gown and gloves during high-contact care activities. R20's physician orders dated 6/18/24 indicated wound care to coccyx every shift and as needed for wound integrity. During an observation on 7/8/24 at 1:55 p.m., R20's door had an EBP sign posted and next to the door was an isolation cart inside it contained personal protective equipment (PPE). During an observation on 7/10/24 at 9:49 a.m., registered nurse (RN)-C entered R20's room, completed hand hygiene, donned gloves but not a gown. R20 was sitting on the toilet with the front of the wheelchair facing them. RN-C asked R20 to lean forward, the dressing was removed, gloves were doffed, new gloves donned, but no hand hygiene completed. The area was cleansed and patted dry twice followed by a skin prep solution spray. Gloves were doffed, and a clean set of gloves donned, but no hand hygiene between. A sealed alginate dressing opened, border foam dressing opened and dated, and two were applied to the wound, alginate followed by the foam dressing. Gloves were doffed, and a clean set of gloves donned, but no hand hygiene between. During an interview on 7/10/24 at 10:03 a.m., RN-C identified the EBP sign on R20's door and stated the precautions were in place due to R20's wound. RN-C stated, that's my fault for not following the precautions and that hand hygiene should have been completed when changing gloves. During an interview on 7/10/24 at 10:14 a.m., RN-B who stated staff should follow EBP by wearing the gown and gloves, and that hand hygiene was to be completed when changing gloves. During an interview on 7/10/24 at 10:31 a.m., the infection preventionist (IP) stated that EBP were placed for anyone with wounds, including pressure injuries. IP expected staff to gown and glove outside the room and hand hygiene to be performed when changing gloves. During an interview on 7/10/24 at 11:00 a.m., the director of nursing (DON) stated that staff should wear gown and gloves in accordance with EBP for high contact care and that it was expected for hand hygiene to be completed between glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled EBP Policy and Procedure dated 4/24, identified the use of gowns and gloves were required for high contact cares for residents at increased risk of multidrug resistant organism (MDRO) acquisition. Therefore, EBP would be implemented for all residents with wounds, even if the resident was not known to be colonized or infected with a MDRO. A facility policy titled Infection Control Standard Precautions Hand Hygiene undated, identified that hand hygiene should be performed before donning and after doffing personal protective equipment.