STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home Minneapolis	5101 Minnehaha Avenue South Minneapolis, MN 55417

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567 Based on interview and document review, the facility failed to ensure a voiced grievance of a missing shirt was acted upon timely to help facilitate prompt resolution for 1 of 1 resident (R232) who reported such item as missing with no follow-up. Findings include: R232's quarterly Minimum Data Set (MDS) dated [DATE], indicated R232 was cognitively intact. R232's progress note failed to identify a missing item reported on 2/28/25. However, there was a late entry on 3/6/25 at 9:30 a.m., R232 expressed to writer his black long sleeve shirt was stolen by a p.m. staff member. R232's progress note dated 3/6/25 at 4:33 p.m., (documented as a late entry) identified R232 pointed out the staff member that allegedly stole his black long sleeve shirt, and the nurse writer immediately removed staff from resident care. The writer and ADON interviewed both the resident and staff member and filed a report with MDH (Minnesota Department of Health). R232's progress notes failed to show follow-up after the missing item was reported. The facility's 2025 Grievance Complaint Log failed to document R232's grievance. The facility's missing item tracker identified R232's with a missing item on 2/28/25. During an interview on 4/7/25 at 4:19 p.m., R232 stated, a black long sleeve shirt was on his chair as he entered his room and while his back was turned a staff member removed the shirt and left the room. R232 stated, when he turned around the staff member and the shirt were gone. The missing item was reported to the nurse manager on 2/28/25. R232 stated the investigation was lacking. The nurse manager waved him down in the hallway to discuss the camera footage and informed him that staff member would no longer float to his unit, but never came to my room to discuss the results of the investigation or that they were done looking for the shirt. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 11:37 a.m., licensed practical nurse (LPN)-A stated anytime a resident reported a missing item staff checked the resident's room first, then talked with aids and other residents, called laundry and charted a general progress note. LPN-A stated family would be called only if it was necessary. The next shift would be notified of any new missing items during a huddle meeting and the nurse manager was always notified. LPN-A confirmed the unit was equipped with security cameras. During an interview on 4/8/25 at 12:04 p.m., registered nurse manager (RN)-C stated when a resident reported a missing item, a missing item form was completed and sent to laundry, the safety officer, assisted director of nursing (ADON), and the unit social worker. If it was a housekeeping item, such as laundry, that item usually turned up and that documentation would be found under progress notes. RN-C stated during R232's investigation the security camera footage was reviewed, and the staff member was not seen holding any item as he exited the room. RN-C verified a report was filed with OHFC. RN-C stated a claim was filed with the social worker on 2/28/25. During observation and interview on 4/8/25 at 1:31 p.m., social services (SS)-A stated the resident had the right to complete a Tort claim if an item could not be recovered. To prove monetary value, the resident would need a receipt. If the resident did not have a receipt a similar item could be found online, and that value would be used to complete the Tort claim. Once the form was completed it was given to legal department and sent to Saint [NAME] where a committee approved the claim. SS-A stated a copy of the claim was not kept on file, and then confirmed R232 never came back to file a Tort claim. SS-A provided a blank settlement of claims-not exceeding $7,000 form. SS-A confirmed no completed forms were kept on file for R232. During an interview on 4/8/25 at 2:30 p.m., assistant director of nursing (ADON-RN)-D stated a report was submitted to the Department of Health, OHFC specifically for R232's black long sleeve shirt that was reported stolen by the nurse on 2/28/25. RN-D confirmed all completed grievance forms were filed and kept with the director of social services and confirmed there was no follow up with the resident after the report was filed. During an interview on 4/8/25 at 3:00 p.m. RN-C recalled having a conversation with R232 regarding the investigation and referred to the spreadsheet for missing items. RN-C confirmed the tracker failed to show results of the investigation in that only demographic information was completed. RN-C also confirmed not going to the resident's room to discuss the investigation, but did confirm the shirt was discussed in passing while R232 visited across the hall with the social worker. During an interview on 4/9/25 at 9:37 a.m., R232 stated the nurse manager never came back to discuss how the investigation ended. He stated she saw him in front of the social workers office and would say, I will get back in touch with him. R232 stated it was dismissed at that point, but he was not satisfied because she never clarified if the investigation was ongoing. R232 confirmed he was not offered the Resident Property Damage/Loss Form and SS-A never offered a Tort or settlement claim for reimbursement on 2/28/25 or anytime thereafter. During an interview on 4/9/25 at 9:40 a.m., RN-C could not provide the resident property damage/loss form completed for R232 that is directed to be completed in step 1 of 4 in the Minnesota Veteran's Home-Minneapolis Stand of Work Resident Lost/Missing Items protocol. RN-C also confirmed there was no follow up progress note to document an investigation or conversations with R232 after 3/6/25 regarding the missing item. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Minnesota Department of Veterans Affairs Policy dated 6/22/23 indicated (A) 1. A claimant will be provided with a claim report and demand form upon request and the claimant has suffered personal injury or negligent loss, damage, or destruction of property.

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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** 51567 Based on interview and document review, the facility failed to conduct accurate and on-going assessments for bruising, and implement skin protection interventions for 1 of 1 resident (R10) reviewed for anticoagulant use, and failed to follow orders for ankle compression sleeves (compression stockings) to legs for 1 of 1 resident (R53) reviewed for edema. Findings include: R10's annual Minimum Data Set (MDS) dated [DATE], indicated R10 was independent with mobility, used a walker on and off the unit, was cognitively intact, had a diagnoses of anemia and atrial fibrillation, and took an anticoagulant (blood thinning) medication. No other skin conditions or skin concerns were documented. R10's annual skin assessment dated [DATE], described on going skin issues as, resident bruises easily r/t apixaban usage. R10's care plan dated 11/29/2024, identified the medical management of anticoagulant therapy and included R10 would be free from discomfort, but failed to apply interventions to protect R10's skin while taking an anticoagulant. R10's care plan dated 11/29/2024, stated he communicated most of his needs. R10's active orders included apixaban (an anticoagulant) oral tablets 5 MG tablet dated 3/15/23 with no end date. R10's active orders dated 12/31/2024, included monitoring for a bruise 8 cm x 10 cm on left hand daily. Document Y (yes) if wound is free from signs and symptoms of infection, if pain is managed, and dressing in intact or was changed during the shift. Document N (no) if any of the above areas are of concern in the progress notes. Discontinue when resolved. R10's annual skin assessment dated [DATE], summarized findings as prone to bruising related to the prescribed medication apixaban, an anticoagulant used to treat atrial fibrillation. R10's progress note dated 4/9/2025, indicated he was independent with mobility. During observation and interview on 4/7/25 at 9:19 am, R10 stated the backs of his hands had been bruised since he started using salve on his legs for edema. R10 confirmed no skin protection sleeves were offered by staff and R10 stated he would like to try skin protection sleeves, especially while sleeping. No skin protection sleeves were observes in the resident's room or bathroom. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/25 at 10:00 am, nurse manager (RN)-C stated sleeves were usually recommended, but some residents were not cognitively intact would remove them. They indicated they care planned to the resident's preference. RN-C confirmed no skin protectant was care planned for R10 and no derma sleeves have been used in the past. RN-C was aware of the bruises on both hands, and believed R10 had a history of taking off the sleeves, which she confirmed again, he had never tried in the past. During an interview on 4/9/25 at 12:08 pm, assistant director of nursing (ADON, RN)-D stated the expectation would be for all residents on an anticoagulant, staff would first observe for bruising, and then apply skin protection interventions, like a derma sleeve. RN-D stated the resident would need to be cognitively intact to be able to use the sleeve. Some residents had sleeves and took them off. RN-D stated the sleeves needed to be offered and if the resident refused, then the nurses documented the refusal. RN-D confirmed that R10 had not been offered derma sleeves in the past. During observation and interview on 4/9/25 at 3:25 pm, R10 stated he had dark bruising on both his hands. The bruising on the right hand did go up to the wrist and stopped. R10 stated his right hand bruised worse because he slept on his right side. The back of the left hand was also bruised. Neither forearm was bruised nor were his face or shins. R10 verified there was no protective or adaptive items in the room to help support skin from bruising nor had R10 tried any in the past. None was observed. Skin Management Program dated 2/13/2025, identified preventive or routine skin care interventions will be instituted and documented in the resident's EMR and on the resident's initial care plan for the care team to follow. Policy on anticoagulant use/monitoring was requested and not received. R53 R53's annual Minimum Data Set (MDS) dated [DATE], indicated R53 had no cognitive impairment, was diagnosed with diabetes, hyperlipidemia, hypertension, and was taking medication used to reduce fluid build up in the body. R53's provider notes dated 1/2/25, and 2/27/25, indicated R53's edema was well managed on low dose Lasix (furosemide - a water pill). R53's medication administration record (MAR) dated for the month of April 2025, included an order for furosemide oral tablet 10 MG in the morning every Monday, Wednesday, and Friday for edema. R53's Skin Risk Factors MVH form dated 3/7/25, included a section to identify risk factors. The checked box next to Edema was not selected. R53's order summary dated 4/3/25 at 7:00 a.m., indicated to apply bilateral ankle compression sleeves in the morning. The orders also indicated removal at 7:00 p.m. R53's treatment administration record (TAR) dated 4/7/25, indicated bilateral ankle compression sleeves were applied in the morning at 8:26 a.m. and indicated at 1:21 p.m. the bilateral ankle compression sleeves were taken off. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53's care plan with a review date of 2/27/25, indicated medical management for diuretic use related to edema, but failed to identify interventions. During observation and interview on 4/7/25 at 6:41 p.m., R53 indicated their right foot was sore and that the pain went away at night. R53 was wearing short, white, socks that extended approximately 2-3 inches above the ankle bone with one inch indentation from the socks on both legs. No compression sleeves, or stockings were worn or visible in the room. R53 stated staff did not put compression sleeves on her legs on 4/6/25 or 4/7/25. During an interview on 4/8/25 at 2:38 p.m., nursing assistant (NA)-A stated R53 did not wear compression socks and confirmed she was wearing anklets. NA-A looked up R53's Kardex in the computer and identified there were no tasks directing staff to apply compression sleeves. During observation and interview on 4/8/25 at 2:50 p.m., R53 removed her right shoe to discuss her sore foot. Licensed practical nurse (LPN)-A was brought to the room and verified the bilateral edema in R53's lower extremities and the short white socks R53 wore. LPN-A stated, this is bad, and indicated she usually wore black socks. LPN-A removed both of R53's white socks. R53 had approximately 1 inch indentation from the socks about 2 to 3 inches above the ankle bone on both legs. LPN-A confirmed the right leg had significantly more edema and confirmed the compression socks were not set up or in the room. During observation and interview on 4/9/25 at 9:55 a.m., R53 wore red tread socks and stated ace wraps would be on later. R53 displayed the right leg with continued edema approximately 1 inch indentation 2-3 inches above the ankle bone. During an interview on 4/9/25 at 1010 a.m., RN-C stated R53 complained of pain and recently recovered from an ankle fracture. RN-C confirmed there was an active order for bilateral ankle compression sleeves to be applied in the morning and removed at bedtime and confirmed the (TAR) indicated on 4/7/25, the ankle compression sleeves were documented as applied and removed. During an interview on 4/9/25 at 12:01 p.m., RN-D stated the expectation was all orders would be followed and the items ordered would be used. A policy for Edema management was requested and not received. Minnesota Department of Veterans Affairs Skin Management Program dated 2/13/25 was provided and however lacked policy and procedures related to edema management.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on interview and document review, the facility failed to follow up and implement treatment for improved hearing for 1 of 1 residents (R277) when complaints of hearing loss were made. Findings include: R277's quarterly Minimum Data Set (MDS) dated [DATE], indicated R277 had intact cognition, adequate hearing (no difficulty in everyday conversation), and did not use hearing aids. R277's provider Admit Note dated 10/8/24, indicated R277 had stated he had an audiogram which showed some hearing loss and particularly had difficulty with hearing in crowded rooms. The note indicated that R277 was interested in pursuing further evaluation for hearing aids. R277's medical record was reviewed and did not indicate further follow-up on R277's request for hearing aids. The note indicated R277 had declined in-house audiology services but was interested in an audiology evaluation to work towards getting hearing aids. During an interview on 4/7/25 at 12:57 p.m., R277 stated he had a hearing test around the time he was admitted to the facility in September of 2024 and was told he needed hearing aids but never received any. R277 stated he talked with a doctor about needing these hearing aids but did not recall any updates on them since. R277 stated he had issues hearing others in crowded environments. R277 stated in these environments, he would not hear things people were saying to him so would just nod my head and smile and hope it is nothing important. During an interview on 4/8/25 at 2:27 p.m., registered nurse (RN)-A, the nurse manager of the unit, stated she was unaware of R277 requesting to get hearing aids. RN-A stated, after a brief review of the medical record, that she did see a note indicating R277 had wanted hearing aids but did not see a follow-up on this request but would further investigate it. On 4/9/25 at 10:39 a.m., RN-A stated she had talked with other staff members and further reviewed R277's medical record but did not find evidence that R277's request for hearing aids had been addressed. The facility's Services Not Covered but Made Available to all Admissions-Residents policy dated 10/13/23, identified services, such as audiology, that the facility may provide and may be charged to the residents' personal fund. The policy did not address the process the facility would take to assist the resident in obtaining these audiology services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to ensure staff assisted 1 of 1 resident (R74), who was reviewed for restorative nursing program, to attend their GI (general term used for government issued) therapy gym sessions or document reasons resident was not available for attendance. The facility further failed to ensure occupational therapist recommendations were care planned and initiated for one of two residents (R184) who was assessed as at risk for bilateral hand contractures and impaired skin due to clenching fist reviewed for services to prevent decrease in range of motion. Findings include: R74 R74's quarterly Minimum Data Set (MDS) dated [DATE], indicated R74 had severe cognitive impairment and no behaviors or rejection of care. R74 had impairment on one side of upper and lower extremity and required substantial to total assistance with activities of daily living. R74 had diagnoses which included coronary artery disease, hypertension, peripheral vascular disease, cerebrovascular accident, hemiplegia or hemiparesis, traumatic brain injury, and asthma. R74 had one day of passive and one day of active range of motion in the last seven days of the look back period. R74's order dated 5/13/22, directed staff to follow fitness gym programming per therapy parameters. R74's care plan printed 4/9/25, indicated the following interventions: -10/4/24, resume fitness GI gym program: Kinevia (motorized therapy device for lower extremities) soft train, base speed 10 rpm (revolutions per minute), resistance 2-3 for 10 minutes for bilateral lower extremity active assisted range of motion/passive range of motion as resident is able. Staff to provide wheelchair transportation to attend. -10/9/24, escort R74 to the GI fitness gym on Mondays, Wednesdays, and Thursdays for their 11 a.m. appointment. R74's Point of Care (POC) Response History printed 4/10/25, indicated R74 attended two GI gym appointments and was not available for 11 out of 13 sessions. R74's progress notes identified the following for days which were marked as resident not available for GI gym appointments: -3/12/25, no notes. -3/13/25, no notes. -3/17/25, documented notes did not indicate reason for R74's missed gym session. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/19/25, no notes. -3/20/25, indicated R74 attended exercise programs during recreation therapy's quarterly charting period and did not indicate reason for R74's missed gym session. -3/26/25, note at 2:15 p.m. indicated R74 had an appointment via MVH (Minnesota Veterans Home) laptop and did not indicate the time of the appointment. -3/27/25, note at 1:51 p.m. indicated R74 had an appointment at 1:30 p.m. with transportation time of 1:15 p. m -4/2/25, no notes. -4/3/25, note at 11:54 a.m. indicated R74 had transportation at 12:15 p.m. for a 1:30 p.m. appointment. -4/7/25, no notes. -4/9/25, note at 3:49 a.m. indicated a nebulizer was given to R74 for wheezing and note at 5:09 a.m. indicated the nebulizer was effective. During observation on 4/9/25 at 11:09 a.m., R74 was in their wheelchair at a table in the unit's television area. A nursing staff member entered another resident's room, and another staff sat at a chair and charted information. During interview on 4/9/25 at 11:24 a.m., nursing assistant (NA)-D stated they brought residents to the GI gym according to a posted schedule. NA-D stated they did not chart on GI gym attendance and reported to the nurse if residents refused to go to the gym. NA-D verified the posted chart indicated R74 should attend their gym session at 11:00 a.m. on Wednesdays and stated R74 attended their session. During interview on 4/9/25 at 12:01 p.m., physical therapy assistant (PTA)-A stated they completed exercise groups around the building, and PTA-B mainly completed the restorative programs in the GI gym. PTA-A stated managers called to let them know when a resident was not able to attend their appointment, so they may reschedule. PTA-B reviewed the 4/9/25 therapy schedule, and R74 had a red line by their name. PTA-B stated the red line indicated R74 did not attend their GI gym appointment. PTA-B stated they received a call earlier this week to notify them R74 would not attend Monday's session related to illness and had not received a call today. PTA-B stated R74 usually attended about two out of three sessions per week, and nursing did not always document why R74 did not attend their gym appointment. PTA-B charted resident not available when R74 did not attend their sessions. PTA-B stated R74 did not tolerate a lot of exercise but pedaled for approximately ten minutes. During interview on 4/9/25 at 2:28 p.m., registered nurse (RN)-G stated nursing assistants brought residents to the GI gym according to the posted schedule and was told all residents were brought to the gym for their appointments today. RN-G stated they would document if someone notified them a resident did not attend their GI gym appointment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/10/25 at 7:42 a.m., R74 agreed it was important for them to attend GI gym appointments and liked to attend at least twice a week. R74 was observed to cough, and the cough sounded wet and/or productive. During interview on 4/10/25 at 9:28 a.m., RN-F expected staff to document reasons residents were not able to attend their GI gym appointments and correspond with the GI gym staff. RN-F reviewed R74's notes and gym session documentation and verified R74 had appointments and respiratory issues on some gym days and lacked documentation other days. RN-F stated R74 may attend fitness activities with PTA-A and was not sure if the fitness activities on the unit conflicted with the times of R74's GI gym appointments. RN-F stated it was important for residents to attend their gym appointments to help maintain optimal levels of mobility. During interview on 4/10/25 at 10:27 a.m., the assistant director of nursing (ADON)-B stated it was important for staff to ensure residents attended their GI gym appointments and expected staff to document if there was a pattern of refusals. ADON-B stated the interdisciplinary team had a schedule to review GI gym participation, so they could adjust resident's schedule if needed. 47495 R184 R184's quarterly Minimum Data Set (MDS), dated [DATE], indicated R184 had a diagnosis of Alzheimer's disease, no impairment of his upper and lower extremities and was dependent on staff for all activities of daily living (ADLs). R184's Progress note, dated 2/28/25, indicated R184 received an occupational therapy (OT) evaluation and would be appropriate for a bilateral upper extremity range of motion restorative nursing program. The note indicated this would be set up by OT. R184's careplan, dated 3/29/24, indicated R184 was at risk for decline in ADLs and functional mobility related to dementia and was on a maintenance program. The careplan lacked any interventions related to bilateral hand contracture prevention (i.e. range of motion, palm protectors or holding an object to prevent clenching hands into a fist.) R184's OT note, dated 2/28/24, indicated R184 did not currently have an upper extremity restorative nursing program and would benefit from holding an object during the day to decrease the resident's incidence of clenching fists. The note also indicated it was recommended for R184 to participate in AAROM (active assisted range of motion) for his bilateral upper extremities. R184's OT note, dated 3/29/25, indicated R184 would not benefit from bilateral palm protectors but would benefit from alternate interventions to manage squeezing of palms (increased tone in hands). OT will instruct the resident's [R184] caregivers regarding encouraging the resident to hold onto a ball or stuffed cat when at rest on the unit. The note further indicated R184 would benefit from a PROM (passive range of motion) program. During observation on 4/8/25 at 2:16 p.m., R184 was laying in bed, awake. He did not have anything to hold onto. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 3:14 p.m., occupational therapist (OT)-A stated it was decided R184 would not be appropriate for a hand splint or palm protector but her goal was to have the nursing assistants do range of motion with R184's hands. OT-A stated she talked to a few nurses about having R184 hold onto his stuffed cat when he was up in his wheelchair but had not documented the conversation. OT-A also confirmed the range of motion program had not been passed along to the nursing staff but OT-A had done range of motion with R184's hands once or twice. During an observation on 4/9/25 at 8:00 a.m., R184 was up in his wheelchair at the breakfast table. There was nothing in R184's hands. Later, at 9:28 a.m., R184 was still up in his wheelchair in the main television area. R184 still had nothing in his hands. During an interview on 4/9/25 at 9:24 a.m., registered nurse (RN)-H stated R184 went to the fitness gym Monday and Friday but was unaware of any intervention for his hands, including range of motion or holding his stuffed cat in his hands. RN-H checked R184's Kardex, used by staff to know how to care for each resident, and confirmed there were no intervention on his Kardex for his hands. During an interview on 4/9/25 at 10:35 a.m., RN senior and registered nurse (RN)-I stated nursing staff had asked OT to assess R184's hands because nursing staff had concerns about him clenching them. RN-I confirmed OT had not passed along interventions for R184 until yesterday, stating R184 did not have any care planned interventions such as range of motion or holding his stuffed cat as recommended by OT. A facility policy titled Restorative Nursing, revised 12/4/24, indicated MVH will assess, plan, and implement a restorative nursing program per applicable state and federal rules and regulations to improve or maintain a resident ' s functional status.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation, interview, and document review, the facility failed to analyze and care plan R596's multiple declinations to wear supplemental oxygen as ordered for 1 of 1 resident (R596) reviewed for oxygen use. Findings include: R596's quarterly Minimum Data Set (MDS) dated [DATE], indicated R596 had intact cognition and no behaviors or rejection of care. R596 had impairments to both sides of lower extremities. R596 required substantial and/or maximal or greater assistance with most activities of daily living, setup or clean-up assistance with eating, and supervision or touching assistance with oral hygiene. R596's diagnoses included anemia, heart failure, hypertension, renal failure, diabetes mellitus, depression, post-traumatic stress disorder, COPD (chronic obstructive pulmonary disease), and respiratory failure. The MDS indicated R596 had oxygen therapy. R596's care plan printed 4/8/25, indicated R596 required oxygen therapy with focus area initiated on 12/31/24. Care plan interventions included: -1/7/25, assist to change from portable oxygen tank to room tank. -1/7/25, assist to set oxygen flow rate as ordered. -1/7/25, monitor oxygen saturation rates. Another care plan focus area dated 1/7/25, indicated R596 was on continuous oxygen treatment for emphysema and/or COPD. Care plan interventions included: -1/7/25, give oxygen therapy as ordered by the physician. -1/7/25, head of bed to be elevated or out of bed upright in a chair during episodes of difficulty breathing. -1/7/25, monitor for difficulty breathing on exertion. Remind resident not to push beyond endurance. R596's care plan lacked documentation of resident refusal to use oxygen, or any other reason for non-oxygen use. R596's order dated 12/30/24, directed staff to maintain R596's oxygen saturation level 90% (percent) or above with continuous supplement oxygen at two to four liters per minute (LPM) via nasal cannula and document liter flow every shift. R596's oxygen saturation summary report printed 4/10/25, indicated oxygen saturation level method was Room Air on 65 times from 12/30/24 to 4/9/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R596's progress notes indicated: -4/9/25 at 11:35 a.m., R596's oxygen saturation level was 92% on RA (room air). -3/11/25 at 8:49 p.m., R596's oxygen saturation level was 92% on RA. -3/9/25 at 11:11 p.m., R596's oxygen saturation level was 97% on RA. -3/6/25 at 10:28 p.m., R596 was offered supplemental oxygen, kept on for less than an hour, then removed and stated they did not need it. R596 was educated about the importance of oxygen and aware of the risk and benefits. The note indicated will continue to monitor as the action taken. -3/6/25 at 10:10 a.m., R596's oxygen saturation level was 91% on RA. -2/28/25 at 1:46 p.m., blood clots were noted in R596's urine bag. R596's oxygen saturation level was 91% at four liters of supplemental oxygen. R596 declined to keep oxygen on and educated on risk and benefits. The notes Action section indicated the nurse practitioner was notified, and staff received new orders for catheter irrigation and did not observe blood clots after irrigation completed. The note indicated the oncoming nurse would be notified about the situation and did not mention other actions taken for declination of oxygen use. R596 also required oxygen therapy. -2/26/25 at 1:37 a.m., R596 refused to use continuous oxygen. -2/25/25 at 2:20 a.m., R596 refused to use supplemental oxygen via nasal cannula for the shift and told staff they did not need supplemental oxygen. -2/22/25 at 7:58 a.m., R596 refused to use oxygen treatment. Staff check oxygen saturation and was between 84-88% on room air. Staff offered to apply oxygen, and oxygen saturation increased to 92% when on three liters of supplemental oxygen. -2/21/25 at 10:52 p.m., R596 refused supplemental oxygen via nasal cannula. -2/20/25 at 11:18 a.m., R596 declined supplemental oxygen, was educated on risks and benefits, and did not have shortness of breath or respiratory distress. -2/17/25 at 6:17 a.m., R596 refused supplemental oxygen and stated they were fine. -1/29/25 at 2:37 p.m., R596's oxygen saturation was 93% on RA. -1/28/25 at 6:07 a.m., R596's oxygen saturation was 94% on RA. -1/27/25 at 5:38 a.m., R596 declined use of supplemental oxygen during most of the night. R596 agreed to wear, and staff would observe nasal cannula removed during checks. R596 reported they did not want the supplemental oxygen and did not need it. R596 was educated on risks and benefits and did not have shortness of breath or respiratory distress. -1/25/25 at 1:33 p.m., R596's oxygen saturation was 94% on RA. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/20/25 at 1:49 p.m., R596's oxygen saturation was 93% on RA. -1/18/25 at 2:42 p.m., R596's oxygen saturation was 94% on RA. -1/16/25 at 2:56 p.m., R596's oxygen saturation was 96% on RA. Provider notes lacked documentation of R596 supplemental oxygen refusals and/or declinations. During observation on 4/7/25 at 1:32 p.m., R596 sat in their wheelchair in the unit's television area near the nursing station and cart. R596 had an oxygen tank on the back of their wheelchair and did not have the attached nasal cannula applied. During observation which started on 4/8/25 at 12:18 p.m., nursing assistant (NA)-E pushed R596 in their wheelchair into the dining room. R596 had an oxygen tank on the back of their wheelchair, and the attached nasal cannula was not applied and on R596's stomach. NA-E positioned R596 at a dining room table and applied a clothing protector on R596. At 12:22 p.m., registered nurse (RN)-G checked R596's blood sugar, and R596 still did not have their supplemental oxygen on. At 12:29 p.m., RN-G wheeled R596 out of the dining area, and R596 still did not have their supplemental oxygen on. At 12:34 p.m., R596 was at the dining table, did not have their supplemental oxygen on, and took deep breaths in and out. At 12:37 p.m., RN-G spoke with R596. R596 was not taking deep breaths and still did not wear their supplemental oxygen. At 12:52 p.m., R596 still did not have their oxygen on and took deep breaths. At 12:56 p.m., R596 asked NA-E to take them back to their room and took deep breaths. At 12:57 p.m., NA-E assisted R596 out of the dining area, and R596 still did not wear their supplemental oxygen. During interview on 4/8/25 at 1:13 p.m., RN-G stated they followed oxygen orders from the provider. RN-G stated they documented if a resident did not wear their ordered supplemental oxygen, monitored the resident closely, encouraged the resident to wear supplemental oxygen, and notified the provider. RN-G stated R596 wore their oxygen during mealtime and did not see R596 with the nasal cannula off. RN-G stated R596 had a history of taking their nasal cannula off, they reminded R596 to wear their supplemental oxygen, and they were not sure why R596 took off their supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/8/25 at 1:24 p.m., NA-E stated some residents did not want to wear their supplemental oxygen even if oxygen use was on their care plan. They encouraged residents to wear their oxygen and notified the nurse when residents did not. NA-E verified R596 did not have their supplemental oxygen on during mealtime and stated R596 agreed to wear the nasal cannula when brought back to their room after their meal. NA-E stated R596 refused supplemental oxygen on and off during the day with no pattern of times and stated R596 reported their breathing was okay. During interview on 4/8/25 at 3:03 p.m., licensed practical nurse (LPN)-B stated they followed orders for oxygen use. LPN-B redirected and educated residents who did not want to wear their supplemental oxygen and monitored their oxygen saturation and other vitals. LPN-B documented continuous refusals and notified the provider and nurse manager. LPN-B stated R596 was quick to place nasal cannula back on when reminded, did not think R596 was aware their nasal cannula was off at times, and did not think it was a deliberate action. During interview on 4/8/25 at 3:11 p.m., NA-F stated R596 took their nasal cannula off at times when in bed, even after staff placed it back on. NA-F was not sure if R596 knew their nasal cannula was off sometimes and stated R596 did not tell them why they removed it. During interview on 4/9/25 at 2:33 p.m., R596 was in their bed and did not have their nasal cannula on. R596 stated the nasal cannula slid off, they could not get it back on, and thought it had been off for thirty minutes. R596 got the oxygen tubing around one ear, nasal cannula in nares, and was unable to loop the tubing around their other ear. R596 placed their call light on and stated they were breathing alright. At 2:36 p.m., NA-E entered the room, placed the nasal cannula on R596, and slid the adjuster upwards towards NA-E's chin. During interview on 4/10/25 at 9:28 a.m., RN-F expected staff to document about residents who refused oxygen use or other reasons for residents to not wear ordered oxygen. RN-F expected staff to contact the provider and care plan non-oxygen use if there was a consistent issue and it affected their oxygen level. RN-F was not aware R596 refused their oxygen use or of other reasons R596 did not wear their oxygen. During interview on 4/10/25 at 10:27 a.m., assistant director of nursing (ADON)-B expected staff to have on-going risk and benefit conversations with R596 and care plan about R596's habits of oxygen use if concerns were on-going. ADON-B expected staff to ask why R596 removed the oxygen or look at a different type of tubing if falling off. ADON-B stated oxygen use was important for residents who had oxygen orders. The facility's Medication Administration policy dated 12/4/24, indicated current standards of practice would be followed when administering medications through alternate routes such as nasal, and medication not administered would include an explanation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567 Based on observations, interview, and document review, the facility failed to ensure staff were competent to apply medicated ointment for 1 of 1 resident (R232) reviewed for self-administration. Findings include: R232's quarterly Minimum Data Set (MDS) dated [DATE], indicated R232 was cognitively intact, had a diagnosis of diabetes and was receiving skin treatments to areas other than his feet. R232's care plan dated 1/30/25, failed to identify a self administration medication program. R232's order summary report identified an active order for Triamcinolone Acetonide External Ointment 0. 025% (Topical) applied to itchy dry skin, with a start date of 9/12/24, with no end date. R232's SAM's (self-administration of medication and/or treatments) dated 2/1/25, indicated the resident did not want to self-administer medications. R232's treatment administration record dated March 2025 through April 2025 indicated daily documentation of unsupervised self administration for Triamcinolone Acetonide External Ointment with directions to be applied to itchy/dry skin topically every morning and at bedtime. During an observation and interview on 4/9/25 at 9:05 a.m., the Triamcinolone Acetonide External Ointment 0.025% container with a pharmacy label was set out on the resident's shelf. R232 stated the aids applied the cream. During an interview on 4/9/25 at 9:52 a.m., nursing assistant (NA)-B stated aids applied cream to R232. During an interview on 4/9/25 at 11:01 a.m., director of nursing (DON) stated medicated creams were not administered by nursing assistants in Long Term Care. During an interview on 4/9/25 at 11:36 a.m., nursing assistant (NA)-C verified he washed R232's body and applied the cream all over the arms and legs. The cream was used for bad, dry, scaling skin. NA-C verified he knew to use a medium amount and to use gloves, once a day, during his shift. NA-C verified the cream stayed in R232's room all the time. During an interview on 4/9/25 at 11:38 a.m., registered nurse (RN)-E, nurse educator for the campus, verified that the campus did not have trained medication aids (TMAs). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/25 at 11:59 a.m., licensed practical nurse (LPN)-A stated nursing assistants could put on prescription/medicated cream and lotion if they knew how it was applied. LPN-A stated as part of her orientation and training it was explained that if the resident could confirm to the nurse that the nursing assistant understood how and where the medicated cream should be applied, then the nursing assistant could apply the cream and report back to the LPN. LPN-A confirmed the e-MAR was then marked off after the nursing assistant completed the task. During an interview on 4/9/25 at 12:02 p.m., assistant director of nursing (ADON RN)-C confirmed no TMAs were trained to work on the campus. If residents had a prescription lotion, the expectation would be a licensed staff would apply the lotion. They stated there was no such program that allowed the LPN to check with the resident to confirm the nursing assistant applied the medicated lotion correctly, and the LPN must apply the lotion and mark the MAR. Per Policy Medication Administration, dated 12/4/24, Only certified/licensed staff will administer medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49339 Based on observation, interview and document review, the facility failed to serve food in a sanitary manner by failing to ensure staff properly contained hair with a hairnet/beard net while preparing plates of foods brought into the facility to serve to residents for a meal. This had the potential to affect 32 residents who reside in building 19 on 3rd floor. Findings include: During observation in building 19 on 3rd floor on 4/9/25 at 12:06 p.m., lunch was being served by staff from the dining room island/counter. The meal consisted of fried chicken, mashed potatoes, gravy, coleslaw and buns. Two staff were observed to be using resident menu ticket and preparing resident plates. The 2 staff were observed to be wearing gloves but were not wearing hairnets while placing food items on resident plates and standing over food items. During interview on 4/9/25 at 12:14 p.m., assistant director of nursing (ADON)-A stated recreational therapy had set up the special meal for today and the food being served was brought into the facility. ADON-A verified the staff who were placing the food on residents' plates were not wearing hairnets and their hair was not properly contained. ADON-A stated she was unsure if this was a requirement as the meal was not being served out of the kitchenette or by the dietary staff. ADON-A stated the staff were wearing gloves. ADON-A stated hairnets were worn so nothing gets in the food. During interview on 4/10/25 at 9:27 a.m., culinary director (CD)-A stated the expectation was staff should wear hairnets when plating food. During an interview on 4/10/25 at 9:28 a.m., director of dietary services (DDS)-A stated the expectation would be whoever was plating the resident food would be expected to wear a hair net. DDS-A stated the reason for wearing hairnets was to not contaminate the food. During an interview on 4/10/25 at 9:54 a.m., director of nursing (DON) stated the expectation of staff who are preparing and preparing residents plates would be hairnets are worn so that the food would not be contaminated. A facility policy titled Dress, Appearance, and Hygiene in the Workplace, revised 2/21/20, indicated Hair (including facial hair) must be tied back and/or covered, if required by work related regulations or because of safety, sanitation or other care reasons and must be clean.

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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** 48299 Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were utilized appropriately for 2 of 2 residents (R269, R595) reviewed for EBP related to wounds. In addition, staff failed to perform appropriate hand hygiene for 1 of 1 resident (R595) observed to receive cares in enhanced barrier precautions. Findings include: EBP NOT FOLLOWED AND LACK OF HAND HYGIENE R595's entry tracking record dated 4/3/25, indicated R595 returned to the facility from a short-term general hospital. R595's care plan printed 4/9/25, indicated: -12/30/24, R595 had MRSA (methicillin-resistant staphylococcus aureus; staph germ which have resistance to antibiotics) to a wound on the second toe of right foot and required contact precautions and meticulous hand washing. -4/1/25, R595 required enhanced barrier precautions. -4/4/25, R595 required assist of two staff to transfer with full body lift and physical assist of one staff for lying/sitting bed mobility. R595 positioned self in bed with used of bilateral grab bars and overhead trapeze. R595's physician order dated 2/28/17, indicated R595 used a condom catheter at night. Another order dated 4/7/25, indicated R595 took cefpodoxime proxetil (an antibiotic which treats certain infections caused by bacteria) oral tablet 200 mg by mouth every twelve hours for seven days for right foot infection. During observation and interview on 4/7/25 at 1:03 p.m., R595 had an enhanced barrier precautions sign on their door which identified the high-contact cares for which staff were required to wear a gown and gloves. A second sign indicated contact precautions-enteric precautions, and highlighted staff needed to wear gowns and gloves. The second sign also indicated staff needed to use dedicated equipment, bleach disinfectant, and soap and water for hand hygiene even after alcohol gel use. Further, the second sign indicated resident must stay in room for 48 hours beyond the last symptom. R595 stated they had an infected wound and had to have their toes amputated. R595 stated they were able to leave their room as they desired. R595 had a shoe on the left foot and boot on their right foot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 4/9/25 at 10:12 a.m., nursing assistant (NA)-G and NA-H wore gloves and no gowns. R595 sat on a commode with a sling around them and was raised with a mechanical lift off the commode. NA-G performed peri-cares, removed gloves, did not perform hand hygiene, applied gloves, grabbed an incontinence bed pad from a drawer, and placed it on the bed. NA-G removed the plastic bag with bowel movement from the commode, removed gloves, did not perform hand hygiene, and applied gloves. NA-G and NA-H assisted R595 onto the bed and assisted R595 to turn in bed to apply R595's incontinence product and pants. NA-G and NA-H then transferred R595 from the bed to wheelchair. During interview on 4/9/25 at 10:25 a.m., NA-H stated R595 had a leg infection, and staff wore gowns when they assisted R595 to dress and didn't need a gown to transfer R595. During interview on 4/9/25 at 10:47 a.m., licensed practical nurse (LPN)-C stated R595 had a wound and was on enhanced barrier precautions. LPN-C stated staff did not need to wear a gown to transfer R595 but needed a gown and gloves to provide peri-cares and wound care. LPN-C stated one sign was related to R595's catheter and another to their wound. During interview on 4/9/25 at 10:54 a.m., NA-G confirmed they should have worn gown and gloves to provide R595 with peri-cares and transfer. NA-G verified they did not perform hand hygiene between glove changes and should have. During interview on 4/10/25 at 10:27 a.m., ADON-B expected staff to wear gloves and gowns when they performed peri-cares and when they transferred a resident on enhanced barrier precautions. ADON-B stated there was a risk for the spread of infection when staff did not use gowns and gloves during high-contact cares. ADON-B expected staff to perform hand hygiene between glove changes to prevent the spread of pathogens. The facility's Infection Prevention and Control Program dated 10/23/24, directed staff to wear gowns and gloves during high contact resident care activities for residents in enhanced barrier precautions. High contact resident care activities included transferring, changing briefs, providing hygiene, and assisting with toileting. The facility's Hand Hygiene policy dated 9/17/24, directed staff to remove gloves and complete hand hygiene during resident care if moving from a contaminated body site to a clean body site and to reapply gloves if appropriate. EBP NOT ASSIGNED R269's quarterly Minimum Data Set (MDS) dated [DATE], indicated R269 had intact cognition and required substantial/maximal to total assistance with dressing, toileting hygiene, footwear, transfers, and bed mobility. R269's diagnoses included diabetes mellitus, osteoarthritis, traumatic brain injury, hemiplegia (weakness on one side of the body), and seizures. The MDS indicated R269 had a stage two pressure ulcer. R269's care plan printed 4/10/25, lacked indication of enhanced barrier precautions. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R269's physician order dated 4/1/25, directed staff to wash left big to with normal saline/wound cleanser, pat dry, apply small amount of medi-honey, cover with two-by-two gauze, wrap with kerlix dressing/tape daily and as needed and to discontinue the order when area healed. Orders did not indicate enhanced barrier precautions. R269's Skin and Wound Evaluation dated 4/6/25, indicated R269 had a stage two pressure ulcer since 3/13/25, to their left dorsum first metatarsal phalangeal joint (the joint located at the base of the left big toe). The wound measured 0.8 by 0.6 cm (centimeters), had 10% (percent) epithelial (pink/white in color and final stage of wound healing) coverage, 20% granulation (red, bumpy tissue in wound bed), 70% slough (dead tissue within a wound which appears yellow, tan, or white), no evidence of infection, and light serous exudate (clear wound fluid or drainage). R269's wound was treated and dressing intact, and the wound was improving. During observation on 4/10/25 at 7:50 a.m., R269 did not have an enhanced barrier precautions sign on their door or personal protective equipment cart outside of their room. During interview on 4/10/25 at 10:02 a.m., licensed practical nurse (LPN)-C stated R269 had an open pressure wound on their left big toe and dressing changes were completed in the evenings. LPN-C stated staff wore gown and gloves during R269's dressing changes. LPN-C stated the wound nurse, assistant director of nursing (ADON), and infection preventionist determined which residents required enhanced barrier precautions. During interview on 4/10/25 at 10:07 a.m., nursing assistant (NA)-I stated staff did not use enhanced barrier precautions for R269. NA-I stated enhanced barrier precautions were not in R269's care plan and confirmed there was no enhanced barrier precautions sign or personal protective equipment cart outside R269's door. NA-I stated R269 did not have a catheter or feeding tube like other residents who required enhanced barrier precautions. During interview on 4/10/25 at 10:20 a.m., registered nurse (RN)-J stated residents who required enhanced barrier precautions had a sign on their door and PPE cart outside their door. The senior RN or floor nurses set up the signage and PPE cart. RN-J stated R269 had a stage two pressure ulcer on their toe and may need enhanced barrier precautions due to R269's wound. During interview on 4/10/25 at 10:27 a.m., ADON-B stated the infection preventionists were the main staff to look over which residents required enhanced barrier precautions, but the interdisciplinary team worked together to ensure residents were on correct precautions. ADON-B stated residents with an open area and MDRO (multidrug-resistant bacteria; organisms which are resistant to typical antibacterial treatments) required enhanced barrier precautions. ADON-B reviewed R269's care plan and stated the care plan did not indicate R269 had an MDRO. The facility's Infection Prevention and Control Program dated 10/23/24, indicated residents with wounds, such as pressure ulcers, or indwelling medical devices are particularly susceptible and should be identified and have EBP established.