STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245625	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home the Gardens	1860 University Avenue West Saint Paul, MN 55104

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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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview and document review, the facility failed to ensure unqualified staff did not administer as needed (PRN) medication used for skin rash for 1 of 1 resident (R1) reviewed for qualified staffing. Findings include, R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact, and had diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) , hypertension (high blood pressure), and diabetes. R1's Clinical Diagnoses record printed 9/12/24, indicated diagnoses of local infection of the skin and subcutaneous tissue (under the skin), and irritant contact dermatitis (a skin rash caused by contact with a certain substance) due to fecal and urinary incontinence. R1's Clinical Orders record printed 9/12/24, included an order for Nystatin powder (used to treat fungal or yeast infections) 100,000 unit/gm (gram) topical under breast every 12 hours as needed (PRN) for skin rash. R1's Medication Administration Record (MAR) dated September 2024, indicated a PRN order for Nystatin powder, which had not been documented as being administered to date during the month of September. During observation on 9/11/24 at 9:07 a.m., nursing assistant (NA)- G and NA-F provided personal cares to R1. NA-F used a wipe to clean R1's skin under her breast, abdomen, and groin areas. NA-F took a bottle of Nystatin powder from R1's nightstand and administered the medication on R1's skin under her breast and groin areas. During interview on 9/11/24 at 2:35 p.m., NA-F stated when she applies the Nystatin powder, she washes the areas, dries the area to ensure it is clean and then she applies the powder. NA-F stated the nurses had talked to her to ensure she understood how to do it, but only the nurses can assess and document. (continued on next page)

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

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 9/12/24 at 10:08 a.m., registered nurse (RN)-C stated the nursing assistants were not authorized to administer the Nystatin powder or any medicated creams. RN-C stated trained medication aids (TMA) were able to administer scheduled creams and powders to the skin, but the administration of PRN medications required a nursing assessment. RN-C stated nursing assistants were not licensed to do assessments. RN-C stated NA-F had not informed her about administering the Nystatin powder to R1. During interview on 9/12/24 at 10:38 a.m., clinical coordinator/licensed practical nurse (LPN)-C stated nursing assistants were not trained to do assessments or apply Nystatin powder. LPN-C stated nursing assistants were supposed to report any resident's skin concerns to the nurse. LPN-C stated only the nurses can do an assessment and determine if a PRN needs to be administrated. Facility policy on medication administration requested but 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 observation, interview and record review the facility failed to ensure assistance with personal hygiene for 2 of 2 residents (R6, R44) reviewed for activities of daily living (ADLs) for dependent residents. Findings include: R6 R6's annual Minimum Data Set (MDS) dated [DATE], identified severe impairment of cognition, diagnoses of Alzheimer's and heart failure, and R6 required extensive assistance with ADL's. In addition, R6 did not display rejection of cares. R6's Care Area Assessment (CAA) identified triggers for delirium, cognitive loss/dementia, functional abilities, psychosocial well-being, mood state, and psychotropic drug use (medications used to treat mental health disorders). R6's care plan (CP) dated 8/2/22, and revised 8/21/23 identified, PERSONAL HYGIENE/ORAL CARE: I require limited to extensive assist of 1 staff for personal hygiene and oral care. R6's nursing assistant (NAR) task form in the electronic medical record (EMR) for dates of 8/12/24 to 9/9/24 identified, PERSONAL HYGIENE: SUPPORT PROVIDED-How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers was documented one to two times per day during that period. All entries but one (9/5/24 at 9:02 p.m.) were documented as, One person physical assist. R6's NAR care sheet titled, Eldershahbaz Care Plan-[NAME] House-4th Floor downloaded 9/10/24, had a column with a section titled, Grooming. The column identified for R6 documented, Extensive assist 1 with no indication anywhere else on the document for shaving support. During observation on 9/9/24 at 1:57 p.m., R6 was observed sitting in a wheelchair in her room. R6 was fully dressed with hair pulled back into ponytail. R6 had several 1.5-inch white hairs noted to left of chin on the face. R6 not interviewable. During observation on 9/10/24 at 1:46 p.m., R6 was laying in bed and stated she had finished eating lunch and was resting. R6 was observed with several 1.5-inch white hairs noted on the left side of her chin. R6 touched the chin hairs and stated, I don't like that one bit. I want them cut. During interview with family member (FM)-A on 9/10/24 at 2:00 p.m., FM-A stated, [R6] would not like to have long facial hair. FM-A stated it was important for [R6] to be well groomed, so having a long whisker or several of them would be awful for [R6]. I know they [facility] clean [R6] up and shower [R6], but they should at least make sure [R6's] facial hair is trimmed. No one from the facility has reached out to me about [R6] possibly refusing to be shaved or trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with NA-A on 9/10/24 at 1:49 p.m., NA-A stated all nursing assistants were expected to review the resident care plan, pointing to the Eldershahbaz Care Plan-[NAME] House-4th Floor to tell us what we need to do for the residents. During interview with NA-C on 9/10/24 at 3:10 p.m., NA-C stated, I get the care plan sheet [sic]. It tells me what to do [for each resident]. NA-C stated if a resident refuses care then we are to re-approach the resident. If resident refuses care completely, then NA-C stated the nursing assistants were expected to document refusals in the EMR and notify the nurse. NA-C stated, women residents should be asked every day if they would like to have their facial hair trimmed. Here, we[staff] have a lot of free time so we can always ask and offer to help to shave them. NA-C stated, nursing assistants were responsible for providing personal hygiene, including facial hairs. During interview with NA-B on 9/10/24 at 3:23 p.m., NA- B stated the expectation for nursing assistants was to always ask. Especially for ladies, we should be offering to shave or trim chin hairs every day if we see long hair on the faces. Most women would not like that at all. NA-B stated all nursing assistants were expected to document in the EMR for tasks assigned to aides per the printed Eldershahbaz Care Plan-[NAME] House-4th Floor. During observation and interview on 9/11/24 at 8:15 a.m., NA-D stated she was familiar with R6 and had worked at facility for two years. R6 was observed sitting at dining room table alone eating breakfast. R6 was dressed, with hair pulled back into a ponytail. R6 with several 1.5-inch white hairs noted to left of chin on face. NA-D stated, the hair on [R6] chin is pretty long. Obviously it is not a good thing. I would not like to have hairs like that on my face. It would really bother me. During observation and interview with licensed practical nurse (LPN)-A on 9/11/24 at 8:35 a.m., LPN-A stated he worked at facility for three years and was familiar with the 4th floor unit residents. LPN-A stated the expectation of nursing assistants was to review the resident care sheets, pointing to the Eldershahbaz Care Plan-[NAME] House-4th Floor sheet and prioritize resident needs. LPN-A stated, shaving is part of personal cares. LPN-A observed R6 and stated, I can see that it [chin hairs] needs to be shaved. It hasn't been done for a couple weeks. The razors are available on the unit [for aides to use]. We should ask her [R6] and then do it. I would not like it if my mom or loved one had long facial hair like that. It would really bother her. [R6] should at least be asked if she wants it cut off or not. During interview with LPN-B on 9/11/24 at 8:55 a.m., LPN-B stated, she was employed full time and worked at facility for over a year and a half. LPN-B stated, personal cares should be every day. Personal cares include washing face, brushing teeth, hair, nails, dressing, and shaving. Shaving should be done on the days it is seen not just on bath days. Facial hair on women is not appealing and long facial hair shows neglect. I would not like if I was left with long facial hair. It is a dignity thing. I would be very angry if my mom was left with long facial hair. That is not ok with me. 47495 R44 R44's quarterly Minimum Data Set, dated dated [DATE], indicated R44 was admitted to the care facility on 5/2/22, had moderate cognitive impairment and was dependent on staff for showers and personal hygiene to include shaving. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R44's care plan, dated 8/15/24, indicated R44 had an ADL [activities of daily living] self-care performance deficit r/t [related to] right BKA [below knee amputation], diabetes, A fib [atrial fibrillation], HTN [hypertension], anemia, osteoporosis, DM [diabetes mellitus], wounds. Elder is needing more assistance with ADLS and does get irritated when asked if they can help him. R44's picture in his electronic medical record (EMR) showed R44 to be clean shaven. During observation on 9/9/24 at 4:09 p.m., R44 was sitting in his room. R44 had a full-face beard at least 1/2 inch long with dried particles stuck in his beard. R44 stated he prefers to be clean shaven but does not get help with his beard despite asking. During an interview on 9/11/24 at 8:50 a.m., nursing assistant (NA)-N stated the NAs should offer to shave resident on bath days or if they notice a resident is out of the usual. NA-N stated R44 had his own shaver and at times would shave himself but he did prefer to be clean shaven and staff should be offering to shave him on bath days. During interview and observation on 9/11/24 at 9:00 a.m., R44 was out at the breakfast table clean shaven. R44 stated they just came at me with a shaver and gave me a shave. It was kind of a forced shaving. During interview with nurse manager and registered nurse (RN)-A on 9/11/24 at 11:43 a.m., RN-A stated the expectation of staff is to provide personal cares daily. RN-A stated a failure to provide shaving or trimming of facial hair is a concern for dignity, especially if you are a woman. Facility policy titled Standard of Care/Elder Rights revised on 4/2022, documented Assistance or supervision of shaving as needed to keep clan[sic] and well groomed.

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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. 47495 Based on observation, interview and document review the facility failed to assess and implement interventions to assist a resident, who was unable to maintain positioning for 1 of 1 resident (R40) reviewed for positioning. Findings include: R40's quarterly Minimum Data Set (MDS) indicated R40 was admitted to the care facility on 4/4/22, had severe cognitive impairment, and was dependent on staff for activities of daily living (ADLs). The MDS further indicated R40 had 2 or more falls with injury since the last assessment. R40's Diagnoses list, printed 9/12/24, indicated R40 had several medical diagnoses including Parkinson's Disease, vascular dementia, and legal blindness. R40's care plan, printed on 9/12/24 lacked interventions to address R40's positioning. During observation on 9/9/24 at 1:21 p.m., R40 was in the common area in a black, high back wheelchair. R40 was leaning over at her waist to the right with her right arm hanging over the side of the wheelchair arm. An unnamed nurse approached R40 to ask if she needed toileting, R40 stated no. The unnamed nurse did not attempt to reposition R40 during the interaction. During observation on 9/11/24 at 8:21 a.m., nursing assistant (NA)-J was observed transferring R40 to a recliner chair in the common area. R40 immediately started to lean to the right. NA-J placed a pillow under R40's legs but did not attempt to assist R40 with repositioning or sitting upright. During observation on 9/11/24 at 11:03 a.m., R40 was sitting with the activities director (AD) out in the common area sitting in a recliner. R40 was leaning over at her waist to the right, with her right arm hanging over the arm of the chair. During an interview on 9/11/24 at 11:17 am licensed practical nurse (LPN)-B stated she was aware R40 had always leaned to the right and R40 had worked with therapy in the past but was not currently because she was on hospice. LPN-B stated she assumed R40 leaned to the right because she was uncomfortable sitting there all day. During observation on 9/12/24 at 8:10 a.m., R40 was up in a broda chair, leaning over to the right, with her arm hanging over the side and fidgeting with the wheel of the broda chair. During an interview on 9/12/24 at 11:51 a.m., nurse manager and registered nurse (RN)-A stated R40 had been leaning in her broda chair for awhile stating she had thought staff were using a pillow to help keep R40 upright. RN-A stated it would be expected for staff to reposition R40 if she was leaning over in her chair and to use a pillow to keep her upright if needed. RN-A confirmed the care plan lacked interventions to address R40 positioning, stating it would be good to have. RN-A stated she could reach out to hospice about a therapy consult to assist with proper positioning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Standards of Care/Elder Rights, revised 4/2022, indicated Elders will be provided with the necessary care and services per our policies and procedures to maintain the highest practicable physical, mental, and psychosocial wellbeing in the accordance with their comprehensive assessments, elder rights, needs, preferences and care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to implement, and care plan, new and appropriate fall interventions to prevent falls for 2 of 2 residents (R40 and R51) reviewed for falls. Findings include: R40 R40's quarterly Minimum Data Set (MDS), dated [DATE], indicated R40 was admitted to the care facility on 4/4/22, had severe cognitive impairment, and was dependent on staff for activities of daily living (ADLs). The MDS further indicated R40 had 2 or more falls with injury since the last assessment. R40's Diagnoses list, printed 9/12/24, indicated R40 had several medical diagnoses including Parkinson's Disease, vascular dementia and legal blindness. R40's past two fall assessments, dated 4/27/24 and 7/27/24, indicated R40 has at risk for falls. R40's care plan, dated 4/5/22 and revised on 8/2/24, indicated R40 had behaviors where I try to stand up, wander and occasionally grab at staff during cares. However, the care plan problem lacked any new interventions since 4/5/22. R40's care plan, dated 5/27/24 and revised on 6/18/24, further indicated R40 was at high risk for falls r/t [related to] Parkinson's [disease], poor vision, hx [history of] UTIs [urinary tract infections], anemia, left MCA [middle cerebral artery] stroke, impaired balance, acute CVA [cerebral vascular accident], I fall frequently, I'm impulsive, I have poor decision making, I don't use my call light or pendant. I sometimes wake up in the middle of the night and wander in my room, in the hallway or I will wander into the room across from my room. The most current fall intervention was dated 2/6/24 and indicated toilet before and after meals and at bedtime, q2h [every 2 hours] during the night. Say 'lets go to the bathroom'. Other fall interventions included a bed and chair alarm dated 1/18/24, massage abdomen on toilet to encourage voiding dated 5/27/23, anticipate needs dated 4/5/22, ensure call light is within reach, every hour checks, more frequent between 3-5 am, dated 9/20/23, keep walker in front of R40 dated 7/24/23, and provide a safe environment with even floors free from spills and clutter, and personal items within reach dated 9/8/23. R40's progress notes indicated R40 had 20 falls since a new care plan intervention was put in place on 2/6/24 and documented the following: On 3/7/24 it was documented R40 was found on the floor with a scratch on her left lower extremity. Approaches previously care planned were documented as bed alarm, walker at bedside, wheelchair. Approaches to prevent reoccurrences were documented as continue bed alarm, monitoring low position of bed, call light within reach, walker at bedside. On 3/16/24 it was documented R40 fell in the dining room, sitting in a regular chair without alarm on and sustained a skin tear to her forehead. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 it was documented R40 was found on the bathroom floor. On 5/21/24 it was documented R40 had an unwitnessed fall in the dining room. Approaches previously care planned indicated R40 had alarms on wheelchair, and walker in front of her while sitting or lying, and toilet the resident as schedule. Approaches to prevent reoccurrences indicated keep an eye on common area while she appears active, assisting with walk, and continue to monitor by staff. On 5/25/24 it was documented R40 had an unwitnessed fall in her room. Approaches previously care planned were documented as toileting the resident as schedule and put walker in front of her. Approaches to prevent reoccurrences were documented as staff assisting the resident with walking, continue monitoring. On 5/27/24 it was documented staff found resident lying on the ground with her walker near by and had hit the back of her head. Approaches previously care planned indicated toileting as needed, keep wheeled walker in front of her, in living area during the day for close monitoring. Approaches to prevent reoccurrences indicated continue POC [plan of care]. On 5/28/24 it was documented R40 was found on the floor kneeling over her walker and appeared weak and lethargic. Approaches previously care planned indicated resident has alarm but they are not available. Approaches to prevent reoccurrences indicated educated on calling out for help. On 6/10/24 it was documented R40 was found in the hallway by her room and had complaints of pain. Approaches previously care planned indicated R40 has bed alarm and is hourly rounding. Approaches to prevent reoccurrences indicated told [R40] the risked of not seeking help when needed and told her to pull call light when assistance is needed. On 6/15/24 it was documented R40 had an unwitnessed fall in the living room and sustained a four-inch skin tear to her left forearm and one-inch skin tear to her right elbow. Approaches previously care planned indicated walker in front of her, proper footwear, in living room for close monitoring, alarm pad. Approaches to prevent reoccurrences indicated continue POC [plan of care]. On 6/27/24 it was documented R40 had a fall around 11:50 a.m., and family, DON and hospice was notified. No previously care planned approaches or new approaches to prevent reoccurrence documented. On 7/11/24 it was documented R40 had a witnessed fall while sitting in the recliner in the common area and sustained a skin tear to her left elbow. Approaches previously care planned indicated the resident [R40] has a bed alarm on the recliner and, put the her bed lowest potion the bed toilet frequently, keep her in common area, keep her walker in front of her. Approaches to prevent reoccurrences indicated to continue R40's care plan. On 7/15/24 it was documented R40 fell from her wheelchair in the dining room. Approaches previously care planned indicated proper footwear, locked wheelchair, keep in common area for close monitoring, chair alarm. Approaches to prevent reoccurrences indicated continue POC [plan of care]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/18/24 it was documented R40 had an unwitnessed fall in the dining area and sustained a skin tear to her right elbow. Approaches previously care planned indicated fall alarm in place, frequent visual checks, assistance w/ [with] all transfers and ambulation. Approaches to prevent reoccurrences: indicated coaching: fall alarm must be placed under elder at all times; attempt regular toileting. On 7/19/24 it was documented R40 had an unwitnessed fall in the dining room during dinner. Approaches previously care planned indicated toilet the resident as schedule, and use bed alarm, bed wheelchair, reclined, assisted with walking. Approaches to prevent reoccurrences was not documented. On 7/26/24 it was documented R40 fell after several attempts to self-transfer from her recliner in the common area, indicating the pressure alarm did not sound. R40 sustained a raised wound on her forehead. Approaches previously care planned indicated pressure/fall alarm in place; routine toileting; assistance with all transfers/ambulation. Approaches to prevent reoccurrences indicated 1:1 care as possible; frequent visual check. On 8/3/24 it was documented R40 was found on lying on the floor in the doorway of another room and hit her head. No previously care planned approaches or new approaches to prevent reoccurrence documented. On 8/3/24 it was documented R40 had a second fall in the common area and sustained a skin tear to her left elbow. Approaches previously care planned indicated assist resident toilet as schedule, bed and chair alarm on, put her walker in front of her while sitting and assist resident with walk. Approaches to prevent reoccurrences indicated check the elder [R40] alarm functio[n]. On 8/31/24 it was documented R40 had a witnessed fall in the common area. Approaches previously care planned indicated ensure that the alarm is activated, and conduct safety checks every 15 minutes. assist resident with using the toilet as per her scheduled. Approaches to prevent reoccurrences was not documented. On 9/3/24 it was documented R40 fell in the dining room and sustained a hematoma to R [right] cheek bone and a skin tear under R [right] eyebrow. Approaches previously care planned indicated proper footwear, chair alarm, walker in front of resident, toileting, keep in common living area for close monitoring. Approaches to prevent reoccurrences indicated continue POC [plan of care]. On 9/6/24 it was documented R40 was found on the floor in the common area and sustained a small skin tear on L [left] elbow. Approaches previously care planned indicated walker in front, proper footwear, chair alarm, keep in living area for close monitoring. Approaches to prevent reoccurrences indicated continue POC [plan of care]. R40's electronic medical record (EMR) lacked a neuro assessment for R40's falls on 9/3/24 and 9/6/24 with known facial/head trauma. During observation on 9/9/24 at 1:20 p.m., R40 was out in the main common area in a black, high back wheelchair. R40's right periorbital skin was black and blue in color and the entire right side of her neck was covered in a black bruise. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 9/11/24 at 7:49 a.m., R40 was sitting in a broda chair with cotton socks on her feet. Nursing assistant (NA)-J approached R40 and wheeled her back to her room to transfer her to bed. NA-J stated R40 fell out of bed and her broda chair, stating she was not sure if R40 could use her call light anymore but that it should be placed near her. During an interview on 9/11/24 at 8:01 a.m., NA-M stated R40 had a lot of falls stating, we basically make sure she always has her alarm on her. During observation on 9/11/24 at 8:04 a.m., R40 was lying in bed, with her broda chair next to her. R40's call light was observed laying on the floor between the right side of the bed and the wall. During observation on 9/11/24 at 8:21 a.m., R40 was becoming restless in bed, attempting to get out of bed. NA-J transferred R40 back to the main common area and placed her in a recliner chair. There was no walker left near R40 as care planned. During an interview on 9/11/24 at 11:17 a.m., licensed practical nurse (LPN)-B stated when a resident fell , they should be assessed for pain or injuries. A neuro assessment should be completed if they resident hit their head for 72 hours post fall. LPN-B stated interventions for R40 to prevent falls were the bed/chair alarm, placing her walker in front of her, keeping R40 in the common area during the day for closer monitoring and staff keeping as quiet at night as possible. During an observation on 9/12/24 at 8:37 a.m., R40 was sitting out at the breakfast table without staff or residents nearby. R40 was not wearing her call light pendant around her neck. During an interview on 9/12/24 at 11:51 a.m., nurse manager and registered nurse (RN)-A stated the expectations when a resident fell was for the nurse to do a full resident assessment and a neuro assessment for 72 hours if warranted, meaning if the fall was unwitnessed or the resident hit their head. RN-A stated falls were discussed at morning meeting and staff would brainstorm to try and come up with new fall interventions. RN-A stated a risk managemnt note would be put in progress notes. RN-A stated it would be expected for new fall interventions to be put in place with continued falls. Fall interventions for R40 were reviewed and RN-A confirmed R40's fall interventions were outdated and not working. RN-A further stated R40 had slid out of her broad chair just the other day and had another fall this morning. 44656 R51 R51's annual Minimum Data Set (MDS) dated [DATE], identified admission to facility on 7/26/23, intact cognition, had no impairment of upper and lower extremities, was independent with hygiene and mobility. Also, one fall with major injury since prior MDS assessment. In addition, R51 was documented as taking antipsychotics (medications prescribed for mood disorders). R51's Care Area Assessment (CAA) dated 7/22/24, identified care plan triggers for delirium, cognitive loss/dementia, communication, functioning abilities, psychosocial well-being, mood state, behavioral symptoms, falls, and psychotropic drug use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's Medical Diagnoses downloaded from electronic medical record (EMR) on 9/10/24 identified R6 with dementia (group of symptoms affecting memory, thinking and social abilities), bipolar (mental health condition that causes extreme mood swings), anxiety, major depression, arthritis, diabetes, heart failure, and history of falling. R51's Provider Notes (PPN) for 8/9/23, 10/13/23, 1/18/24, 3/19/24, and 8/9/24 do not mention any falls. However, falls were noted from the following PPNs: * 3/22/24 documented R51 with fall on 3/20/24 with rib injury requiring x-ray. *7/3/24 documented R51 with fall on 6/25/24 with right toe fracture. *9/12/24 documented R51 with fall on 9/11/24 with injury to right arm requiring x-ray. R51's Risk Management Reports (RMR) for 10/29/23, 2/7/24, 3/20/24, 3/30/24, 6/25/24, and 9/2/24 identified un-witnessed falls on each of the dates each with a different root cause. R51's Care Plan (CP) downloaded 9/11/24, identified of the six RMR's, only one subsequent CP was updated. R51's fall risk CP was updated on 4/1/24 related to the fall on 3/30/24 with a new intervention of remind me to use my walker when ambulating at all times. I tend to leave it and then attempt to walk without it. During interview with Administrator on 9/12/24 at 11:39 a.m., Administrator stated if there is a resident fall or injury the expectation is for staff to ensure safety of the resident first, assess for injury and then fill out a risk management report, update provider, family, director of nursing (DON), and Administrator. Also, staff were expected to update resident care plan and put in interventions in place right away. Facility policy titled Fall (POST) Assessment reviewed 11/25/2022 state expectation of staff to document the fall in risk management in the EMR, document the fall in the progress notes, care plan fall and fall prevention measures and update caregivers as warranted. Policy included Documentation Hints to include, all interventions and treatments, any fall interventions in place at the time for the fall, and any interventions put in place after the fall.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures during the use of an antipsychotic medication (used to manage delusions, hallucinations, paranoia, or disordered thought) for 1 of 5 residents (R51) reviewed for antipsychotic medications. Findings include: R51: R51's annual Minimum Data Set (MDS) dated [DATE], identified admission to facility on 7/26/23, intact cognition, independence with ambulation, standing and transfers and was taking antipsychotics (medications prescribed for mood disorders). R51's Care Area Assessment (CAA) dated 7/22/24, identified care plan triggers for delirium, cognitive loss/dementia, communication, functioning abilities, psychosocial well-being, mood state, behavioral symptoms, falls, and psychotropic drug use. R51's Medical Diagnoses downloaded from electronic medical record (EMR) on 9/10/24, identified R51 with dementia (group of symptoms affecting memory, thinking and social abilities), bipolar (mental health condition that causes extreme mood swings), anxiety, major depression, arthritis, diabetes, heart failure, and history of falling. Orthostatic Blood Pressures Per Centers for Disease Control and Prevention (CDC) Assessment Measuring Orthostatic Blood Pressure tool containing Stopping Elderly Accidents, Deaths & Injuries (STEADI), dated 2017, identified process for obtaining orthostatic blood pressure by: 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. A drop in BP of more than or equal to 20 mm Hg [millimeters in Mercury], or in diastolic BP of more than or equal to 10mm Hg, or experiencing lightheadedness or dizziness is considered abnormal. CDC's STEADI tools are resources can help you screen, assess, and intervene to reduce your patient's fall risk. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A National Library of Medicine (NIH) Management of Commons Adverse Effects of Antipsychotic Medication article, dated 9/2018, identified the elderly were at risk of adverse effects (i.e., falls) of antipsychotic medication. The article outlined, All antipsychotics carry some risk of orthostatic hypotension [which can] lead to dizziness, syncope, falls. It should be evaluated by both history and routine measurement. R51's physician orders (PO) downloaded from EMR on 9/11/24 identified the following: * Risperidone Oral tablet 3 milligrams (MG) orally at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE with start dated of 7/26/23. Order type: Antipsychotic Orders-[MAR]. Order was revised 1/3/24 with no changes to dose or diagnoses. *Psychoactive-ortho BPs monthly for Haldol, Clozapine, Seroquel, Risperadal, Compazine, Reglan with directions of, one time a day every 1 month(s) starting on the 26th for 1 day(s) for drug monitoring sitting AND one time a day every 1 month(s) starting on the 26th for 1 day(s) for drug monitoring laying AND one time a day every 1 month(s) starting on the 26th for 1 day(s) for drug monitoring standing. Starting date for order was 7/26/23. R51's Vital Sign Log (VSL) downloaded from the EMR on 9/11/24, identified blood pressure readings since admission to facility on 7/23/23. The VSL identified orthostatic blood pressures were completed and documented 5 of 13 months. During interview with licensed practical nurse (LPN)-A on 9/11/24 at 8:35 a.m., LPN-A stated, he had worked at facility for three years and was familiar with R51. LPN-A reviewed R51's PO for medications and the monthly orthostatic blood pressures and stated the expectation of all vital signs obtained by staff appear in the VSL of the EMR. LPN-A stated, it is very important to do orthos [orthostatic blood pressures] when ordered because they can tell us if there is variation in vitals from laying, sitting, and standing. If we don't do the orthos [orthostatic blood pressures] then it can be dangerous for the resident because of a fall risk. They could stand and the BP [blood pressure] will bottom out and then they will fall. Those meds (pointing to R51's medication orders) can alter the persons balance and they can fall. They can cause balance and other health problems so that is why we must do them when ordered. The order to do the orthos [orthostatic blood pressures] will show up on the computer for the nurse to tell the nurse to do [them] and document the vitals [signs]. I don't know why it wasn't done for [R51], but it has not been done and it should be done correctly. During interview with LPN-B on 9/11/24 at 8:55 a.m., LPN-B stated she had worked at facility for year and a half. LPN-B stated the PO for blood pressures will show up in our tasks pointing to R51's EMR. This is where the order will tell the nurse to do the orthos [orthostatic blood pressures] and to document it. If [R51] refuses there should be a notation. I don't see anywhere that R51 ever refused it. It is important to do orthos [orthostatic blood pressures] and we want to make sure that they don't get weak and faint. It is a side effect of some of those meds that R51 takes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with registered nurse (RN)-A on 9/11/24 at 11:22 a.m., RN-A stated orthostatic blood pressures include, standing, sitting, and laying. We do that once a month when [residents] are on antipsychotics. It is important to do them because the meds can change the BPs and [leave the residents] prone to falling. RN-A reviewed R51's PO and stated, The orders say orthos every month on the 26th started July 2023. RN-A also stated, [R51] is taking Risperdal and has been on it for a long time. 3 mg at bedtime. RN-A reviewed R51's TAR and stated, it [order] should pop up on the nurse's tasks to remind them to do the orthos on the 26th of each month. I can see that they [nurses] have not been putting in the complete orthos for [R51] and the nurses should .if resident refuses it should be documented. R51 will agree to anything and would not decline or refuse. Facility policy titled Psychoactive Medication, revised 03/01/18 documented, All elders receiving antipsychotic medication will have monthly orthostatic BP checks documented in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation and interview, the facility failed to ensure mediations were safely and securely stored for 1 of 1 resident (R38) reviewed for medication storage. Findings include: R38's quarterly Minimum Data Set (MDS) dated [DATE], indicated R38 had moderate cognitive impairment, was dependent with dressing, toileting, bathing, transfers, but ate independently. The MDS indicated the following diagnoses, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), diabetes (a group of diseases that result in too much sugar in the blood), anxiety, depression, and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). R38's care plan printed 9/12/24, indicated R38 was unable to ambulate, transferred with assist of staff and a standing lift, and used a manual wheelchair with brake extenders. The care plan also indicated R38 had poor safety awareness, and impaired cognitive function related to mild cognitive impairment. During observation on 9/9/24 at 12:17 p.m., R38's medication cabinet located in R38's room was observed open and unsecured. The cabinet had 19 cards of medications, about 10 lidocaine patches, and a glucometer. R38 was not in her room. During interview on 9/9/24 at 12:24 p.m., registered nurse (RN)-B stated she went to the team's office across from R38's room and forgot to close the cabinet. RN-B stated she needed to grab something and was going to come back right away, but a resident went to the office to talk to her. RN-B acknowledged the office's blinds were closed and she couldn't see if anybody walked by or entered R38's room. RN-C stated the cabinet needed to be locked to prevent resident or other residents from getting the medications or consuming them. During interview on 9/12/24 at 12:39 p.m., clinical nurse/licensed practical nurse (LPN)-C stated if the medicaiton cabinet is unsecured, anybody can come along and take the medications. LPN-C added, residents might be allergic to the medication, or have difficulty swallowing, and it's dangerous. LPN-C stated , the medications cabinets should always be kept closed. Facility policy title Med Storage dated 1/1/15, indicated the facility maintains equipment and supplies necessary for medication preparation and administration in a manner that is orderly, effective and follows the standards of infection control practice. The policy also indicated the facility will maintain proper storage, preparation and administration of medications including lockable medication carts, medication cabinets, drawers, and rooms with well lit dose preparation areas.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47495 Based on observation, interview and record review the facility failed to have a process in place to monitor refrigerator, dishwasher and breakfast food temperatures in all six unit kitchens in the care facility. In addition the facility failed to ensure opened food and beverage containers were dated to prevent unsafe consumption by residents. This had the ability to affect all 55 residents residing in the care facility. Findings include: During interview and observation on 9/9/24 at 11:45 a.m., the registered dietician (RD) stated there was one central kitchen where lunch and dinner were cooked, and each resident floor (two through seven) had their own full kitchen. Breakfast was cooked to order for each resident on the floors and lunch and dinner were kept warm in a steamer on the floors. Each floor had an industrial refrigerator, one unit residential type refrigerator and a high temperature dishwasher. During observation the second-floor kitchen lacked any temperature logs for the industrial and unit refrigerators and the dishwasher. The industrial refrigerator was showing two different temperatures on different thermometers of 8 degrees Fahrenheit and 50 degrees Fahrenheit. The RD stated, it feels cold, but I don't think that is right [the temperatures]. The third-floor kitchen also lacked any temperature logs for the industrial and unit refrigerators and dishwasher. The sixth-floor kitchen also lacked any temperature logs for the industrial and unit refrigerators and dishwasher. The RD stated she would assume it should be her that is currently monitoring the temperatures in the kitchen, stating there had been a gap in the position (of kitchen manager) and the unit kitchens were not up to standard yet. The RD stated they were further in a transition from kitchen staff overseeing the unit kitchens to the nursing staff and that the nursing assistants needed training on proper food temperatures and monitoring refrigerator and dishwasher temperatures and their currently was a process in place for checking food temperatures for the breakfast prior to serving. During observation on 9/9/24 at 1:23 p.m., the sixth-floor unit refrigerator had a temperature log hung on the side that was dated December 2023 and blank. Inside the refrigerator was an open, undated milk container. During observation on 9/9/24 at 1:31 p.m., the seventh-floor unit refrigerator had an open, undated milk container and liquid eggs in an opened and undated container. During interview and observation of the breakfast service on seventh-floor on 9/11/24 at 7:35 a.m., R39 was served a glass of milk out of the unit refrigerator. R39 stated, I think this milk has turned, it tastes sour. During an interview at 9/11/24 at 7:47 a.m., nursing assistant (NA)-M they worked with preparing breakfast meals for residents and stated the kitchen staff were responsible for taking food temperatures and was unsure who was responsible for monitoring the refrigerator or dishwasher temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/11/24 at 8:50 a.m., NA-N stated the NAs were responsible for making the residents breakfast and that the kitchen staff were responsible for taking all the food temperatures for the other meals, refrigerator temperatures and dishwasher temperatures. NA-N further stated it was expected for all opened food containters to be dated when opened and discarded after seven days. During an interview on 9/11/24 at 8:18 a.m., a cook (C)-A from the central kitchen stated the kitchen staff were responsible for taking lunch and dinner temperatures before taking the food to the unit kitchens and they did not temp the breakfasts. C-A stated the NAs were responsible for monitoring the temperatures of the refrigerators and dishwashers on the individual floors and for temping any food prepared on the individual floors. During observation on 9/12/24 at 8:31 a.m., the second-floor unit refrigerator did not have a temperature log and had an open, undated milk carton and an opened, undated container of half and half inside. The industrial refrigerator had a temperature log hanging on the outside with one temperature recorded for the month on 9/9/24. The dishwasher had a temperature log hanging above it with temperatures recorded on 9/10/24 and 9/11/24 only. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures. During observation on 9/12/24 at 8:25 a.m., the third-floor unit fridge did not have a temperature log. The industrial refrigerator had a temperature log hanging on it however lacked any recorded temperatures. The dishwasher had a temperature log hanging above it with temperatures recorded for the month on 9/9/24, 9/10/24, and 9/11/24 only. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures. During observation on 9/12/24 at 8:22 a.m., the fourth-floor unit refrigerator did not have a temperature log and had an open, undated milk carton and an opened, undated container of half and half inside. The industrial refrigerator had a temperature log hanging on the outside with one temperature for the month recorded on 9/11/24. The dishwasher had a temperature log hanging above it however lacked any recorded temperatures. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures. During observation on 9/12/24 at 8:18 a.m., the fifth-floor unit refrigerator did not have a temperature log and had an open, undated milk carton and an opened and undated liquid eggs container inside. The industrial refrigerator had a temperature log hanging on the outside with two temperatures recorded for the month on 9/10/24 and 9/11/24. The dishwasher had a temperature log hanging above it however lacked any recorded temperatures. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures. During observation on 9/12/24 at 8:14 a.m., the sixth-floor unit refrigerator did not have a temperature log. The industrial refrigerator had a temperature log hanging on the outside with two temperatures for the month recorded on 9/9/24 and 9/10/24. The dishwasher had a temperature log hanging above it with two temperatures recorded on 9/9/24 and 9/10/24. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 9/12/24 at b8:15 a.m., the seventh-floor unit refrigerators had a temperature log hanging on the side with one recorded temperature from 9/9/24. The industrial refrigerator had a temperature log hanging on the outside however lacked any recorded temperatures. The dishwasher had a temperature log hanging above it however lacked any recorded temperatures. A food temperature log was also hanging on the refrigerator however it lacked breakfast food temperatures. During an interview on 9/12/24 at 10:00 a.m., the RD acknowledged and stated awareness of the temperatures for the refrigerators and dishwashers were not being monitored on the resident floors as well as the temperatures not being monitored for the breakfasts prepared on the individual floors. The RD stated the expectation was for the NAs to monitor breakfast food temperatures and they would need to receive training on that. The RD further stated it was expected for all opened food or drinks to be dated and discarded within seven days or discarded if a food container was in the refrigerators open and undated. The RD stated monitoring of food, refrigerator, and dishwasher temperatures, along with dating opened food or drink containers was important due to the vulnerable state of the population they serve and to prevent any potential food borne illness. A facility policy titled Date Marking and Labeling, dated 3/2016, indicated that all food held for more than 24 hours would be labeled. A policy on refrigeration and dishwasher temperature monitoring was requested but not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to the facility failed to ensure proper use of gloves while providing personal cares for 1 of 1 resident (R35) observed for personal cares. In addition, the facility failed to sanitize a standing lift sling shared by residents for 2 of 2 residents (R35 and R9) observed for infection control practices. Findings include: Hand Hygiene R35's quarterly Minimum Assessment Data (MDS) dated [DATE], indicated R35 had moderate cognitive impairment, needed setup to eat, supervision with oral hygiene, and was dependent with bathing, toileting, dressing, bed mobility and transfers. R35's clinical diagnoses record printed 9/12/24, indicated diagnoses of epileptic syndrome (a unique combination of symptoms or by the location in the brain where the seizures originate), malignant neoplasm of the frontal lobe (brain cancer), essential hypertension(abnormally high blood pressure that's not the result of a medical condition), pain, unspecified dementia, type 2 diabetes (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), left bundle branch block (a delay or blockage of electrical impulses to the left side of the heart), dysphagia (difficulty swallowing), and erythematous condition (red discoloration of the skin caused by infectious agents, drug hypersensitivity, or underlying disease). During observation on 9/11/24 at 7:30 a.m., two nursing assistants (NA)-H and NA-I entered R35's room to assist R35 with personal cares. R35 had used a bed pan to have a bowel movement. After removing the bed pan, R35 laid down on her back. NA-H wore gloves and provided peri-care. NA-I assisted R35 to stay on her side while NA-H used wipes to clean R35's rectal area. When R35 was cleaned NA-H and NA-I put on a clean brief. NA-H did not change her gloves and proceeded to assist resident to get dressed. NA-H and NA-I assisted resident to put on clean pants, a top, and shoes. Still wearing the same gloves, NA-H pulled the standing lift closer to R35's bed, grabbed the stand's sling, and with the help of NA-I they put on sling, connected it to lift, and transferred R35 to her wheelchair. NA-H gathered garbage in a clear plastic bag and removed her soiled gloves. NA-H rubbed her hands with hand sanitizer and left the room. During interview on 9/11/24 at 8:17 a.m., NA-H stated she failed to change her gloves or wash her hands and put on new gloves after she provided peri care for R35. NA-H stated she should have changed her gloves to minimize the potential of contaminating R35's clothes with body fluids, her own clothes, and any surface she touched with her dirty gloves. During interview on 9/11/24 at 8:24 a.m., clinical coordinator/licensed practical nurse (LPN)-C stated the expectation was for nursing assistants to change their gloves after they provided peri-care. LPN-C stated failure to change gloves after peri-care increased the risk for cross-contamination and was an infection control issue. (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 - Some	Standing lift slings During observation on 9/11/24 at 7:30 a.m., NA-H and NA-I provided personal cares and assisted R35 to get ready for breakfast. NA-H and NA-I moved a standing lift close to R35's bed. The NAs put a sling around R35's lower back, connected it to lift, and transferred R35 to her wheelchair. During observation and interview on 9/11/24 at 7:41 a.m., after providing personal cares and using a standing lift to transfer R35, NA-H was observed cleaning the standing lift but not the sling. NA-H stated the standing lift and slings were shared by several residents on the second floor. NA-H stated the standing lifts were cleaned/sanitized after each use but not the slings. NA-H stated the laundry washes the slings, I think once a week. During interview on 9/11/24 at 7:43 a.m., NA-I stated staff sanitize the standing lifts after every use, but they did not sanitize the slings between residents. R9's quarterly Minimum Assessment Data (MDS) dated [DATE], indicated R9 had severe cognitive impairment, was dependent with toileting and transfers, maximal assistance with dressing and bathing, and needed moderate assistance with upper body dressing and personal hygiene. Diagnoses included hypertension, diabetes (A group of diseases that result in too much sugar in the blood), hyperlipidemia (high levels of fat particles in the blood), dementia, hemiplegia (paralysis of one side of the body), anxiety, and depression. Nursing Assistants care plan printed on 9/12/24, indicated R9 transferred with staff assistance and a standing lift. During continuous observation on 9/11/24 at 7:52 a.m., NA-H and NA-I took standing lift and unsanitized sling from R35's to R9's room. After providing personal cares and dressing R9, NA-H and NA-I used standing lift and the unsanitized sling to transfer resident from her bed to her wheelchair. During interview on 9/11/24 at 8:17 a.m., LPN-C stated the standing lifts and the slings needed to be sanitized after every use. LPN-C stated the laundry didn't wash the slings, the NAs wash the slings in the laundry rooms located in each floor. LPN-C stated failure to sanitize slings between residents was an infection control concern. Facility policy's titled Standard Precautions dated March 10, 2020, indicated Gloves are to be worn when contact with blood, body fluids, secretions, excretions, and contaminated items is possible. New clean non-sterile gloves are to be worn immediately after washing hands and just prior to touching mucous membranes and non-intact skin. New gloves will be applied when performing tasks and procedures on the same elder when cross-contamination is possible. Gloves are to be removed immediately after use, and before touching non-contaminated items and environmental surfaces and before going to another elder or different task. Hands are to be washed immediately after gloves are removed. Gloves are to be removed prior to leaving room. Facility policy titled Infection Control - Equipment & Care Items (reuse) dated March 2020, indicated To ensure that all reusable resident/patient equipment is not used by another person until the item has been cleaned and or disinfected according to current Infection Prevention guidelines written in this policy and procedure. This policy also ensures that single use items are disposed of properly.