STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora on France	6500 France Avenue Edina, MN 55435

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on interview and document review the facility failed to ensure comprehensive care plans were developed for montioring side effects in 2 of 5 residents (R4, R147) reviewed for antipsychotic drug use. Findings include: R147 had a diagnosis of dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R147's physician's orders dated 6/12/24, indicated quetiapine fumarate (Seroquel) oral tablet 25 milligrams (mg). Give 12.5 mg by mouth as needed for anxiety twice a day. R127's care plan lacked any indication of side effect montioring for antipsychotic medications. During interview on 6/20/24 at 9:50 a.m., the director of nursing stated residents who were taking an antipsychotic medication should also be monitored for side effects (on the care plan). During interview on 6/20/24 at 10:57 a.m. the Pharmacist stated she had made a recommendation on 6/18/24 to monitor for side effects, add non pharmacological interventions for psychotropics and monthly orthostatic blood pressure for R147 since she was taking an antipsychotic medication. The pharmacist also stated these recommendations should have been started at the time the antipsychotic was prescribed and while developing the care plan 46885 R4's admission Minimum Data Set (MDS) dated [DATE], indicated R4 admitted to the facility on [DATE], had intact cognition, did not have behaviors, did not reject care, had depression, and took an antidepressant 7 out of 7 days. R4's Care Area Assessment (CAA) dated 5/20/24, indicated R4 had depression and took fluoxetine 40 mg every day and had an order for trazodone for insomnia and had not used the medication. Further, the CAA indicated, adverse consequences of antidepressants exhibited by R4 included an increased risk for falling and depression. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's care plan dated 5/23/24, indicated R4 would remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood through the review date and interventions indicated to monitor, document, and report as needed any risk for harm to self, suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. The care plan lacked interventions for monitoring for side effects. R4's Physician's Orders form indicated the following orders: 5/14/24, trazodone HCl Oral Tablet (trazodone HCl) Give 50 milligrams (mg) by mouth as needed for Sleep. 5/14/24, fluoxetine HCl Oral Capsule 40 MG (Fluoxetine HCl) Give 40 mg orally one time a day for depression. The Physician's Orders form was reviewed and lacked any monitoring for side effects. R4's Consultant Pharmacist's Medication Regimen Review form dated 5/21/24, indicated to update the care plan and kardex to include behavior, intervention and side effect monitoring for continued fluoxetine, trazodone, and atarax as needed use. During interview on 6/20/24 at 10:39 a.m., the pharmacist consultant (PC)-D stated she completed a medication review on 5/21/24 and recommended indications for medications along with updating the care plan to include behavior monitoring, non pharmacological interventions, and side effect monitoring for psychotropic medications. PC-D stated she expected staff should have already address the care plan interventions by now. During interview on 6/20/24 at 1:41 p.m., the director of nursing stated each area nurse manager printed off recommendations and gave them to the nurse practitioner and stated since the facility was a transitional care unit (TCU), they try to turn around the recommendations quickly and expected the nurse's to follow up within 5 business days. DON further stated R4 had a depression care plan to monitor for harm but stated R4 did not have anything regarding nonpharmacologic interventions and side effect monitoring for the psychotropics and stated it should be in the care plan but did not see anything in R4's care plan.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586 Based on observation, interview, and document review the facility failed to develop and implement interventions to prevent pressure ulcers. The facility further failed to ensure residents with current pressure ulcers were turned and repositioned timely for 1 of 2 residents (R13) reviewed for pressure ulcers. Findings include: R13's admission Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and a diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, chronic pain, and polyneuropathy. It further indicated R13 had impairment on both sides of upper and lower extremities, required substantial/maximal assistance with bed mobility, and was at risk for and had (1) unstageable facility acquired (not present on admission) deep tissue injury. R13's care area assessment (CAA) for skin was triggered and indicated the following: -at risk for skin breakdown due to decreased mobility, decreased range of motion (ROM) to upper/lower extremities, residual right hemiparesis, bowel incontinence, use of Foley catheter, and use of Apixaban 5 milligrams (mg) twice a day which may cause easy bruising. -admitted with a PICC line in his right upper arm with catheter checked for length, peripherally inserted central catheter (PICC) line dressing change per order. -deep tissue injury (DTI) to his right heel. Orders for heel protectors, barrier film twice a day with army battle dressing (ABD) and wrapped in Kerlix per order. He will be seen by wound physician's assistant on 6-6-2024. -requires assistance with bed mobility and transfers, using an alternating pressure mattress (APM) and needs assistance with turning/repositioning/offloading every 2 hours and as needed. -all catheter cares done by nursing, checked/changed and offered bedpan for bowel movements, assisted with pericare, incontinent pad change, and wears an incontinent pad for his comfort. -receiving physical and occupational therapy (PT/OT) and expected to improve in some of his activiites of daily living (ADL). -Braden score is 10 and again 15, at risk, weekly skin audits. R13's admission assessment dated [DATE] indicated, no skin issues. R13's physician's orders dated 6/8/24 indicated, reposition every 2 hours and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R13's comprehensive skin assessment dated [DATE] indicated, a Braden score of 10, high risk, no pressure reducing device in bed/chair, risk factors-cognitively impaired, requires assistance with ADL's, bowel incontinence, no pedal pulses, no interventions. Patient is a two assist with all ADL's and is incontinent of bowel. Nursing staff will check on the patient every hour and offer assistance with all ADL's as needed. R13's care plan dated 5/26/24 indicated, R13 had an ADL self-care performance deficit related to physical deconditioning/acute cystitis with an intervention of asssistance of (2) staff for repositioning and turning in bed. R13's care plan dated 5/31/24, further indicated R13 had an actual impairment to skin integrity and potential for further impairment to skin with an intervention to turn and reposition every 2 hours in bed and/or chair. R13's progress note dated 5/29/2024, indicated pressure wound found on right heel today. See wound notes for measurements. New orders from physician's assistant which include heel protectors at all times, APM, barrier film x2 to area, allow to dry, cover with ABD and Kerlex twice daily. Message left to update son. During continuous observation and interview on 6/18/24 from 10:15 a.m. to 1:00 p.m. the following was observed/occurred: -10:15 a.m. occupational therapist (OT)-A was leaving R13's room and stated R13 required assistance to reposition and was unable to do so by himself due to severe back pain. OT-A further stated during therapy R13 had been repositioned. -10:18 a.m. R13 was laying in bed on his back with the head of bed (HOB) slightly elevated and a pillow between his right arm and the bed rail. -10:25 a.m. licensed practical nurse (LPN)-A enterd R13's room and asked what his pain level was. -10:35 a.m. LPN-A exited the room and stated while in the room, she had applied R13's pain patch to his neck, looked at/assessed his feet, fixed his watch so it wasn't pinching his skin, checked his PICC line dressing and assessed his pain level. LPN-A did not repostion R13. -10:40 a.m. speech therapist (SLP)-A entered the room -10:53 a.m. nursing assistant (NA)-A entered the room and asked R13 what he would like for lunch. -10:54 a.m. SLP-A exited the room and stated she was talking to him about the difficulty of eating certain foods and liquids. SLP-A also stated she didn't do any cares with R13. -10:55 a.m. NA-A exited room. -11:08 a.m. R13 was in the same position. -11:18 a.m. R13 put on the call light, NA-A entered room, asked How can I help you? and then stated Oh, you want some more water. -11:19 a.m. NA-A exited the room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11:21 a.m. NA-A entered the room with a glass of water. -11:24 a.m. NA exited the room and stated she brought the resident some water and had to thicken it. R13 was in the same position. -11:54 a.m. R13 was in the same position. -12:04 p.m. NA-A entered room with R13's lunch tray, set it up for him, and exited at 12:05 p.m. -12:07 p.m. NA-A R13 was in the same position except the HOB was elevated to a sitting position. -12:17 p.m. same position, no staff have entered the room. -12:28 p.m. NA-A removed R13's meal tray from his room, R13 was in the same position. -12:50 p.m. R13 was in the same position, no staff have entered the room. -1:01 p.m. NA-A stated the last time R13 was repositioned was about an hour or two ago then she stated Well actually I put the head of his bead back down about a half hour ago and asked him if he was comfortable, but the last time I actually turned him on his side was about two hours ago. During interview on 6/20/24 at 11:26 a.m., NA-A stated the NA's complete rounds every 2 hours which included checking/changing briefs and re-positioning, also as needed. NA-A further stated if a resident refused to have their brief changed or to re-position they try to reapproach them later and if they still refuse, they should let the nurse know and document it. During a follow up interview on 6/20/24 at 1:01 p.m., NA-A stated the last time R13 was repositioned was about an hour or two ago then she stated Well actually I put the head of his bead back down about a half hour ago and asked him if he was comfortable, but the last time I actually turned him on his side was about two hours ago. During interview on 6/20/24 at 7:25 a.m. LPN-B stated nurses were responsible for completing skin assessments twice a week on bath days. If they observe a new skin concern they are required to fill out a skin check form, if there are no new skin concerns they can just check it off on the treatment administration record (TAR) that it was completed. When a resident was admitted to the facility the receiving nurse was responsible for documenting if a resident was at risk for or had any skin alterations and then the nurse manager was responsible for adding interventions. It was the nurse managers responsiblity to follow up and make sure it was care planned. LPN-B further stated NA's were responsible for completing rounds every 2-3 hours which included checking/changing briefs, repositioning, and seeing if the resident needed anything. Repositioning would be considered to be when a resident was laying on their back and then would be repositioned on their side or using pillows to relieve pressure on one area of the body. Raising/lowering the HOB by itself would not be considered repsotioning a resident. NA's should report refusals by resident to reposition and the nurses should document it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/20/24 at 7:38 a.m., NA-E stated NA's should complete rounds every 2-3 hours and included checking/changing brieds and repositioning. NA's generally reposition residents from side to side, or onto their back if they are on their side and raising/lowering the HOB would not be considered repositioning a resident. During interview on 6/20/24 at 8:20 a.m., the nurse manager registered nurse (RN)-A stated nurses and managers were expected to put in interventions on the admission assessment depending on what the receiving nurse triggered and she would expect skin interventions to be added right away upon admission, if the resident was at risk for skin breakdown. RN-A further stated re-positioning a resident would be considered side to side, onto their back, or raising the HOB and the feet, not just raising the HOB by itself. Also, asking a resident if they are comfortable dosen't mean they shouldn't be offered to be reprositioned. we want to prevent those skin breakdown. Usually in a TCU the residents need help to do those things and staff should encourage them. We want to prevent skin breakdown. RN-A also verified R13 didn't have any skin interventions added upon admission (before 5/29/24 when a pressure ulcer was noted on his heel). During interview 6/20/24 at 8:40 a.m., the director of nursing (DON) stated nurses were responsible for completing skin checks once a week on bath day and documenting it in the medical record. THe DON further stated interventions should be added right away on admission when a resident was at risk for skin breakdown. The DON would not consider raising/lowering the HOB of a resident to be repositioning. The facility's policy on the management of skin alterations dated 5/24/24, indicated on admission, readmission, quarterly, and significant change in condition, each resident will have a skin risk assessmentt and Braden assessment for determination of risk. Appropriate interventions will be implemented based on assessment and will be placed on resident care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure a Foley catheter was removed according to physician orders for 1 of 1 resident (R4) who was admitted to the facility with an indwelling Foley catheter. Findings include: R4's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, was dependent on staff for toileting hygiene, toileting transfers, had an indwelling catheter. R4's Medical Diagnoses form indicated the following: unspecified fracture of the lower end of the left femur (thigh bone), periprosthetic fracture (fracture around a joint replacement prostheses) around unspecified internal prosthetic joint, and retention of urine. R4's hospital encounter summary dated 5/14/24, indicated R4 had postoperative urinary retention and a history of urinary incontinence and failed a voiding trial on 5/9/24, and a catheter was replaced on 5/10/24. Further, the hospital discharge orders indicated a trial of voiding at the transitional care unit (TCU) in 5 days, and if R4 failed, could consider a urology evaluation as an outpatient. R4's Care Area Assessment (CAA) dated 5/14/24, indicated R4 had a diagnosis of urinary retention and admitted with a Foley catheter and all catheter cares were by nursing. Additionally, the CAA indicated there was no order for a voiding trial and R4 was assisted with the bedpan for bowel movements upon request. R4's Physician Orders form indicated the following orders 5/19/24, monitor/record/report to the medical doctor signs and symptoms of a urinary tract infection, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Make sure output is recorded in point of care. 5/19/24, catheter care every shift. Document on characteristics of urine and output, make sure the urine bag is hanging below the level of your waist and check for kinks. 6/10/24, Change catheter and overnight bag every month and as needed unless otherwise directed. R4's Physician Orders form was reviewed and lacked the order for a trial of voiding at the transitional care unit (TCU) in 5 days and if R4 failed, can consider a urology evaluation as an outpatient. R4's medication administration record (MAR) and treatment administration record (TAR) was reviewed for May 2024, and June 2024, and lacked information a voiding trial was completed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's care plan dated 5/23/24, and revised on 6/6/24, indicated R4 had an indwelling catheter for a diagnosis of urinary retention and the goal was to remain free from catheter related trauma through the review date. Interventions indicated R4 required catheter care every shift and as needed, the catheter bag and tubing should be positioned below the level of the bladder and away from the entrance room door, the tubing should be checked for kinks, monitor intake and output as per facility policy, monitor for signs and symptoms of discomfort on urination and frequency, monitor, record, report to medical doctor signs and symptoms of a urinary tract infection, and observe and document pain and discomfort due to the catheter. R4's care sheet indicated R4 was incontinent of bowel and bladder. During interview and observation on 6/17/24, at 2:09 p.m., R4 had a Foley catheter and stated she had the catheter because she could not get up to go to the bathroom and had the catheter since she was in the hospital. During interview on 6/18/24 at 1:19 p.m., licensed practical nurse (LPN)-A stated she was not aware of any trial for removing R4's catheter and stated R4 had been at the facility a few times and could not recall R4 having a catheter on previous admissions to the facility and stated she would have to look in R4's chart to see why R4 had a catheter. During interview on 6/18/24 between 1:50 p.m., and 2:09 p.m. registered nurse (RN)-A stated if a resident had a catheter, they discussed with the provider and voiding trials were documented in the orders and they documented a bladder scan and how much resident was going and how much residual was documented in the treatment administration record (TAR). RN-A stated admission orders were located in the document tab and verified in the orders that R4 was to have a voiding trial with in 5 days of admission and stated she did not think R4 had a trial and would have expected R4 to have a trial. RN-A further stated the admission orders were supposed to be located in the computer and in the resident's hard chart. RN-A viewed R4's medication administration record (MAR) and TAR and verified there was no documentation of a voiding trial. RN-A further viewed R4's progress notes and verified there was no documentation a voiding trial was completed. RN-A stated it was important to complete a voiding trial because of the risk of infection and stated the longer a catheter was in, the longer it took to recover and stated she did not know how the order was missed and stated generally they had a health unit coordinator (HUC) and another nurse check the orders. At 2:09 p.m., RN-A viewed the hard chart and verified the order for the trial of voiding and stated the order had been missed. During interview on 6/18/24 at 2:48 p.m., NA-D stated R4 was alert and oriented and able to report reliable information. During interview on 6/20/24 at 8:40 a.m., R4 stated she just had the catheter removed. During interview on 6/20/24 at 9:29 a.m., the director of nursing, (DON) stated orders were placed in the electronic medical record (EMR) for catheter cares. During interview on 6/20/24 at 9:31 a.m., RN-B stated they completed a comprehensive bowel and bladder assessment and look for the reason for the catheter and then document in the EMR. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/20/24 at 9:32 a.m., DON stated there may be an order on admission to remove a catheter and they would ask the nurse practitioner about a voiding trial and if a resident failed a voiding trial, they referred out. DON further stated if a resident had a voiding trial he expected the trial to be documented and stated R4 did not have parameters for the voiding trial and expected the nurse practitioner to provide parameters and further expected staff to clarify the orders and expected staff to document if they sought clarification. DON stated it was important to complete a voiding trial to make sure a resident was not retaining urine. A policy, Catheter Care, dated 9/2023, indicated it was the policy of the facility to provide care to the individual who must use an indwelling catheter with care that meets the necessary standards of infection control and dignity. An indwelling catheter will only be used after all other alternatives have been explored to minimize the risk of infection and GU (genitourinary) trauma. The catheter will be removed as soon as possible after the risks and benefits have been evaluated.

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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** 46885 Based on interview, and document review, the facility failed to ensure residents that were prescribed psychotropic medications were monitored for side effects, for 2 of 5 residents (R4, R147) reviewed for unnecessary medications and the facility failed to ensure non pharmacologic interventions were in place for R4 who had psychotropic medications ordered. Findings include: R4's admission Minimum Data Set (MDS) dated [DATE], indicated R4 admitted to the facility on [DATE], had intact cognition, did not have behaviors, did not reject care, had depression, and took an antidepressant 7 out of 7 days. R4's Care Area Assessment (CAA) dated 5/20/24, indicated R4 had depression and took fluoxetine 40 mg every day and had an order for trazodone for insomnia and had not used the medication. Further, the CAA indicated, adverse consequences of antidepressants exhibited by R4 included an increased risk for falling and depression. R4's care plan dated 5/23/24, indicated R4 would remain free of signs and symptoms of distress, symptoms of depression, anxiety or sad mood through the review date and interventions indicated to monitor, document, and report as needed any risk for harm to self, suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. The care plan lacked interventions for monitoring for side effects. R4's Physician's Orders form indicated the following orders: 5/14/24, trazodone HCl Oral Tablet (trazodone HCl) Give 50 milligrams (mg) by mouth as needed for Sleep. 5/14/24, fluoxetine HCl Oral Capsule 40 MG (Fluoxetine HCl) Give 40 mg orally one time a day for depression. The Physician's Orders form was reviewed and lacked any monitoring for side effects. R4's Consultant Pharmacist's Medication Regimen Review form dated 5/21/24, indicated to update the care plan and kardex to include behavior, intervention and side effect monitoring for continued fluoxetine, trazodone, and atarax as needed use. (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 on 6/20/24 at 10:39 a.m., the pharmacist consultant (PC)-D stated she completed a medication review on 5/21/24 and recommended indications for medications along with updating the care plan to include behavior monitoring, non pharmacological interventions, and side effect monitoring for psychotropic medications. PC-D stated she expected staff should have already address the care plan interventions by now. During interview on 6/20/24 at 1:41 p.m., the director of nursing stated each area nurse manager printed off recommendations and gave them to the nurse practitioner and stated since the facility was a transitional care unit (TCU), they try to turn around the recommendations quickly and expected the nurse's to follow up within 5 business days. DON further stated R4 had a depression care plan to monitor for harm but stated R4 did not have anything regarding nonpharmacologic interventions and side effect monitoring for the psychotropics and stated it should be in the care plan but did not see anything in R4's care plan. 42586 R147 had a diagnosis of dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R147's physician's orders dated 6/12/24, indicated quetiapine fumarate (Seroquel) oral tablet 25 milligrams (mg). Give 12.5 mg by mouth as needed for anxiety twice a day. R147's medication administration and treatment administration record (MAR/TAR) for June of 2024 lacked any indication of side effect monitoring for antipsychotic medications. R127's care plan lacked any indication of side effect montioring for antipsychotic medications. During interview on 6/20/24 at 8:38 a.m., licensed practical nurse (LPN)-B stated when a resident takes an antipsychotic medication, side effect monitoring should be done. LPN-B further stated the nurse manager and the health unit coordinator (HUC) were responsible for putting in those orders and the nurses were responsible for making sure it was completed by documenting side effects on the medication administration and treatment administration records (MAR/TAR). LPN-B verified R147 was taking Seroquel and had no side effect monitoring. During interview on 6/20/24 at approxiately 8:45 a.m., the nurse manager registered nurse (RN)-A stated she would expect a resident who was taking an antipsychotic medication to also be monitored for side effects. RN- verified R147 was taking an antipsychotic and had no antipsychotic montioring in place. During interview on 6/20/24 at 9:50 a.m., the director of nursing stated residents who were taking an antipsychotic medication should also be monitored for side effects (on the care plan). During interview on 6/20/24 at 10:57 a.m. the Pharmacist stated she had made a recommendation on 6/18/24 to monitor for side effects, add non pharmacological interventions for psychotropics and monthly orthostatic blood pressure for R147 since she was taking an antipsychotic medication. The pharmacist also stated these recommendations should have been started at the time the antipsychotic was prescribed and while developing the care plan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora on France	6500 France Avenue Edina, MN 55435

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy regarding psychopharmacological drug use last revised on 10/6/22, indicated the resident will be monitored for the effectiveness of the medication or possible adverse consequences. Results will be documented in the resident's active record. It further indicated behavioral interventions means modification of the residents behavior or environment, including staff approaches to care, to the largest degree possible to accommodate the resdient's behavioral symptoms. Nursing services, social services and other members of the interdisciplinary team will address the behavior in progress notes, care plans, on the nursing assistant care sheets/kardex, treatment medication sheets or other forms per facility behavior monitoring program. Medication use is not the sole approach for behavioral interventions. Other interventions will be identified in the care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 The facility failed to ensure dishware was cleaned and sanitized in a manner to reduce the risk of foodborne illness. This had potential to affect all 42 residents. Findings include: During observation and interview on 6/17/24 at 6:36 p.m., dietary (DA)-A loaded silverware, forks, and spoons in the dish washer. The dish washer temperature was 142 for wash cycle and 188 for rinse. Trays went through the washer, and the wash temperature was 142 and rinse temperature was 188. Plates went through the washer, and the washer temperature was 140 and the rinse temperature was 190. Items washed were being placed or stacked for later use. DA-B and DA-A referred to director of culinary (CD) and dining room coordinator (DRC) when asked about the dish washer temperatures. During subsequent observation and interview, CD stated the dish machine was a heat machine and a chemical rep comes out once a month. Dish detergent and dish rinse aid were observed to be attached to the dish machine. DRC stated they regularly put silverware, glasses, and other items through the dish washer multiple times as a standard practice. DA-B was stacking dishes and placing away from clean area of dish washer, and DRC directed DA-B to bring silverware to be washed through the dish machine again. CD reviewed the temperature log where dish washer temperatures were recorded, and the log indicated for the wash temperature to be 150 to 165 and the rinse temperature to be at least 180. The log directed staff to notify supervisor and/or maintenance immediately if temps not as specified. The log indicated wash temperatures between 140 to 174 and rinse temperatures between 165 to 192, and the dish washer temperatures for dinner had not been recorded yet. CD stated the timing of checking the dish washer temperatures surrounding meals varied but usually was done prior to washing dishes to ensure the dish washer was running correctly. More dishes ran through the dish washer, and DRC verified the wash temperature at 142 and rinse at 190. DRC pointed to a stick on the front of the machine which indicated 140 was the low temperature and 150 the high temperature. DRC pointed to different setting which may be used to wash heavier More dishes were washed, and CD verified wash temperature of 144 and rinse temperature of 190. CD expected staff to tell them when the dish machine was not getting to the correct temperatures, and then CD contacted maintenance who fixed immediately. DRC stated if they could not use the dish washer, they used plasticware until fixed again. During observation on 6/18/24 at 10:06 a.m., the dish machine had a manufacturer sticker which identified the minimum wash temperature as 150 and the minimum rinse temperature as 180. During interview on 6/20/24 at 12:39 p.m., DA-C stated they checked dish washer temperatures after breakfast, lunch, and dinner meal. DA-C stated the wash temperature either needed to be 140 or 150 and higher and 180 for the final rinse temperature. DA-C stated they would let senior chef or CD know if the dish washer was not getting up to appropriate temperature. During follow up interview on 6/20/24 at 1:38 p.m., CD verified the dish machine in the transitional care unit kitchen was a high temperature dish washer and stated they wanted to provide safe food service and did not want residents to get sick from the food service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility provided [NAME] TempStar manual dated 8/31/23, directed operators to refer to the machine data plate for specific water requirements. The facility policy Cleaning Dishes with Dish Machine dated 2/19, indicated the wash temperature must reach temperatures between 140 to 160 degrees and rinse temperature must reach 180 degrees or higher. The policy and procedure directed staff to monitor temperatures throughout the dish washing process and record one set of temperature for each meal service.

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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** 46885 Based on interview, observation, and document review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) for 1 of 3 (R4) residents who had a Foley catheter reviewed for infection prevention and control. Findings include: R4's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, was dependent on staff for toileting hygiene, toileting transfers, had an indwelling catheter. R4's Medical Diagnoses form indicated under a heading, Special Instructions, EBP-Foley. Additionally, R4's diagnoses included: unspecified fracture of the lower end of the left femur (thigh bone), periprosthetic fracture (fracture around a joint replacement prostheses) around unspecified internal prosthetic joint, and retention of urine. R4's Physician Orders form lacked information under the heading Special Instructions. Additionally, an order dated 6/10/24, indicated the following: Change catheter and overnight bag every month and as needed unless otherwise directed. R4's care plan provided on 6/20/24 at 11:45 a.m., indicated under a heading, Special Instructions, EBP-Foley. The information under the heading, Special Instructions, was undated. Additionally, R4's care plan dated 5/23/24, indicated R4 had an indwelling catheter for urinary retention and interventions lacked instructions for EBP. R4's care sheet lacked information R4 was on EBP. R4's hospital encounter summary dated 5/14/24, indicated R4 had postoperative urinary retention and a history of urinary incontinence and failed a voiding trial on 5/9/24 and a catheter was replaced on 5/10/24. Further, discharge orders indicated a trial of voiding at the transitional care unit (TCU) in 5 days, and if R4 failed, can consider a urology evaluation as an outpatient. During observation on 6/17/24 at 1:55 p.m., nursing assistant (NA)-B was wearing gloves, but no gown and drained urine from R4's catheter into a cylinder and then poured it down the toilet. No signs were located on R4's door for EBP and no carts were located outside R4's door. During interview and observation on 6/17/24, at 2:09 p.m., R4 had a Foley catheter and stated she had the catheter because she could not get up to go to the bathroom and had the catheter since she was in the hospital. There was no EBP signage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 6/18/24 at 11:57 a.m., NA-C was in R4's room and donned gloves and had a cylinder with urine and brought the cylinder into the bathroom. NA-C did not have a gown on. NA-C wiped up a spill on the floor below where R4's catheter was located. NA-C stated she emptied R4's catheter and verified she wore gloves but did not wear a gown and stated anyone who was on precautions had signage inside the doorway and verified R4's room lacked any signage and stated R4 did not have any precautions. NA-C further stated the infection control nurse put signage up for residents on precautions and NA-C went by the signage to know if anyone was on precautions. During interview on 6/18/24 at 12:10 p.m., trained medication aide (TMA)-A stated the signage on doors let staff know what type of precautions a resident was on. TMA-A further stated she had education on EBP and thought residents with catheters should be on EBP and staff should wear a gown, mask, and gloves. During interview on 6/18/24 at 12:14 p.m., licensed practical nurse (LPN)-A stated residents on EBP had signage posted and residents who had a catheters, wounds, or IV's, were on EBP and verified R4's doorway lacked signage and stated staff would not know R4 was on EBP and would let the infection preventionist know there was no signage. During interview on 6/18/24 between 1:14 p.m., and 1:17 p.m., LPN-A stated she had the isolation cart ready and planned to add signage for R4. At 1:17 p.m., LPN-A stated she explained to R4 she needed EBP because of the catheter. During interview on 6/18/24 at 2:48 p.m., NA-D stated R4 was alert and oriented and able to report reliable information. During interview on 6/20/24 at 9:32 a.m., the director of nursing (DON) stated staff were alerted to EBP because there would be an isolation cart and signage to indicate what isolation precautions someone was on, and it would also indicate what kind of personal protective equipment (PPE) to donn when going into the room. Further, the DON stated he expected EBP to be in place to prevent infection. A policy, Enhanced Barrier Precautions, dated 4/1/24, indicated EBP expanded the use of PPE beyond situations in which exposure to blood and body fluids was anticipated and referred to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi drug resistant organisms (MDROs) to staff hands and clothing. EBP are indicated for residents with an infection or colonization with a CDC (Centers for Disease Control) targeted MDRO when contact precautions do not otherwise apply, or wounds and or indwelling medical devices. The policy lacked information on where staff look to know whether a resident was on EBP.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to ensure 3 of 5 resident (R2, R16, R27) were offered or received pneumococcal vaccination in accordance to Center for Disease Control (CDC) recommendations. Findings include: Review of the current CDC Pneumococcal Vaccine Timing for Adults dated 3/15/23, indicated adults [AGE] years or older should make sure residents were up to date with pneumococcal vaccination according to the following vaccine schedules: -If residents had no prior vaccines, option A was to receive PCV20 and option B was to receive PCV15 and then PPSV23 one year or more later. -If residents had PPSV23 only at any age, option A was to receive PCV20 one year or more later and option B was to receive PCV15 one year or more later. -If residents had PCV13 only at any age, option A was to receive PCV20 one year or more later and option B was to receive PPSV23 one year or more later. -If residents had PCV13 at any age and PPSV23 at less than [AGE] years old, option A was to receive PCV20 5 years or more later and option B was to receive PPSV23 5 years or more later. -If residents had PCV13 at any age and PPSV23 at [AGE] years or older, together, with the resident, vaccine providers may choose to administer PCV20 5 years or more after the last pneumococcal vaccination. This was called the shared clinical decision-making option. R2's significant change Minimum Data Set (MDS) dated [DATE], indicated R2 was [AGE] years old and usually understood others, admitted to facility 3/3/24, did not have behaviors or reject cares, had diagnoses of anemia, deep vein thrombosis, arthritis, osteoporosis, and depression, and R2's pneumococcal vaccinations were up to date. R2's Minnesota Immunization Information Connection (MIIC) dated 6/21/24, indicated R2 received PPSV23/Pneumovax 23 on 10/23/14 and PCV13/Prevnar 13 on 11/9/15. R2's electronic health record (EHR) lacked documentation of shared clinical decision-making regarding PCV-20 dose. R16's admission MDS dated [DATE], indicated R16 was [AGE] years old (currently [AGE] years old), had intact cognition, admitted to the facility 5/10/24, did not have behaviors or reject cares, had diagnoses of cancer, hypertension, diabetes mellitus, thyroid disorder, arthritis and fracture, and R16's pneumococcal vaccines were up to date. R16's MIIC dated 6/21/24, indicated R16 received PCV13/Prevnar13 on 10/8/15 and PPSV23/Pneumovax 23 on 10/11/16. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's EHR lacked documentation of shared clinical decision-making regarding PCV-20. R27's significant change MDS dated [DATE], indicated R27 was [AGE] years old, others understood R27 and R27 usually understood others, admitted to facility 4/6/24, did not have behaviors or rejected cares, had diagnoses of anemia, atrial fibrillation, heart failure, hypertension, and renal failure, and R27's pneumococcal vaccines were up to date. R27's MIIC dated 6/21/24, indicated R27 had PCV13/Prevnar 13 on 1/21/16 and PPSV23/Pneumovax 23 on 8/2/18. R27's EHR lacked documentation of shared clinical decision-making regarding PCV-20. During interview on 6/20/24 at 9:48 a.m., registered nurse (RN)-C stated the charge nurse or someone else whom they were not able to specify checked resident vaccination record and eligibility, talked to the resident or responsible party about vaccine to get consent, and then assigned a task for nursing to give the vaccine. RN-C explained vaccine before giving to resident. RN-C stated they documented consents under nursing notes and vaccines were documented under immunizations in the EHR. During interview on 6/20/24 at 1:04 p.m., RN-D stated the infection preventionist tracked resident's MIIC and who was up to date with immunization. During interview on 6/20/24 at 2:23 p.m., infection preventionist (IP) stated they looked at residents' vaccine history and MIIC to check which vaccines residents still needed. IP stated the pharmacist also sent recommendations on which vaccines were needed. IP followed CDC guidelines for vaccine timing. IP had a spreadsheet on the computer which listed resident name, vaccine information, if consented to vaccine, and noted if follow-up was needed such as if a resident needed to get over an illness before receiving a vaccine. IP pulled vaccine information on Monday and placed on spreadsheet to follow up from there. IP reviewed vaccine information for R16. R16 was not listed on IP's vaccine spreadsheet, and IP stated they had not conversed with the provider about if R16 should receive Prevnar 20. IP reviewed vaccine information for R2. IP stated depending on which vaccines were given and the time frame, resident could be eligible for Prevnar 20 when it had been at least five years. IP stated R2 was on their list to follow-up and needed to check with the nurse practitioner about whether R2 should receive the Prevnar 20. IP reviewed vaccine information for R27. IP stated the previous IP was at the facility until May 2024 and had not been able to go back further to check on all residents' immunization status. IP was not sure if R27 had refused the Prevnar 20 and stated refusals were documented in their spreadsheet or progress notes. IP reviewed R27's progress notes, and R27's EHR did not reflect refusal or declination of Prevnar 20. IP stated they would check with the provider if R27 was eligible for the Prevnar 20. IP stated residents were at risk of more severe symptoms and increased spread of illness when not up to date with pneumococcal vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure Resident Pneumococcal Vaccine dated 11/1/23, directed staff to follow the CDC guidance for appropriate dosing and decision-making tree based on age, vaccination history, and immunocompromised conditions. The policy and procedure directed staff to document refusals in the medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to ensure the Coronavirus Disease (COVID-19) vaccination was offered and/or provided to reduce the risk of severe illness to 1 of 5 residents (R16) reviewed for immunizations. Findings include: Center of Disease Control and Prevention (CDC) Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States reviewed 4/4/24, directed the following guidance: For people [AGE] years or older who are not moderately or severely immunocompromised: -unvaccinated= 1 dose of an updated (2023-2024 Formula) mRNA COVID-19 vaccine OR 2 doses of updated Novavax vaccine. -Previously received 1 or more Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of Original monovalent Novavax vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of [NAME] vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine or Original monovalent Novavax doses= 1 dose of any updated COVID-19 vaccine. -Special situation for people ages [AGE] years and order= People ages [AGE] year and older should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months following the previous dose of updated COVID-19 vaccine. For initial vaccination with updated Novavax COVID-19 vaccine, the 2-dose series should be completed before administration of the additional dose. For people [AGE] years or older who are moderately or severely immunocompromised: -Unvaccinated= 3 homologous (i.e., from the same manufacturer) updated (2023-2024 Formula) mRNA vaccine doses OR 2 updated Novavax vaccine doses. -Previously received 1 or 2 Original monovalent or bivalent mRNA vaccine doses= Complete the 3-dose series with 2 or 1 homologous updated mRNA vaccine doses, respectively. -Previously received a combined total of 3 or more Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Previously received 1 or more Original monovalent Novavax vaccine doses, alone or in combination with any Original monovalent or bivalent mRNA vaccine doses= 1 dose of any updated COVID-19 vaccine. -Previously received 1 or more doses of [NAME] vaccine, alone or in combination with any Original monovalent or bivalent mRNA vaccine or Original monovalent Novavax doses= 1 dose of any updated COVID-19 vaccine. -People ages 12-[AGE] year may receive 1 or more additional doses of any updated COVID-19 vaccine. -People ages [AGE] years and older should receive 1 additional dose and may receive further additional doses of any updated COVID-19 vaccine. R16's admission MDS dated [DATE], indicated R16 was [AGE] years old (currently [AGE] years old), had intact cognition, admitted to the facility 5/10/24, did not have behaviors or reject cares, had diagnoses of cancer, hypertension, diabetes mellitus, thyroid disorder, arthritis and fracture. R16's MIIC dated 6/21/24, indicated R16 had Spikevax-Moderna COVID-19 immunizations on 3/9/21, 4/6/21, 10/28/21, 4/5/22, Comirnaty Pfizer Bivalent on 9/16/22, and Spikevax Moderna 23-24 on 11/1/23. R16's immunization record in the electronic health record (EHR) lacked documentation of the COVID-19 23-24 immunization and documentation of second COVID-19 23-24 immunization being offered and accepted or declined. During interview on 6/20/24 at 9:48 a.m., registered nurse (RN)-C stated the charge nurse or someone else whom they were not able to specify checked resident vaccination record and eligibility, talked to the resident or responsible party about vaccine to get consent, and then assigned a task for nursing to give the vaccine. RN-C explained vaccine before giving to resident. RN-C stated they documented consents under nursing notes and vaccines were documented under immunizations in the EHR. RN-C stated they had not administered COVID-19 vaccine to residents. During interview on 6/20/24 at 1:04 p.m., RN-D stated infection preventionist (IP) tracked resident COVID vaccines and would receive pharmacy reviews regarding COVID vaccines which they would forward to IP. RN-D stated IP or nurses would administer COVID vaccines to residents, and consents or refusals were found in residents' EHR. Vaccine administration information was found under the immunization tab. During interview on 6/20/24 at 2:23 p.m., infection preventionist (IP) stated they looked at residents' vaccine history and MIIC to check which vaccines residents still needed. IP stated the pharmacist also sent recommendations on which vaccines were needed. IP followed CDC guidelines for vaccine timing. IP had a spreadsheet on the computer which listed resident name, vaccine information, if consented to vaccine, and noted if follow-up was needed such as if a resident needed to get over an illness before receiving a vaccine. IP pulled vaccine information on Monday and placed on spreadsheet to follow up from there. IP stated most residents were eligible for the 23 - 24 COVID vaccine formula unless they received earlier. IP reviewed R16's vaccine information for acceptance or declination of COVID-19 vaccination, and R16 was not listed on IP's vaccine spreadsheet. IP stated ensuring residents were up to date with their COVID-19 vaccinations helped lessened severity of symptoms if residents got COVID-19. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure COVID-19 Preparedness Plan dated 10/9/23, directed staff to check residents COVID-19 vaccination status on admission to the facility. If the resident had not received COVID-19 vaccine, information about the vaccine and the vaccine were offered and administered to those that choose to be vaccinated.