STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andrew Residence	1215 South 9th Street Minneapolis, MN 55404

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review, the facility failed to revise the care plan to include a smoking-related safety intervention for 1 of 3 residents (R1) reviewed for safety. Findings include: R1's facesheet dated 5/7/25, indicated he had diagnoses including schizoaffective disorder (chronic illness causing changes in thoughts, moods, and behaviors) and tobacco use. R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. R1 was independent with activities of daily living (ADLs) and mobility, had behavioral symptoms not directed towards others, and currently used tobacco. R1's physician orders included an order dated 10/25/24, to observe forearms for self-inflicted burns or picking two times per day and to notify nurse if present. R1's physician note from psychiatrist dated 4/15/25, indicated R1 had a history of schizoaffective disorder and baseline included some ongoing paranoia and anxiety. Further, he has preservative focus on his hair and skin, resulting in picking and [NAME] [sick, burning] hair in the past. R1 denied recent issues with hair/removal and substance use included pipe tobacco. R1's Vulnerability Assessment and Abuse Prevention Plan dated 4/23/25, identified he was unable to recognize unsafe smoking behavior with status of vulnerable. The summary noted R1 had a history of sustaining burns to skin and clothing due to unsafe smoking and to prevent burns he was provided with flameless lighters which were kept behind the staff desk. The assessment also identified R1 had severe psychiatric symptoms or cognitive deficits that significantly impair judgment and functioning with status of vulnerable. The summary noted on 7/27/21 R1 was observed to burn his arm hair with a lit cigarette, on 4/23/22 R1 burned his arm with a flameless lighter, and on 6/9/22 staff observed micro burns to his arms from flameless lighter and staff to begin assisting with hair removal twice monthly. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Tobacco and Electronic Delivery Device Use Screening dated 4/24/25, identified R1 was vulnerable for unsafe smoking behaviors and had a history of intentionally burning himself with cigarettes in an attempt to remove body hair. The assessment included, as outlined in [R1's] treatment plan, he is discouraged to utilize cigarettes . instead encouraged to use his pipe and loose tobacco. He may request his flameless lighter at program times. Before providing his flameless lighter, staff ask [R1] if he endorses urges to burn his hair or engage in other unsafe smoking behaviors. Smoking and vaping materials used by the resident on assessment included pipe and filtered cigarettes. Visual observation of tobacco use identified no concerns though it is important to note that he refused to follow through with his care plan and utilized a cigarette rather than a pipe. R1's progress note dated 5/1/25, noted at 8:45 p.m. staff conducted a routine skin check after administering bedtime medications and observed a number of wounds down R1's forearms. R1 reported he had used a lit cigarette to attempt to remove the hair on his forearms. Nursing staff assess R1, provided wound care, and made notifications. R1 was to be placed on one hour precaution checks, smoking patio restrictions, and shift checks. Facility Incident Report dated 5/1/25, indicated staff completed a routine skin check on R1 and observed a significant number of wounds on his forearms. R1 reported that he had used a lit cigarette to attempt to remove the hair on his forearms. Identified antecedents or triggers to the incident included R1 reporting to his program manager (PM) on 4/19/25 that his pipe was broken and he had thrown it away, stated he did not know what his plan was for smoking since he did not have another pipe, and when asked directly he described no plan to smoke until he purchased a pipe. The incident's outcome and follow-up (to include interventions/corrective action implemented) noted R1 reported having two boxes of cigarettes, did not want them discarded, and gave them to his unit's program director (PD). R1 and the PD developed a plan to store the cigarettes behind the staff desk, request one cigarette and flameless lighter at program times, and then be escorted outdoors by staff for 1:1 [one-to-one] observation to ensure safety. R1 reported he received personal funds that day and was open to purchasing a new pipe and tobacco and re-engaging with his previous smoking plan which had been effective in preventing burns with last burns from a cigarette in 2022. The report's interventions implemented section included a list of possible interventions. Selected interventions included 1:1 staff support. R1's care plan problem dated 5/29/18, identified he was unable to recognize unsafe smoking behavior. Interventions included: - Staff will notify/consult with psychiatric provider, primary health care provider, and/or other community professionals as needed, dated 5/29/18. - Staff will provide education on smoking risks and encourage smoking cessation, dated 5/29/18. - Provide and encourage use of smoking cessation aides, dated 5/29/18. - Staff will discourage R1 from obtaining cigarettes from others and smoking cigarette butts, dated 5/29/18. - Staff will encourage R1 to refrain from spending time in smoking areas, dated 5/29/18. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provide R1 with options for positive replacement activities as an alterative to smoking, dated 5/29/18. - Staff will provide and encourage use of adaptive smoking/lighting equipment, dated 5/29/18. - Staff will encourage R1 to allow staff to assist in hair removal as needed, dated 5/1/25. Staff will encourage R1 to have his pipe and loose tobacco with him before going downstairs to smoke, dated 5/2/25. Staff will encourage R1 to seek out staff available on the first floor if in need of immediate assistance/support in order to address concerns without having to return to the floor, dated 5/2/25. R1's care plan problem dated 12/10/18, identified he had severe psychiatric symptoms or cognitive deficits that significantly impair judgment and functioning. Interventions included: - Staff will visualize R1's arms for new burns twice a day. If new burns are present, staff will notify the charge nurse and person in charge immediately, dated 6/9/22. Staff will request that R1 checks out/in a flameless lighter immediately before/after he smokes. Lighters will be kept behind the staff desk. Before providing a lighter, staff will ask R1 if he has any urge/intention to use lighter/cigarette to remove hair, ask to show staff his pipe and loose tobacco, remind to refrain from obtaining cigarettes from others and remind to turn in his lighter within 20 minutes. After receiving a lighter, staff will ask R1 if he used lighter/cigarette to remove hair, dated 5/4/23. - PM will meet with R1 to discuss hair removal needs and assist with removing hair weekly. If R1 declines, PM will provide education about history of hair removal incidents and strongly encourage his agreement to shave in the moment, dated 5/2/25. - Staff will encourage R1 to utilize as needed (PRN) medication when endorsing increased anxiety, impulses related to unwanted hair, and as needed, dated 5/2/25. - Staff will encourage R1 to notify staff as soon as possible when feeling urges to remove unwanted hair from his body, dated 5/2/25. R1's care plan did not identify or include the implemented intervention of staff escorting him outside for one-to-one observation when smoking cigarettes. Coffee/Cigarettes & Programs signage, undated, posted behind the staff desk identified the daily program times for smoking. Additional undated signage titled Smoking Plan for [R1], identified R1 could check e-lighters in/out at the desk. The plan noted before checking a lighter out, staff were to ask if R1 had any urge/intention to use lighter/cigarettes to remove hair, ask to show staff R1's pipe and loose tobacco, remind to refrain from obtaining cigarettes from others, and remind to turn in his lighter within 20 minutes. After checking a lighter in, staff were to ask if he used lighter/cigarette to remove hair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/5/25 at 2:04 p.m., mental health worker (MHW)-B stated if someone was deemed unsafe to smoke a vulnerability care plan was created. Staff knew which specific interventions or assistance a resident needed based on the care plan and smoking safety assessment. MHW-B stated the care plan was always updated to fit individual resident needs. MHW-B stated R1 had a smoking program where he checked lighters in/out from staff and staff asked him safety questions. MHW-B noted R1's pipe broke recently and he had been smoking cigarettes instead until obtaining a new pipe. During an interview on 5/5/25 at 2:36 p.m., registered nurse (RN)-B stated she looked at care plans to see what interventions or assistance residents needed for smoking. RN-B stated if R1 didn't have a flameless lighter or pipe he would be at an increased risk of being unsafe with smoking. During an interview on 5/5/25 at 3:56 p.m., MHW-C stated she was working when R1's recent burns happened, she noted the burns when completing his evening skin check, and he had reported burning himself with a cigarette. MHW-C stated R1 usually smoked a pipe and that's part of his care plan as well because he didn't burn himself with a pipe. MHW-C noted after R1's pipe broke the plan was to get him a new pipe. While smoking cigarettes, MHW-C stated staff were helping him more frequently with hair removal. MHW-C identified additional interventions for R1's smoking safety while using cigarettes included checking in with him more frequently. MHW-C stated R1 was now back to smoking a pipe. During an observation on 5/5/25 at 4:39 p.m., R1 approached the staff desk to request smoking materials. Program director (PD)-A asked if he wanted a cigarette or his pipe and R1 stated he wanted a cigarette. PD-A asked R1 safety questions and confirmed no intent or urges to burn. PD-A retrieved two cigarettes from storage behind the staff desk and a flameless lighter, and escorted R1 off the floor to smoke. During an interview on 5/5/25 at 4:42 p.m., therapeutic recreation intervention specialist (TRIS)-A was seated at the staff desk and present when R1 retrieved cigarettes from PD-A. TRIS-A noted R1 usually only smoke a pipe and hadn't always had cigarettes stored behind the desk but must right now. TRIS-A noted if R1 asked for a cigarette, staff would have to make sure someone was available to go outside with him. During an interview on 5/7/25 at 9:07 a.m., MHW-A stated she was R1's program manager (PM). MHW-A stated R1 had been smoking cigarettes after his pipe broke and she had completed a safety assessment and observed him smoke a cigarette. MHW-A noted staff need to be hyper vigilant when he [R1[is using cigarettes because that is not part of his care plan. Regarding interventions for R1 when smoking cigarettes, MHW-A stated, let me check the care plan, I don't know if anything new was added specifically for that, but what I would do personally is observe him and escort him. During an interview on 5/7/25 at 9:47 a.m., MHW-D stated R1 was smoking cigarettes and had to be on one-to-one's for cigarettes and had to be supervised because he had used a cigarette to burn himself. R1 did not require supervision if smoking a pipe. MHW-D stated he was positive the one-to-one supervision with cigarettes was an intervention on R1's care plan and it would be on someone's care plan if they required a staff escort for smoking. MHW-D reviewed R1's care plan and did not see where this intervention was located. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 3:55 p.m., R1 stated he recently got a new pipe but had some cigarettes left, almost two packs that he bought a while ago. R1 stated I always go out with staff if I smoke them, they want me to go out with them. He noted staff checked in with him and asked him how he was doing before smoking when he went to the desk to retrieve a lighter. R1 had a bandage on his left forearm, did not identify the source of the wound, but stated it was doing okay. During an interview on 5/7/25 at 10:22 a.m., PD-A stated R1 started smoking cigarettes when his pipe broke in mid-April. R1 still had some cigarettes, agreed to keep them behind the desk, had obtained a new pipe, but continued smoking the cigarettes. PD-A stated, any time he is going to smoke a cigarette he is on a one-to-one with staff until the cigarettes are gone. PD-A stated staff were aware of this intervention because it was discussed verbally and was in R1's progress notes and incident report. PD-A stated this documentation identified he needed a one-to-one escort for cigarettes, but it's not in his care plan at this time. Further, PD-A noted, she would expect this to be on the care plan and it would have been a helpful care plan intervention. During an interview on 5/7/25 at 1:48 p.m., the director of nursing (DON) stated she would expect to see one-to-one staff escorts for smoking identified on a resident's smoking vulnerability care plan. The DON noted if this was not on the care plan staff would know R1 needed a one-to-one escort because it would be included in the staff communication log and on a resident's individual program sheet for smoking. The DON was not aware R1's individual Smoking Plan sheet at the staff desk lacked this information. The DON stated the director of clinical services (DCS) had been more involved in R1's recent burn incident and knew more. During an interview on 5/7/25 at 3:04 p.m., the DCS stated since R1's recent burn incident he had been on a one-to-one with staff if smoking cigarettes. The DCS stated she would expect to see the intervention of a one-to-one staff escort on the care plan. The DCS noted staff had been effective in providing one-to-one supervision for R1 with cigarettes and it one hundred percent makes sense for it to be care planned, for the continuity and consistency. The DCS confirmed she did not see this intervention on R1's care plan. Facility policy titled Smoking and Vaping Policy and Procedure dated 2/25/25, indicated residents were assessed on admission and quarterly for unsafe smoking and vaping behavior in the Vulnerability Assessment and Abuse Prevention Plan. If assess to be vulnerable in this area, would have a vulnerability plan outlined in the Vulnerability Assessment and Abuse Prevention Plan and interventions may be documented in the resident's treatment plan. Facility policy title Tobacco and Electronic Delivery Device Use Screening Procedure dated 2/25/25, indicated this screening was to screen for a resident's ability to safely smoke and utilize an electronic delivery device. The information gathered from the screening would be shared with the treatment team in order to determine whether the resident is able to use tobacco without intervention due to a low burn risk or requires intervention to reduce burn risk and/or use an electronic delivery device safely. If determined to require intervention due to burn risk, the treatment team would make recommendations as to how to best ensure resident safety and a subsequent Vulnerability Care Plan will be created. The Vulnerability Care Plan would be reviewed quarterly and as needed to ensure [NAME] practices were being followed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on observation, interview, and document review, the facility failed to ensure professional standards of practice for documentation were followed during transcription and administration of a standing order medication for 2 of 2 residents reviewed (R1, R2) with wounds requiring antibiotic ointment. Findings include: Facility policy titled Standing Medication and Treatment Orders dated 5/18/22, included a copy of the facility standing orders list. Non-oral/topical routine treatments included: bacitracin zinc (antibiotic used to treat minor skin injuries such as cuts/scrapes/burns) ointment, apply topically to affected areas up to three times daily PRN, with a seven-day time limit. R1 R1's annual Minimum Data Set, dated dated dated [DATE], indicated R1 admitted to the facility on [DATE] with primary diagnosis of schizoaffective disorder (chronic illness causing changes in thoughts, moods, and behaviors) and did not have any ulcers, wounds, or skin problems. R1's care plan included a problem dated 5/1/25, of burns to bilateral arms. Interventions included administer analgesics as ordered. R1's care plan included a problem dated 5/6/25, of scratch to right fourth finger. Interventions included provide skin care as indicated. R1's care plan included a problem dated 5/7/25, of abrasion to left hand. Interventions included apply sterile bandage as needed. Physician orders in R1's electronic health record (EHR) included order dated 11/27/1998, for medications noting [facility] PRN [as needed] list OK. R1's progress note dated 5/1/25 at 10:16 p.m., indicated R1 sustained self-inflicted burns to both forearms totaling 82 burns. Both forearms were cleaned with dermal wound cleanser and thin coating of bacitracin to all burns of both arms. R1 declined application of dressings. R1's progress note dated 5/2/25 at 2:13 p.m., indicated two open areas on left forearm and the site was cleansed using a BZK (benzalkonium chloride) wipe but R1 would not allow application of a bandage. It did not indicate if bacitracin was applied or refused. R1's progress note dated 5/2/25 at 8:52 p.m., indicated the burns on left forearm were cleansed with an antiseptic wipe and transparent dressings applied to all blisters on left forearm. It did not indicate if bacitracin was applied or refused. R1's progress note dated 5/3/25 at 9:14 a.m., indicated two open areas on left forearm were cleansed with wound cleanser spray, and bacitracin and 2x2 island dressing [gauze bandage] placed on top of both open areas. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated 5/3/25 at 8:27 p.m., indicated affected areas were cleansed with wound cleansing spray, bacitracin applied, and covered with two 2x2 island dressings. R1's progress note dated 5/4/25 at 9:14 a.m., indicated three open areas on left forearm were cleansed with BZK, and bacitracin and 2x2 island dressing placed over top of all three wounds. Areas were healing without concern with plan to decrease physical health checks from twice to once daily for monitoring and daily dressing changes. R1's progress note dated 5/5/25 at 9:58 a.m., indicated one of the three open areas had scabbed over and they were cleansed with BZK and bacitracin and 2x2 island dressing placed over top of all three wounds. R1's progress note dated 5/6/25 at 10:36 a.m., indicated three open areas on left forearm were cleansed with a BZK wipe, thin layer of bacitracin ointment applied, and all three areas covered with island dressings. R1's progress note dated 5/6/25 at 12:58 p.m., indicated R1 sustained a scratch on his right fourth finger. The area was cleansed with a BZK wipe, a thin layer of bacitracin applied, and covered with a Band-aid. Plan to place on once daily physical health checks to monitor healing. R1's progress note dated 5/7/25 at 1:44 p.m., indicated the scratch on R1's right fourth finger was cleansed with BZK wipe with bacitracin and Band-aid placed over top. R1's progress note dated 5/7/25 at 1:45 p.m., indicated three wounds on left forearm were cleansed with BZK wipes with bacitracin and an island dressing placed over top. R1's progress note dated 5/7/25 at 2:00 p.m., indicated R1 presented with a bleeding superficial abrasion on left hand that occurred while staff assisted with shaving. Wound was cleansed with BZK with bacitracin and Band-aid placed over top. R1's paper medication and treatment administration records (MAR/TAR) dated month of May 2025, included an order noting facility PRN list okay with note FYI (for your information). The MAR/TAR did not include an order for bacitracin zinc ointment to be applied topically to affected areas up to three times daily PRN with a seven-day time limit, as identified in the referenced standing orders list. The MAR/TAR lacked identification of the medication's prescribing practitioner's name, full medication name, dosage, route of administration, frequency, duration, specific indication for use, or date of medication order for the administrations of bacitracin documented in progress notes as follows: -5/1/25 once to both arms -5/3/25 twice to left arm -5/4/25 once to left arm -5/5/25 once to left arm -5/6/25 once to left arm and right finger (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/7/25 once to left arm, right finger, and left hand Physician orders in R1's EHR did not include transcription of the specific standing order for bacitracin including the prescribing practitioner's name, medication name, dosage, route of administration, frequency, duration, indication for use, or date of medication order. During an interview on 5/5/25 at 2:36 p.m., registered nurse (RN)-B stated she had been providing wound care for R1's forearm burns. The wound care was cleaning it with an antiseptic wipe, putting a little bacitracin ointment on, and then a small bandage. During an observation on 5/7/25 at 8:45 a.m., R1 had a new small bleeding cut on the back of his left hand and presented to the nursing station. RN-A cleansed the area with a BZK wipe, applied bacitracin, and placed a Band-aid on top. During an interview on 5/7/25 at 8:53 a.m., RN-A stated she believed bacitracin was a medication and it was once of the facility's standing orders. RN-A stated staff documented in a resident's MAR if they had active wound care and we would write down the specifics of like cleanings, bacitracin, and then would sign for it in the MAR. We would write in the standing order for the bacitracin and sign for it there. RN-A stated she had applied bacitracin to R1's forearm wounds over the previous weekend and documented this in progress notes but not in his MAR. She confirmed the bacitracin standing order should have been transcribed into R1's MAR. She noted the process for standing orders was to have a nurse assess the need for it and, if indicated, write it into the paper MAR, date it, sign it, then administer and document it. On 5/7/25 at 10:03 a.m., RN-A stated if nursing staff enter an order on the paper MAR, you also put it into the physician orders in [EHR]. RN-A reviewed R1's paper MAR and the physician orders in R1's EHR and confirmed she did not see an order for bacitracin in either location. R2 R2's quarterly MDS dated [DATE], indicated R2 admitted to the facility on [DATE] with no ulcers, wounds, or skin problems. R2's care plan included a problem dated 5/2/25, of burn to right middle finger. Interventions included administer analgesics as ordered. Physician orders in R2's electronic health record (EHR) included order dated 12/8/24, for medications noting [facility] PRN list OK - Has different melatonin and nicotine lozenge order prescribed by [provider name]. R2's progress note dated 5/2/25 at 8:54 a.m., indicated R2 sustained a burn on his right middle finger. The area was cleansed with an antiseptic wipe and aloe vera and a Band-aid applied. R2's progress note dated 5/3/25 at 12:31 p.m., indicated bacitracin and a bandage were applied to the finger. R2's progress note dated 5/3/25 at 8:41 p.m., indicated bacitracin and a bandage were applied to the finger. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's progress note dated 5/4/25 at 9:19 am, indicated bacitracin and a bandage were applied. Physical health checks were decreased from twice daily to daily to monitor healing and continue daily dressing changes. R2's progress note dated 5/5/25 at 8:34 a.m., indicated the burn was cleansed and bandage applied. Further noted will put a daily wound care/Band-aid change in his MAR and reduce physical health checks to Monday, Wednesday, Friday. R2's progress note dated 5/7/25 at 9:22 a.m., indicated the burn was cleansed and bandage applied. Daily wound care and bandage changes in the MAR were ongoing. R2's paper MAR/TAR dated month of May 2025, included an order noting facility PRN list okay with note has different melatonin and nicotine lozenge order. The MAR/TAR also included an order for daily wound care (cleanse with BZK wipe, apply bacitracin ointment) and Band-aid change to right third finger until healed scheduled for a.m. (morning) with start date 5/5/25. Administrations were documented on 5/5/25 and 5/7/25. The application of bacitracin identified in progress notes twice on 5/3/25 and once on 5/4/25 was not documented, as they were prior to the wound care order start date of 5/5/25. Wound care documentation, including application of bacitracin, dated 5/6/25 was blank. Further, while the wound care order identified the use of the bacitracin, the MAR lacked transcription of the specific order for the bacitracin including the prescribing practitioner's name, full medication name, dosage, route of administration, frequency, duration, specific indication for use, or date of medication order for the administrations of bacitracin documented in progress notes and wound care order. In addition, the wound care order did not identify the parameters included in the standing order for bacitracin limiting its use to seven days. Physician orders in R2's EHR did not include transcription of the specific standing order for bacitracin including the prescribing practitioner's name, medication name, dosage, route of administration, frequency, duration, indication for use, or date of medication order. On 5/7/25 at 10:10 a.m., R2 stated he accidentally burnt his middle finger four or five days ago. R2 stated staff looked at it that morning and they put some bacitracin and the Band-aid on it. The middle finger on R2's right hand had a Band-aid present. During an interview on 5/7/25 at 12:56 p.m., RN-C stated if a resident had a minor wound, it would be treated per nursing judgement with treatment orders written on the MAR for type of treatment and frequency. This would include identifying use of bacitracin and the type of dressing used. RN-C stated resident MARs typically included a physician order noting the facility's standing orders were okay to administer and would note exceptions, so she did not transcribe the individual orders into the EHR. If a resident had standing orders and a new medication from the list was administered, she would transcribe it onto the paper MAR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E116	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andrew Residence	1215 South 9th Street Minneapolis, MN 55404

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 1:48 p.m., the director of nursing (DON) stated the process for using standing orders included staff first checking a resident's MAR to see if it included an order directing it was okay to use facility standing orders. The DON stated wound care based on standing orders included bacitracin as an antibiotic as indicated by the type of concern. She noted this was not expected to be documented on the MAR but would be part of progress notes for wound treatment, including the type of ointment or bandaging and wound care provided. The DON confirmed bacitracin is an ordered medication and medications should be documented on the MAR. The DON was unable to articulate further explanation as to why the specific standing order for bacitracin administration was not transcribed onto the MAR but noted she saw the rationale and opportunity for changing this practice. The DON was not able to articulate how this aligned with professional standards of practice. The DON noted if a resident was transferred to a different facility it wouldn't be abundantly clear if bacitracin was being used on a wound. The DON confirmed the standing order for bacitracin included a seven-day time limit for use. When asked how staff were adhering to this parameter if they were not transcribing the order and documenting the administration she replied, they aren't. The DON noted it had been facility practice to refer to all medications in the standing orders collectively as the facility's standing orders within the physician orders in the EHR rather than transcribing individual orders upon utilization. She further noted in an emergency transfer, individual medications administered from standing orders would not be identified in the EHR physician orders and it was not facility practice to provide a copy of standing orders. The DON then noted for a standing order used for the first time, nurses needed to transcribe the order onto the paper MAR prior to administration. Facility policy titled Standing Medication and Treatment orders dated 5/18/22, indicated the orders were entered into the electronic medical record system as [Facility] Standing Orders O.K. Any standing medication and treatment order that was administered would be entered on the MAR individually if it was utilized. Facility policy titled Medication Orders: Communication and Transcription dated 10/13/23, indicated following specific procedures in transcribing medication orders would reduce the potential for medication error, which was the purpose of the policy. A complete medication order was identified to include the following elements: resident name, prescribing practitioner's name, medication name, dosage, route of administration, frequency, duration, indication for use, date of medication order. Facility policy titled PRN Medication Administration dated 4/13/09, indicated PRN medication orders would be filed in a resident's chart and documented on the MAR.

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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** 49338 Based on observation, interview, and document review, the facility failed to use appropriate personal protective equipment during high-contact cares for 1 of 1 resident (R1) reviewed with enhanced barrier precautions implemented. Findings include: Enhanced Barrier Precautions (EBPs): the use of personal protective equipment (PPE) including gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. R1's facesheet dated 5/7/25, indicated R1 had diagnoses including bladder disorder, urethral stricture (narrowing of urethra), benign prostatic hyperplasia (BPH, enlarged prostate), bladder neck obstruction, and overactive bladder. R1's annual Minimum Data Set (MDS) dated [DATE], indicated R1 had an indwelling catheter. R1's care plan dated 2/8/24, indicated R1 had altered urinary elimination related to urinary retention, BPH, urethral stricture with outlet obstruction requiring suprapubic catheter, and history of atonic bladder (weak bladder muscles). Interventions included: annual urinary assessment, suprapubic catheter care per medical provider instructions, labs and diagnostics per physician order, encourage limiting fluids and caffeine in the evening, provide incontinence pads as needed, instruct regarding proper disposal of soiled items and assist as needed, provide education about proper technique for emptying catheter bag, assessment by physician as needed, and instruct to notify staff if experiencing hematuria (blood in urine) or pain at catheter site. The care plan did not identify that EBPs were implemented for R1 due to his indwelling catheter. R1's Activities of Daily Living Documentation Record dated May 2025, instructed staff to shave R1's head and body with full staff assist twice monthly. Documentation noted R1's arms, pubic area, and buttock were shaved on 5/7/25. EBP signage on R1's door undated, indicated everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toilet use, when caring for or using devices, and when caring for wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/7/25 at 8:29 a.m., Mental Health Worker (MHW)-A stated she was a nursing assistant (NA) and trained medication aide (TMA). MHW-A stated she assisted R1 with shaving every Wednesday. MHW-A noted the EBP sign on R1's door (a room shared by three residents) was because R1 had a catheter. Outside of R1's door were drawers containing gowns, masks, and glasses but no gloves or hand sanitizer. MHW-A entered R1's room without completing observed hand hygiene or donning (putting on) PPE including gloves or gown, though had gloves with her along with shaving supplies. MHW-A noted there was hand sanitizer present on R1's bedside table at the far end of the room, with R1's bed the farthest from the door. MHW-A put gloves on once inside the room and proceeded to shave R1's inner thigh/pubic, buttock, and arm hair. Upon completion, MHW-A exited the room without completing hand hygiene and carrying soiled shaving supplies in her gloved hands down the hallway. During an interview on 5/7/25 at 9:07 a.m., MHW-A stated she had completed online training about EBPs and received information about EBPs at orientation. MHW-A stated all staff members should be taking those precautions and anyone providing direct care with a resident should wear gloves. She stated PPE needed for shaving R1 was definitely gloves but staff don't need to gown up or anything like that. MHW-A noted when shaving R1 earlier, she had used hand sanitizer and obtained gloves at the nursing station prior to walking to R1's room. She stated she didn't put on a gown when shaving him, I don't ever do that. When shaving him I clean my hands and use gloves. She stated she had not ever been told to put on a gown for shaving R1. During an interview on 5/7/25 at 1:48 p.m., the director of nursing (DON) stated the facility had a new infection preventionist starting tomorrow and she was currently assuming those responsibilities. The DON confirmed EBPs were needed for residents with indwelling devices, including suprapubic catheters. She noted staff needed hand hygiene, gloves, and a gown when providing direct care to residents and anyone providing high contact activities needed to adhere to EBPs. The DON confirmed staff needed to perform hand hygiene and wear gloves and a gown when shaving R1. The DON noted the risk of not doing so included MDROs and though R1 did not have an MDRO he was at an enhanced risk for infection due to his indwelling device. The DON stated EBPs should be part of the care plan for an indwelling device, and she would expect to see EBPs on the care plan. Facility policy titled Enhanced Barrier Precautions Policy dated 8/14/23, indicated EBPs would be implemented during high-contact resident care activities when caring for residents with an increased risk of acquiring an MDRO such as residents with wounds, indwelling medical devices, or residents infected or colonized with an MDRO. EBPs required gown and glove use for residents with indwelling medical devices during specific high-contact resident care activities including bathing/showering, device care or use, and providing hygiene cares. Indwelling medical devices included urinary catheters. In addition, an isolation care with PPE was to be immediately outside the resident room and alcohol-based hand sanitizer both inside and outside the resident room.