STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 West 31st Street Minneapolis, MN 55408

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 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 34083 Based on interview, the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect all residents in the facility who received personal mail, including but not limited to 2 of 2 residents (R4, R17) who verbally confirmed mail was not received on Saturdays. Finding include: Resident Council was held on 5/2/25 at 3:00 p.m., with R4 and R17 in attendance. When asked whether residents received their mail on Saturdays, R4 and R17 voiced mail that came on the weekend was not delivered until Monday when the medical records staff person returned to work. Interview on 5/2/24 at 8:51 a.m., with the medical records staff person reported mail was delivered to the facility six days per week including Saturdays, and she was responsible for delivery to the residents. She reported she did not work on the weekends and mail recieved on weekends was not delivered until Monday when she returned to work. Interview on 5/2/24 at 10:30 a.m. with the interim administrator reported his expectation for mail to be delivered six days per week. He reported he was not aware mail was not being delivered on Saturdays. He reported there was always staff at the facility and there was no reason a different person could not deliver mail received on Saturdays. A policy on mail delivery was requested, but not provided by the end of the survey period.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on interview and document review, the facility failed to notify the medical provider of on-going medication refusals for 1 of 1 resident (R14) reviewed for notification of change. Findings include: R14's quarterly Minimum Data Set, dated dated dated [DATE], identified R14 had short- and long-term memory problems and made moderately impaired decisions regarding tasks of daily life. R14 had hallucinations, delusions, inattention, disorganized thinking, and no rejections of care. R14 was independent with all ADLs. R14 had diagnoses of diabetes mellitus and schizophrenia. R14's Care Area Assessment (CAA) dated 11/3/23, dlirium triggered for inattention and disorganized thinking. The CAA identified the symptoms were not new and had abnormal blood sugar levels due to R14's refusal to take insulin. The CAA cognitive loss triggered due to refusal of cognitive assessment and staff indicating short and long-term memory loss, poor decision making, inattention, and disorganized thinking. The CAA indicated R14 received frequent reorientation, reassurance, reminders to help make sense of things, and redirection and cues for appropriate responses and better decisions. The CAA psychotropic drug use trigged for antipsychotic use and behavioral symptoms triggered related to rejection of care and noted behavior as worse. R14's cognition care plan revised 12/8/19, indicated R14 believed they had an allergy to insulin and listed interventions such as nursing will update doctor/Psychiatrist about any reports of increased delusions, ACP therapist periodic and/or as needed, medications per doctor/psychiatrist order, social services will follow up with resident as needed with delusional beliefs, staff to attempt to re-direct when delusions are bothering self and/or other residents, and staff to offer reality based support and reassurance to R14 when experiencing delusions. R14's other cognition care plan revised 4/8/24, identified R14 had a court commitment 11/16/23 through 5/22/24, and R14 had to follow up with primary care and psychiatry and take all prescribed medications including insulin. The care plan listed an intervention for resident services to contact appropriate case manager if there is a violation of the commitment or [NAME] order. Another cognition care plan regarding decision making skills revised 12/8/15, also listed R14 as refusing insulin. Interventions included 1:1 visits to re-direct and cue when making poor decisions as needed and as resident allows, and staff to petition for guardian if resident unable to make good decisions with assistance from staff, family, and case manager. R14's behavior care plan revised 11/22/22, identified R14 refused insulin and other diabetic medications since September 2015, doctor shopping to get one to agree with them, leaves appointments if provider attempts to challenge delusional beliefs, and takes insulin at hospital but chooses not to take medication when returns to facility. Interventions included house psychologist will see as needed and/or desired, medications per doctor order, nursing will monitor resident blood sugars per doctor order, and re-direct and cue resident. The potential for complications care plan revised 4/30/24, again identified R14 was noncompliant with insulin and blood sugar checks. Interventions included to administer medication as ordered, nursing to assess resident's resistance to treatment, nursing will encourage resident to express feelings and fears and clarify misunderstandings, nursing will involve doctor/family for continued refusals, and nursing will reiterate the purpose and advantages of treatment for the resident as appropriate to cognitive understanding. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's injection administration record (AR) identified insulin degludec subcutaneous solution 100 unit/mL with directions to inject 25 unit subcutaneously one time a day at 7 p.m. and start date of 12/20/23. The February AR identified administration until 2/24/24, which was marked with an indicator for Drug Refused. The March AR identified the injection was refused. The April AR identified the injection as refused throughout the month. The AR indicated to check R14's blood sugar three times a day with start date of 7/9/21. The February AR identified blood sugar levels until 2/26/24, which was marked as refused for the rest of the month. The March AR identified one blood sugar level of 87 on 3/3/24 for 8:00 a.m The April AR did not indicate a blood sugar level and marked as refused throughout the month. The injection AR identified insulin aspart flexpen solution pen-injector 100 unit/mL with directions to inject eight units subcutaneously three times a day and hold until after R14 ate if blood sugar was under 90 and had a start date of 12/20/23. The February AR identified blood sugar levels and administration until 2/25/24. The March AR identified R14 refused the medication throughout the month, and the April AR indicated refusals throughout the month. The injection AR identified insulin aspart penfil solution cartridge 100 unit/mL with sliding scale parameters and to inject subcutaneously three times a day and further directions for six units with meals plus coverage. The order had a start date of 10/20/22. The February AR identified consistent refusals started 2/26/24. The March AR identified refusals throughout the month. 3/24/24 identified a blood sugar of 222 and administration of one unit for 8:00 a.m The April AR identified refusals throughout the month. R14's blood sugar report dated 5/2/24, identified blood sugar levels multiple times a day until 2/25/24. 222 mg/dL was recorded on 3/24/24 at 9:02 a.m R14's facesheet dated 5/3/24, indicated nurse practitioner (NP)-A as R14's primary physician. A behavior note dated 2/25/24 at 9:38 a.m., indicated R14 started refusing insulin 2/24/24. Writer explained R14 had a [NAME] order and had to send R14 to hospital if they did not take their insulin. Writer called DON and R14's parents to notify them R14 was transported to HCMC. The progress note did not indicate a medical provider was notified. A physician visit/call note dated 2/25/24 at 8:28 p.m., indicated R14 returned from HCMC emergency room at approximately 4:15 p.m R14's blood sugar was checked before supper and was at 87. R14 refused insulin after eating and stated their feet were cold and squishy because of the insulin and was not taking insulin until they see a doctor. HCMC indicated labs were drawn and identified to follow up with primary care provider (PCP) from M Health Fairview Clinic. The progress note did not indicate a medical provider was notified. A behavior note dated 2/26/24 at 11:01 a.m., indicated R14 refused all diabetic cares. The registered nurse (RN) educated R14 about diabetes mellitus and possible outcomes and symptoms of refusing diabetic cares. The RN told R14 to notify staff if R14 was having symptoms of a diabetic emergency. The progress note did not indicate a medical provider was notified. A general condition note dated 3/8/24 at 7:16 p.m. and indicated R14 continued to decline insulin and blood glucose checks. The progress note did not indicate a medical provider was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note dated 3/12/24 at 5:42 p.m., indicated R14 continued to refuse blood sugar checks and insulin and did not indicate a medical provider was notified. A general condition note dated 3/26/24 at 4:40 p.m., indicated R14 declined blood sugar checks and insulin and did not indicate a medical provider was notified. A physician visit/call note dated 4/17/24 at 7:56 a.m., indicated R14 cancelled primary provider appointment for 5/20/24 and scheduled an appointment with a different provider for 6/10/24. A behavior note dated 4/23/24 at 12:53 p.m., indicated R14 complained of dizziness and lethargy and declined to have vitals taken. R14 stated the insulin made her feet spongy and was tired and ill feeling. R14 stated they had a psych appointment in June and would likely schedule an appointment with a physician after then. R14 was looking for a provider who would not endorse insulin or diagnosis of diabetes. R14 stated they would not take insulin again as it has caused their health problems. The note did not indicate a medical provider was notified. A behavior note on 4/28/24 at 12:58 p.m., indicated R14 refused insulin, and the note did not indicate a medical provider was notified. The After Visit Summary from HCMC emergency department dated 2/25/24, indicated R14 should follow up with primary care provider (PCP) from M Health Fairview Clinic, and the resident was seen for delusions and noncompliance with diabetes treatment. R14's blood sugar was 301 mg/dL. A Nursing Home Visit Encounter note dated 3/5/24, indicated R14 had no recent acute care stays, was on a commitment with mental health, required ongoing observation and support with diabetes, and in denial of diabetes and neuropathy. NP noted R14's blood sugars had been stable and tend to be a little hyper glycemic and ranged from 87 to 243. R14 had no new concerns. NP noted Northern Lights Health will take over primary care provider relationship going forward and would follow-up for routine check-up, or sooner if needed. NP would monitor patient and work with nursing staff to work towards positive patient outcomes. During interview on 4/30/24 at 1:48 p.m., nursing assistant (NA)-A stated when resident refused cares, they reapproach for a total of three attempts and then report to the director of nursing (DON) or someone else higher up. NA-A stated there were target behaviors in the application they charted in, and R14 had history of refusing insulin. NA-A stated R14 was more comfortable now with allowing NA-A to help with cares and conversing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/24 at 2:58 p.m., licensed practical nurse (LPN)-B stated when residents refused cares or medications, staff reapproached and sometimes staff had to approach in a different way to assist the resident to comply. Behaviors and refusals were charted in progress notes or under a behavior tab in their charting system. If residents refused psych medications, they notified the psychiatrist right away, so they knew what was happening and talk about refusals and behaviors in their stand-up meetings as well. Notifications and responses should be documented in progress notes. LPN-B stated R14 did not believe they were diabetic, got angry when staff spoke about R14's diagnosis, and fires every doctor. LPN-B stated R14 was sick and tried to get R14 to comply with diabetic medications. LPN-B stated R14 had the nurse practitioner (NP) as a provider, but NP would not prescribe R14 medications if they do not see R14. R14 needed to see a doctor every 60 to 90 days, and 3/5/24 was the last time NP saw R14. R14 was agreeing to take their insulin and have blood sugar checks as R14 was on a [NAME] commitment but then stopped when R14 believed the insulin made their feet mushy and cold. R14 was sent to the hospital when R14 stopped taking insulin, and the hospital sent R14 back to the facility and stated R14's [NAME] was not for insulin and only psychiatric medications and concerns. R14 stopped taking their insulin and blood sugars after they returned from the emergency room . LPN-B stated NP was aware of the insulin and blood sugar refusals. During observation on 5/2/24 at 8:19 a.m., R14 was sitting in the main dining area with beverages and breakfast. R14 was asked if their blood sugar could be checked, and R14 declined and stated the DON should have told you. During interview on 5/2/24 at 9:15 a.m., the NP stated they followed R14 every three months for compliance and started to see R14 around November 2023. The NP was aware R14 went back and forth with providers and would generally have residents choose which provider they wanted to visit. NP was at facility on Tuesdays and would attempt to see R14 three times per month. NP stated they send their after-visit notes to the facility's medical records employee. NP stated staff would either call them or place a note in their communication book if there were concerns with residents. NP stated staff should make them aware of refusals after a couple days and hadn't been notified R14 was not taking insulin or checking blood sugars. NP believed R14 had an order to send R14 to the hospital if they would not take their insulin, and R14 had a psychiatric issue which affected their health. NP stated they should have been notified to assist to develop a plan for R14's refusals. NP stated R14 was at risk for hyperglycemia, diabetic coma, and many systemic failures. NP reviewed their last visit note in March 2024, which did not note R14's insulin and blood sugar refusals. NP stated R14 had not been to the hospital since they started following R14 and would expect to be notified if R14 went to the hospital. NP reviewed R14's emergency room visit from February 2023 and stated they should know some of those things that are happening. During interview on 5/2/24 at 3:25 p.m., the DON expected staff to notify providers about changes with residents, such as medication and other refusals, as soon as possible. Not notifying the provider timely could affect residents' wellbeing, since residents were on their medications for a reason. During another interview on 5/2/24 at 5:54 p.m., the DON stated R14 did not have a primary provider at this time, since R14 tried to establish with one provider and then went to another. DON expected staff to speak with the medical director (MD) as back up when residents were between providers. DON believed MD was aware of R14 but had not consulted with R14. During follow-up interview on 5/2/24 at 6:14 p.m., the DON stated R14 did not give consent to be seen by anyone from Hennepin Health Care, which the MD was affiliated with. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/24 at 6:35 p.m., the MD was not aware of R14's consistent refusals of blood sugars and insulin and the multiple changes of providers. MD stated they would want to be notified of situations such as this to assist in finding a primary provider for the resident and figure out a solution for R14's medication refusals, such as suggestions for oral diabetic management. MD stated they did not know how severe R14's diabetes was but possible complications from chronically not taking diabetic medications were hyperglycemia, diabetic ketoacidosis (DKA; a complication of diabetes in which acids build up in the blood to levels which can be life-threatening), and hyperglycemic coma. The facility's policy Medication Refusal by Resident dated August 2023, directed staff to report to the ordering physician when medications refused for more than three days. The facility's policy Acute Change in Condition- Emergency Procedure dated August 2023, directed call the doctor if resident exhibited a sudden decrease in ability to care for self and if resident had a change in mental status or level of consciousness. Staff were to call the on-call doctor if unable to reach the primary physician. If the on-call doctor was not available, staff were to call the medical director. If the resident was in acute distress or lost consciousness, staff were to call 911.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34083 Based on interview and document review, the facility failed to ensure 2 of 2 residents (R47 and R 53)'s grievances were documented, responded to and resolved in a timely manner. Findings include: R47's 2/23/24 quarterly Minimum Data Set (MDS) assessment identified his cognition was intact, and he had behaviors which included hallucinations, delusions, and verbal behavior directed toward others. He had diagnoses which included Schizophrenia, major depressive disorder, dependent personality disorder, and obsessive compulsive disorder (OCD). R47 was independent with activities of daily living (ADLs), but needed redirection and cueing to correct daily routines. R47's current undated care plan identified target behaviors of hallucinations, thought blocking delusions, paranoia and disorganized thinking. Interventions included validation when he expressed delusional content, Associated Clinic of psychology (ACP) services weekly and as needed (PRN), 1:1 visits to allow R47 to vent his feelings. Medications as ordered, with monitoring for side effects and effectiveness. Observation/interview on 4/29/24 at 3:20 p.m. with R47 as he sat in a wheel chair facing the wall with the curtain divider pulled between the two beds. R47 verbalized acceptance to being interviewed, reported he was not concerned that his room mate was in the room, and was offered to use a different location. R47 began answering questions and reported he had no issues with other residents, felt safe, and had not been abused in any way. He then reported he was done and did not want to answer any more questions, laid back on his bed and closed his eyes. R53's 2/9/24 quarterly MDS identified his cognition was intact, he was independent with ADLS and had behaviors identified as hallucinations, delusions, and self isolation due to pain. He had diagnosis of Complex Regional pain syndrome (a chronic condition that causes severe, debilitating pain in an arm, hand, leg or foot after an injury), major depressive disorder, low back pain, anorexia, prediabetes, and history of suicidal ideations with no current plan. R53 was able to direct his own care and chose if he wanted to move around in the facility or remain in his room based on his level of pain. R53's current undated care plan identified psychotropic medication usage with Interdisciplinary Team (IDT) monitoring for effectiveness and any side effects to be completed quarterly and PRN. R53 reported he had an intrathecal pain pump (a surgically implanted device that delivers medication into the spinal fluid to treat chronic pain or spasticity). The device was managed by his pain clinic who provided maintenance and refilled the device. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/Interview on 4/29/24 at 3:40 p.m., with R53 who was lying on his bed with the divider curtain closed around his bed. The TV was on and R53 lowered volume and agreed to interview. During interview the TV on R53's side of the room, changed channels and the volume increased. R53's TV remote was lying on the bed beside him, and he was observed not touching the control. R53 reported this happened all the time, especially if R47 was upset with him and would change channels or adjust the volume with his control. R53 reported R47 liked to follow where ever he went and identified he had even recorded a previous incident when R47 was yelling and made allegation that R53 had beat on him. R53 reported he had asked R47 to clean up after himself in the bathroom after smearing BM all over the the toilet seat, and R47 had become upset and started yelling. He reported he had never touched R47 and would not do so. He stated he was fearful he would be in trouble due to R47 making allegations. R53 reported he had informed multiple staff (unable to identify who he had spoken with), about his concerns and had requested a room change, but no one had ever gotten back to him, or offered to file a grievance or report about his concerns. R53 also stated due to his physical condition he liked the room cooler, and R47 was always complaining the room was too cold. The temperature was observed set a 74 degrees, and R53 reported he had actually turned the thermostats up, to 74 but R47 was still not satisfied, and complained the room was to cold. Interview on 4/30/24 at 1:47 p.m. with LPN-B reported she was aware of the requirement for reporting of any abuse, or mistreatment and also the grievance process. She reported she was not aware of the verbal issues between R47 and R53 and would investigate further. She reported she was aware there had been some concern about cleanliness of the shared bathroom but the facility had hired a new cleaning service and she thought it would be better. LPN- reported she would also update the social worker and director of nursing of the concerns, but was not aware of any grievance forms completed by staff or residents. Interview on 4/30/24 at 2:47 p.m. with the licensed social worker (LICSW) reported resident room assignments were made dependent on bed availability and if any room changes were indicated. The LICSW reported if problems/concerns developed between room mates it was discussed at the interdisciplinary meeting (IDT) and work to make changes as they were able. She further reported it was difficult due to the number of residents and number of beds available. She reported she was aware of some conflict between R47 and R53, but had not provided a grievance form or offered to assist in completing one. Interview on 5/1/24 at 1:00 p.m., interview with R 53 reported licensed practical nurse (LPN)-B had come and spoke with him and either he or his room mate were going to be separated and he was glad about that. Stated following lunch he had placed his call light cord over the wall unit to enable him to reach it, and R47 had grabbed it and thrown it on the floor. He reported he told R47 he was not able to get it if it was on the floor. R53 reported when he went downstairs for his medication he had asked the nurse passing meds to talk with R47 about the call light and she had done so. R53 reported R47 had left the call light alone after that, but had been continuously complaining the room was too cold. Review of the 4/29/24 at 10:37 a.m., Progress notes identified R53 had talked about issues with his roommate, reported he followed him when he left his room, put on the same TV station and then turn up the volume. R53 reported he tried to ignore him, but R53 reported he thought R47 did those things just to aggravate him. R53 reported he liked his room and didn't want to move so he just tolerated R47. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/1/24 at 1:30 p.m. with the director of nursing (DON) reported she was aware the facility had a grievance policy, but was not aware of any grievances or concerns voiced between R47 and R53. She was not able to provide either a log of grievances or a policy which had been requested and was not provided.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure allegations of potential abuse were reported to the administrator and State Agency (SA) immediately, but not later than 2 hours after the allegation is made, for 1 of 1 residents (R45) reviewed for resident-to-resident verbal altercation. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderate impairment with tasks of daily life, fluctuating inattention behaviors, continuous disorganized thinking, and no altered level consciousness. R28's MDS indicated he was usually able to make himself understood and was able to understand others. MDS indicated R28 experienced hallucinations and delusions and displayed verbal behaviors directed towards others in addition to other behavioral symptoms not directed towards others. MDS indicated R28 did not have physical behavioral symptoms director towards others. R28's diagnoses included schizophrenia and anxiety. R28's Care Area Assessment (CAA) for communication dated 7/7/23, indicated R28 had loose associations and was being treated with medications for active delusional symptoms. R28's CAA for psychosocial well-being dated 7/7/23, indicated he had a long-standing diagnosis of schizophrenia and had been treated over the years for his symptoms, which had impacted his communication. The CAA indicated other disciplines were working with R28 for improvement with staff interventions in place to address his psychosocial well-being. R28's care plan dated 10/27/20, indicated tangential speech that did not make sense as evidence by R28 responding to internal stimuli and becoming paranoid over the TV/radio and believing he is being harassed. Interventions identified by the care plan included providing medications as ordered, redirection and cueing. The care plan also indicated R28 had verbally abusive behaviors and identified that he was short-tempered with staff peers, and strangers. The care plan identified behaviors such as cussing and yelling at other residents in R28's way. The care plan listed interventions of contacting a mobile crisis unit, administering medications as ordered, and updating his psychiatrist and case manager of behaviors. A progress note dated 3/27/24, indicated the interdisciplinary team (IDT) met to discuss R28's behaviors after peers complaints related to inappropriate comments and yelling to other residents. The progress note indicated staff needed to make attempts to redirect R28 when he was yelling or screaming at other residents. The progress note lacked documentation of any specific incident or if a grievance was offered or filed in relation to R28's behaviors. A progress note dated 4/3/24, indicated R28 had been very abusive towards staffs and other residents. He was at some point found using the 'N' word in the dining area. The progress note lacked indication of a grievance being offered or filed. (continued on next page)

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	24E166	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 West 31st Street Minneapolis, MN 55408

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service MDS progress note dated 4/3/24, indicated R28 had a history of aggressive behaviors towards other residents. The progress note indicated during a nurse interview, R28 was reported to be at his baseline and continued verbal aggression towards staff and residents. Furthermore, the progress note indicated during a nursing assistant (NA) interview R28 had been verbally aggressive towards certain residents. On 4/30/24 at 8:52 a.m., R28 was not available for interview. On 4/30/24 at 9:14 a.m., R28 was not available for interview. R45's admission MDS dated [DATE], indicated intact cognition with adequate hearing, the ability to make herself understood and to understand others. MDS indicated no hallucinations or delusions and no behavioral symptoms directed towards self or others. R45's diagnoses included anxiety, bipolar disorder, and post-traumatic stress disorder (PTSD, or a disorder that can bring back memories of a traumatic experience accompanied by intense emotional and physical reactions). R45's care plan lacked documentation of a focus, goal, and interventions to keep her safe from the potential for abuse, neglect and/or exploitation. A review of R45's progress notes did not reveal any documented complaints by R45. During interview on 4/29/24 at 4:53 p.m., R45 stated there was another resident who was verbally confrontational with her. R45 stated one resident, R28, made racist and sexist comments towards her. R45 stated R28 called her a black cunt bitch, and had used racial slurs, such as the N word, when referring to her and other residents of color. R45 stated she felt R28 was directing what he was saying towards her and other residents because of the racial and sexist connotations. She stated his words felt disrespectful and abusive. R45 stated she reported R28 to staff and felt they gave the name calling a go-pass and brushed it under the rug. She stated no staff had follow up with her, offered to file a grievance, or provided a phone number for her to make a formal complaint. R45 stated she brought this up on multiple occasions, including at her first care conference. She stated she felt hurt by R28's comments and it felt like a disservice to her. Additionally, she stated it did not feel fair that staff knew about the situation and had not done anything to protect her or the other residents. A care conference progress note dated 3/27/24, lacked documentation of complaints or reported behaviors by R45. During interview on 4/29/24 at 6:36 p.m., the administrator denied being aware of any complaints from R45 but stated that may be due to his short-term presence in the facility. The administrator stated if staff heard something like that, they would report it. The administrator stated R28 was always grumbling about something to everyone. He's just a grumpy old man. A review of Aspen Complaints/Incidents Tracking System (ACTS) on 4/30/24 at approximately 11:00 a.m., did not reveal reported events regarding R45's complaints. R45 declined further interview on 5/1/24 at 11:17 a.m., and on 5/2/24 at 11:29 a.m. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/24 at 1:30 p.m., the administrator stated some issues needed to be reported within 24 hours and other issues where there was no physical harm or altercation could be reported within five days. The administrator stated during a recent standup meeting, the team discussed that if in doubt, it would be better to over-report than to not report. The administrator verified other staff, including the director of nursing (DON), were aware of the incident prior to 4/29/24. The administrator stated the facility should take R45's complaints seriously, but after collaboration with the IDT, did not feel the resident-to-resident verbal altercation was reportable. The administrator stated LPN-B talked to R45 and provided reassurance and apologized. When asked to describe the investigation process, the administrator stated there was not a formal process until the team collaborated and decided if the incident was reportable or not. If the incident was deemed reportable, then the investigation would become more of a formal process. The administrator stated staff were really good about monitoring for potential or actual reported allegations of abuse by reviewing incidents from each resident throughout the shift and either reporting them or bringing them up during standup meetings. The administrator stated the DON was responsible for supervising and monitoring bedside care delivery. During interview on 4/30/24 at 2:15 p.m., activities staff (AS)-A verified becoming aware of R45's complaint about R28's verbal behaviors during her care conference. AS-A stated R45's complaint was what prompted the IDT meeting to address R28's behaviors and interventions. AS-A stated what was discussed would be shared under the communications tab in Point Click Care (PCC) and all staff should be checking that daily. Additionally, AS-A stated the information from the IDT meeting was shared during daily standup meetings and managers were responsible for sharing that information to their shift. AS-A stated the incident was addressed with R45 and R28's interventions were documented in his care plan. AS-A stated it was difficult to determine if R45's behavior changed after the incident since she was a newer admission to the facility. AS-A stated R28's baseline behavior was sitting in a general area and, making slurs about whoever is passing by. AS-A stated if a problem is brought to staff's attention, the first step is to get the full report either from a progress note or from a verbal report. AS-A stated most of the time it goes to social services (SS), who would determine if it was reportable. If the incident was reportable, SS would make the report. AS-A stated the most recent abuse identification, prevention, and reporting requirement training was completed last January. During interview on 4/30/24 at 2:52 p.m., NA-A stated R45 reported R28 made unprovoked racist comments towards her about a month ago and it really had her down. NA-A stated the incident was reported to the charge nurse on duty. NA-A was unaware of recent abuse training, but stated, if you see something, say something so things don't escalate beyond that. During interview on 4/30/24 at 3:26 p.m., LPN-B verified being aware of the incident and stated, I became aware of the situation because she came and told me after it happened. LPN-B stated, I did what I was supposed to do, and stated the incident was reported to SS during that morning's standup meeting. LPN-B stated if there were concerns for abuse, staff should never worry about being wrong and need to report incidents. LPN-B stated for instances with physical contact, a report needed to be made within 24 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/24 at 9:43 a.m., SS-A stated if there was serious injury, an event would need to be reported immediately or within an hour. If no serious injury occurred, it should be reported within 24 hours. SS-A stated the investigative process included gathering details, talking to the administrator and DON, and moving forward to report the event if it was deemed reportable. SS-A verified being aware of the incident involving R28 and R45 during risk management after R45's care conference. SS-A stated interventions were aimed at R28's behaviors and how staff should be attentive to him. SS-A stated R45's complaint was not documented in the care conference note nor was it brought up as a resident-specific complaint. SS-A stated R45's complaint was not reported because it was brought up as more as a general concern and not a resident-specific complaint. During interview on 5/1/24 at 1:17 p.m., LPN-A stated after gathering the details of a resident's complaint or concern, I would get social services involved. LPN-A stated most residents come to staff directly with concerns. During off-hours, if a resident had a complaint or concern, LPN-A stated the expectation was to document the issue in a progress note or in the communications tab in PCC under that specific resident. If the issue was urgent, LPN-A stated staff were expected to contact the on-call manager. If a resident complained about another resident making offensive comments, LPN-A stated, I would probably speak to both of them to determine what was going on, document that and then get SS involved. LPN-A stated incidents involving physical aggression needed to be reported within 24 hours but was unsure about other types of reportable events. During interview on 5/2/24 at 12:26 p.m., the DON stated when a resident had a complaint, staff should first determine if it involved a safety issue that needed to be addressed immediately. If not, the DON stated a grievance form could be filled out. The DON stated, when the grievance form is filled out, it can be discussed amongst the departments involved and we can resolve it. The DON stated the expectation was for staff to document what the situation was and what interventions were provided. The DON stated the key was to make sure the resident felt reassured even after reporting an incident, staff should ensure the resident received the help they needed and followed up. A facility policy titled Vulnerable Adult Information last updated 6/23/17, indicated the facility's objective was to assure protection of each resident from possible maltreatment. The policy indicated any situation where you have reason to believe a vulnerable adult is being or has been mistreated is a situation to report. Furthermore, the policy identified with any suspicion of a vulnerable adult incident a staff member shall inform their supervisor and/or charge nurse, the director of resident services, director of nursing, MDS coordinator, and/or therapeutic recreation director. Additionally, the policy directed staff to call [PHONE NUMBER] to make a verbal report. The policy also indicated staff should immediately make the initial report at the SA website and to the administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Vulnerable Adult/Resident Protection Plan dated 7/21/23, identified abuse as a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy indicated instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish and includes verbal abuse, sexual abuse, physical abuse and mantal abuse including abuse facilitated or enabled through the use of technology. Furthermore, the policy defined verbal abuse as the use or oral, written or gestured language that willfully includes disparaging and derogatory terms to resident and families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy indicated the purpose was to ensure all residents that live at the Birchwood Care Home (BCH) and Grand Avenue Rest Home (GARH) are protected from any and all abuse, neglect, misappropriate of resident property, exploitation, and harm in accordance with federal law and state statute that they maintain the highest practical physical, mental and psychosocial well-being of each resident. The policy indicated it was the policy of BCH and GARH that all reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to determine what happened. The policy advised the designated facility personnel will begin the investigation immediately. For an investigation of abuse, when an incident or suspected incident of abuse is reported, the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include the following key elements: a. Who was involved? b. resident statements - for non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview the resident first. If unable, observe the resident, complete an evaluation of resident behavior, affect and response to interaction and document findings. c. Resident's roommate statements, if possible. d. Involved staff and witness statements of events. e. A description of the resident's behavior and environment at the time of the incident. f. Injuries present. g. Observation of resident and staff behaviors during the investigation. h. Environmental considerations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy indicated the resident(s) will be protected from the alleged offender(s) and immediately upon receiving a report of abuse, neglect and/or harm, the administrator (or designee) will coordinate delivery of appropriate medical and/or psychological care as well as any attention needed to provide for the safety of other residents. The policy indicated the guidelines were to immediately remove the resident from the situation, examine and interview the resident to ensure proper documentation of any injury. If the resident could be at risk in the same environment, the policy indicated staff should evaluate the situation and consider some options including a room change, roommate change and/or risks of resident self-abuse. The policy indicated the resident and/or representative should be notified of the completion of the investigation and whether the incident was substantiated. Information would be provided according to the agency policy and guidelines. The policy identified that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source misappropriate of resident property) are reported per federal and state law and the facility will ensure that all alleged violations involving abuse are reported immediately. Employees will report the above examples immediately to their supervisor or person in charge and reports would be made to the administrator and other individuals as identified, including state agency in accordance with state and federal law. The policy includes reporting timelines for what to report, to whom, and when to report. The policy guides any covered individual (including the owner, operator, employee, manager, and agency or contractor of the facility) to report all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source or misappropriation of resident property to the facility administrator and to the other officials in accordance with State law, including the State Survey Agency (SA) and the adult protective services where state law provides jurisdiction in long-term care facilities. The policy indicated staff must report all alleged violations immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury or 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on observation, interview and document review, the facility failed to ensure allegations of resident-to-resident verbal abuse were thoroughly investigated, and protection provided for 1 of 1 residents (R45) who were involved in a resident-to-resident verbal altercation by R28. Findings include: R28's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderate impairment with tasks of daily life, fluctuating inattention behaviors, continuous disorganized thinking, and no altered level consciousness. R28's MDS indicated he was usually able to make himself understood and was able to understand others. MDS indicated R28 experienced hallucinations and delusions and displayed verbal behaviors directed towards others in addition to other behavioral symptoms not directed towards others. MDS indicated R28 did not have physical behavioral symptoms director towards others. R28's diagnoses included schizophrenia and anxiety. R28's Care Area Assessment (CAA) for communication dated 7/7/23, indicated R28 had loose associations and was being treated with medications for active delusional symptoms. R28's CAA for psychosocial well-being dated 7/7/23, indicated he had a long-standing diagnosis of schizophrenia and had been treated over the years for his symptoms, which had impacted his communication. The CAA indicated other disciplines were working with R28 for improvement with staff interventions in place to address his psychosocial well-being. R28's care plan dated 10/27/20, indicated tangential speech that did not make sense as evidence by R28 responding to internal stimuli and becoming paranoid over the TV/radio and believing he is being harassed. Interventions identified by the care plan included providing medications as ordered, redirection and cueing. The care plan also indicated R28 had verbally abusive behaviors and identified that he was short-tempered with staff peers, and strangers. The care plan identified behaviors such as cussing and yelling at other residents in R28's way. The care plan listed interventions of contacting a mobile crisis unit, administering medications as ordered, and updating his psychiatrist and case manager of behaviors. A progress note dated 3/27/24, indicated the interdisciplinary team (IDT) met to discuss R28's behaviors after peers complaints related to inappropriate comments and yelling to other residents. The progress note indicated staff needed to make attempts to redirect R28 when he was yelling or screaming at other residents. The progress note lacked documentation of any specific incident or if a grievance was offered or filed in relation to R28's behaviors. A progress note dated 4/3/24, indicated R28 had been very abusive towards staffs and other residents. He was at some point found using the 'N' word in the dining area. The progress note lacked indication of a grievance being offered or filed. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service MDS progress note dated 4/3/24, indicated R28 had a history of aggressive behaviors towards other residents. The progress note indicated during a nurse interview, R28 was reported to be as his baseline and continued verbal aggression towards toward staff and residents. Furthermore, the progress note indicated during a nursing assistant (NA) interview R28 had been verbally aggressive towards certain residents. On 4/30/24 at 8:52 a.m., R28 was not available for interview. On 4/30/24 at 9:14 a.m., R28 was not available for interview. During observation on 4/30/24 at 3:03 p.m., R28 walked down the hallway towards the smoking lounge. He used the handrail as he walked and was talking to himself out loud. When approached, R28 was mumbling to himself and was unable to be understood. He continued walking and went out into the smoking lounge to smoke a cigarette. At 3:13 p.m., R28 remained in the smoking lounge with his head down. During observation on 5/1/24 at 2:13 p.m., R28 was standing at the nurse's station, yelling through the glass at staff, where are my goddamn cigarettes? Unidentified staff told R28 they did not have his cigarettes. The administrator walked out of his office and followed R28 as he walked away from the nurse's station and through the dining area to the recreation room. The administrator asked R28 if there was something he needed help with. R28 walked away from the recreation room and into the bathroom. At 2:23 p.m., R28 walked back through the dining room without further verbal behaviors. R45's admission MDS dated [DATE], indicated intact cognition with adequate hearing, the ability to make herself understood and to understand others. MDS indicated no hallucinations or delusions and no behavioral symptoms directed towards self or others. R45's diagnoses included anxiety, bipolar disorder, and post-traumatic stress disorder (PTSD, or a disorder that can bring back memories of a traumatic experience accompanied by intense emotional and physical reactions). R45's care plan lacked documentation of a focus, goal, and interventions to keep her safe from the potential for abuse, neglect and/or exploitation. A review of R45's progress notes did not reveal any documented complaints or reported grievances by R45. During interview on 4/29/24 at 4:53 p.m., R45 stated there was another resident who was verbally confrontational with her. R45 stated one resident, R28, made racist and sexist comments towards her. R45 stated R28 called her a black cunt bitch, and had used racial slurs, such as the N word, when referring to her and other residents of color. R45 stated she felt R28 was directing what he was saying towards her and other residents because of the racial and sexist connotations. She stated his words felt disrespectful and abusive. R45 stated she reported R28 to staff and felt they gave the name calling a go-pass and brushed it under the rug. She stated no staff had follow up with her, offered to file a grievance, or provided a phone number for her to make a formal complaint. R45 stated she brought this up on multiple occasions, including at her first care conference. She stated she felt hurt by R28's comments and it felt like a disservice to her. Additionally, she stated it did not feel fair that staff knew about the situation and had not done anything to protect her or the other residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care conference progress note dated 3/27/24, lacked documentation of complaints or reported behaviors by R45. During interview on 4/29/24 at 6:36 p.m., the administrator denied being aware of any complaints from R45 but stated that may be due his short-term presence in the facility. The administrator stated if staff heard something like that, they would report it. The administrator stated R28 was always grumbling about something to everyone. He's just a grumpy old man. During interview on 4/30/24 at 1:18 p.m., R45 stated she was nervous about having reported the incident. R45 stated she feared getting into trouble because she was newer to the facility. R45 stated licensed practical nurse (LPN)-B spoke with her earlier about the incident and felt like LPN-B was trying to smooth it over. R45 declined further interview on 5/1/24 at 11:17 a.m., and on 5/2/24 at 11:29 a.m. During interview on 4/30/24 at 1:30 p.m., the administrator stated some issues needed to be reported within 24 hours and other issues where there was no physical harm or altercation could be reported within five days. The administrator stated during a recent standup meeting, the team discussed that if in doubt, it would be better to over-report than to not report. The administrator verified other staff were aware of the incident involving R28 and R45 prior to 4/29/24. The administrator acknowledged the facility should take R45's allegations seriously, but stated after collaboration with the IDT, determined it was not reportable. The administrator stated LPN-B talked to R45 and provided reassurance and apologized. When asked to describe the investigation process, the administrator stated there was not a formal process until the team collaborated and decided if the incident was reportable or not. If the incident was deemed reportable, then the investigation would become more of a formal process. The administrator stated staff were really good about monitoring for potential or actual reported allegations of abuse by reviewing incidents from each resident throughout the shift and either reporting them or bringing them up during standup meetings. The administrator identified interventions to protect R45 as watching R28, and stated, we all just watch R28. If I hear or see R28 having any interaction with someone, I'm watching him and others. We have to constantly watch all of the residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/30/24 at 2:15 p.m., activities staff (AS)-A verified becoming aware of R45's complaint about R28's verbal behaviors during her care conference. AS-A stated R45's complaint was what prompted the IDT meeting to address R28's behaviors and interventions. AS-A stated what was discussed would be shared under the communications tab in Point Click Care (PCC) and all staff should be checking that daily. Additionally, AS-A stated the information from the IDT meeting was shared during daily standup meetings and managers were responsible for sharing that information to their shift. AS-A stated the incident was addressed with R45 and R28's interventions were documented in his care plan. AS-A was unable to locate documentation of R45's allegations in her electronic health record (EHR). AS-A stated, R28 always escalates, and our decision was to verbally intervene but then he immediately went to the hospital, so we never got a chance to try out interventions. He just got back not too long ago so it might not seem to R45 like we've really done anything. AS-A stated it was difficult to determine if R45's behavior changed after the incident since she was a newer admission to the facility. AS-A stated R28's baseline behavior was sitting in a general area and, making slurs about whoever is passing by. AS-A stated if a problem is brought to staff's attention, the first step is to get the full report either from a progress note or from a verbal report. AS-A stated most of the time it goes to social services (SS), who would determine if it was reportable. If the incident was reportable, SS would make the report. AS-A stated the most recent abuse identification, prevention, and reporting requirement training was completed last January. During interview on 4/30/24 at 2:52 p.m., NA-A stated R45 reported R28 made unprovoked racist comments towards her about a month ago and it really had her down. NA-A stated the incident was reported to the charge nurse on duty, LPN-B. NA-A was unaware of recent abuse training, but stated, if you see something, say something so things don't escalate beyond that. During interview on 4/30/24 at 3:26 p.m., LPN-B verified being aware of the incident and stated, I became aware of the situation because she came and told me after it happened. LPN-B stated, I did what I was supposed to do, and stated the incident was communicated to SS during that morning's standup meeting. LPN-B verbalized be unsure if the incident was reported and stated, I just know that I told them. LPN-B stated if there were concerns for abuse, staff should never worry about being wrong and need to report incidents. LPN-B stated for instances with physical contact, a report needed to be made within 24 hours. LPN-B identified interventions to de-escalate R28's behaviors and stated, if we can't get him out of the area, we get other people out of the area to make sure everyone else is okay and safe. During interview on 5/1/24 at 9:43 a.m., SS-A stated if there was serious injury, an event would need to be reported immediately or within an hour. If no serious injury occurred, it should be reported within 24 hours. SS-A stated the investigative process included gathering details, talking to the administrator and DON, and moving forward to report the event if it was deemed reportable. SS-A verified being aware of the incident involving R28 and R45 during risk management after R45's care conference. SS-A stated interventions were aimed at R28's behaviors and how staff should be attentive to him. SS-A stated R45's complaint was not documented in the care conference note nor was it brought up as a resident-specific complaint. SS-A stated R45's complaint was not reported because it was brought up as more as a general concern and not a resident-specific complaint. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/24 at 1:17 p.m., LPN-A stated for grievances or complaints, I would get social services involved. LPN-A stated most residents come to staff directly with concerns. During off-hours, if a resident had a complaint or concern, LPN-A stated the expectation was to document the issue in a progress note or in the communications tab in PCC under that specific resident. If the issue was urgent, LPN-A stated staff would be expected to contact the on-call manager. If a resident complained about another resident making offensive comments, LPN-A stated, I would probably speak to both of them to determine what was going on, document that and then get SS involved. LPN-A stated incidents involving physical aggression needed to be reported within 24 hours but was unsure about other types of reportable events. During interview on 5/2/24 at 12:26 p.m., the DON stated the grievance process was to get the complaint, fill out the grievance form and if it needed to be addressed immediately, we would want to address that immediately. The DON stated, when the grievance form is filled out, it can be discussed amongst the departments involved and we can resolve it. The DON stated the expectation was for staff to document what the situation was and what interventions were provided. The DON stated the key was to make sure the resident felt reassured even after reporting an incident, staff should ensure the resident received the help they needed and followed up. During interview on 5/2/24 at 3:25 p.m., SS-A stated there was an anonymous box in the hallway with papers that were always stocked for residents to make grievances or formal complaints. SS-A stated residents were reminded of this during resident council. SS-A stated residents can either file a grievance or speak to SS directly. SS-A stated when a grievance form was received, it was reviewed and distributed to the related department. SS-A stated the department manager was responsible for proposing a resolution and after review by the team, it was proposed to the resident for approval. If the resident felt the resolution was an appropriate solution to the problem, it would then go to the administrator for implementation. SS-A stated the process for anonymous grievances would be the same without the review process by the resident. SS-A stated if the grievance was related to an abuse claim, it would be discussed in IDT and brought to the administrator and DON to discuss the next actions. A facility policy titled Vulnerable Adult Information last updated 6/23/17, indicated the facility's objective was to assure protection of each resident from possible maltreatment. The policy indicated any situation where you have reason to believe a vulnerable adult is being or has been mistreated is a situation to report. Furthermore, the policy identified with any suspicion of a vulnerable adult incident a staff member shall inform their supervisor and/or charge nurse, the director of resident services, director of nursing, MDS coordinator, and/or therapeutic recreation director. Additionally, the policy directed staff to call [PHONE NUMBER] to make a verbal report. The policy also indicated staff should immediately make the initial report at the SA website and to the administrator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Vulnerable Adult/Resident Protection Plan dated 7/21/23, identified abuse as a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy indicated instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish and includes verbal abuse, sexual abuse, physical abuse and mantal abuse including abuse facilitated or enabled through the use of technology. Furthermore, the policy defined verbal abuse as the use or oral, written or gestured language that willfully includes disparaging and derogatory terms to resident and families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. The policy indicated the purpose was to ensure all residents that live at the Birchwood Care Home (BCH) and Grand Avenue Rest Home (GARH) are protected from any and all abuse, neglect, misappropriate of resident property, exploitation, and harm in accordance with federal law and state statute that they maintain the highest practical physical, mental and psychosocial well-being of each resident. The policy indicated it was the policy of BCH and GARH that all reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to determine what happened. The policy advised the designated facility personnel will begin the investigation immediately. For an investigation of abuse, when an incident or suspected incident of abuse is reported, the administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include the following key elements: a. Who was involved? b. resident statements - for non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview the resident first. If unable, observe the resident, complete an evaluation of resident behavior, affect and response to interaction and document findings. c. Resident's roommate statements, if possible. d. Involved staff and witness statements of events. e. A description of the resident's behavior and environment at the time of the incident. f. Injuries present. g. Observation of resident and staff behaviors during the investigation. h. Environmental considerations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy indicated the resident(s) will be protected from the alleged offender(s) and immediately upon receiving a report of abuse, neglect and/or harm, the administrator (or designee) will coordinate delivery of appropriate medical and/or psychological care as well as any attention needed to provide for the safety of other residents. The policy indicated the guidelines were to immediately remove the resident from the situation, examine and interview the resident to ensure proper documentation of any injury. If the resident could be at risk in the same environment, the policy indicated staff should evaluate the situation and consider some options including a room change, roommate change and/or risks of resident self-abuse. The policy indicated the resident and/or representative should be notified of the completion of the investigation and whether the incident was substantiated. Information would be provided according to the agency policy and guidelines. The policy identified that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source misappropriate of resident property) are reported per federal and state law and the facility will ensure that all alleged violations involving abuse are reported immediately. Employees will report the above examples immediately to their supervisor or person in charge and reports would be made to the administrator and other individuals as identified, including state agency in accordance with state and federal law. The policy includes reporting timelines for what to report, to whom, and when to report. The policy guides any covered individual (including the owner, operator, employee, manager, and agency or contractor of the facility) to report all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source or misappropriation of resident property to the facility administrator and to the other officials in accordance with State law, including the State Survey Agency (SA) and the adult protective services where state law provides jurisdiction in long-term care facilities. The policy indicated staff must report all alleged violations immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury or 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect a resident's diagnosis of post traumatic stress disorder (PTSD) (a mental health condition triggered by a traumatic event) for 2 of 2 residents (R57, R14) reviewed for MDS accuracy. Findings include: The resident assessment instrument (RAI) manual version 3.0 indicated under section I, Active Diagnoses, the items in this section were intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. Section I in the RAI manual further indicated definitions of active diagnoses were physician documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7 day look back period. For the assessment, there are two look back periods: 1. Diagnosis identification is a 60 day look back period and 2. Diagnosis status: active or inactive is a 7 day look back period. The disease conditions in this section require a physician documented diagnosis or by a nurse practitioner, physician assistant, or clinical nurse specialist in the last 60 days. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis, problem list, and other resources as available. If a diagnosis problem list is used, only diagnoses confirmed by the physician should be entered. Further, the RAI indicated once a diagnosis was identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7 day look back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7 day look back period as these would be considered inactive diagnoses. Further, the following information sources in the medical record for the past 7 days is checked to identify active diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available. R57's admission MDS dated [DATE], indicated moderate cognitive impairment, had bipolar disorder, factitious disorder, and depression. Further, the MDS under section I, I6100, lacked a check mark indicating R57 had PTSD. R57's quarterly MDS dated [DATE], indicated R57 had intact cognition, had bipolar disorder, manic depression, and under section I, I6100, lacked a check mark indicating R57 had PTSD. R57's psychiatric evaluation and management note dated 12/9/23, indicated R57 had bipolar disorder, PTSD, factitious disorder, and unspecified neurocognitive disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R57's physician progress notes dated 12/10/23, from the hospital referral on page 33 of 103 indicated R57 had neurocognitive disorder, bipolar disorder, PTSD. The note further indicated R57 had bipolar disorder and PTSD with recent discharge and rehospitalization . R57's hospital progress notes dated 12/12/23, and signed by the physician on page 8 of 103, indicated R57 had bipolar disorder, PTSD, and factitious disorder. R57's Level II Preadmission Screening (PAS) for Persons with Mental Illness Determination for Nursing Facility Admission form dated 12/27/23, indicated a physician recommended nursing facility level of care for R57. The form further indicated R57 had current mental health diagnoses of bipolar disorder and PTSD and was receiving psychiatry services. R57's Adult Crisis Assessment social worker note dated 3/22/24, indicated the assessment was requested to assess safety, provide diagnosis, and appropriate referral. Further, the note indicated a provisional diagnosis of PTSD based on the brief crisis assessment, as well as reported by R57, and a historical diagnosis per review of records. Additionally, the note indicated R57 endorsed, displayed, or was reported to have the following symptoms: isolating self, outbursts of anger, easily startled, trouble with sleep, low energy, body or muscles tense, being on guard or constantly alert, and feeling short of breath, excessive worry, feeling restless, poor concentration, increased irritability, racing thoughts, feeling on the verge of losing control, and feared not being able to move to a more safe place to live. R57's goals were to continue to see and talk with his psychiatrist and take prescribed medications. R57's care plan dated 3/25/24, indicated R57 was short tempered, easily annoyed, emotionally labile, argumentative, irritable and impulsive and had neurocognitive disorder, bipolar, and PTSD. R57's Associated Clinic of Psychology (ACP) noted dated 4/23/24, indicated R57 had bipolar disorder, and PTSD. R57's medication administration record (MAR) dated May 2024, indicated the following diagnoses: bipolar disorder, PTSD. R57's Face Sheet indicated the following diagnoses: bipolar disorder with a date of onset on 1/5/24, PTSD with a date of onset on 1/5/24, factitious disorder with a date of onset 1/5/24, and depression with a date of onset on 12/22/23. During interview on 5/2/24 at 10:43 a.m., registered nurse (RN)-B stated she completed the MDS including section I and stated she utilized the form Medical Diagnosis, in the electronic medical record (EMR) to determine diagnoses for the MDS and stated R57 had bipolar disorder, PTSD, and factitious disorder. RN-B further stated only the diagnoses that were being treated or had ordered to treat such as medications or treatments were incorporated on the MDS and stated R57 has PTSD, but was not being treated for it and further stated PTSD was something the facility could care plan such as what the symptoms were and further stated they were not aware what R57's trauma was, but would be important to know if there were triggers. During interview on 5/2/24 at 9:52 a.m., social worker (SW)-A stated R57 had PTSD. 48299 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14 R14's annual Minimum Data Set (MDS) dated [DATE], indicated R14 had short- and long-term memory problems and made moderately impaired decisions regarding tasks of daily life. R14 had diagnoses of schizophrenia and depression. Further, the MDS under section I, I6100, lacked a check mark indicating R14 had post-traumatic stress disorder (PTSD). R14's quarterly MDS dated [DATE], indicated R14 had short- and long-term memory problems and made moderately impaired decisions regarding tasks of daily life. R14 had diagnosis of schizophrenia. Further, the MDS under section I, I6100, lacked a check mark indicating R14 had PTSD. R14's cognition care plan related to psychosis and delusions and behavioral care plan related to delusions revised 12/8/19, indicated R14 had schizophrenia, PTSD, major depressive disorder and was actively delusional on a daily basis. R14's annual social service MDS documentation dated 8/18/23 at 3:01 p.m., indicated R14 had diagnoses of schizophrenia, PTSD, major depressive disorder and was actively delusional on a daily basis. A Nursing Home Visit Encounter with R14's nurse practitioner dated 3/5/24, indicated R14 had schizophrenia, PTSD, major depressive disorder, among other diagnoses. R14's Face Sheet indicated the following diagnoses: schizophrenia with a date of onset on 8/19/15, major depressive disorder with a date of onset on 8/19/15, PTSD with a date of onset on 8/19/15, among other diagnoses. During interview on 4/30/24 at 1:48 p.m., nursing assistant (NA)-A stated their charting identified triggers and behaviors for residents. NA-A reviewed R14's target behaviors were refusing insulin and carrying belongings. NA-A reviewed R14 had no information on triggers of trauma. NA-A stated R14 believed people were trying to do things to them like poison them. NA-A stated R14 was more comfortable with them now and allowed NA-A to help with cares when needed compared to when NA-A was a newer employee. During interview on 4/30/24 at 2:58 p.m., registered nurse (RN)-C stated staff gave each other report between shifts on resident behavior and interventions completed in response. Besides report, the medical record had a communications area where they could record such information. RN-C stated care plans showed behavior plans for residents. During same interview on 4/30/24 at 2:58 p.m., licensed practical nurse (LPN)-B stated they believed R14 was abused and spoke about someone stalking them and was frightened and jumpy at times thinking someone was watching them. LPN-B stated residents had care plans related to trauma if they were open enough to talk about it, or residents' care plans reflected staff observations. LPN-B said the social work or MDS nurse completed trauma-based assessments. During interview on 5/2/24 at 9:53 a.m., the social worker (SW)-A stated R57 had PTSD. SW-A reviewed the care plan and stated R14 did not have specific information related to PTSD like triggers. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/24 at 10:43 a.m., RN-B stated they completed the MDS including section I and utilized the form Medical Diagnosis, in the electronic medical record (EMR) to determine diagnoses for the MDS and stated R14 had schizophrenia, PTSD, major depressive disorder, among others. RN-B further stated only the diagnoses being treated or had orders to treat, such as medications or treatments, were incorporated on the MDS and stated R14 had PTSD but was not being treated for it and further stated PTSD was something the facility could care plan, such as what the symptoms and triggers were. During interview on 5/2/24 at 3:05 p.m., the director of nursing stated they expected PTSD diagnosis to be included on the MDS and expected staff to look at all the notes for diagnoses and stated it was important to have an accurate MDS in order to know what they are treating and managing. A policy, Interdepartmental MDS Review, dated August 2023, indicated each resident's MDS would be completed on admission, quarterly, annually, and significant change using current, accurate documentation and assessments specific to that resident. The interdisciplinary team (IDT) would review and discuss each resident during the 7 days assessment period and provide information, documentation and assessments they have from the prospective of their area of expertise. Discussions and evaluations of each resident were done for the purpose of identifying possible areas of conflict of information and to ensure accuracy of the completion of the MDS. The IDT will review the reports prepared by the resident's physicians, house psychologist and all other sources available to determine what and how the information will be used in the MDS process. Further, nursing was responsible for completion of section I of the MDS plus care area assessments triggered.

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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** 49617 Based on interview and document review, the facility failed to develop a comprehensive care plan for psychotropic medications for 1 of 5 residents (R56) reviewed for psychotropic medications. Findings include: R56's admission Minimum Data Set (MDS) dated [DATE], indicated R56 had intact cognition and experienced hallucinations. MDS indicated R56 had diagnoses of diabetes, depression, and a psychotic disorder other than schizophrenia. MDS indicated R56 received an antipsychotic on a routine basis and an antidepressant medication. R56's Care Area Assessment (CAA) dated 2/14/24, for psychotropic drug use indicated R56 had mental illness diagnoses and was being treated with long-term psychotropic medications. The CAA further indicated staff would follow the plan of care to maintain R56's current level of functioning for improvement with symptom relief. R56's physician orders included the following: - Olanzapine (Zyprexa) oral tablet 7.5 milligrams (mg), Give 1 tablet orally at bedtime to treat psychotic depressive illness, dated 2/8/24. - Mirtazapine (Remeron) oral tablet 15mg, Give 1 tablet by mouth at bedtime to treat depression, dated 2/8/24. R56's care plan dated 2/8/24, indicated he had antipsychotic use and had target symptoms but lacked documentation of what antipsychotic medication was being used and lacked resident-specific target symptoms or behaviors to monitor. Interventions included staff will use non-pharmacologic interventions but lacked documentation of resident-specific non-pharmacologic interventions. Furthermore, R56's care plan lacked documentation of his antidepressant use and resident-specific target symptoms related to antidepressant use as well as related interventions. The care plan identified R56 had suicidal ideation with hospitalization and identified interventions of providing 1:1 visits with resident as needed, assisting resident to make a No Harm Contract, visiting an in-house therapist, medications as ordered, and updating the provider of increased suicidal ideation and/or plans. The care plan also identified R56's psychotropic drug use but lacked resident-specific medications and lacked documentation of resident-specific target symptoms to monitor. During interview on 5/2/24 at 12:34 p.m., the director of nursing (DON) stated the social services department was responsible for updating the care plan with the behavioral aspect of psychotropic medications. The DON stated expectations for residents on psychotropic medications were to see target behaviors and interventions in the care plan. The DON verified R56's care plan lacked resident-specific symptoms and interventions. Additionally, the DON expected R56's antidepressant medication to be identified in his care plan but verified it was not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/24 at 3:33 p.m., social services (SS)-A stated the process for monitoring psychotropic medications and related symptoms and behaviors was to review notes to determine what the medications were and what the symptoms were. SS-A stated for a new admission, it might take some time to develop resident-specific non-pharmacologic interventions because it is an interdisciplinary approach, and the ideas could come from nursing staff, providers, or therapists. SS-A stated the expectation was resident-specific symptoms and interventions should be documented in a resident's care plan if they were taking psychotropic medications. SS-A verified R56's care plan lacked resident-specific interventions and stated, his care plan was not completed. A psychotropic drug use policy was requested but not received.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure appropriate interventions, as a result of multiple falls and comorbidities contributing to the risk of additional falls, were identified and implemented for 1 of 2 residents (R2) reviewed for accidents, hazards and supervision. Findings include: R2's Face Sheet form indicated the following diagnoses: paranoid schizophrenia, end stage renal disease, hypokalemia (low potassium), bilateral myopia (difficulty in focusing on objects that are far away), presbyopia (the loss of your eyes ability to focus on nearby objects), hypertension, and osteoarthritis. R2's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, had hallucinations and delusions, did not reject care, had a cane or crutch and a walker, did not have impairment in range of motion, was independent with activities of daily living (ADLs), was occasionally incontinent of bladder, had two or more falls without injury since the previous assessment, took antipsychotics, antidepressants, diuretics, and antiplatelet medications. Additionally, the MDS indicated R2's vision was adequate with glasses or other visual appliances and used corrective lenses. R2's physician orders indicated the following order: 11/29/23, ok to try four wheeled walker with bench needs to balance personal items and maybe a safer option. R2's care plan dated 3/28/24, indicated R2 was at risk for falling due to a history of falling, and medications. R2 fell downstairs and fractured his rib and fingers on 8/15/23, and on 12/13/23, R2 fell on the stairs due to the elevator out of service and R2 decided to use the stairs, on 1/8/24 R2 sat down and missed the chair and on 1/14/24 R2 fell in his room and was unable to explain what happened. Interventions included nursing to check orthostatic blood pressures, educate resident to slow down when walking on ice and watch walking carefully for safe foot placement, encourage resident to avoid icy sidewalks, encourage resident to stay in when icy and snowing. R2's nursing assistant caresheet indicated R2 was independent, anticipate needs, had dentures and check for a cup and required supervision to follow through. The caresheet lacked information how R2 ambulated, or making sure room was free from clutter and crowding. R2's Incident report dated 8/14/23, indicated R2 fell on the floor by the stairway because his shoe got stuck on the steps. Interdisciplinary team (IDT) met and interventions to be put in place to minimize risks of injury included R2 should use the elevator when going from floor to floor for safety. R2's Incident Audit report dated 12/10/23, indicated R2 fell utilizing the stairs when he lost his footing. (continued on next page)

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	24E166	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 West 31st Street Minneapolis, MN 55408

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Fall report dated 12/10/23, indicated R2 was sitting on the main stairs inside the building at approximately 12:00 p.m. Additionally, the report indicated R2 did not have any injuries, and under the heading, Predisposing Environmental Factors, indicated Other, however no additional information was documented on the predisposing environmental factor. R2's Incident Audit report dated 1/8/24, indicated R2 went to sit down and missed the chair due to being in a hurry and IDT met and determined staff would continue with education on watching when R2 sat down to feel the chair was behind him and reminders to sit down slowly, staff to continue to encourage use of the elevator when moving from floor to floor. R2's Incident Audit report dated 1/14/24, indicated R2 was found on the floor between the bed and the dresser and did not know why he fell . Additionally, there was crowding under predisposing environmental factors and the note indicated there was a lot of stuff in R2's room between the bed and dresser. IDT met regarding the incident and R2's fall was likely related to increased potassium level and staff were to continue using the elevator and provide education on diet and foods to avoid. R2's progress note dated 12/15/23 at 1:56 p.m., indicated R2 had two falls in the past three months related to using the stairs when ambulating between floors and the first incident R2 was sent to the ER and found to have a fractured rib and fingers and was instructed to only use the elevator. R2 fell a second time using the stairs when the elevator was out of service and the second incident did not result in any injury. R2 was advised to only use the elevator and if it was out of service R2 should request staff to assist him. R2's progress note dated 1/14/24 at 11:02 a.m., indicated R2 was found lying on his right side leaning forward between his dresser and his bed and his glasses frame was broken but did not remember what happened or why he fell . R2's progress note dated 1/16/24 at 11:21 a.m., indicated R2 was admitted to the hospital for an elevated potassium and potassium levels were improving. R2's progress note dated 3/27/24 at 9:57 a.m., indicated R2 was at moderate risk for falls related to medications, falls, and incontinence. During observation on 4/30/24 at 2:21 p.m., R2's room was dark, there was a small path between the bed and television night stand. R2 had a chair with clothes on top of it along with a cane and a seated walker was located towards the middle bed. There was a water gallon on the floor towards the head of the bed and a bag located on the floor. R2 entered the room and ambulated into the bathroom without his walker. During interview on 5/1/24 at 11:36 a.m., nursing assistant (NA)-A stated she relied on information in the electronic medical record to know what cares a resident required along with just seeing a resident and if a resident asked for help. NA-A stated R2 did not refuse cares and stated the only time she recalled R2 refuse was when he was too tired to come down for breakfast. NA-A stated R2 was mostly independent and had fallen a couple of months ago and was alerted by R2's room mate that R2 had fallen. NA-A stated R2 was reaching for his cigarettes and fell on the side of his head and it happened in his room. NA-A stated the paramedics came and stated everything in R2's room is close together, stating the bed and the chair were close together and then had the walker and had to bend over to pick up his cigarettes and was a lot in that small of a space. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/24 at 12:07 p.m., NA-A stated R2 was supposed to have a walker. During interview on 5/2/24 between 8:33 a.m., and 8:55 a.m., licensed practical nurse (LPN)-A stated she looked at the care plan or the nursing assistant worksheets to know what kind of cares a resident required. LPN-A stated when a resident falls, the emergency contact, director of nursing (DON), administrator, and provider is contacted and a risk management and progress note is completed. LPN-A stated the risk management report asks nursing the description of the environment and what could contribute and interventions started after the fall and injury. LPN-A further stated the care plan should be updated but was not a protocol discussed. LPN-A stated she recalled R2 falling and stated R2 had three risk management reports. LPN-A viewed the fall report on 1/14/24 and stated R2 fell between the bed and dresser and factors related was crowding with a lot of stuff in between the bed and dresser and no new interventions were added. At 8:55 a.m., LPN-A went up to R2's room and verified R2 had a bag and water, a box, books and various items located on the floor and R2's walker was located by the middle bed in the room, R2's bed was located by the door to the hall. LPN-A stated R2's walker was in reach and stated R2 was at risk for falls because his pathway between the bed and the chair was so cluttered. During interview on 5/2/24 at 3:19 p.m., the director of nursing (DON) stated the nurse assesses the resident after a fall and based on the situation would be sent and the physician, family, DON, administrator would be notified and the risk assessment would be completed and the root cause is determined and interventions are put in place. The DON further stated she expected the care plan be updated and implemented because it was important for resident safety and to prevent further occurrence. During interview on 5/2/24 at 3:31 p.m., registered nurse (RN)-B stated care plans were updated during a resident's assessment period with the MDS assessment. RN-B further stated fall risk scores were populated before a care conference and stated it did not look like the elevator reminder was added to the care plan and planned to do so and further stated it should be on the care plan to keep R2's room free from clutter and stated the crowding was never discussed and the room environment wasn't taken into account in the falls risk score. A policy, Fall Management Policy, dated 7/3/23, indicated the purpose of the policy was to ensure that the resident environment remains as free of accident hazards as possible and each resident is assessed for fall risk and have preventative measures in place that maintain the resident's highest level of independence.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to comprehensively assess for and identify potential triggers to avoid re-traumatization for 2 of 2 residents (R57, R14) who had a history of trauma. Findings include: R57's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, had moderate depression symptoms, sometimes socially isolated, had verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed at others such as physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds 1 to 3 days of the previous 7 days. The MDS indicated R57 had delusions and further, rejected care, was independent with most activities of daily living (ADLs) had bipolar disorder, and manic depression. R57's Medical Diagnosis form dated 1/5/24, indicated R57 had post traumatic stress disorder (PTSD) (a mental health condition triggered by a traumatic event). R57's psychiatric evaluation and management note dated 12/9/23, indicated R57 had bipolar disorder, PTSD, factitious disorder, and unspecified neurocognitive disorder. R57's physician progress notes dated 12/10/23, from the hospital referral on page 33 of 103 indicated R57 had neurocognitive disorder, bipolar disorder, PTSD. The note further indicated R57 had bipolar disorder and PTSD with recent discharge and rehospitalization . R57's hospital progress notes dated 12/12/23, and signed by the physician on page 8 of 103, indicated R57 had bipolar disorder, PTSD, and factitious disorder. R57's Level II Preadmission Screening (PAS) for Persons with Mental Illness Determination for Nursing Facility Admission form dated 12/27/23, indicated a physician recommended nursing facility level of care for R57. The form further indicated R57 had current mental health diagnoses of bipolar disorder and PTSD and was receiving psychiatry services. R57's Adult Crisis Assessment social worker note dated 3/22/24, indicated the assessment was requested to assess safety, provide diagnosis, and appropriate referral. Further, the note indicated a provisional diagnosis of PTSD based on the brief crisis assessment, as well as reported by R57, and a historical diagnosis per review of records. Additionally, the note indicated R57 endorsed, displayed, or was reported to have the following symptoms: isolating self, outbursts of anger, easily startled, trouble with sleep, low energy, body or muscles tense, being on guard or constantly alert, and feeling short of breath, excessive worry, feeling restless, poor concentration, increased irritability, racing thoughts, feeling on the verge of losing control, and feared not being able to move to a more safe place to live. R57's goals were to continue to see and talk with his psychiatrist and take prescribed medications. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R57's care plan dated 3/25/24 indicated R57 was short tempered, easily annoyed, emotionally labile, argumentative, irritable and impulsive and had diagnoses of PTSD, bipolar, and neurocognitive disorder and included interventions for an in house therapist to visit weekly, nursing would medicate per physician orders, and nursing to notify the psychiatrist with increased anger with self and or others. The care plan was reviewed and lacked information identifying R57's PTSD triggers. R57's medical record lacked evidence of an assessment for PTSD triggers. R57's care area assessment (CAA) dated 1/3/24, identified psychosocial wellbeing, mood, cognition, psychotropic drug use, behavioral symptoms, however lacked information regarding PTSD triggers. During interview on 4/29/24 between 4:04 p.m., and 4:16 p.m., R57 stated he felt overloaded with information regarding forms for going to another facility. Additionally, R57 stated he did not like the overhead intercom because it startled him and stated the noise emitted was a very loud beeping noise. During interview on 5/1/24 at 1:23 p.m., R57 stated he heard the city tornado alarm test going off this afternoon and it startled him. During interview on 5/2/24 at 9:06 a.m., maintenance (M)-A stated the overhead intercom system was loud and could startle people. M-A further stated the overhead intercom was loud for residents to hear it and verified it sounded louder because of the small space and stated it would help if the staff who used the intercom knew how to use the speaker because they push the button which makes a beeping noise which may startle somebody. M-A verified the speaker for the intercom was located two doors from the speaker. During interview on 5/2/24 at 9:52 a.m., social worker (SW)-A stated if a resident had a specific trauma, it was care planned and the facility would care plan for any triggers or flashbacks in order to try to avoid a trigger. SW-A further stated they used the associated clinic of psychology (ACP) weekly and further stated PTSD should be care planned and if a resident with PTSD startled easily would be interviewed to identify the triggers and care plan accordingly. SW-A verified R57 had PTSD and verified R57 has not had an assessment that identified and assessed triggers for his PTSD and verified it was up to the facility to assess him for PTSD and triggers. During interview on 5/2/24 at 10:43 a.m., registered nurse (RN)-B stated R57 had PTSD and bipolar disorder and stated she did not do any assessments for PTSD and stated all of that was done via the provider and further stated she would possibly expect a resident with a history of PTSD to be assessed for triggers however it would not be within her scope. RN-B further stated it would be up to social services to add a care plan and verified there was no specific care plan related to PTSD triggers and added they were not aware what the trauma was for R57 and stated it would be important if there were triggers or behaviors and added R57 was short tempered and stated the intercom was used to announce everything such as phone calls, medication times and stated it was used multiple times throughout the day. During interview on 5/2/24 at 10:56 a.m., the director of nursing stated she expected staff know R57's triggers to manage the situation. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Trauma Informed Care, dated 12/20/22, indicated it was the policy of the facility that all residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with residents' preferences and experiences. Residents who display and or are diagnosed with a mental disorder, psychosocial adjustment difficulty, and or PTSD will be provided with appropriate treatment and services to attain the highest practicable level of mental and psychosocial wellbeing. Residents will be screened and assessed upon admission, quarterly and or significant change by social services department in order to identify any history of trauma and or PTSD which includes review of current records, resident and or resident representative interviews. IDT will document and care plan for any areas of trauma. This will include identification of the stressor past life trauma, potential actual triggers that may cause re-traumatization of the resident, experiences, preferences, and or other interventions that eliminate or mitigate triggers that may cause re-traumatization of the resident. 48299 R14 R14's quarterly Minimum Data Set (MDS) dated [DATE], indicated R14 had short- and long-term memory problems and made moderately impaired decisions regarding tasks of daily life. The MDS indicated a mood interview should be conducted for R14, but R14 did not respond when asked questions about mood and social isolation. The MDS indicated R14 had hallucinations, delusions, and had other behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, verbal/vocal symptoms like screaming, etc. daily of the previous 7 days. The MDS indicated R14 did not reject cares, was independent with activities of daily living (ADLs) and had schizophrenia. R14's annual social service MDS documentation dated 8/18/23 at 3:01 p.m., indicated R14 had diagnoses of schizophrenia, PTSD, major depressive disorder and was actively delusional on a daily basis. A Nursing Home Visit Encounter with R14's nurse practitioner dated 3/5/24, indicated R14 had schizophrenia, PTSD, major depressive disorder, among other diagnoses. R14's Face Sheet dated 5/3/24, indicated R14 had post-traumatic stress disorder (PTSD; a mental health condition triggered by a traumatic event). R14's Care Area Assessment (CAA) dated 11/3/23, delirium triggered for inattention and disorganized thinking. The CAA identified the symptoms were not new and had abnormal blood sugar levels due to R14's refusal to take insulin. The CAA for cognitive loss also triggered due to refusal of cognitive assessment and staff indicating short and long-term memory loss, poor decision making, inattention, and disorganized thinking. The CAA indicated R14 received frequent reorientation, reassurance, reminders to help make sense of things, and redirection and cues for appropriate responses and better decisions. The CAA psychotropic drug use trigged for antipsychotic use. The CAA mentioned diagnoses of schizophrenia and major depressive disorder. The CAA behavioral symptoms triggered related to rejection of care and noted behavior as worse. The care area assessments did not mention PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R14's cognition care plan related to psychosis and delusions revised 12/8/19, identified R14 had delusional beliefs their mother was abused by their father, was paranoid about thing getting stolen so carried all belongings with them, believed they had allergy to insulin, made accusations of theft by peers and/or staff, and had diagnoses of schizophrenia, PTSD, major depressive disorder and was actively delusional on a daily basis. R14's behavior care plan related to delusions revised 12/8/19, indicated R14 had paranoid delusions daily, made accusations of people being in their room during the night taking papers, belongings, and messing up or destroying locked cabinet drawers, and had diagnoses of schizophrenia, PTSD, and major depressive disorder. R14's medical record lacked evidence of an assessment for PTSD triggers. During interview on 4/30/24 at 1:48 p.m., nursing assistant (NA)-A stated their charting identified triggers and behaviors for residents. NA-A reviewed R14's target behaviors were refusing insulin and carrying belongings. NA-A reviewed R14 had no information on triggers of trauma. NA-A stated R14 believed people were trying to do things to them like poison them. NA-A stated R14 was more comfortable with them now and allowed NA-A to help with cares when needed compared to when NA-A was a newer employee. During interview on 4/30/24 at 2:58 p.m., registered nurse (RN)-C stated staff gave each other report between shifts on resident behavior and interventions completed in response. Besides report, the medical record had a communications area where they could record such information. RN-C stated care plans showed behavior plans for residents. During same interview on 4/30/24 at 2:58 p.m., licensed practical nurse (LPN)-B stated they believed R14 was abused and spoke about someone stalking them and was frightened and jumpy at times thinking someone was watching them. LPN-B stated residents had care plans related to trauma if they were open enough to talk about it, or residents' care plans reflected staff observations. LPN-B said the social work or MDS nurse completed trauma-based assessments. During interview on 5/2/24 at 9:53 a.m., social worker (SW)-A stated if a resident had a specific trauma, it was care planned and the facility would care plan for any triggers or flashbacks in order to try to avoid a trigger. SW-A reviewed R14's diagnoses and care plan. SW-A verified R14 had diagnosis of schizophrenia and had not had an assessment which identified and assessed their triggers for PTSD. SW-A stated staff were more focused on R14's hallucinations, delusions, and uncooperation with medications and other health management. During interview on 5/2/24 at 10:43 a.m., registered nurse (RN)-B stated R14 had PTSD and stated they did not do any assessments for PTSD and stated all of that was done via the provider and further stated they would possibly expect a resident with a history of PTSD to be assessed for triggers however it would not be within their scope. RN-B further stated it would be up to social services to add a care plan and would be important to have triggers or behaviors care planned. During interview on 5/2/24 at 10:56 a.m., the director of nursing stated she expected staff know residents' triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Trauma Informed Care, dated 12/20/22, indicated it was the policy of the facility that all residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with residents' preferences and experiences. Residents who display and or are diagnosed with a mental disorder, psychosocial adjustment difficulty, and or PTSD will be provided with appropriate treatment and services to attain the highest practicable level of mental and psychosocial wellbeing. Residents will be screened and assessed upon admission, quarterly and or significant change by social services department in order to identify any history of trauma and or PTSD which includes review of current records, resident and or resident representative interviews. IDT will document and care plan for any areas of trauma. This will include identification of the stressor past life trauma, potential actual triggers that may cause re-traumatization of the resident, experiences, preferences, and or other interventions that eliminate or mitigate triggers that may cause re-traumatization of the resident.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49617 Based on interview and record review, the facility failed to ensure there was adequate monitoring and provider notification for insulin parameters for 1 of 3 resident (R56) reviewed for unnecessary medications. Findings include: R56's admission Minimum Data Set (MDS) dated [DATE], indicated R56 had intact cognition, experienced hallucinations, had no delusions, exhibited no physical or verbal behaviors, and had no rejection of cares. The MDS also indicated R56 had diagnoses of type 2 diabetes, depression, and schizoaffective disorder (a disorder characterized by a combination of symptoms of schizophrenia, like hallucinations and delusions, and a mood disorder, like depression). R56's Care Area Assessment (CAA) for self-care and mobility dated 2/14/24, indicated he was able to perform activities of daily living (ADLs) independently but required some cues and reminders as he could loose focus related to having active false fixed perceptions that required staff supervision to ensure follow through. R56's physician's orders included the following: - Insulin Aspart subcutaneous solution pen-injector 100 unit/milliliter (mL); Inject per sliding scale subcutaneously three times a day to treat type 2 diabetes, dated 4/24/24. Sliding scale is as follows: 70 mg/dL - 149 mg/dL = 0 units 150 mg/dL - 199 mg/dL = 1 unit 200 mg/dL - 249 mg/dL = 2 units units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 5 units; 400+ = 6 units <400 6 units and call provider, If blood glucose is less than 70 mg/dL, hypoglycemia protocol - Don't give corrective dose for as needed (PRN), post-prandial or nocturnal glucose checks unless ordered. - Lantus SoloStar subcutaneous solution pen-injector 100 unit/mL (Insulin Glargine) Inject 14 unit subcutaneously in the evening to treat type 2 diabetes, dated 03/1/2024. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R56's care plan dated 2/13/24, indicated R56 had the potential for diabetic complications and identified a goal to have blood sugars remain below 100 milligrams/deciliter (mg/dL). The interventions included Metformin and Lantus medications as ordered, accuchecks (a way to assess blood sugar or glucose levels) as ordered, and to observe for signs and symptoms of high blood sugar (fatigue, frequent urination, headaches, increased thirst, weight loss, nausea, vomiting, diarrhea, tingling hands and feet, blurred vision) and low blood sugar (confusion, tachycardia, shaking, sweating, nervousness, anxiety, dizziness, and hunger). A review of R56's blood sugar readings in Point Click Care (PCC) revealed the following readings: - 442 mg/dL dated 4/28/24 at 19:24 (7:24 p.m.). - 579 mg/dL dated 4/25/24 16:55 (4:55 p.m.). A review of R56's progress notes lacked documentation of a provider update for these elevated blood sugar readings greater than 400 mg/dL, as orders indicated staff should call provider. During interview on 5/1/24 at 11:20 a.m., registered nurse (RN)-A stated for residents receiving insulin based on a provider-ordered sliding scale, the amount of insulin administered was dependent on the blood sugar. RN-A stated if the blood sugar was low, the resident may not require insulin and if the blood sugar was elevated, the resident may require more insulin. RN-A stated R56 was a recent admission, and his sliding scale insulin was a new order. RN-A reviewed R56's sliding scale insulin order and stated to know how much insulin to administer, R56 would first need to have his blood sugar checked. RN-A stated if R56's blood sugar was a reading of 400 mg/dL or higher, R56 would require 6 units of insulin and his provider would need to be updated. RN-A stated staff were expected to contact the provider at this blood sugar reading and could either update the provider while they were on site or through their triage nurses via telephone and document in the progress notes. RN-A verified R56 had elevated blood sugars greater than 400 mg/dL on 4/25/24 at 16:55 (4:55 p.m.) and 4/28/24 at 19: 24 (7:24 p.m.) in PCC. RN-A stated R56 should have received 6 units of insulin for these elevated blood sugar readings and most of the time, he will eat first before getting the blood sugar checked. I don't think there was a note put in. RN-A verified there was no progress note documentation of R56's provider being updated about his elevated blood sugars. During interview on 5/2/24 at 9:40 a.m., R56's advanced practical registered nurse, certified nurse practitioner (APRN, CNP) acknowledged being familiar with R56's care and began overseeing his care in February with his last visit being in April. The APRN, CNP expected to be notified of blood sugar readings of greater than 400 mg/dL and stated, We only see patients every three months, so I'd like to have that update. The APRN, CNP stated while understanding R56 might be eating prior to having his blood sugar checked, the expectation would be to continue to be notified per the orders so that the long-acting insulin dose was not adjusted. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/2/24 at 12:34 p.m., the director of nursing (DON) stated staff were expected to follow orders and update the providers if a resident's blood sugar was above the parameter limit. The DON reviewed R56's blood sugars for 4/25/24 at 16:55 (4:55 p.m.) and 4/28/24 at 19: 24 (7:24 p.m.) in PCC and verified they were greater than 400 mg/dL and stated staff should have administered the insulin as ordered and called the provider. The DON stated the nurse that had not updated the provider during these instances had mentioned R56 ate before he got his blood sugar checked and the DON stated the nurse received coaching at the time about documentation and updating the provider per the orders. A request for medication monitoring policy was requested but not received. A request for diabetic management policy was requested but not received. A request for a change of status and/or notification of change policy was requested but not received.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and manufacturer guidelines for 3 of 5 residents (R260, R46, R10) observed to receive medication. A total of (3) errors out of 25 opportunities were identified resulting in a 12% (percent) facility error rate. Findings include: R260's physician orders dated [DATE], included the following order: mucus relief oral tablet extended release 12 hour 600 milligram (MG) (guaifenesin) give 600 mg by mouth two times a day for RSV, respiratory distress related to acute respiratory distress syndrome. There was no stop date on the order. During interview and observation on [DATE] from 7:20 a.m., to 7:32 a.m., registered nurse (RN)-A stated she would be helping to administer medications until the trained medication aide (TMA) arrived. At 7:20 a.m., RN-A prepared R260's medications, except for the mucus relief and stated she did not see the medication for mucus relief. At 7:30 a.m., RN-A gave R260 her medications with the exception of the mucus relief. At 7:32 a.m., RN-A verified she did not administer R260's mucus relief and stated there was not a stop date on the medication and would contact the pharmacy to reorder the medication. R46's physician orders dated [DATE], indicated the following order: risperidone tablet 2 mg give 1 mg by mouth two times a day related to schizoaffective disorder, bipolar type. Give ,d+[DATE] of 2 mg tablet. During observation on [DATE] between 7:51 a.m., and 7:56 a.m., TMA-A prepared R46's medications and put a whole 2 mg risperidone tablet in the medication cup and gave the cup to R46 who gave the cup back and stated she took a half a tablet. At 7:56 a.m., TMA-A cut the 2 mg risperidone tablet in half and gave the half tablet to R46. R10's physician orders dated [DATE], indicated the following order: oyster shell calcium/D tablet ,d+[DATE] mg-mcg (microgram) (calcium carb-cholecalciferol) give 1 tablet by mouth two times a day for calcium and vitamin D insufficiency with breakfast and dinner. During observation on [DATE] between 8:25 a.m., and 8:34 a.m., TMA-A prepared R10's medications. The stock calcium medication had an expiration date of ,d+[DATE]. TMA-A began to give R10 her medications when the TMA-A was asked what the expiration was and whether the medication was expired. TMA-A asked for R10's calcium back and stated it was expired and at 8:28 a.m., located R10's personal bottle of calcium and administered the calcium to R10. At 8:34 a.m., TMA stated when medications are administered you have to check for the right patient, right route, right medication, right dose, right time, and stated the medication expiration should be checked prior to administering medications and verified she did not check the expiration date until prompted. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE] at 11:05 a.m., the director of nursing (DON) stated medications should be ordered ,d+[DATE] days before the supply runs out and as soon as possible and stated R260's medications should have been ordered prior to running out. Additionally, the DON stated she expected staff follow the 5 rights of medication administration and stated medications needed to be checked for the expiration prior to administering. A policy, Ordering Medication From Pharmacy, dated [DATE], indicated each nurse/TMA med pass person will be responsible for pulling the label off an over the counter medication, cream or lotion, or injectable or medication that is not on automatic renewal, that has less than a five day supply of the medication left. If a medication is needed for the same day or the next morning, the nurse/TMA should write beside the label Need today please. A policy, Administering Medications, dated [DATE], indicated the facility staff administer medications in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering medications verifies the resident's identity before giving the resident his/her medications. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi dose container, the date opened is recorded on the container.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to accommodate dietary preferences for 1 of 1 resident (R57) reviewed for food. Findings include: The facility form, Alternate Meal Choices, available seven days a week, indicated if a resident did not like a meal on the menu, a request for an alternate meal: peanut butter and jelly sandwich, grilled cheese sandwich, meat and cheese sandwich, and chef salad could be submitted. The facility Week 4 at a Glance menu dated 4/28/24, through 5/4/24 indicated the following food items: 4/28/24: the breakfast items indicated choice of cereal, egg bake, sweet roll, milk; the noon meal indicated fried chicken mashed potatoes, chicken gravy, cascade veggies, pie, and milk. The alternate food item was country fried steak and gravy. The evening meal indicated corn dogs, macaroni and cheese, baked beans, seasonal fresh fruit and milk and the alternate was taco salad. 4/29/24: the breakfast items indicated choice of cereal, fried eggs, toast, margarine and jelly; the noon meal indicated goulash, carrots, mandarin oranges, bread stick and the alternate indicated turkey wrap. The evening meal indicated open hot beef sandwich, mashed potatoes, creamy coleslaw, mixed fruit, and the alternate was a hot do on a bun. 4/30/24: the breakfast items included choice of cereal, sausage patty, waffles, maple syrup, milk; the noon meal indicated baked ham, fried potatoes, fruit, monster cookie cake, and milk, and the alternate was a tuna salad sandwich. The evening meal indicated summer chicken tortellini soup, crackers, chopped salad and dressing, breadstick, banana berry cup, milk and the alternate was lemon pepper cod. 5/1/24: the breakfast items included choice of cereal, sausage gravy biscuit, milk; the noon meal indicated fruited turkey pasta salad, tomato slices, breadstick, French chocolate cheesecake, and milk, and the alternate was a sloppy joe on a bun. The evening meal indicated Italian sausage sandwich, tater tots, corn, mixed fruit, milk, and the alternate was an egg salad sandwich. 5/2/24: the breakfast items included choice of cereal, boiled eggs, bacon, toast, margarine and jelly, and milk; the noon meal indicated smothered cube steak mashed potatoes, buttered peas, bread and margarine, fluffy strawberry dessert, milk and the alternate were baked pork chops. The evening meal indicated baked chicken drumstick, pasta salad, balsamic tomato cucumber salad, garlic toast, pears, cookie, and milk and the alternate were grilled cheese sandwiches. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/3/24: the breakfast items included choice of cereal, sausage link, French toast and syrup, milk and the noon meal indicated shrimp and chips, broccoli with cheese, cornbread and margarine, seasonal fresh fruit and milk and the alternate indicated pork tenderloin on a bun. The evening meal indicated Spanish beef and rice bake, seasonal vegetable bread margarine, butterscotch brownie and milk and the alternate indicated an egg salad sandwich. 5/4/24: the breakfast items included choice of cereal, fried eggs, donut holes, and milk; and the noon meal indicated lemon Dijon pork chop, baked yam, green beans, bread and margarine, sherbet, and milk and the alternate were cottage cheese and fresh fruit plate and crackers. The evening meal indicated a deli sandwich, potato chips, peaches, cake roll, and milk and the alternate were a chef salads, rolls and margarine. R57's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, was independent with activities of daily living. R57's Medical Diagnosis form indicated the following diagnoses: bipolar disorder, post traumatic stress disorder, unspecified symptoms and signs involving cognitive functions and awareness, factitious disorder imposed on self, and depression. R57's physician's orders indicated the following order dated 12/26/23: regular diet, regular texture. R57's care plan dated 1/3/24, indicated R57 was at risk for nutritional problem related to a low protein intake related to vegetarian status. Interventions included encouraging three meals a day and weekly weights. R57 had the following weights documented: 12/28/23, 138 pounds standing. 2/4/24, 133.2 pounds standing. 3/3/24, 132.2 pounds standing. 4/6/24 131.8 pounds standing. R57's admission Nutritional MDS Assessment/Monthly form dated 1/3/24, indicated R57 did not skip meals, ate only certain foods because R57 stated he was a vegetarian. The assessment form further indicated dietary would work to accommodate for preferences. R57's quarterly Nutritional MDS Assessment/Monthly form dated 3/25/24, indicated R57 did not skip meals, ate only certain foods because R57 was a vegetarian and was noted to eat some meats. The assessment form further indicated R57 received a regular diet and dietary would work to accommodate for preferences though R57 ate some meats at mealtimes. R57's nursing progress note dated 12/28/23 at 10:30 p.m., indicated R57 did not eat supper because he was a vegetarian. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R57's nursing progress note dated 12/29/23 at 2:06 p.m., indicated R57 did not want to eat the food at the facility and staff were arranging vegetarian meal options per resident preferences. R57's care conference note dated 1/17/24 at 11:38 a.m., indicated R57 was going to meet with the dietician on 1/17/24, to discuss vegetarian mean preference changes and R57's goal weight was 160 pounds and was 130 pounds as of 1/15/24. R57's progress note dated 2/16/24 at 10:13 a.m., indicated R57 requested to meet with the dietician to review his diet and concerns and stated he was a vegetarian and did not want to consume dairy products in addition to not having meats due to gas issues causing ongoing stomach pains and would eat eggs, peanut butter, beans, and rice and would try vegetarian burgers. R57's progress note dated 4/4/24 at 6:37 p.m., indicated R57 participated in a discussion about trying to make healthy choices and R57 stated it was super challenging to eat healthy at this facility. The note further indicated another member suggested R57 talk with the dietician again and R57 discussed being a vegetarian. R57's care conference note dated 4/10/24 at 11:09 a.m., indicated R57 did not attend the conference and was on a regular diet and R57's weight was 131.8 as of 4/6/24. The note further indicated R57 met with the dietician on 1/17/24 to discuss vegetarian mean preference changes. During interview on 4/29/24 at 3:51 p.m., R57 stated he went shopping on Amazon because he was a vegetarian and the facility had a lot of meats and was difficult for him to receive food for his diet. R57 further stated he ate peanut butter, but sometimes the facility ran out of it. During observation on 5/1/24 at 7:21 a.m., R57 had biscuits and gravy for breakfast and was eating at the table. During observation on 5/1/24 between 11:53 a.m., and 11:54 a.m., R57 came into the dining room and at 11:54 a.m., went to the window in the dining room by the kitchen and ordered his meal and was provided a brownie type dessert from the server and no other meal and a beverage. During interview and observation on 5/1/24 at 12:16 p.m., R57 finished his dessert and walked towards the elevator and stated he had cheesecake for lunch. During interview on 5/1/24 at 12:25 p.m., the dietary manager (DM)-C stated residents had turkey pasta salad and sliced tomatoes, bread, and cheesecake for lunch and stated they did not provide a vegetarian option and further stated they did not have any resident on vegetarian diets at the time. DM-C further stated residents had cards with their pictures on them and a blue card indicated a resident had a regular diet, a red card indicated a consistent carbohydrate diet. DM-C viewed R57's card and verified it only indicated R57 was on a regular diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/1/24 at 1:32 p.m., the registered dietician (RD) stated she was a contracted dietician and completed all the assessments and followed up on anything that required interventions for special diets. RD stated if a resident was on a special diet she let staff including the DM know. RD stated R57 stated he was a vegetarian and stated R57 indicated the day prior he was comfortable with the foods he had been receiving. RD further stated residents were provided two options at meals and in addition the RD stated there were always available options but added she did not know whether this menu was always followed and stated she did not document a note from her conversation with R57 the day prior, but could add documentation. Additionally, RD stated they tried to keep veggie burgers, and peanut butter on the always available options. During interview on 5/1/24 at 2:32 p.m., dietary aide (DA)-A stated she knew what kind of diet a resident was on based on their cards. DA-A further stated menus were posted in the dining room and on each floor and stated if a resident requested, they could have a peanut butter and jelly or other sandwich, grilled cheese sandwich, meat and cheese sandwich and chef salad and pointed to a posted sign labeled, Alternate Meal Choices that indicated, If you don't like a meal on the menu, you can place your request for an alternate meal: peanut butter and jelly sandwich, grilled cheese sandwich, meat and cheese sandwich, chef salad. Additionally, the meal choices were available seven days a week. During observation on 5/1/24 at 2:38 p.m., the menu in the dining room indicated for lunch a fruited turkey pasta salad, tomato slices, breadstick, French chocolate cheesecake, milk and the alternate was a sloppy joe on a bun and the breakfast choice was cereal, choice of juice, sausage gravy biscuit and milk. During interview on 5/2/24 at 9:52 a.m., social worker (SW)-A stated R57 was very specific and did not want meat and bought his own peanut butter and expected staff to accommodate his diet preferences. During interview on 5/2/24 at 3:05 p.m., the director of nursing (DON) stated she expected staff to provide a vegetarian menu for patient centered care in order to meet R57's needs. A policy, Nutritional Assessment, dated August 2023, indicated all residents would have a nutritional assessment completed within 14 days of admission and would be updated annually. The food service supervisor would visit new residents to record food and beverage preference, food intolerance, past food habits and inform resident of food service programs and meal and nourishment times. The consulting dietician will review information obtained and complete nutritional assessment form.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49617 Based on interview and document review, the facility failed to conduct ongoing quality assessment and assurance activities, develop, and implement appropriate plans of action to correct repeated quality deficiencies identified during the survey the facility was aware of or should have been aware of which had the potential to adversely affect all 60 residents which resided in the facility. Findings include: The facility's QAPI meeting minutes for the past 12 months were requested, however not received. Documentation and evidence of the facility's ongoing performance improvement projects (PIPs) was requested, however not received. Documentation and evidence of a recent performance improvement plan (PIP) was requested, however was not received. When interviewed on 5/2/24 at 5:10 p.m., the administrator stated the facility held quarterly QAPI meetings but due to being interim, he was unable to access the shared network where he believed the previous administrator saved the previous meeting minutes. The administrator stated the facility was also involved in PIPs but was unable to locate documentation of the projects during interview. The facility's QAPI plan dated 4/2024, indicated the QAPI committee, comprised of all department managers, the administrator, director of nursing, infection control and prevention officer, medical director, consulting pharmacist, and quality coordinator, would meet quarterly. The QAPI plan indicated QAPI activities and outcomes would be on the agenda of every staff meeting, and the committee would review data, suggestions, and input to prioritize opportunities for improvement. The facility's QAPI plan indicated the committee would solicit individuals from the organization to conduct PIPs and would monitor their progress. Additionally, the QAPI plan indicated the facility used a Plan-Do-Study-Act model to test actions and recognize and address unintended consequences of planned changes when working to prevent future events and promote sustained improvement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49617 Based on document review and interview, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) committee that was effective in identifying and responding to quality deficiencies, and developing procedures for feedback, data collection and monitoring systems. In addition, the facility failed to provide evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas. This deficient practice had the potential to affect all 60 residents currently residing in the facility. Findings include: Quality tracking data was requested from the facility but was not provided. During interview on 5/7/24 at 7:24 p.m., the administrator stated, I think the last administrator had meetings, but was unsure where the meeting minutes were located. The administrator also stated he believed the facility had a PIP but was unable to locate any information regarding the project. A facility policy titled QAPI Plan - 2024 dated 4/2024, indicated the facility implement PIPs to improve processes, systems, outcomes, and satisfaction. The QAPI plan indicated the facility would conduct PIPs to revise and improve care or services in areas identified as needing attention. The QAPI plan indicated topics for PIPs were identified during quarterly review of data and input from data sources (Centers for Medicare and Medicaid Services (CMS) quality measures, falls, medication errors, rehospitalization rates, resident satisfaction, abuse, neglect, and maltreatment reports, complaints, resident council and family council, satisfaction surveys, and suggestion boxes). The plan indicated it would look at issues, concerns, and areas that need improvement as well as areas that will improve quality of life and quality of care and services for the residents. The plan also indicated PIPs would include high-risk, high-volume, or problem-prone areas that affected health outcomes and quality of care and areas that affected staff. Additionally, the plan indicated other considerations would include existing standards or guidelines, measures that could be used to monitor progress, quality measures publicly reported on Nursing Home Compare, goal areas from the Advancing Excellence in America's Nursing Homes Campaign, and projects that require system or environmental changes, and those affecting staff.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to accurately assess residents' eligibility to receive the pneumococcal vaccination according to The Centers of Disease and Control and Prevention (CDC) for 2 of 5 (R360, R26) reviewed for vaccinations. Findings include: The CDC identified on the Pneumococcal Vaccine Timing for Adults Chart, dated 3/15/23, Adults 19-[AGE] years old with chronic health conditions, such as diabetes mellitus, who received PCV13 (pneumococcal conjugate vaccine) should receive either one dose of PCV20 or one dose of PPSV23 (pneumococcal polysaccharide vaccine). The dose of PCV20 or PPSV23 should be administered at least one year after PCV13. Adults 19-[AGE] years old with chronic health conditions, such as diabetes mellitus, who received PPSV23 should receive either one dose of PCV15 or PCV20 at least one year after the most recent PPSV23 vaccination. R360's admission Minimum Data Set (MDS) dated [DATE], indicated R360 was [AGE] years old, had intact cognition and diagnosis of diabetes mellitus. Furthermore, R360's MDS indicated R360 was not up to date with pneumococcal vaccination and not offered the pneumococcal vaccine. R360's Minnesota Immunization Connection (MIIC) report undated, indicated R360 had received the Prevnar (PCV)13 on 9/13/19. Review of the current CDC pneumococcal vaccine recommendations 3/15/23, indicated R360 required one dose of PCV20 or PPSV23 at least one year after PCV13. R26's quarterly MDS dated [DATE], indicated R26 was [AGE] years old, had intact cognition and diagnoses of hypertension, renal insufficiency or failure and diabetes mellitus. Furthermore, R26's MDS indicated R26 was not up to date with pneumococcal vaccination and not offered the pneumococcal vaccine. R26's MIIC report undated, indicated R26 had received the PPSV23 on 10/7/3, 12/11/9, and 10/2/20. Review of the current CDC pneumococcal vaccine recommendations 3/15/23, indicated R26 required one dose of PCV20 or PCV15 at least one year after PPSV23. When interviewed on 5/2/24 at 12:20 p.m., registered nurse (RN)-A stated resident vaccinations were assess upon admission. Staff made sure the immunization records were up to date and called the hospital or wherever the resident was admitted from to obtain the most current immunization record. When interviewed on 5/2/24 at 12:37 p.m., RN-B, who was the infection preventionist, stated they accessed the MIIC to verify residents were up to date with vaccinations and asked residents if they wanted the pneumococcal vaccinations during their assessment interviews. RN-B checked yearly to ensure current residents were up to date with vaccines. RN-B stated if residents needed the pneumococcal vaccines they would receive from their provider or go to a pharmacy if safe to go out to community. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Care Home	715 West 31st Street Minneapolis, MN 55408

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 5/2/24 at 3:25 p.m., the director of nursing (DON) stated staff annually assessed which residents needed pneumococcal vaccinations following the CDC guidance. Ensuring residents were up to date on vaccines was important to minimize resident risks. The facility was asked for documentation of R360 and R26's pneumococcal vaccination offer and/or declination but did not receive.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48299 Based on observation and interview, the facility failed to ensure resident call light cord was within reach from the shower floor for 1 of 1 multi-resident (R39, R14, R25, R32) bathroom reviewed for call light accessibility. Findings include: R39's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition, had hallucinations and delusions and no refusals of care. R39 was independent with activities of daily living (ADLs) but needed substantial and/or maximal assistance with showers/bathing. R39 had diagnoses which included schizophrenia and cataracts. R39's care plan printed 5/3/24, identified R39 was a low fall risk and directed staff to educate and remind R39 to use the call light and call for staff when weak. R14's quarterly MDS dated [DATE], identified R14 had short- and long-term memory problems and made moderately impaired decisions regarding tasks of daily life. R14 had hallucinations, delusions, inattention, disorganized thinking, and no rejections of care. R14 was independent with all ADLs, including showering. R14 had diagnoses of diabetes mellitus and schizophrenia. R14's care plan printed 5/3/24, identified R14 was a low fall risk. R25's quarterly MDS dated [DATE], identified R25 had short- and long-term memory problems and made moderately impaired decisions regarding tasks of daily life. R25 had hallucinations, delusions, inattention, disorganized thinking, and altered level of consciousness. R25 did not reject cares. R25 was independent with most ADLs but required substantial and/or maximal assistance with shower. R25 had diagnosis of schizophrenia. R25's care plan printed 5/2/24, identified R25 was at moderate risk for falls and indicated call light at bedside. R32's annual MDS dated [DATE], identified R32 had intact cognition, delusions, and no behaviors nor rejection of cares. R32 was independent with ADLs and had diagnoses of diabetes mellitus and schizophrenia. R32's care plan printed 5/2/24, identified R32 was a low fall risk. During observation and interview on 4/29/24 at 12:12 p.m., R39's bathroom had a call light cord and box by the toilet. A string was tied around the call light cord, and the string went above the door frame and back down to dangle by the shower. The string with a plastic piece at the end of it was looped a couple times and approximately four feet from the ground. The string by the shower was out of reach if a resident fell in the shower or was sitting in the shower chair. R39 stated they did not have assistance with showers. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 5/1/24 at 8:52 a.m., nursing assistant (NA)-A stated R39 was not very stable when first getting up in the morning and needed stand by assistance and reminders to use her walker. NA-A stated R39 showered in evening so unsure of how much assistance was usually given. NA-A stated the light outside room doors turned on when a resident had their call light on. NA-A either observed call lights on and went to assist, or a phone at the nurse's station also indicated a call light was on. NA-A stated call lights needed to be within reach, including in the bathroom and shower. NA-A observed the string by the shower and agreed the call light is high and should be lower like the other call lights they have seen. NA-A grabbed the string and pulled down. The part of the string tied around the call light by the toilet slid down the call light which lengthened the amount the NA-A had to pull until the string tightened enough to turn on the call light. NA-A agreed they had to pull the string excessively to turn on the call light. During interview on 5/2/24 at 12:20 p.m., registered nurse (RN)-A stated staff looked at assignment sheets and care plans to know how much assistance residents needed. R39 did not like assistance, but staff tried to assist R39 with showers. R14 did not allow staff to assist with showers, but staff reminded R14 to try to let staff assist. R32 was independent with ADLs, but staff stood by when R32 showered for safety. R25 needed assistance with showers. During interview on 5/2/24 at 3:25 p.m., the director of nursing (DON) stated call lights should be within reach of residents, which included when in shower and using toilet. The DON stated staff may not be able to respond to or be aware of an emergency if a resident could not reach or turn on their call light. The facility policy Call Lights dated 12/23, indicated the nursing station should be equipped to receive resident calls form the resident room, bath and bathrooms.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48299 Based on observation, interview, and document review, the facility failed to ensure a multi-resident bathroom ceiling vent fan was cleaned for 4 of 4 residents (R39, R14, R25, R32) reviewed for cleanliness of environment. Findings include: During observation on 4/29/24 at 12:24 p.m., grayish white colored dust thickly covered 50 to 75% of a bathroom ceiling vent. The ceiling vent fan ran but no air flow felt. During interview on 5/1/24 at 9:16 a.m., the administrator (admin) expected maintenance and housekeeping to keep vents and fans clean as often as necessary. Admin stated usually maintenance cleaned high vents and fans, and housekeeping cleaned lower vents and fans. The facility recently changed housekeeping from in-house to a contracted company, so a cleaning schedule was being developed. During interview on 5/1/24 at 9:22 a.m., the assistant director of maintenance (M)-B stated they cleaned vents and fans when dust was observed or when residents came and told them. M-B stated they tried to check rooms twice a month but sometimes didn't happen. M-B stated they had a log for tracking cleaning and would have to find it. During interview on 5/1/24 at 9:51 a.m., the head of maintenance (M)-A stated vents and fans should be cleaned every month. M-A stated they had an old checklist but needed to clean it up and create a checklist sheet for the whole year. M-A observed the bathroom ceiling vent fan and stated maintenance needed to clean it. M-A stated dirty vents and fan caused elements to fly around the air and were important to keep clean to improve air flow and equipment performance. The facility's Room Order Cleaning Procedure dated 8/23, directed staff to follow room order guideline and check general appearance of unit and did not mention to check and clean vents and fans.