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	03/20/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on observation, interview, and document review, the facility failed to ensure grievances were acted upon and if needed investigated or resolved for 1 of 1 residents (R46) reviewed for grievances. Findings include: R46's Annual Minimum Data Set (MDS) dated [DATE], indicated it was very important to choose what clothes to wear, take care of personal belongings. R46's quarterly MDS dated [DATE], indicated intact cognition, did not have inattention, disorganized thinking, or an altered level of consciousness, did not have hallucinations or delusions, behaviors, and did not reject cares. R46's progress notes were reviewed from 8/7/2023, and lacked information R46 was missing clothing items. R46's progress notes dated 10/4/23, indicated R46 reported missing money and a vulnerable adult report and online police report were completed. R46's care plan dated 2/4/25, indicated R46 had intact cognition. During interview on 3/17/25 at 3:52 p.m., R46 stated when he first came, his clothes were missing and never got them back. R46 stated he reported it and thought he completed a form and stated he was missing two pairs of shorts and a number of shirts adding his memory was not the greatest and further stated he asked to be reimbursed, but nothing came of it and stated his clothes were old, but he had no income for replacing them. During interview and observation on 3/18/25 at 11:37 a.m., the laundry assistant (LA)-A stated if a resident reported missing items, she had a list she wrote down and stated she would search in closets and had a 90% success rate in finding items and stated missing clothing happened a lot. LA-A provided a handwritten list located in the laundry room that indicated a date, 9/25/24, with R46's name and a list that contained a shirt, shorts, and boxer shorts and stated she had not yet been able to locate the items and further stated if she cannot locate something, she updates the supervisor. (continued on next page)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/19/25 at 8:57 a.m., nursing assistant (NA)-B stated R46 was an accurate historian and if residents reported missing items, they look for the missing items and if they cannot locate them, report to social services. During interview on 3/19/25 between 12:54 p.m., and 12:56 p.m., social worker (SW)-A stated they try to locate missing items and sometimes residents miss place items and they try to track steps when they last saw the missing item. SW-A stated she has residents make a list and if they are unable to locate it, a notification is sent to maintenance, and nursing. At 12:56 p.m., social services assistant (SSA)-B stated a grievance form was normally completed in order to track it and asks to conduct a room search, and if items are clothing articles, goes to the laundry room and documents on the grievance form. SW-A and SSA-B stated they don't always document other than on a grievance form. SSA-B viewed the grievance log and stated she did not recall R46 reporting missing clothing items and verified there were no grievances in the grievance log for R46. SW-A stated she was not aware of R46 missing any items. SW-A further stated they completed an inservice on grievances and stated staff were supposed to report to her or SSA-B. During interview on 3/19/25 between 1:04 p.m., and 1:07 p.m., with LA-A and SW-A, LA-A stated she informed SW-A of the missing items and showed SW-A the missing items list dated 9/25/24, and read off the missing items stating R46 was missing a green shirt with gray on the back, a pair of white shorts with blue stripes and a pair of boxer underwear. LA-A further stated R46 was looking for reimbursement for the items. At 1:07 p.m., SW-A stated she did not recall being informed of missing items and stated there should have been a grievance form completed by now. SW-A viewed R46's chart and verified there was no documentation regarding missing clothing items and stated the facility reimbursed if they determine they were responsible for losing items and stated it was important to complete a grievance form in order to follow through on missing items. During interview on 3/19/25 at 1:34 p.m., LA-A stated R46 reported the missing items on 9/25/24, and added she thought R46 completed a grievance form, but stated SW-A could not recall. During interview on 3/19/25 at 1:50 p.m., the director of nursing (DON) stated a grievance form is completed when a resident reports missing items and staff update social services and try to locate the missing items and follow up as soon as possible. The DON further stated it was important to complete the grievance in order to follow up. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Procedure for Missing Items dated 6/23/24, indicated it was the policy of the facility that all missing items were acknowledged and investigated. When a resident reports a missing item or money, staff will assist resident to search for it in all appropriate locations, including but not limited to talking to other staff members. This will be completed within 24 hours of original complaint and documented in resident's chart. If the item is not found upon the initial search, staff will complete a grievance form and turn it into the grievance officer and or designee. Social services director or designee will make copies of the grievance form and forward them to the appropriate department for further follow up. The department manager(s) that receive a grievance form will do a thorough search and or investigation regarding missing item, money, etc and complete the grievance form and return it to social service director and or designee within 72 hours of receiving the grievance form. the director of social services and or designee and appropriate staff will discuss possible actions to take to prevent re-occurrences, room changes, labeling clothing, putting money in a trust fund etc, final outcome and actions will be documented in resident's chart and care planned for as deemed appropriate. The director of social services and or designee will maintain a log of all missing items in order to monitor for trends and or patterns. A policy, Grievances, dated 8/8/23, indicated the facility will make every effort to resolve the issue within three working days of receipt of the grievance or complaint, and the resolution will be communicated to the resident, resident representative, family member, friend, or health care agent who originated it. A copy of the written response with proposed resolutions may be given to the grievant if the resident, family, friends, or health care agent does not accept the proposed resolution, an appointed administrative designee may request an appropriate advocacy organization to intervene. All files and information pertaining to the grievances are confidential and will be kept by the grievance official and administrator or designee and the facility will maintain original written responses and three years of grievance records and logs. All grievances will be reviewed with resident voicing concern to ensure they are satisfied with the resolution.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 accurately code the Minimum Data Set (MDS) for 5 of 5 residents (R9) reviewed for restraints, (R26) reviewed for dialysis and Preadmission Screening and Resident Review (PASARR), and (R27, R53) reviewed for falls. Findings include: The Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2024, directed staff under section J to identify whether a resident had any falls since admission, entry or reentry or prior Assessment (OBRA or Scheduled PPS), whichever was more recent. If a resident fell , the RAI directed staff to continue to J1900, number of falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS). The RAI further defined prior assessment as the most recent minimum data set (MDS) assessment that reported on falls. J1900 directed staff to code either none, one, or two or more falls in three separate boxes that included: 1. No Injury, defined as no evidence of injury was noted on physical assessment by the nurse or primary care clinician, no complaints of pain or injury by the resident, no change in the resident's behavior is noted after the fall, 2. Injury (except major) defined as skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains or any fall-related injury that causes the resident to complain of pain, and 3. Major Injury defined as bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma. R27's annual MDS dated [DATE], indicated R27 had moderate cognitive impairment, and had not fallen since admission or prior assessment. R27's quarterly MDS dated [DATE], indicated R27 had severe cognitive impairment, had falls since admission, entry or reentry or prior assessment (OBRA or Scheduled PPS) whichever was more recent, had two or more falls without injury, had 2 or more falls with injury (except major), and had 2 or more falls with a major injury. R27's care plan dated 9/15/24, indicated R27 was at risk for falls due to multiple risk factors. Interventions indicated R27 had fallen on 12/3/24, 12/24/24, and 12/29/24. The fall on 12/3/24 resulted in no injuries noted. The interdisciplinary team (IDT) discussed R27's falls on 12/24/24, and 12/29/24, and R27 was encouraged to call for assistance upon ambulation and was educated to stay in bed during ECT treatment and to call for assist if she required help. The care plan lacked information whether R27 received any injuries on 12/24/24, and 12/29/24. R27's physician's orders dated 8/28/23, indicated to monitor for falls and unsteady gait every shift. R27's progress notes dated 12/3/24 at 11:27 a.m., indicated R27 fell on [DATE], and denied any pain or discomfort, was assessed and found to have no injuries. R27's progress notes dated 12/24/24 at 9:45 a.m., indicated R27 fell at ECT (electroconvulsive therapy) and there were no signs of acute injury, R27 had full range of motion, R27 dug her fingernails into her arm and injured a fingernail that was wrapped. R27 denied pain or discomfort. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R27's progress notes dated 12/29/24 at 4:35 p.m., indicated R27 had a questionable fall and directed staff to see the risk assessment for further information. R27's Fall Risk Assessments located under the Assessments tab indicated the most recent fall risk assessment was dated 1/3/25, and then again on 10/4/24. R27's Fall Risk assessment dated [DATE], indicated R27 was mostly steady during transitions from sitting to standing, walking, turning, and transferring on and off the toilet and was independent with all mobility without any device. R27 had no functional limitation in range of motion. After ECT treatments, R27 can sway or not fully watch where she is going and can be tired and obtunded and had every shift orders to monitor for gait and stability changes. The form lacked information pertaining to falls and injuries. R27's Fall reports dated 12/3/24, 12/24/24, and 12/29/24, were reviewed and R27 had no injuries on 12/3/24. On 12/24/24, R27 dug her fingernails into her arm and injured a fingernail and otherwise was documented as having no acute injury. On 12/29/24, R27 was on the floor and no injuries were noted. During interview on 3/19/25 at 9:25 a.m., registered nurse (RN)-A stated she was the MDS nurse and was still training and working with the director of nursing and took over the MDS in August or September and stated she completed the coding and helped with the care plan. During interview on 3/19/25 at 11:26 a.m., licensed practical nurse (LPN)-A stated when a resident falls, they are assessed and if injured, call 911 and send the resident to the hospital and complete a risk assessment. LPN-A stated the risk assessment was documented under care management and stated she saw R27 had two falls dated 12/3/24 and 12/29/24. LPN-A stated R27 did not have any injuries from the falls and further stated R27 had not had any falls she was aware of that resulted in injury. LPN-A stated the MDS may be documented in error. During interview on 3/19/25 at 11:43 a.m., registered nurse (RN)-A stated if a resident fell , the facility assesses the resident and if the fall was unwitnessed, complete neuro checks, update the family, doctor, director of nursing, and complete a progress note. Further, they care plan and discuss at IDT in order to create fall interventions. RN-A viewed the risk management reports since 10/4/24, and stated R27 had a fall on 12/3/24, 12/24/24, and 12/29/24. RN-A stated R27 had no injuries after viewing each of the notes and verified R27 had three falls since October. Both RN-A and the director of nursing (DON) verified R27 had no injuries and the DON stated the MDS should have indicated R27 had no injuries. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy, Interdepartmental MDS Review, dated January 2025, indicated it was the policy of the facility to ensure that each resident's MDS will be completed on admission, quarterly, annually and significant change using current, accurate documentation and assessments specific to that resident. Each resident will be assessed on admission, quarterly, annually and significant change for the purpose of the completion of the MD. Each department represented by the IDT will complete the following assessments for the purpose of gathering the most accurate information specific to each resident. Nursing will complete bowel and bladder assessment with summary note, monthly self administration of medication with summary note, pain, falls, EPSE, foot, DISCUS assessments, care plan initiation, review and updating, nursing will review MDS/Care Conference schedule and distribute to all IDT members on a quarterly basis. Documentation in progress notes upon completion of the MDS interviews. Nursing will be responsible for the MDS sections B, GG, H, I, J, L, M, N, O, P, plus CAAs (care area assessments) triggered for these areas. Nursing is also responsible for sections J and L. 48065 R53 R53's quarterly Minimum Data Set (MDS) dated [DATE] indicated R53 was cognitively intact, had delusions, hallucinations, had no behaviors, was independent with activities of daily living but needed set up for eating and showers. MDS indicated R53 had a fall with major injury. R53's clinical diagnosis report printed 3/20/25, indicated schizoaffective disorder, bipolar disorder, anxiety and renal disease. R53's progress note dated 1/23/25, indicated R53 reported she fell in her room at 2:00 a.m. R53 stated she fell by her bed on her way to the bathroom and did not hit her head. Progress note indicated a head-to-toe assessment was completed and no injuries were noted. During interview on 3/17/25 at 1:33 p.m., R53 stated she fell , didn't harm herself, and added I took responsibility, but I don't want to talk about it. During interview on 3/19/25 at 2:09 p.m., registered nurse (RN)-A stated she started to do the MDS assessments in September 2024 and was still learning the MDS process. RN-A indicated she completed R53's MDS. RN-A reviewed the R53's record, and verified R53 didn't injured herself when she fell . RN-A stated it was a coding error. 49617 R9 R9's quarterly Minimum Data Set (MDS) dated [DATE], indicated she had intact cognition and diagnoses of anxiety and schizophrenia (a chronic mental condition that affects a person's ability to think, feel, and behave clearly). Her MDS further indicated she utilized a limb restraint less than daily. R9's order summary report printed 3/21/25, showed her active orders as of 12/1/24 and lacked an order for a limb restraint. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's assessments were reviewed 3/19/25 and lacked documentation of an assessment for a restraint. R9's care plan was reviewed 3/19/25 and lacked documentation of the use of a limb restraint. R9's electronic health record (EHR) was reviewed on 3/19/25 and lacked documentation of the use of a limb restraint. Per interview on 3/19/25 at 11:46 a.m. with licensed practical nurse (LPN)-A, there was no use of restraints in the facility. Furthermore, LPN-A stated R9 gets anxiety and gets nervous, but is nobody that would ever need to be restrained. LPN-A could not think of any device that would be considered a restraint for R9. During interview on 3/19/25 at 2:43 p.m., registered nurse (RN)-A verified completing R9's quarterly MDS dated [DATE] and the affirmative response to the use of a restraint for R9. RN-A stated, nobody here uses a restraint. This was an error. R26 R26's annual Minimum Data Set (MDS) dated [DATE], indicated he had intact cognition and had diagnoses of cirrhosis (chronic liver disease), kidney failure, kidney stones, liver failure, and diabetes. The MDS also indicated he was considered by the state level II Preadmission Screening and Resident Review (PASARR) process to have a serious mental illness. Furthermore, the MDS reported he was not receiving dialysis. R26's order summary report printed 3/19/25, included the following orders: - assess thrill ad [sic] bruit each shift. If not present, notify MD. No blood pressure on left arm, dated 11/18/08. - daily weight one time a day for dialysis, dated 11/16/24. R26's care plan dated 2/9/24, identified his risk for complications related to chronic kidney disease and indicated he was receiving dialysis on Mondays, Wednesday, and Fridays. Additionally, his care plan identified his potential for complication related to his permcath (a type of long-term venous access to the bloodstream used for hemodialysis) hemodialysis access, which was placed in the hospital on 12/14/23. A Davita treatment details report dated 1/2/25, indicated R26 received hemodialysis treatment on 1/2/25. A Davita treatment details report dated 1/4/25, indicated he received hemodialysis treatment on 1/4/25. A Davita treatment details report dated 1/6/25, indicated he received hemodialysis treatment on 1/6/25. A Davita treatment details report dated 1/13/25, indicated he received hemodialysis treatment on 1/13/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Level I: Screening for Mental Illness or Mental Retardation dated 11/17/08, indicated R26 did not meet the requirements to be referred for a level II evaluation and determination. R26's electronic health record (EHR) was reviewed 3/19/25 at lacked documentation of a level II PASAAR. Per interview on 3/17/25 at 6:39 p.m., R26 confirmed he went to dialysis three times per week, on Mondays, Wednesdays, and Fridays. Per interview on 3/19/25 at 11:42 a.m. with licensed practical nurse (LPN)-A, R26 had been on dialysis for about a year. During interview on 3/19/24 at 2:44 p.m., registered nurse (RN)-A verified completing his annual MDS dated [DATE] and confirmed he was on dialysis. RN-A stated R26's MDS should have identified his use of dialysis. A request was made for R26's level II PASARR on 3/19/25 at 2:39 p.m. During interview on 3/19/25 at 3:18 p.m., social worker (SW)-A stated he did not have a level II PASARR because he did not require one. SW-A reviewed his annual MDS dated [DATE] and verified the incorrect data and stated, that was coded wrong, it should have been no. A facility policy pertaining to MDS accuracy was requested, but the director of nursing (DON) stated the facility did not have one.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46885 Based on interview and document review, the facility failed to ensure physician's orders were in place for 1 of 1 resident (R46) who self catheterized. Findings include: R46's Optional State Assessment (OSA) dated 2/7/25, indicated intact cognition, did not have hallucinations, delusions, or behaviors, and did not reject cares. The OSA further indicated R46 was independent with activities of daily living (ADLs), was not on a urinary or bowel toileting program. R46's quarterly Minimum Data Set (MDS) dated [DATE], indicated R46 did not have an indwelling catheter, external catheter, ostomy, or had intermittent catheterizations and was always continent of bowel and bladder. R46's Medical Diagnosis form indicated R46 had the following diagnoses: fusion of the spine, lumbar region, and an unspecified disorder of the prostate. R46's Orders form was reviewed and lacked physician orders on how R46 self catheterized, why R46 self catheterized, what type of catheter was used, how often catheterization was required, or where R46 obtained catheter supplies from. R46's medication administration record (MAR), and treatment administration record (TAR), was reviewed for January 2024, February 2024, and March 2024, and lacked information how R46 self catheterized, why R46 self catheterized, what type of catheter was used, how often catheterization was required, or where R46 obtained catheter supplies from. R46's care plan dated 2/4/25, indicated R46 had intact cognition. R46's care plan dated 8/24/23, indicated R46 was continent of bowel and bladder, would remain continent of bowel and bladder and interventions included to review and assess on a quarterly and annual basis. Further, R46 self catheterized due to a medical history and retention. R46's goal indicated he would report no difficulties in self catheterization and stay free from infection. Interventions included staff would make and alert R46 of urinary and urology appointments, and staff will report any difficulties that resident expresses to urology. The care plan lacked information what type of catheter R46 used, how often R46 self catheterized, and where R46 obtained catheter supplies. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's Bladder Assessment Documentation dated 2/7/25, indicated no further assessment was necessary and further, R46 performed self catheterizations, but was continent of bladder. Under a heading, Potentially Reversible Causes of Urinary Incontinence a check box was marked for a history of urinary retention. The assessment further indicated R46 had prostatitis (inflammation of the prostate gland)/BPH (benign prostatic hyperplasia). The form indicated a physical exam was not performed and recorded and registered nurse (RN)-A attempted the examination for the second time on 2/7/2027 and was not appropriate for toileting or a retraining program. Under the heading, Progress note indicated R46 was continent of his bladder and intermittently self catheterized when having a CRPS (complex regional pain syndrome) flair and was in severe pain due to retention. No further assessment or examination needed at this time, no concerns at time of assessment. R46's Care Area Assessment (CAA) Summary form dated 8/9/24, indicated urinary incontinence and indwelling catheter was not triggered for a care planning decision. R46's History and Physical dated 3/18/25, indicated R46 had a status post lumbar fusion, complex regional pain syndrome type two (CRPS) of the left lower extremity (a chronic pain condition that causes severe, persistent pain, along with other symptoms like swelling, skin temperature changes, and sensitivity to touch in the affected limb), BPH with urinary hesitancy, and urinary retention. R46's admission progress note dated 8/7/23, indicated R46 did not urinate on his own, and straight cathed himself when he knows he needs to empty his bladder. R46's Care Conference note dated 5/22/24, indicated R46 straight cathed for his bladder. R46's Care Conference note dated 8/21/24, indicated NA under the heading Urology. R46's Care Conference note dated 11/20/24, indicated R46 straight cathed for his bladder. R46's Aide Task form did not include a task for self catheterization. During interview on 3/17/25 at 3:57 p.m., R46 stated he self catheterized 3 times a week due to his CRPS affecting his groin area. R46 stated it didn't matter how full his bladder was, he was unable to urinate and added he does void sometimes. During interview on 3/19/25 at 8:57 a.m., nursing assistant (NA)-B stated she was not aware R46 self catheterized and stated LPN-A ordered supplies and further stated R46 was alert, an accurate historian, but had pain all the time and needed encouragement, but was cooperative. During interview on 3/19/25 at 9:10 a.m., licensed practical nurse (LPN)-A stated the facility did not have any paper charts and doctor visits were located in the computer and it was determined what medical supplies were needed based on the physician orders. LPN-A further stated staff knew what cares a resident required based on the care plan, but was more a tool the social worker used and staff looked at the orders. LPN-A stated she was responsible for ordering supplies and added they did not have catheters at the facility and added R46 self catheterized himself as needed three to four times a day and obtained his own supplies adding that R46 was completely with it. LPN-A stated R46 had been self catheterizing since prior to admission to the facility. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 3/19/25 at 9:25 a.m., registered nurse (RN)-A stated R46 self catheterized, and staff did not assist and did not know how often R46 self cathed, what size catheter, and stated they did not have an order and added it would be helpful for nursing to know because if they had the physician's order they would know there is an issue and when R46 would be out of supplies and could follow up. During interview on 3/19/25 at 9:41 a.m., the director of nursing stated R46 did not self cath, then reviewed R46's bladder assessment and RN-A verified the assessment indicated R46 self catheterized and stated R46 should have an order in the chart for the nurse to supervise and stated it was important to ensure it was going well and if there were any complications and would need to know the catheter type. A policy, Catheter Use, dated 1/25/25, indicated resident self-catheterization may be done by a resident to relieve the bladder of residual urine if approved by a urologist and performed with nursing supervision. The nurse supervises and promotes techniques to allow for correct procedure and reduced chance of infection. Both the nurse and the resident will wash hands prior to procedure in accordance with infection control policy. Nurse will wear gloves during this procedure. Position the resident on the toilet with enough room to allow end of catheter to drain into the toilet freely. The nurse will remove sterile wipe from the package and hand to the resident. The resident will open the wipe by shaking and cleanse peri area by wiping front to back. The nurse will remove the lubricant packet being careful not to touch the tip or end of the catheter. The resident will open the lubricant packet and the nurse will place the tip of the catheter into the lubricant, then hand the catheter to the resident. The resident will place the tip of the catheter into the urinary meatus allowing end of catheter to drain residual urine while the nurse ensures that the catheter is draining into the toilet. When the draining stops, the catheter will be removed by the resident and placed into the waste receptacle. Both the resident and the nurse wash hands after the procedure is complete.

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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 interview, observation, and document review, the facility failed to ensure interventions for safe smoking were implemented for 1 of 2 residents (R6) reviewed for smoking. Findings include: R6's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have range of motion impairment to upper extremities, did not have physical or verbal behaviors directed towards others, and did not reject care. R6's Medical Diagnoses form indicated the following diagnoses: tobacco use, and mild intellectual disabilities, and schizophrenia. R6's Orders form was reviewed and lacked information regarding safe smoking. R6's care plan dated 12/26/24, indicated R6 had moderate cataracts and a surgical consult was provided, however R6 declined treatment, interventions included staff to observe for visual changes or ability to maneuver safely in the environment. R6's care plan dated 12/26/24, indicated R6 heard voices and had paranoid accusations others wanted R6's money or were in her business. R6's care plan dated 12/26/24, indicated R6 was a safe cigarette smoker with proper safety interventions. R6 had burned fingertips and nose and had been observed with holes in clothes and was encouraged to use a smoking apron, refused a cigarette holder, and was able to light her own cigarette with a no-flame lighter, or staff would light R6's cigarettes. Interventions included assessing smoking safety upon admission, significant change, and annually, and staff would offer praise to R6 for safe smoking and redirection as needed. R6's care plan dated 3/6/25, indicated R6 required re-direction and cuing to make appropriate decisions related to mild intellectual disabilities and interventions included staff conducting one to one visits to re-direct and cue when R6 made poor decisions as needed and as resident allowed. R6's care conference progress note dated 9/11/24, indicated R6 smoked, and a policy was explained to R6 and R6 agreed and was reminded of interventions rec. Apron/ no flame lighter. [NAME] Smoking review completed 8/2024. R6's care conference progress note dated 12/11/24, indicated R6 smoked, and a policy was explained to R6 and R6 agreed and was reminded of interventions rec. Apron/ no flame lighter. Safe smoking review completed 8/16/24. Resident is safe to smoke unsupervised. Resident now pays the facility to purchase her cigarettes, tubes and roll her cigarettes. Resident receives 20 cigarettes/day. R6's progress note dated 3/7/25, indicated staff witnessed resident providing a cigarette to another resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's care conference progress note dated 3/12/25, indicated R6 smoked, and a policy was explained to R6 and R6 agreed, interventions included rec. Apron/ no flame lighter. Safe Smoking review completed 8/16/24. Resident is safe to smoke unsupervised. Resident now pays the facility to purchase her cigarettes, tubes and roll her cigarettes. Resident receives 20 cigarettes/day. R6's Safe Smoking Evaluation form dated 8/16/24, indicated R6 smoked, had cognitive loss, did not have a vision deficit, could light her own cigarette, smoked only in designated areas, did not have a history of injuries secondary to smoking, did not need a lighter and cigarettes stored by the facility, check boxes for whether R6 required adaptive equipment were left unmarked. The adaptive equipment check boxes included smoking apron, cigarette holder, supervision, and one on one assistance. Further, the assessment indicated R6's clothing had burn holes and additional check boxes were included under clothing condition if clothing had burn holes. The check boxes included what R6 wanted to do with the clothing if R6 had burn holes: throw away the clothing, keep and continue to wear clothing, and N/A. Not Applicable. N/A was documented. The assessment further indicated R6 knew how to put cigarettes out correctly, knew not to save cigarettes and put them out half way, and was given the risk and benefits of smoking. During interview and observation on 3/17/25 at 3:06 p.m., R6 stated she kept cigarettes with her all the time and was wearing a dark gray sweater with a burn hole and a few smaller holes. R6 stated she didn't burn herself, and put cigarette butts out in the pail and pointed to a small green canister with a small circular opening located on the floor in her room and stated she could not smoke in her room and used the canister for smoking on the third floor. During interview and observation between 3/18/25 at 11:51 a.m., and 11:59 a.m., R6 was at the dining room table and at 11:55 a.m., got up, filled a cup near the water dispenser and left the dining room. At 11:57 a.m., R6 went out the front door, took out a roll of several cigarettes and lit a cigarette with a lighter that had an obvious flame. R6 was wearing a gray shirt that contained burn holes and was not wearing a smoking apron. R6 took out a light blue lighter to light the cigarette. No staff were located outside. At 11:59 a.m., social worker (SW)-A, came outside assisting another resident. SW-A did not ask or encourage R6 to use an apron. During interview and observation on 3/18/25 between 12:05 p.m., and 12:20 p.m., SW-A stated staff looked to care plans to know what cares a resident required and stated R6 was supposed to use an apron in the smoke room if there was one available because R6 got ashes on herself, but because R6 had an ashtray in her room, staff were going to have another smoking assessment completed. Social services assistant (SSA)-B stated she planned to complete the smoking assessment. SW-A verified R6 was not wearing a smoking apron when outside smoking and stated it would be important to encourage the apron because R6 had burn holes on her clothing and the apron prevented cigarette holes because R6 dropped on her clothing. SSA-B stated a no flame lighter was an electric lighter and added she never used or saw a no flame lighter. At 12:15 p.m., SSA-B stated they had an apron that hung in the smoking room, but staff didn't do anything if residents went outside. At 12:19 p.m., R6 pulled out a BIC blue lighter and SSA-B verified R6's lighter was not a flameless lighter at 12:20 p.m., and would look for the flameless lighter identified on the care plan. During interview on 3/18/25 at 12:27 p.m., the director of nursing stated she expected care plans be followed and was important to have an apron to protect R6's clothing and the possibility of burns and planned to follow up as to why R6 did not have an apron and stated they should be closely monitoring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy, Resident Smoking, revised 3/18/25, indicated residents will be safe while smoking, policies will be reviewed upon admission and annually with residents, a smoking assessment will be completed at admission and annually for each resident. Additional assessments will be completed upon significant change or if any safety concerns are identified. The care plan will reflect outcomes of the safe smoking assessment. If there are suspected safety concerns staff will follow up immediately interventions included remind and encourage safe smoking practices, request another safe smoking assessment, document the behavior in the electronic medical record, use of smoking apron, supervised smoking, regulated use of smoking materials, and discharge.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49617 Based on observation, interview, and document review, failed to ensure the posted nurse staffing information included the daily census. Additionally, the facility failed to ensure the posted nurse staffing information reflected accurate total number and actual hours worked per shift for licensed and registered staff for each shift on a daily basis. This had potential to affect all 56 residents or visitors who wished to review the information. Findings include: During observation on 3/18/25 at 9:48 a.m., the posted nurse staffing information was hung above the main reception area and lacked the facility's daily census. The facility's posted nurse staffing information dated 2/17/25 - 3/18/25 were reviewed on 3/20/25 at 8:19 a.m. and indicated no registered nurse (RN) hours worked for day, evening or night shift on the following dates: 3/8/25, 3/9/25, 3/13/25, and 3/16/25. Additionally, the posted nurse staffing information lacked daily census on all reviewed dates. The facility's staffing schedule dated 2/17/25 - 3/18/25 was reviewed on 3/20/25 at 8:19 a.m., and indicated there was RN coverage on 3/8/25 during the evening shift and on 3/13/25 during the day shift. The facility's employee timecards dated 3/8/25 - 3/9/25 verified RN coverage for 3/8/25 and 3/9/25. The facility's employee timecards dated 3/10/25 - 3/20/25 verified RN coverage for 3/13/25 and 3/16/25. During interview on 3/20/25 at 10:54 a.m. with the director of nursing (DON), the employee timecards dated 3/8/25 3/9/25 and 3/10/25 - 3/20/25 were reviewed. The DON confirmed RN coverage for the dates 3/8/25, 3/9/25, 3/13/25, and 3/17/25. The DON further confirmed the posted nurse staffing information lacked accurate data to reflect the total number and actual hours in addition to lacking the facility's daily census. A facility policy pertaining to posted nurse staffing information was requested; however, the administrator did not believe they had one.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48065 Based on observation, interview, and document review, the facility failed to ensure food items were properly stored, labeled, and dated to reduce the risk of physical cross-contamination and potential foodborne illness. This had the potential to affect all 59 residents, staff, and visitors who consumed food from the kitchen. Findings include: On 3/17/25 at 12:11 p.m., an initial kitchen tour was completed with dietary aid (DA)-A. In the walking refrigerator a sheet pan cart with several unwrapped and undated trays contained the following items: * Three trays with about 20 cheese and eggs English muffin sandwiches with a piece of parchment paper on top * Two trays with tater tots with a piece of parchment paper on top * Two trays with apple bran bowls, each containing about 35 bowls with a piece of parchment paper on top. * One tray of mint and chocolate dessert with a piece of parchment paper on top * In the bottom of the cart there were two trays of breaded pieces of chicken, with no parchment paper on top. During interview on 3/17/25 DA-A verified the unwrapped and undated trays and stated, The cook should wrap the trays before she puts them on the freezer. DA-A stated the trays have food prepared in advanced. The food on the trays will be cooked and served for dinner tonight or the next day. During interview on 3/18/25 at 8:15 a.m., the director of nutritional services (DNS) stated we didn't know we had to wrap the trays. DNS stated storing unwrapped food items could posed a risk for cross contamination, especially if something drips. During interview on 3/20/25 at 9:46 a.m. the administrator stated all the food should be labeled with dates and wrapped. It's an infection control issue due to contamination and the risk for foodborne illnesses. Administrator added It's not acceptable. A Food Storage policy was requested but was not provided.