STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E508	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayes Residence	1620 Randolph Avenue Saint Paul, MN 55105

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure call lights were accessible to 1 of 1 resident (R3). Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition and diagnoses of paranoid schizophrenia and post traumatic stress disorders (PTSD). It further included R3 had upper extremity impairment on one side, required staff assistance with most activities of daily living (ADL) and mobility, and was frequently incontinent of bladder and occasionally incontinent of bowel. During observation on 6/25/25 at 8:00 a.m., R3 was sitting in his recliner/lift chair in his room. His call light was stuck inside the bottom of his chair and not within reach. During observation and interview on 6/25/25 at 10:13 a.m., nursing assistant (NA)-A entered the room and assisted R3 to reposition in his chair. NA-A verified his call light was stuck in the chair and that it should be within reach. NA-A attempted to remove the call light from being stuck but was unable to do so and stated they would fix it when he got up for lunch. During interview on 6/26/25 at 8:17 a.m., licensed practical nurse (LPN)-A stated all residents should have their call lights within reach when they are in their room. During interview on 6/26/25 at 11:45 a.m., the director of nursing (DON) stated resident call lights should be placed within reach of the resident in order for them to have access to safety. A facility policy regarding call lights was asked for but not received.

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

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident's wishes for resuscitation were accurately documented in all areas of the medical record for 1 of 36 residents (R24) reviewed for advanced directives. This resulted in an IJ for R24 who would have received CPR against his wishes in the absence of a pulse or respirations. The IJ began on [DATE], when the facility failed to accurately document a resident's code status in the EMR. The facility administrator and owner were notified of the IJ on [DATE] at 5:20 p.m. The IJ was removed on [DATE] at 3:44 p.m. but non-compliance remained at the lower scope and severity of a level D, no actual harm with potential for more than minimal harm, that is not immediate jeopardy. Findings include: R24's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition and diagnoses of delusional disorders and chronic obstructive pulmonary disease (COPD). It further indicated R24 was independent with activities of daily living (ADL) and mobility. R24's face sheet/banner in point click care (PCC) indicated advanced directives: Cardiopulmonary Resuscitation (CPR). R24's physician's orders dated [DATE] as transcribed by the health unit coordinator (HUC), indicated Do Not Resuscitate (DNR). No directions specified for order. Pending confirmation. R24's Physician's Orders for Life Sustaining Treatment (POLST) dated [DATE], located in the paper chart, indicated CPR. R24's POLST dated [DATE], indicated DNR and was signed by R24, but was located in the physician folder awaiting signature from the physician. R24's care plan dated [DATE], indicated Advanced Directive (AD): POLST CPR/Full code with the following interventions: -document changes in AD as needed -ensure R24's health care providers and case manager (CM)/family are aware of current directive and any changes made. -respect R24's wishes around his AD for CPR R24's progress notes dated [DATE], entered by the HUC, indicated hospital preference and code status updated. Upon updating code status resident informed writer that he does not want to have CPR. Code status changed to DNR. However, the electronic medical record (EMR) did not reflect the new code status change, as R24 remained a full code on the face sheet/banner in the EMR. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 2:55 p.m., R24 stated the HUC recently asked him if he wanted to have life saving measures in the event of an emergency and he decided he didn't want to be resuscitated stating if I'm going to die, I'm going to die. During interview on [DATE] at 1:00 p.m., the HUC verified interviewing R24 and completing a new POLST and placed the POLST in the physician folder to await a signature. Further, HUC stated the process for when a resident requested to change their code status (and they don't have a guardian), was to update it in PCC first and then the paper chart. The provider had to sign off on it so it takes awhile to get it in the actual chart (paper). The resident's code status would remain the same until the physician signs off on it (POLST), and once it was signed, the facility would change the AD to the new code status. The HUC further stated the provider was notified by mail or by leaving it in their file at the facility to review and sign the next time they came in. The doctor comes to the facility once a month and the nurse practitioner (NP) comes twice a month. The nurse (facility) can also reach out to the provider directly to get a verbal order for more serious concerns but they don't reach out to them for a change in code status. The HUC stated she does not reach out to the nurse directly to report a resident's change in code status but put's in a progress note which would then populate to the 24-hour report. The nurse was supposed to read the 24-hour report before the start of each shift. The HUC further stated she had explained the POLST to R24 (specifically the difference between CPR and DNR) but the Social Worker (SW) was also able to explain it. During interview on [DATE] at 1:26 p.m., licensed practical nurse (LPN)-A stated if a resident was found unresponsive, they would look in the hard chart under the AD tab (POLST) first for their code status or if they couldn't find it there, then on the face sheet/banner in PCC. LPN-A further stated if a resident wanted to change their code status, they would contact the provider right away and get a verbal order. During a follow up interview at 2:49 p.m., LPN-A stated the HUC was responsible for verbally letting the nurse know if a resident wanted to change their code status and then the nurse should put in a progress note. LPN-A further stated what if a resident was DNR and I'm sitting here doing compressions, that would be a problem. If LPN-A were to see the resident wanted to change their code status in PCC, they would call the provider immediately and get a verbal order to change it. LPN-A was aware R24 changed his AD because they saw the pending order in PCC but LPN-A did not notify the doctor. LPN-A further stated, no one had notified the doctor to her knowledge. LPN-A verified R24's POLST in his paper chart and the face sheet/banner in PCC both indicated to perform CPR and therefore would've performed CPR on R24 in the event of an emergency. During interview on [DATE] at 3:07 p.m., LPN-B stated if a resident was found unresponsive, they would look in the hard chart under the AD tab (POLST) first for their code status or if they were closer to the computer, then on the face sheet/banner in PCC. LPN-B further stated if a resident wanted to change their AD (and they are their own guardian) they would call the provider and get a verbal order to change it. It should be done as soon as possible during the shift. The resident shouldn't have to wait until the next time the provider or NP visits the facility. LPN-B was unaware R24 wanted to change his AD. LPN-B verified R24's POLST in his paper chart and the face sheet/banner in PCC both indicated to perform CPR and therefore would've performed CPR on R24 in the event of an emergency. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview on [DATE] at 4:36 p.m., the director of nursing (DON) stated if a resident was found unresponsive, the first place nursing staff should look for their code status was on the outside of their hard/paper chart which had a red or blue tab. The red tab meant the resident was DNR and the blue tab meant CPR. The staff could also check the resident's code status on the face sheet/banner in PCC if they were closer to the computer. The DON further stated if a resident requested to change their code status the nurse should notify the provider right away to get a verbal order to do so, stating it shouldn't take a lot of time to do, since we have 24 access to our providers. This is important because if a person wanted a code status of DNR/Do Not Resuscitate and we assist in CPR, they made a choice and we are taking that choice always from them and the dignity and autonomy to make that choice themselves. A facility policy regarding AD last updated [DATE], indicated during the quarterly RAI process and with any significant changes of condition, facility staff will: i. Identify, clarify and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive ii. Define and clarify medical issue, review the resident's condition and existing choices and present information regarding relevant health care issues to the resident or resident representative as appropriate to determine continuation or modification of choices of care iii. Assess the resident for decision-making capacity and based on assessment, if the resident is determined not to have decision-making capacity, facility staff will invoke the health care agent or legal representative iv. Identify situations where health care decision-making is needed, such as a significant decline or improvement in the resident's condition v. Changes to the resident choices for advance directives will be documented, included in the resident plan of care, State specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care through resident care plan. vi. Staff must verify the legal authority of the resident's health care proxy, power of attorney, or legal representative before implementing changes to the resident's care preferences, particularly when the resident lacks decision-making capacity. vii. Updates or overrides to previously documented advance directives must be clearly documented in the resident's medical record, with confirmation of capacity or legal authority to make such changes. viii. Informed consent, including documentation of risks, benefits, and alternatives, must be obtained and documented before initiating or increasing any medications or life-sustaining treatments, consistent with the resident's advance directive. ix. Identify the process in which the facility and/or physician do not believe they can provide care in accordance with the resident's advance directives or other wishes on the basis of conscience (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	x. Facility staff shall review, upon admission, the resident's verbal or written CPR/code status wishes; if a resident verbally declines CPR and no written order exists, two staff members shall witness and document the conversation. Staff shall immediately notify the physician and document discussions and actions taken while awaiting a written order. The resident's verbal refusal shall be honored as the care plan unless or until a written physician order is received. XI. In cases where a verbal refusal is not yet ordered but clearly expressed by the resident or representative and appropriately witnessed, staff must honor the resident's wishes regarding CPR. The IJ was removed on [DATE] at 3:44 p.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review, which included an audit of all resident's medical records (physical and virtual) in order to determine any discrepancies in the orders and the residents wishes. If a current advance directive wasn't available, the resident was immediately interviewed to determine their wishes. The facility also reviewed and updated their Advanced Directive and CPR policy and procedure. Education on CPR and Advanced Directive policy and procedure were provided to nursing staff and social services on [DATE], (in person for staff present, and electronically for staff who were not present).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a comfortable environment, having hot water available for 4 of 4 residents (R36, R34, R31, R15) who were received for concerns with cold showers. Findings include: R36's admission Minimum Data Set (MDS) assessment dated , 4/10/25 indicated cognition moderately impaired and independent for personal hygiene cares including bathing/shower. R36's care plan indicated independent with set up, it was very important showering early in the morning assist as needed. If declines offer at another time and day. R34' s admission MDS assessment dated , 3/26/25 indicated cognitively intact and set up or clean up assistance for personal hygiene cares including bathing/shower. R34's care plan indicated independent with set up assist as needed. If declines shower on assigned date offer another time or day. R31's quarterly MDS assessment dated [DATE] indicated cognitively intact and independent with set up for personal hygiene cares including bathing/shower. R31's care plan indicated prefers tub bath, requires set up assist and assist in/out of whirlpool tub. Independent with shower with set up assist. During observation on 6/25/25 at 8:08 a.m., R15 complained of cold water in the shower to another resident in the main hallway. Stated they took a shower on Monday, and it was ice cold. Observed another resident stated they took a shower, too cold on Monday and today. During interview on 6/23/25 at 6:41 p.m., R36 reported that they requested to take shower at approximately 5:00 a.m., always had been an early riser. Asked staff to open shower, staff won't. R36 stated it was a simple request, benefits staff for starting showers early, but they acted like its an inconvenience. R36 discussed situation with director of nursing (DON-D), the answer R36 reported was, shower rooms were under the staff's care, it was their rules. The showers were usually cold, R36 washed and rinsed off very quickly. During interview on 6/23/25 at 7:39 p.m., R 31 reported the water for showers were cold, like really cold. The shower rooms were locked, staff won't open shower rooms without being rude. They acted like it was a big deal, and R31 was being a bother. During interview on 6/24/25 at 8:45 a.m., R34 reported there wasn't hot water in the shower and the towels and wash cloths were locked up, talked with staff, was told to go ask housekeeping for towels, staff were not going to get them for me. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 6/25/25 at 8:08 a.m., with environmental services director (EVS-A) stated maintenance checked the boiler temperature, documentation not observed. Requested temperature for water coming out of shower head fixture, unable to temp, the facility had a broken water thermometer, did not report, did not know when facility would get a new one. Re-confirmed that the temperature from the shower head fixture could not be assessed, EVS-A verified unable to obtain water temperature from the shower. Obtained boiler temperature in the basement, the thermometer read almost 100 degrees Fahrenheit. EVS-A stated boiler temperature for warm showers was 120 degrees F. The boiler system was more than [AGE] years old, multiple repairs requested, had a quote for a new system for building. During interview on 6/25/25 at 8:21 a.m., R15 reported liked taking warm showers in the morning. Their days are Wednesday and Saturday, the water had been cold. Stated told nurses, they say not to take a shower if the water is cold. They need to wait until there was hot water, can wait over a day to get hot water. R15 stated not seen staff temp water, they ran hand under the shower water. Sometimes staff go downstairs and check. Sometimes the nurse will come and inform me when there was hot water, and then R31 was able to shower During interview on 6/26/25 at 12:07 p.m., with DON-D stated was aware of cold water in the showers the boiler will overheat, tripping off a safety switch, not send the warm water upstairs, only the cold water. Maintenance was responsible for the monitoring of safety switch, and water temperature with the boiler. The showers were locked in safety and monitoring of residents, the showers needed to clean and sanitized between each use. The towels and linen were held for residents until use for infection prevention. The shower hours were in place, so the medication passes and meals were not interrupted. Staff made accommodations for requests when able. During interview on 6/26/25 12:22 p.m., with the administrator-C, stated was aware of cold water in the showers, repair company worked on water heater, it kept tripping, a reset was needed. Called service company had maintenance staff trained on how to perform the task. Additionally, had parts replaced, the boiler system was old. The facility also received quote for replacing heater. The expectations for the residents regarding showers was to choose day and time, one to two times a week, a shower or a tub, if able. The staff was to be flexible with resident's requests. The temperatures were obtained in tub with a gauge, was unaware the facility had a broken water thermometer. Administrator stated they had their own water thermometer. They will investigate it; they temped water in the past. The times for the shower were flexible if it did not interrupt medication passes, mealtimes, or quiet nighttime hours. The showers are locked in safety of the residents and ability to clean and sanitize between residents' usage. The Hot Water Policy: Purpose: To ensure adequate hot water in building. Procedure: *Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained with a within a temperature range of 105 degrees Fahrenheit to 115 degrees Fahrenheit at the fixtures. *The Environmental services staff shall maintain a quarterly temperature log (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*If the temperature is outside of above temperature range, staff will call Environmental Services Director or Designee to inform; if unable, staff to call Administration inform. If EVS or Designee is unable to detect and resolve failure, staff will call St. [NAME] Boiler Repair (651) [PHONE NUMBER], Cities 1 (651) [PHONE NUMBER] (or similar HVAC company) and request emergency repair.

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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** Based on observation, interview and document review, the facility failed to provide quality of care for 1 of 1, resident (R34) to ensure bruises were adequately assessed, monitored and documented. Findings include: R34's Minimum Data Set (MDS) dated [DATE], indicated Brief Interview for Mental Status (BIMS) cognition score 13, cognitively intact. R34's Care Area Assessment (CAA) for mood dated 3/26/25, indicated mood severity score 12. Risk for change in mood due to mental illness and needed to adjust to new environment. Staff to observe for change in mood, offer support and reassurance, and update doctor/Psych as needed. Functional abilities: R34 is new admit to [NAME] from home for ongoing support services for mental health and diabetes management. R34 was living in family home with brother until home sold. He was alert and oriented with forgetfulness, mental illness had diagnosis of schizoaffective disorder with baseline delusion about Satan and how he tried to control him. Had challenges of coping with his anxiety and become overwhelmed, with racing paranoid thoughts causing R34 to become fearful about trying new things, causing low energy and lack of motivation affecting his ability to complete activities of daily living (ADL). R34 had delusions since admit self-reporting to writer that when he was watching TV downstairs Satan told him to stop watching TV and then tells him to hit himself. R34 benefited from validation and reassurance. Had been followed by ACT team and will continue to be routinely seen by psychiatry. PHQ-2-9 assessment completed with score 12 indicating moderate depression. R34 stated was lonely often due to being shy and difficult being in crowds. Nurse to do foot/skin checks weekly any abnormalities document in progress note. Skin risk assessment on 6/24/25, identified risk for bruising due to daily use of aspirin. R34 was independent with all activities of daily living and mobility with no assistive devices used. Continent of bowel and bladder. The nurse was to check feet/skin for changes weekly. Currently has bruise under left eye stated the devil told him to hit himself. R34's current physician orders included the following: Shower/bath during week, assist as needed, start date 3/22/25 Monthly weight, start date 3/22/25 Monitor change in mental status and progress note the changes, if any. Start date 3/20/25 Clozapine oral tablet 100 mg, 2 tablets by mouth daily, start date 4/11/25 Clozapine oral tablet 50 mg, ½ tablet by mouth at bedtime, start date 4/30/25 Standing orders for Skin and Wound management: -Assess all wounds and dressings daily (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Complete wound measurements weekly if not a higher frequency by ordering provider -Moisture barrier cream or ointment two times a day as indicated to keep irritants or moisture from skin surface -Moisturizing cream two times a day as needed for dry skin -Cleanse minor skin tear, abrasions, pressure injury, and minor injuries with normal saline or non-cytotoxic wound cleanser. Cover with non-adherent dressing and secure appropriate cover dressing avoiding tape to the skin. -Change all dressings every 3 days and as needed -May initiate pressure reduction mattress and/or occupational therapy wheelchair positioning eval and treat as clinically indicated for patients with, or at high risk for skin breakdowns. -Discontinue dressings and other treatments when wound resolved. For localized reaction apply cold compress 15 minutes every two hours as needed. Notify provider if worsening or no improvement in 24 hours. R34's Treatment Administration Record (TAR) dated June 2025 reflected the following: Nurse to do, monitor change in mental status and progress note the changes, if any. Every day and evening shift, start date 3/20/25. Shower/bath every Saturday start date 3/22/25 Skin check, nurse to do, one time a day every Saturday document abnormal finding in progress note, start date 3/22/25 Self-injury related to command hallucinations, repetitive questions. Repetitive questions. Anxiety and obsession surrounding medical conditions: excessive blood sugar monitoring and repeated testing, rumination, redundant outreach to providers, etc. Offer non-pharmacologic intervention and document response: 1) Massage 2) Redirection 3) Music Therapy 4) Change of surrounding 5) Validation Therapy 6) Warm Blanket 7) Doll therapy 8) Pet therapy 9) Family visit 10) Spiritual Care every shift for Behavior Monitoring related to SCHIZOAFFECTIVE DISORDER, BIPOLAR Document if target behavior was observed and interventions provided, start date 3/22/25 Monitor change in mental status and progress note the changes, if any, start date 3/22/25 R34's care plan dated (6/26/25): Focus: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34 experienced chronic auditory hallucinations, included derogatory and command voices, which have previously led to self-injurious behavior. Recently, R34 reported hitting himself under the influence of these voices, resulted in a bruise under his left eye. Although he currently denies active self-harm urges, he acknowledged that symptoms could intensify with increased anxiety, paranoia, or change in routine. R34 was aware of his symptoms, receptive to support, and agreed to engage with staff and clinical supports to manage internal stimuli and prevent harm. Start day 4/22/25 Goals: Remain free from self-injurious behavior or risk of harm to self/others through the review period. Start date 4/22/25 Report any negative internal stimuli or urges to self-harm to staff upon on onset for intervention and support. Start date 4/22/25 Demonstrate use of at least one positive coping strategy when distressed by hallucinations. Start date 4/22/25 Work with staff and providers to explore distress tolerance and cognitive strategies to challenge hallucinations and associated behaviors. Start date 4/22/25 Interventions: Collaborate with clinical providers to support R34 participation in distress tolerance training, cognitive behavioral therapy, or similar interventions aimed at challenging hallucinations and associated thoughts/behaviors. Start date 4/22/25 Collaborate with clinical providers to update and review safety plans and coping strategies regularly with R34. Start date 4/22/25 Conduct frequent check-ins to assess mental state, especially signs of increased anxiety, paranoia, or preoccupation with hallucinations. Start date 4/22/25 Encourage and facilitate the use of positive coping strategies. Start date 4/22/25 Encourage open and nonjudgemental communication. Document and report any signs of distress, changes in routine, or signs of self-injurious behavior immediately. 4/22/25 If at any point R34 poses imminent threat of harm to himself or others, staff are to contact emergency medical services (EMS)/authorities, inform clinical management, update providers and emergency contacts, and document accordingly. Start date 4/22/25 If R34 reports that he has self-injured, assess for signs of injury, report to clinical management, and utilize EMS when necessary. Offer hospital evaluation and/or connection with [NAME] County Crisis. Start date 4/22/25 R34's electronic health record (EHR) was reviewed on 6/24/25 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayes Residence	1620 Randolph Avenue Saint Paul, MN 55105

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's Medical Medication Review on 6/24/25 reported no changes. Provider notes: R34 provider note dated 6/5/25 presented for review of systems, hypertension, schizoaffective disorder. Physical examination: psychiatric, orientated to person, place and time, anxious. Skin: warm and dry. No rashes or lesions on exposed skin. R34 denied any blood pressure issues or mood concerns. He thinks he is otherwise doing ok. Plan: continue Clozaril, following with psych. R34 provider note dated 5/13/25 presented for follow up. R34 told me doing well but concerned of feeling tired easily. No concerns per nursing staff. Physical examination: psychiatric: orientated to person, place and time, judgement appropriate, mood and affect appropriate. Skin: warm, dry. No rashes or lesions on exposed skin. Plan: continue Clozaril, following with psych, monthly CBC. R34 provider note dated 4/9/25 presented for follow up, no complaints, other than oral sores, no bleeding appointment for dentist. No concerns per nursing staff. Skin: Warm and dry. No rashes or lesions on exposed skin Psychiatric: Oriented to person, place and time. Judgment appropriate, mood, and affect appropriate. Plan: Continue Clozaril, following with psych, monthly CBC. R34 provider note dated 3/27/25 presented for long term care admission, schizoaffective disorder. Skin: Warm and dry. No rashes or lesions on exposed skin. Psychiatric: Oriented to person, place and time. Judgment appropriate, mood, and affect appropriate. Plan: continue Clozaril, following with psych. Ordered CBC, CMP, TSH, hba1c. Progress notes: R34 progress note dated 6/24/25 social services followed up with resident again regarding preoccupation with roommate's fan use and belief that he cannot be exposed to dry air medically. Writer explained options were being discussed with clinical management to decide on best rooming option and inquired if he would be open to moving to an open double room contingent on all parties agreeing and clinical indications. Resident was receptive to this and will follow-up with writer once other residents have been addressed. Writer updated DON and administrator. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34 progress note dated 4/22/25 Writer followed up on nursing note that resident had purple bruise under his left eye that he reports was a result of Satan telling me to hit myself. Per skin/wound note resident was assessed to have no open wounds/swelling, reported pain, and agreement to communicate regarding these thoughts and actions in the future. R34 confirmed that he had tapped hard on my temple, pointing to left side of face where centimeter long purple bruise was noted. He did not have any residual pain, however, agreed to allow staff to monitor with report made to doctor, psychiatry, and ACT team. R34 endorsed chronic auditory hallucinations of the devil making derogatory statements about his character and command hallucinations instructed himself to hit himself: A couple years ago I gave myself two black eyes. Resident noted that he generally manages these voices and urges well, however, when he is anxious or paranoid they tend to escalate. Resident acknowledged that changes in his medication i.e. Metformin discontinuation had elevated his anxiety, however, he understood clinical rationale given by (nurse practitioner) NP. Writer assessed for safety and resident denied any current urges to self-harm or presence of unsafe thoughts or internal stimuli. Resident declined need to be evaluated in the hospital setting, however, was made aware that if he is at risk of harm to self in future evaluation may be recommended. Encouraged resident to communicate openly if experiencing these symptoms and utilize staff as support to devise safety plan, discussed ability to reach out to ACT team, brother, or crisis team as coping skill alongside spending time outside of his room and reading the Bible. Resident was receptive and in agreement to expand care plan to include the above and explore onboarding with therapist to practice distress tolerance and challenging voices. Staff will continue to monitor and update providers ongoing. R34 progress note dated 4/21/25 The resident was seen a with purple bruise under his left eye. He stated, Satan makes him hit himself. There were no open wounds, nor swelling. Asked him to speak with staff when he is having these thoughts or conversations. he said he would. During observation on 6/24/25 at 8:45 a.m., left eye red bruise underneath it. During interview on 6/24/25 at 8:45 a.m., R34 stated he did it to himself and refused to elaborate. During interview on 6/24/25 at 9:49 a.m., nursing assistant (NA-A) stated R34 had a bruise under left eye, inquired what happened, R 34 stated, Satan beats his ass. R34 reported a way to calm down was to pray. NA-A documented findings in progress note, and updated charge nurse. During interview on 6/26/25 at 11:38 a.m., with licensed practical nurse (LPN-A) the process for a non-pressure injury was assess it, implement standing orders, notify doctor, measure and describe it in progress note and skin and wound, continue to monitor and document assessment until healed. Also, fill out an incident report. Additionally, report to director of nursing (DON). If the injury is of unknown origin do investigation, research, and evaluate, and document findings. It was an expectation for staff to follow doctor's orders. LPN-A reviewed point click care (PCC) electronic health records (EHR), hard chart that contained paper documentation, stated there was a bruise documented in progress notes by NA-A, however, no follow up of nurse initial evaluation of injury. Furthermore, documentation lacked any additional assessments for monitoring of injury. R34 skin assessment checks on 6/7/25, 6/14/25 and 6/21/25 documented skin assessment was completed, no bruises observed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/25 at 12:03 p.m., with director of nursing (DON-D) the expectation of staff if a skin injury was observed, contact the lead nurse, release standing house orders for wound care and observation treat injury accordingly. Monitor and assess skin injury daily, document in PCC under skin assessment and progress note. Additionally, fill out an incident report and if its behavioral, notify behavior team. The expectations for all staff to was follow doctor's orders. A facility policy for Skin Assessment updated on 6/26/25 reflected: Purpose: To assure skin impairment was identified, assessed and treated in a timely manner. Guidelines: Completes a head-to-toe skin assessment/skin check by nursing staff to observe for skin changes and address wound care needs. Procedure: 1. Provide for resident privacy and explain procedure to the resident. Maintain dignity during skin assessment by exposing only one area at a time 2. Assessment was conducted from head to toe in systematic order. The nurse conducting the assessment does not have to remove dressing-only confirms a wound exists and the documentation and treatments have been established. 3. Assess skin surfaces for *Reddened areas *Heat *Tenderness *Excoriations *Rashes *Spongy areas *Bruises *Breaks in skin integrity, including new skin tears or abrasions *Areas of dry, scaly, or cracked skin 4. Document skin condition. NAs to communicate to nurse on duty for any observed skin conditions for further nursing assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. If the skin assessment reveals a change requiring treatment, orders, and/or interventions, the nurse will initiate the appropriate action. 6. Nursing staff to utilize standing house orders for general wound care management and treatment. Additional orders for treatment/management of wounds requiring care beyond standing house orders to be received from provider.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure weekly monitoring and measurement of pressure ulcers were completed for 1 of 1 resident (R3). Findings include: R3's quarterly Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognition, delusions, and diagnoses of paranoid schizophrenia and Post Traumatic Stress Disorder (PTSD). It further included upper extremity impairment on one side, required supervision with bed mobility, substantial assistance with toileting hygiene and transfers, was frequently incontinent of bladder and occasionally incontinent of bowel. R3's physician's orders dated 6/17/25, indicated nursing staff to measure wounds on right and left buttocks weekly and document in the nursing progress notes, in the evening every 3 days for wound care. It further included an order dated 1/19/24, which indicated weekly skin checks (to be done on shower day) every night shift, (Friday) for skin monitoring and to document any skin abnormalities in the progress notes. R3's care plan dated 6/20/25, indicated on 6/10 during morning (a.m.) cares night staff found a pressure ulcer (open area) on both buttocks. The right side measured about 2.5 centimeters (c.m.) by 2 cm while the left side measured 0.3 c.m. by 0.5 cm. Report was passed to next shift to follow-up with the order for wound care. It further included the following interventions: -Administer treatments as ordered and monitor for effectiveness. -Educate the resident/family/caregivers as to causes of skin breakdown: including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. -Monitor dressing Allevyn and Optiview dressing to right and left buttock to ensure it is intact and adhering. Report lose dressing to treatment nurse. - Monitor nutritional status. Administer 8 ounces (oz.) Boost glucose control one time a day for healing. Document amount consumed and discontinue if develops loose stool. Ok for equivalent brand. diet as ordered, monitor intake and record. -Nursing: Allevyn and Optiview dressing to right and left buttock. Change every 3 days until healed. -Nursing: measure wounds on right and left buttocks weekly and document in nursing progress notes. -Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. -The resident requires : pressure relieving/reducing device on chair and bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Treat pain per orders prior to treatment/turning etc. to ensure resident comfort. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. R3's skin and wound notes for the months of May and June of 2025 indicated the following: -6/24/2025 R3's bottom was looking good, no drainage, no odor. Dressing changed today and measured. Right buttocks was 2 c.m. in width and 2 c.m. in length, left buttock was 3 c.m. in width and 4 c.m. in length. No complaints of pain to the area. Will continue to monitor healing process. -6/17/2025 R3's progress note lacked documentation the wounds had been measured. -6/10/25 during morning care, open area was noted on both buttocks, the right side measured 2.2 c.m. by 2 c. m. while the left side measure 0.3 by 0.5 c.m. Report passed to next shift to follow up with the order of wound care. -6/3/25 R3's medical record lacked documentation the wounds had been monitored or measured. -5/28/25 R3's medical record lacked documentation the wounds had been monitored or measured. -5/22/25 R3's medical record lacked documentation the wounds had been monitored or measured. -5/16/25-The gluteus maximus of the resident was observed. It appears to be purple and blue in color 4 inch by 4 inch across bilateral aspect. There seems to be some openings bilaterally. Left side 1 inch long, 0.5 c. m. wide, the area is blanchable. Staff will continue to monitor and document that resident continues to offload his weight. -5/8/25 R3's medical record lacked documentation the wounds had been monitored or measured. -5/1/25 late entry: During the brief change noted R3 had purple and blue bruising to his buttock. The resident was up and cream applied. R3's progress note lacked documentation to continue to monitor and/or measure the area. During interview on 6/26/25 at 8:17 a.m., licensed practical nurse (LPN)-A stated the nurse was responsible for completing weekly skin checks. R3 had a pressure ulcer on his buttocks and he was supposed to have his wounds measured, dressing changed, and documentation every 3 days. They don't have an official wound doctor but if the wound get's worse they should inform the provider. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 6/26/25 at 11:45 a.m. the director of nursing (DON) stated the nurses were responsible for performing weekly skin checks and if the resident refused, the nurse was still expected to document what they could see and/or document the refusal. If a resident developed a new pressure ulcer, it should be measured, document the description, provide basic wound care, continue to monitor, and then get a wound care order from the provider. They do not have formal wound rounds but they monitor all residents on a weekly basis. The DON further stated on 5/1/25, she noticed R3 had bruising on his buttocks and put in a progress note regarding it. She didn't measure it because he was firing everyone. The TMA (unknown) said it had been there for awhile so she asked staff to keep an eye on it. The DON verified she hadn't put in a note to monitor the area and R3's medical record lacked documentation of consistently monitoring and measuring his pressure wounds weekly and it should have been. The facility policy regarding treatment and services to prevent/heal pressure ulcers dated 5/1/25, indicated if a pressure ulcer was present, appropriate staff within proper scope and practice will provide treatment and services to heal it and to prevent infection and the development of additional pressure ulcers.

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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** Based on observation, interview and record review the facility failed to ensure a root cause analysis and ensure interventions were implemented for 1 of 1 residents (R5) reviewed for falls. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 had moderately impaired cognition and diagnoses of paranoid schizophrenia. R5 required substantial assistance for toileting and partial assistance to transfer from bed to chair. R5 was at risk of falls and had 2 or more falls since the prior assessment. R5's fall risk assessment dated [DATE], indicated R5 was at high risk for falls due to intermittent confusion, 1-2 falls in the past 3 months, chair bound and need for assistance with elimination. R5's nursing progress note dated 6/13/25 at 8:15 a.m., indicated R5 was found on the floor at 7:50 a.m., R5 was sitting upright with her back against the bed reaching for their shoes. Apparently, R5 had slid out of bed. No injury was noted. R5 was assisted back to bed. The TMA staff remained with R5 for morning cares. A facility document titled Fall assessment dated [DATE], indicated R5 had an unwitnessed fall. The document indicated R5 was transferring in their room and had glasses in place. There was no indication if R5 had appropriate footwear. The form indicated R5 used a wheelchair and was unsteady. The form lacked indicate of a root cause for the fall or what may have contributed to the fall. The form also lacked indication R5's care plan and treatment sheet were reviewed, or interventions implemented. R5's nursing progress note dated 6/23/25 at 12:03 a.m., R5 was found lying on the floor next to their bed. R5 told staff wanted to use the bathroom. R5's legs were extended with socks on. R5 was assisted back to bed with an assist of 2. A facility document titled Fall assessment dated [DATE], indicated R5 had an unwitnessed fall. The document indicated R5 was transferring in their room and had glasses in place. R5 did not have appropriate footwear in place, used a wheelchair and was unsteady. The form lacked indicate of a root cause for the fall or what may have contributed to the fall. The form also lacked indication R5's care plan and treatment sheet were reviewed, or interventions implemented. R5's care plan revised 5/12/25, indicated R5 was at risk for falls due to food drop, a shuffling gait, and walking on tip toes when in pain. Interventions included encourage use of cane or rolling walker, monitor gait and keep provider up to date of changes, and provide skin checks weekly. R5's care plan lacked indication falls interventions had been revised after the 6/13/25 or 6/23/25 fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 6/25/25 at 7:26 a.m., R5 was in bed sleeping. R5 was laying curled up and was lying sideways in their bed. R45's wheelchair was folded and had been placed next to the bed. Nursing assistant (NA)-A entered the room. NA-A moved the wheelchair out of the way to see if R5 wanted to get up. R5 was agreeable and the folded wheelchair was further moved out of the way to the end of the bed. NA-A assisted R5 to get straightened out in bed. R5 had regular socks on. NA-A and NA-B then assisted R5 with shoes and then unfolded the wheelchair and transferred R5 to the chair. Supplies were gathered and R5 was brought to the bathroom. When interviewed on 6/25/25 at 7:54 a.m., NA-A stated R5 was a fall risk and had been falling more lately and had fallen over the weekend. NA-A was not aware of any interventions R5 needed to help prevent falls and stated staff round every hour or so to check on residents. NA-A verified the care plan was used to determine what interventions were in place and verified the interventions were not related to the resident self-transferring to use the bathroom. When interviewed on 6/258/25 at 8:10 a.m., licensed practical nurse (LPN)-A stated when a resident falls, the nurse needs to assess them to see if there was any injury. If no injury was noted, the resident would be assisted up and monitored for the next 24 hours. Monitoring would include skin check, vitals, neuro checks if they hit their head. The family and provider would be notified. Then a progress note would be written. LPN-A stated a paper form would be filled out that described the situation around the fall. Then that form would be filed in the chart. LPN-A stated there was a new risk management form in the electronic medical record, however, that wasn't in use yet and paper forms were still used for risk management. LPN-A verified R5 had recent falls and didn't have a paper risk management form that was in use. LPN-A stated it must have been completed and placed in the chart. LPN-A further stated the DON or Administrator would update the care plan for any new interventions. When interviewed on 6/26/25 at 8:32 a.m., the Director of Nursing (DON) expected nurses to complete a risk management form and monitor for 24 hours. The nurses were expected to complete the details and determine the root cause of the fall. After that, the DON signed off on the form. Any new interventions would be entered by the nurse or MDS nurse. DON verified R4 was at risk of falls and had become weaker over the past several months. DON verified R5 had a fall from bed on 6/13/25 and 6/23/25. DON stated nurses were supposed to be switching to the risk management forms in the EMR, however they were not found. DON stated when the falls risk managements were requested, she completed it with what she knew about the fall from the progress notes and the resident. DON was not aware if a root cause analysis was completed or if new interventions were determined due to not being able to get to the electronic risk management report. A facility policy titled Fall Assessment Policy revised 6/2025, directed staff to re-assess residents with any fall, complete an incident report, and notify the provider and family. Any incident involving a resident will be reviewed by the DON to assure the resident's safety plan was appropriate.

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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. Based on observation, interview and record review the facility failed to ensure resident snack refrigerator temperatures were maintained to prevent food and drink items from spoiling and items in the snack refrigerator were labeled and dated. Furthermore, the facility failed to ensure the dishwasher was reaching temperatures required for proper sanitization and expired milk was removed from the main kitchen refrigerator. This had the potential to affect all residents who reside in the facility. Findings include: A facility document titled Nursing Refrigerator Log (bottom fridge) dated 6/2025, directed staff to notify maintenance if the temperature was greater than 41 degrees F. The document indicated temperatures were monitored on the following dates: 6/19/25, for 40 degrees Fahrenheit (F) -6/20/25, no temperature recorded -6/21/25, no temperature recorded -6/22/25, no temperature recorded -6/23/25 50 degrees F. -6/24/25 48 degrees F. A facility document titled Dish machine Temperature Log dated 6/2025, indicated temperatures were monitored twice daily and were within range for washing and rinsing. The document instructed staff to notify the supervisor if temperatures were not adequate. Wash temperatures were to be 150 degrees F. and rinse temperatures 180 degrees F. An observation on 6/23/35 at 6:27 p.m., the resident snack refrigerator was reviewed. On the outside of the refrigerator was a temperature log. The last temperature recorded was on 6/19/25 and the temperature was 40 degrees F. The refrigerator had two unlabeled, open half empty cups of vanilla snack pudding cups in the door. There was also an unlabeled take-out container. The fridge also contained two pitchers of juice and an open gallon of 2 percent milk. The items in the refrigerator felt warm. A round temperature gauge read 50 degrees F and was in the red zone. When interviewed on 6/23/25 at 6:32 p.m., trained medication assistant (TMA)- A verified the open items in the refrigerator. TMA-A stated the pudding was likely from medication passes and stated they should not be left in there open and unlabeled. TMA-A further stated the take-out container also should have been labeled. The items were removed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 6/23/25 at 6:35 p.m., licensed practical nurse (LPN)-B verified the temperature of 50 degrees F. and stated the items were a little warm. LPN-B was not aware of any temperature issues with the snack refrigerator and would need to let the maintenance team know. LPN-B further stated the night shift was responsible for monitoring the temperatures and writing it down on the log. An observation on 6/23/25 at 7:39 p.m., the snack refrigerator temperature was reviewed. The temperature now read 48 degrees F and was still in the red zone on the thermometer. This was verified by LPN-B. An observation on 6/24/25 at 8:35 a.m., the refrigerator in the main kitchen was reviewed. Inside was a half-gallon of Dairy Star lactose free milk had a best by date of 6/18/25. When interviewed on 6/24/25, at 8:40 p.m., cook-A verified the expired milk and further stated on Mondays, the cook would go through and check items and removed anything that was old or out of date. Cook-A further stated this must have been missed. An observation on 6/24/25 at 8:52 p.m., the snack refrigerator was reviewed. The log on the outside of the refrigerator was updated for 6/23/25 and a temperature of 50 degrees F was recorded. The temperature read 46 degrees F and was still in the red zone on the thermometer. The refrigerator still contained the opened gallon of 2 percent milk. When interviewed on 6/24/25 at 9:00 a.m., LPN-A verified the temperature. LPN-A was not aware of any concerns about the refrigerator temperatures and verified it was unknown when the last time it was in range. LPN-A verified residents had not had milk out of there today and stated it needed to be thrown out and maintenance would need to be notified. An observation on 6/25/25 at 10:38 a.m., the Eco lab high temperature sanitization dishwasher was observed. Two temperature dials were noted on the top of the machine. The wash temperature dial stated needed tor reach 150 degrees F. The rise temperature dial stated needed to reach 180 degrees F. During a wash cycle, the wash temp reached 160 degrees F on the dial and the rinse temp reached 115 degrees F. Cook-A ran the load again and the wash temperature was 160 and the rinse temperature was 120. Cook-A stated there had been some problems with the rinse gauge and wasn't sure what was wrong with it, and further stated it was working this morning. Cook-A further stated would need to let the owner know as he knows how to reset it. At 10:48 a.m., Cook-A was setting up tables for lunch. The owner walked by and cook-A did not report the low dishwasher temperatures. At 11:19 a.m., cook-A ran another dishwasher load, and the wash temperature was 160 degrees F, and the rinse was 120 degrees F. An observation on 6/25/25, at 1:13 p.m., cook-A was finishing the last load of dishes from lunch. The wash temperature was 155 degrees F, and the rinse temperature was 120 degrees F. Cook-A verified it still was not showing the correct temperature. Cook-A stated they weren't sure about the temperatures, but the dishes coming out were hot. Cook-A further stated the owner, maintenance and Ecolab were all aware and wasn't sure when it would get fixed or how to ensure the temperatures were in range. (continued on next page)

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	24E508	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hayes Residence	1620 Randolph Avenue Saint Paul, MN 55105

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When interviewed on 6/25/25 at 1:45 p.m., the Environmental Service Director (ESD) stated he was aware of an issue with the temperature gauge not working correctly and stated he had checked it sometimes but had not been told about it today. ESD further stated the machine was rented from Ecolab and they should be notified and fix it. ESD was aware of the snack refrigerator not being at the correct temperature on 6/24/25. ESD further stated staff often adjust the dials when they should not be and verified it takes a while to get the temperature back to where it should be. When interviewed on 6/25/25 at 2:37 p.m., the clinical dietician (CD) was told the dishwasher hadn't been getting to the correct temperature when checking in with staff. CD stated the facility had recently obtained a 180-degree testing strip and a surface temp plate that could be used to verify if temperatures were not reading correctly. CD stated these were new and there training had not been completed with any staff until today after hearing the temperatures were not reading accurately. When interviewed on 6/26/25 at 8:20 a.m., the Director of Nursing (DON) expected nursing staff to monitor the refrigerator temperatures were too warm, maintenance should be notified and items should be removed and placed in the kitchen refrigerators. When interviewed on 6/26/25 at 11:50 p.m., the owner stated the dishwasher gauge had not been working and it was first noticed on 6/21/25. The owner stated he had turned it off and then back on a few times to reset the machine and then it would read properly. On 6/21/25, Ecolab had been called and a message left, however had not come out. On 6/25/25, they did come out in the evening and everything was working correctly now. A facility policy titled Dish Machine Temperature revised 6/25/25, directed staff to ensure wash temperatures were 150 degrees F, rise temperatures were 180 degrees F, and surface temperatures were 160 degrees F. Staff were to notify supervisor when temperatures were not adequate and describe corrective action taken in the log. If maintenance staff were not ale to resolve, staff will notify Ecolab for emergent repair. A facility policy for food storage was requested however was not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure separately purchased bed rails and bed frame were compatible for 1 of 1 resident who was reviewed for bed rail use. Findings include: R8's quarterly Minimum Data Set (MDS) dated [DATE], indicated R8 had moderate cognitive impairment and diagnoses of schizophrenia. R8 had grab bars in place and was independent with sitting to standing and bed mobility. R8's care plan revised 3/17/24, indicated R8 was at risk for falls related to gait instability and used a grab bar on the bed to assist with independent bed mobility and transfer. The manufactures recommendations for R8's bed rails installed at the time of entrance was requested however was not received. An observation on 6/23/25 at 6:40 p.m., R8 was lying in their bed. R8's bed was placed against a wall and had a bed rail placed on the other side. The bed rail mounted in the middle of R8's bed in a sleeve like bar. R8 grabbed the rail to assist themselves up to the edge of the bed. The rail did not appear to be tight and had movement back and forth. R8 stated he wouldn't be able to get up by himself without the bar. R8 stated it always moved some and showed it slid in that sleeve up and down some as well as back and forth. When interviewed on 6/24/25 at 1:50 p.m., licensed practical nurse (LPN)- A stated residents were assessed quarterly for use of bed rails or grab bars. When a resident wanted one or could use one, nursing completed an assessment and then maintenance was notified to install them. LPN-A was aware R8 had a bed rail in place to help with mobility and wasn't aware of any problems with it. LPN- A verified R8's bedrail moved back and forth and slid up and down. LPN-A stated maintenance would need to be notified. When interviewed on 6/24/25 at 1:59 p.m., the Environmental Service Director (ESD) stated bed rails applied when there was a provider orders. Quarterly checks were completed to ensure the rails were secure. ESD reviewed the completed logs. Maintenance-A was already in R8's room attempting to tighten the railing and told ESD the bar would not tighten any further and R8 didn't want the bar to be moved up towards the top of the bed. ESD verified R8's bed rail was loose and further stated the rail was not made for that bed. Some of the beds need to be updated, but there were budget constraints. Maintenance-A and ESD attempted to determine the manufacturer of the bed rail, and the bed were, however, were unable to. ESD stated the bed and rail had numbers on them, but there was no manufacture name. ESD stated he had put the bar in place and had put some extra screws in it to ensure it was secure. ESD acknowledged this could be a safety issue and further stated some of the beds and rails were old and there was no way to determine compatibility. ESD had been trying to make it work for R8 how he wanted it. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview on 6/25/25 at 1:45 p.m., ESD verified R8's bed rail had not been addressed yet. ESD stated R8's room would need a deep clean next week, and it would have to have another screw placed to be more secure. When interviewed on 6/25/25 at 3:04 p.m., the Administrator expected nursing to notify maintenance when a side rail assessment was completed, and one could be installed. Bed rails were expected to be installed per manufacturer's guidelines. The Administrator further stated the only rails ordered were universal rails that were compatible with all kinds of beds as there are different beds in use. R8's loose bed rail was confirmed by the Administrator stated this was a safety risk and would be changed out right away. A facility policy titled Bedrails revised 6/26/25, directed staff to ensure the bed was appropriate for the resident and the bed rails were properly installed per manufacturers guidelines.