



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 16, 2025

Administrator
St Anthony Park Home Inc
2237 Commonwealth Avenue
Saint Paul, MN 55108

RE: CCN: 245063
Cycle Start Date: May 29, 2025

Dear Administrator:

On May 29, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 29, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/29/2025
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments On 5/27/25 - 5/29/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 5/27/25 to 5/29/25, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, complaint investigations were also completed. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. MN 00105923 H50637193C MN 00107162 H50635470C MN 00107448 H50635471C MN 00108231 H50635472C MN 00108536 H50635473C MN 00109471 H50635475C MN 00109860 H50635474C MN 00110466 H50635476C	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2025

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.

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550			7/3/25

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F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience by serving meals on hard plastic trays which had the potential to affect all residents who ate in the dining room. Additionally, the facility failed to ensure all staff knocked on individual resident bedroom doors and introduced themselves prior to entry for 1 of 1 residents (R62) reviewed with concerns with staff entering their room. Findings include: DIGNIFIED DINING: R47's quarterly Minimum Data Set (MDS) assessment, dated 4/11/25, indicated R47 was severely cognitively impaired with no hallucinations or delusions. Further indicated R47 was set up assistance for eating.	F 550	Disclosure: It is the policy of St Anthony Park Home to follow all Federal, State, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission and implementation of this plan of correction will serve as our credible allegation of compliance. F550 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice.		

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F 550	Continued From page 3 During an observation on 2nd floor dining room on 5/27/25 at 8:41 a.m., residents were observed to be eating breakfast. On the table in front of each resident was a breakfast meal that sat on a hard plastic tray. During an observation on 3rd floor dining room on 5/27/25 at 8:44 a.m., residents were observed to be in the dining room eating breakfast. In front of all residents, were a hard plastic tray that contained breakfast items. R40 was observed to be seated in his wheelchair with his head down on his plate which sat on a hard plastic tray. Unidentified staff prompted him to sit up and eat. R40's hard plastic tray, which contained breakfast items, was moved from directly in front of him and R40 put his head back on the table. On 5/27/25 at 12:03 p.m., the lunch meal service on the first floor was observed in the main dining room. The room had multiple tables present with residents seated at each and, in the middle of the room, was a large metallic mobile cart which had meal trays inside them. The staff members removed the trays from the mobile cart, brought them to another table and set them down while they prepared drinks, and then took the drinks and place them back onto the hard-plastic meal tray. The entire hard-plastic tray was then delivered to the seated resident at their table. However, the hard-plastic service trays were then left on the table with plates, cutlery and drinks on top of them. During this time, no staff serving trays were observe to ask or offer to remove the items from the tray and place them onto the table. At 12:07 p.m., R13 was observed eating from the hard-plastic meal tray despite sitting at the table. When asked about using a tray despite being at the table, R13 shrugged his shoulders and	F 550	No lasting effect noted related to failure to knock on door for R62. Affected resident was interviewed to ensure their right to privacy is being met. No lasting effect noted related to dining experience for R47, R40 and R13. R47 and R40 were asked about being served the plastic trays during meals, both residents had no concerns. R13 deceased on 6/17/25. Dining changes were made to ensure a homelike environment, and meals will not be served on trays in dining rooms beginning July 3, 2025. All staff educated on door knocking and dignified dining during all staff training. R40 was evaluated for the need of supervision during dining, care plan reviewed with no changes made 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practices. Staff educated on resident rights and dignity. Dining changes were made to ensure a homelike environment, and meals will not be served on trays in dining rooms beginning July 3, 2025. All staff educated on door knocking and dignified dining during all staff training. 3)What measures will be put in place or		

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F 550	Continued From page 4 responded aloud, "I don't mind it." R13 added, "Given the clientele here, on the plate [removed from tray] would be too messy." At 12:09 p.m., a single table positioned by the hallways was observed which had three residents present along with nursing assistant (NA)-A and NA-B whom were seated at the same table. The three residents each had a hard-plastic meal tray placed in front of them on the table and were being assisted with eating by NA-A and NA-B. NA-A and NA-B were asked about the trays being used and both responded meals were "always" served on them, adding items weren't removed from the trays and placed on the tables as everything "comes together" on the tray from the kitchen. Further, NA-A and NA-B expressed nobody from management had ever told them to offer to remove items from the trays for residents when served. During an observation on 3rd floor dining room on 5/27/25 12:08 p.m., residents were observed coming to the dining area for lunch. Lunch carts were brought to 3rd floor and delivered to the 2nd floor dining room by unknown dietary staff. Each lunch cart was an enclosed metal cart on wheels with slots which held hard plastic trays that contained resident meals. Each slot could hold two hard plastic trays which could be slid from the front or back of the approximately 6-foot metal cart. The hard plastic trays each contained a paper slip that identified who the meal was intended for, and a plate of food that was sitting on a plate warmer covered with a hard plastic dome shaped lid. The tray contained a set of silverware along with a napkin. Staff grabbed the trays from the lunch cart, added the drinks that were requested from a different cart, and delivered the entire tray to residents sitting at the	F 550	what systemic changes will you make to ensure that the deficient practice does not recur. Door Knocking The organizations policy on Dignity was reviewed and is up to date. Staff educated on expectation that staff knock, introduce self and wait for permission to enter residents room. Dining Staff educated on serving patients in a dignified manner with home like environment. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Door knocking, and dignified dining will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 550	Continued From page 5 table. Staff left the food and drinks on the hard plastic tray that contained the entire meal including the drinks and silverware. At 12:23 p.m., R47 was served lunch on the hard plastic tray, just as all residents were. R47 was non-interviewable. During an observation on 5/27/25 at 12:28 p.m., all residents (approximately 15) seated in the second-floor dining room were observed at dining tables with filled cups and plates placed on top of hard gray plastic trays. During interview on 5/27/25 at 12:41 p.m., registered nurse (RN)-B stated resident food and drinks came on trays so they were served in the same manner. RN-B stated residents usually seemed to eat okay with their food and drinks on the trays and was not aware of any concerns with food or dining. During an interview on 5/27/25 at 12:51 p.m., nursing assistant (NA)-F stated it was the nursing assistant's responsibility to serve the residents the meals during mealtimes, make sure they get what they need, and give them their preferences. NA-F stated all meals were served on hard plastic trays as "that is how we are supposed to do it." NA-F stated the meals came up from the kitchen that way and it was expected to serve it that way. NA-F stated it was more dignified to serve meals on hard plastic trays but was not able to explain this. On 5/28/25 at 11:29 a.m., the dietary manager (DM) was interviewed, and they verified each floor's meal service was done on hard-plastic serving trays. DM stated they had, prior,	F 550			

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F 550	Continued From page 6 attempted to remove the trays and leave items on the table but then some residents got upset. As a result, they just served all meals on the trays to everyone, however, DM expressed removing the items and placing them on the table was "more dining etiquette." DM stated the management had a discussion about this, however, it was not recorded or documented adding they had discussed potentially care-planning which residents wanted or didn't want the trays kept on the table. Further, DM stated they had not ever brought the issue to the resident council for review or input, either, adding aloud, "I never thought about that." During an interview on 5/29/25 at 12:58 p.m., the administrator and director of nursing (DON) verified residents had not been individually assessed for preferences on meals served on hard plastic trays. Furthermore, they stated it has not been discussed during resident council meetings. DON stated after the last annual survey they discussed dining with residents but did not recall if the conversations were related to serving meals on the hard plastic trays and how that related to a dignified dining experience, nor did they have documentation of any such conversations. DON stated no resident care plans had been updated to reflect preferences regarding a resident's preference to keep their meals on a hard plastic tray. DON and administrator verified it was important to have a dignified, home-like dining experience for residents as this was their home. A policy regarding dignified dining was requested and not received.			F 550			

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F 550	Continued From page 7 ROOM KNOCK During observation and interview on 5/27/25 at 2:34 p.m., R62 was in their bed in a shared room near the window and furthest from the door. Nursing assistant (NA)-I peeked into the room without knocking, made an unheard comment, and then brought in linens and set them on a chair close to the door before exit. R62 confirmed they did not hear a knock on the door. Surveyor exited the door after interview with R62, and NA-I entered R62's shared room without knocking and went into the bathroom. During interview on 5/27/25 at 2:55 p.m., NA-I acknowledged not knocking on R62's door. During interview on 5/28/25 at 2:13 p.m., R62 stated he was bothered by staff entering the room when not knocking and stated the action made him feel "vulnerable". During interview on 5/29/25 at 8:17 a.m., NA-F stated staff should knock on residents' doors before entering, introduce themselves with their name, and explain why they are there. During interview on 5/29/25 at 1:46 p.m., registered nurse (RN)-E expected staff to knock and announce themselves when entering a room. During interview on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON) stated they would not want anyone "barging" in their home and could be "scary" if staff did not have permission to enter. The facility Quality of Life - Dignity policy dated 4/17/24, indicated residents' private space and property shall be respected at all times. The	F 550			

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F 550	Continued From page 8			F 550			
F 552 SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits, for 4 of 4 residents (R56, R10, R40, R47) reviewed for use of psychotropic medications. Findings include: R56 R56's significant change in status Minimum Data			F 552	1)What corrective actions will be accomplished for those residents found to be affected by the deficient practice No lasting effect noted related to, failure to obtain and document informed consent, including explanation of risks and benefits for R56, R10, R40 and R47. Affected residents were provided with consent form and risks vs benefits. All documentation uploaded to resident records.		7/3/25

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F 552	Continued From page 9 Set (MDS), dated 4/10/25, identified R56 had both long-term and short-term memory impairment, demonstrated hallucinations during the review period, and had episodes of rejection of care behaviors. The MDS recorded R56 as consuming multiple psychotropic medications and being on hospice care while a resident. R56's Order Summary Report, signed 5/2/25, identified R56's current provider-ordered medications and treatments. These included lorazepam (anti-anxiety medication) 0.5 milligrams (mg) three times a day scheduled and every 4 hours as needed (PRN), haloperidol (anti-psychotic medication) 0.5 mg every 4 hours PRN, and Dilaudid (narcotic medication) 1 mg every hour as needed for pain/shortness of breath. In addition, R56's Medication Administration Record (MAR), dated 5/2025, identified R56's medications and treatments along with spacing to record their administration or refusals. The MAR recorded multiple administrations of the PRN medication(s) including: On 5/5/25 at 10:23 a.m., R56 was given a PRN dose of haloperidol which had a response recorded as, "U [unknown]." A corresponding progress note, dated 5/5/25, identified the medication was given with symptoms recorded, "agitated yelling help help." On 5/19/25 at 4:31 a.m., R56 was given a PRN dose or lorazepam which was recorded as effective. However, R56's medical record was reviewed and lacked evidence a signed consent for use of the medication was obtained prior to them being			F 552	2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents taking psychotropic medications have the potential to be affected by the deficient practice. Consent forms are completed for all residents receiving psychotropic medications. Nurses educated on the right to be informed on 7/1/25 & 7/2/25. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Consent forms are completed for all residents receiving psychotropic medications. Psychotropic informed consent policy reviewed by IDT and is up to date. Staff educated on the need for informed consent along with risks vs benefits for psychotropic medications before placing a new order or changing a dose on 7/1/25 & 7/2/25. 4)How the corrective actions will be monitored to ensure the deficient practice will not recur. Consent form audits will be completed weekly for 1 month, then monthly for 2 months. Audit review and analysis will be		

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F 552	Continued From page 10 provided. Further, the record lacked evidence the risks of expected benefits of the medication regimen had been reviewed or discussed with R56 or his responsible family member prior to initiation of the medications. On 5/29/25 at 8:34 a.m., a telephone call was placed to R56's family member (FM). However, they were unable to be reached. When interviewed on 5/29/25 at 9:30 a.m., licensed practical nurse (LPN)-A explained the medical provider who ordered the medication was responsible to review the medication risks and benefits with the resident adding the direct care nurses rarely, if ever, do it. LPN-A added, "Usually we don't [do that]." LPN-A reiterated, "Usually the nurse practitioner does." LPN-A stated any conversation on the medications, including consent or risks and benefits, would be charted in the progress notes. R10 R10's quarterly Minimum Data Set (MDS), dated 3/21/25, indicated R10 was cognitively intact, had no hallucinations, delusions, behaviors and did not refused cares. MDS indicated R10 was independent with activities of daily living and mobility. MDS indicated diagnoses of Alzheimer's disease, hypertension, anemia and arthritis. R10's Clinical Orders, printed 5/28/25, indicated orders for quetiapine fumarate (antipsychotic medication used to treat schizophrenia, bipolar disorder and depression) 125 milligram (mg) tablets via gastric tube for anxiety, paranoia related to bipolar disorder currently in remission.	F 552	brought to QAPI to determine ongoing frequency and duration of audits 5)Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 552	Continued From page 11 R10's electronic medical record lacked a consent including risk and benefits related to the anti-psychotic medication. During interview on 05/28/25 at 1:48 p.m., LPN-A stated she was not sure if R10 had a consent to take a psychotropic medication. R40 R40's annual MDS assessment, dated 3/21/25, indicated R40 was moderately cognitively impaired with no hallucinations or delusions, no behaviors, wandering or rejection of care. MDS indicated R40 was on an antidepressant. Relevant diagnoses included: depression. R40's Order Summary Report, printed 5/27/25, included the following orders: -duloxetine HCL (antidepressant medication) give 60 milligrams (mg) by mouth one time a day for depression R40's May's Medication Administration Record (MAR), printed 5/28/25, included the following orders: -"DULoxetine HCl Oral Capsule Delayed Release Particles (Duloxetine HCl) Give 60 mg by mouth one time a day for depression -Start Date- 10/10/2024." Documentation indicated administered as ordered. A review of R40's progress notes in the electronic medical record (EMR), dated 11/27/24 to 5/28/25, lacked documentation of education being provided regarding duloxetine.	F 552			

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F 552	Continued From page 12 Review of R40's entire EMR lacked evidence of a signed consent for antidepressant medication which would include risks, benefits and alternatives. R47 R47's quarterly Minimum Data Set (MDS) assessment, dated 4/11/25, indicated R47 was severely cognitively impaired with no hallucinations or delusions, no behaviors or rejection of care. MDS did note R47 wandered daily. Further, identified R47 was on an antidepressant. R47's relevant diagnoses included: Parkinson's disease without dyskinesia and without fluctuations (a disorder of the central nervous system that affects movement, often including tremors), orthostatic hypotension (condition when blood pressure decreases when rising from sitting or lying down causing dizziness, lightheadedness or fainting), dementia (a group of thinking and social symptoms that interferes with daily functions), depression, psychotic disorder, hypopituitarism (condition where the pituitary gland doesn't produce enough hormones), benign neoplasm of pituitary gland, and tremor. R47's Order Summary Report, printed 5/29/25, included the following orders: -Celexa (antidepressant medication) give 10 mg by mouth one time a day for major depressive disorder with a start day of 5/13/25. R47's May Medication Administration Record (MAR), printed 5/29/25, included the following: - "CeleXA Oral Tablet 10 MG (Citalopram Hydrobromide) Give 10 mg by mouth one time a day related to MAJOR DEPRESSIVE	F 552			

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F 552	Continued From page 13 DISORDER, RECURRENT, IN FULL REMISSION (F33.42). Start celexa after zoloft is d/c [discontinued]-Start Date- 05/13/2025." Documentation indicated administered as ordered. - " Sertraline (antidepressant medication) HCl Tablet 25 MG Give 25 mg by mouth one time a day for Major Depression Disorder related to MAJOR DEPRESSIVE DISORDER, RECURRENT, IN FULL REMISSION (F33.42) for 7 Days -Start Date- 05/06/2025. " Documentation indicated it was administered all scheduled days except 5/11/25 and 5/12/25 when it was coded as "6" indicating R47 was hospitalized. - "Sertraline HCl Tablet 25 MG Give 50 mg by mouth one time a day for Major Depression Disorder related to MAJOR DEPRESSIVE DISORDER, RECURRENT, IN FULL REMISSION (F33.42) -Start Date- 11/21/2023 0900 -D/C Date- 05/05/2025." Documentation indicated administered as ordered. During an observation on 5/27/25 at 12:30 p.m., R47 was observed sitting at the dining room table for lunch. During an observation on 5/28/25 at 9:04 a.m., R47 was observed sitting in the dining room in his wheelchair with his eyes closed. R47 does not respond to questions when asked. A voicemail was left for resident representative (RR)-B on 5/29/25 at 9:35 a.m. requesting a call back. No return call was received. A review of R47's progress notes in the EMR, dated 4/1/25 to 5/29/25, lacked documentation of notification of starting new antidepressant (Celexa), decreased doses of sertraline, or	F 552			

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F 552	Continued From page 14 notification to the RR-B. Furthermore, lacked documentation of risks vs benefits of medications or alternatives. Review of R47's EMR lacked evidence of a signed consent for antidepressant medication which would include risks, benefits and alternatives. During an interview on 5/29/25 at 10:23 a.m., registered nurse (RN)-A stated that floor nurses did not obtain consents for any psychotropic medications. RN-A stated she was unaware of who did that and added "I know we (floor nurses) don't do that." On 5/29/25 at 12:50 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed the medical records for R56, R10, R40, and R47. ADON acknowledged the lack of a clear signed, informed consent for several of the residents' psychotropic medications and explained the "standard practice" was to notify family when a medication was started and to document that. ADON verified the records lacked evidence of this, and explained they were currently trying to develop a consent form to record this moving forward. ADON stated consent was important as residents and families have "the right to choose if they want to take that medication or not." During interview on 05/29/25 at 1:34 p.m., director of nursing (DON) stated their QAPI (Quality Assurance and Performance Improvement) team had been talking about psychotropic medications. DON stated the facility needed to get consents and educate the residents and families about psychotropic			F 552			

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F 552	Continued From page 15 medications to ensure residents were aware of the risks and benefits, and it was documented.	F 552			
F 554 SS=D	A facility policy on residents rights regarding medications was requested and not received. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication was administered safely for 1 of 1 resident (R10) who had been assessed as unable to safely self-administer medications. Findings include: R10's quarterly Minimum Data Set (MDS) dated 3/21/25, indicated R10 was cognitively intact, had no hallucinations, delusions, behaviors and did not refused cares. MDS indicated R10 was independent with activities of daily living and mobility. MDS indicated diagnoses of Alzheimer's disease, hypertension, anemia and arthritis. R10's Clinical Orders printer 5/28/25, indicated orders for levothyroxine sodium 75 micrograms (mcg) by mouth once a day in the evening without a diagnosis for this medication. Levothyroxine is prescribed for hypothyroidism. R10 also had and order for NPO (nothing per mouth) except for pleasure foods in liquid form. All other medications were ordered to be administered via	F 554	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R10 medications were reviewed for proper administration. Self-administration assessment performed on 6/14/25 indicated resident should not self-administer medication. Reviewed diagnosis for Synthroid was hypothyroidism that was entered in her record 11/3/16. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. All self-administration orders have been reviewed to ensure the appropriateness. Care plans and orders updated as needed 3) What measures will be put in place or	7/3/25	

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F 554	Continued From page 16 tube feeding (TF). R10's care plan printed 5/28/25, indicated she had impaired cognition/thought processes related to Alzheimer's disease and bipolar disorder and directed staff to administer medications as ordered. Also, the care plan indicated R10 had hypothyroidism and directed staff to give thyroid replacement therapy as ordered. R10's Self Administration of Medications Assessment (SAM) dated 3/16/25, indicated resident did not want to self-administer her medications and was not able to identify the expiration date of each medication. During observation and interview on 5/27/25 at 10:36 a.m., R10 was in her room sitting at the edge of the bed. Two round pills were observed on the floor. R10 stated "sometimes the nurses leave my thyroid medication in a small cup, and I take it on my own. Sometimes the pill slips out of my hand, falls on the floor, and I often forget to tell the nurses, and they don't ask if I took it." R10 added, "I don't take the medication in front of the nurses, they leave the room. I put the pill in my mouth, take a sip of water and let the pill dissolve and I swallow it." During interview on 5/27/25 at 10:46 a.m., licensed practical nurse (LPN)-B stated R10 can swallow a little bit and takes the pill with water. LPN-10 stated she did not know why R10 took this medication by mouth when all other medications were administered through her TF. During interview on 5/28/25 at 1:48 p.m., LPN-A stated she usually worked in the evenings, and R10 took her levothyroxine by mouth. LPN-A	F 554	what systemic changes will you make to ensure that the deficient practice does not recur. Nurses educated on the 6 rights of med pass and self-administration of medication assessment on 7/1/25 & 7/2/25 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Self admin of medication and medication administration competency audit to be performed weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 554	Continued From page 17 stated the nurses tried to give it, but sometimes R10 couldn't take it or wanted to take it later. "I leave the medication with her, I go back to her room and if the medication is no longer in the medication cup, it means she [R10] took the medication. I don't see her taking the medication." LPN-A stated R11 had never reported dropping the medication on the floor. LPN-A verified the SAM indicated R10 was not able to self-administer medications and had no order for self-administration of medications. During interview on 5/28/25 at 2:21 p.m., nurse manager/registered nurse (RN)-E verified R10 did not have a physician's order to self-administer medications. RN-E also verified R10's SAM indicated she was not capable of self-administering medications. During interview on 05/29/25 at 1:25 p.m., director of nursing (DON) stated on admission a SAM was completed for all residents. DON stated if a resident requested to self-administer their own medications, the nursing staff will determine if it's appropriate and call the physician to obtain an order for self-administration of medications. DON stated the expectation was for nurses to administer the medications as ordered and never leave the medications at bed side without an order for self-administration. Facility's policy titled Self-Administration of Medications dated 12/13/21, indicated as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.	F 554			

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F 570 F 570 SS=B	Continued From page 18 Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident personal fund accounts were insured with adequate surety bond coverage (a contract or promise by a surety or guarantor to pay a certain amount if a second party fails to meet the obligation) to cover the total account balance. This had potential to affect all residents identified to have an account with a positive balance. Findings include: During interview on 5/29/25 at 8:42 a.m., the administrative assistant (AA) stated the total amount of resident funds in the facility was \$91,117.79. Immediately after interview with AA, the administrator was asked to provide the facility's surety bond amount. A Resident Trust Fund Surety Bond dated 3/10/25, indicated the facility had a surety bond in place for up to \$50,000 with an effective date of 5/1/25. During an interview on 5/29/25 at 2:45 p.m., the administrator stated their bond amount was based on an average of their 12-month balance.	F 570 F 570			7/3/25

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F 570	Continued From page 19 The administrator stated one resident had a recent property sale which made the resident balance higher than usual and accounted for \$40,000 in resident accounts. The administrator acknowledged the \$91,117.79 total resident fund amount and \$50,000 surety bond and stated they would provide more current documents. In an email sent on 5/30/25 at 6:04 p.m., the administrator identified R17 and one other resident's balance made up more than \$58,000 of the total resident fund amount balance. The email included the following attachments: -R17's Resident Statement Landscape dated 5/30/25, identified a balance of \$20,995.70 after a \$20,656.46 credit from a bank on 5/23/25. -A facility Trial Balance document dated 5/28/25, identified 166 residents (included residents with no balance) had an account at the facility. The total amount of these accounts was recorded as \$91,117.79. The facility Deposit of Resident Funds policy dated 8/15/23, indicated resident personal funds held and managed by the facility would be safeguarded. The policy lacked information about a resident trust fund surety bond.	F 570			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity	F 577			7/3/25

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F 577	Continued From page 20 to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent recertification survey along with subsequent complaint investigation results were readily available and accessible within the care center. This had potential to affect all residents, staff, and visitors whom could wish to review the information. Findings include: The Centers for Medicare and Medicaid (CMS) Aspen Central Office (ACO) database identified the most recent standard recertification survey was exited on 8/7/2024, with 15 health (i.e., F-Tags) issued. Further, the ACO database identified an abbreviated complaint survey was exited on 10/8/24, which had immediate jeopardy (IJ) findings cited.	F 577	The survey results from the most recent standard recertification survey with the exit date of 8/7/2024 and abbreviated complaint survey dated 10/8/24 were added to the facilities survey binder, so it continues to be readily accessible to current residents, family members and legal representatives of residents. All residents, family members or legal representatives of residents have the potential to be affected by this deficient practice. An audit of the public survey binder was completed in the month of June to ensure completeness. The organizations policy on Examination of Survey Results was reviewed and updated. The administrative		

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F 577	Continued From page 21 On 5/28/25 at 1:56 p.m., an interview was completed with resident (R18) whom often attended the monthly resident council meeting. R18 stated they were unsure where in the care center the most recent state agency (SA) survey results were kept. Immediately following, on 5/28/25 at 2:06 p.m., a tour of the care center main floor was completed. A white-colored binder labeled, "Annual Survey Results 2023-2024," was found on a lower shelf down by the administrators office. This binder was inspected, however, neither the most recent recertification survey (exited 8/7/24) nor the abbreviated complaint survey (exited 10/8/24) results were contained in the public binder for review. On 5/28/25 at 2:11 p.m., the administrator was interviewed. He verified the white-colored binder kept adjacent to his office was the only location on the campus where the survey results were posted. The administrator reviewed the binder, and verified it lacked the most recent standard survey (exited 8/7/24) or the abbreviated survey (exited 10/8/24). The administrator stated he was responsible to update the binder and the lack of those results were an "oversight." The administrator verified the most recent results should be available for public review without having to ask for them. A facility provided Survey Results, Examination Of policy, dated 4/2024, identified a copy of the most recent standard survey along with a state-approved plan of correction (POC) would be kept, " ... in a 3-ring binder located in an area frequented by most resident, such as the main			F 577	team who managed the survey book at time of deficient practice was educated on the facilities policy. The monthly QAPI agenda was updated with a new topic called "Survey binder update" ensuring monthly updates should it be needed. Administrator or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 577	Continued From page 22	F 577			
F 605 SS=D	lobby or resident activity room." Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3) (d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 605			7/3/25

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F 605	Continued From page 23 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 605			

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F 605	Continued From page 24 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure symptoms of potential psychiatric distress were recorded; and non-pharmacological interventions were attempted then documented prior to the use of as-needed (i.e., PRN) psychotropic medication to improve continuity of care for 1 of 5 residents (R56) reviewed for unnecessary medication use. Findings include: R56 R56's significant change in status Minimum Data Set (MDS), dated 4/10/25, identified R56 had both long-term and short-term memory impairment, demonstrated hallucinations during the review period, and had episodes of rejection of care behaviors. The MDS recorded R56 as	F 605	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No lasting effect noted related to failure to record symptoms of psychiatric distress and non-pharmacological interventions used prior to giving PRN for R56. Non-pharmacological interventions prior to PRN use added to the MAR 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. Staff educated on documentation of behaviors and non-pharmacological interventions.		

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F 605	Continued From page 25 consuming multiple psychotropic medications and being on hospice care while a resident. On 5/28/25 at 7:36 a.m., R56's morning cares were observed with nursing assistant (NA)-A and NA-B involved. R56 was lying in bed which had an air-pressure mattress in place; along with staff helping to wash him up. R56 would converse with staff as they provided care, however, it was not always sensical to the situation including, "A bridge of bread, that's perfect for ya." NA-A and NA-B completed R56's morning cares without R56 having any visible, physical behaviors towards them. R56's care plan, dated 9/2024, identified R56 had behaviors including yelling, cursing, accusations and physical aggression. The care plan listed multiple non-pharmacological interventions which could be attempted including redirection, distraction, and providing a calm environment. The care plan continued and identified R56 consumed psychotropic medications due to sleep issues and behavioral needs. The care plan directed to administer the medications as ordered, monitor for their effectiveness, and monitor/record occurrences of R56's target behaviors and interventions. R56's Order Summary Report, signed 5/2/25, identified R56's current provider-ordered medications and treatments. These included lorazepam (anti-anxiety medication) 0.5 milligrams (mg) three times a day scheduled and every 4 hours PRN, haloperidol (anti-psychotic medication) 0.5 mg every 4 hours PRN, and Dilaudid (narcotic medication) 1 mg every hour as needed for pain/shortness of breath.	F 605	Non-pharmacological interventions added to all PRN psychotropic orders. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Psychotropic medication policy reviewed by IDT. Staff education provided on PRN medications and non-pharmacological intervention including documentation on 7/1/25 & 7/2/25. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Psychotropic medication audits will be completed weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 605	Continued From page 26 R56's Medication Administration Record (MAR), dated 5/2025, identified R56's medications and treatments along with spacing to record their administration or refusals. The MAR recorded multiple administrations of the PRN medication(s) including: On 5/5/25 at 10:23 a.m., R56 was given a PRN dose of haloperidol which was recorded as, "U [unknown]." A corresponding progress note, dated 5/5/25, identified the medication was given with symptoms recorded, "agitated yelling help help." However, again, the note lacked what, if any, non-pharmacological interventions were attempted or offered prior to the medication. On 5/19/25 at 4:31 a.m., R56 was given a PRN dose of lorazepam which was recorded as effective. A corresponding progress note, dated 5/19/25, identified the medication was given, however, lacked any symptoms R56 displayed to warrant the medication nor what, if any, non-pharmacological interventions were attempted prior to help calm or settle R56 down. Further, the MAR recorded on 5/19/25 at 4:30 a.m. (same time), R56 was provided Dilaudid for a pain rating of six (6) and was recorded as effective. However, again, the record lacked information or evidence on what symptoms R56 displayed, rationale why both medications were provided at nearly the same time nor what, if any, non-pharmacological interventions were attempted prior to multiple PRN(s) being given. R56's POC (Point of Care) Response History, printed 5/29/25, identified spacing for staff to record behaviors and interventions attempted to reduce them. This identified:	F 605			

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F 605	Continued From page 27 On 5/5/25, R56 was recorded as having no behaviors present by the nursing assistant (NA) staff members. The corresponding response of interventions attempted recorded, "Response Not Required." On 5/19/25, R56 was recorded as having no behaviors present by the NA staff members. However, the corresponding response of interventions recorded staff attempted providing a calm environment but the behavior was unchanged. This entry of the intervention attempted was recorded at 6:43 p.m. (over 12 hours after the PRN medication was given). When interviewed on 5/29/25 at 9:30 a.m., licensed practical nurse (LPN)-A stated R56 demonstrated behaviors like calling out and would, at times, become immediately aggressive with staff adding, "It can be challenging [to care for him]." LPN-A stated R56 was hard of hearing which they felt contributed to his behaviors, and expressed staff often had to leave him alone and then reproach him to get cares done. LPN-A stated giving R56 snacks seemed to help with his behaviors. LPN-A explained if a PRN medication needed to be given, staff should attempt non-pharmacological interventions prior and those should be documented in the progress notes. LPN-A stated PRN medications should only be given "one at a time" and rarely, if ever, should multiple ones be given at the same time. LPN-A stated it was important document symptoms and the non-pharmacological interventions attempted so as "to see if that will help and stuff before you give the medication." LPN-A added, "Maybe he just needs someone to talk to, or maybe he's hungry."	F 605			

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F 605	Continued From page 28 On 5/29/25 at 12:50 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed R56's medical record. ADON stated, "I saw what you saw," and verified the lack of consistent symptom or non-pharmacological charting with the PRN medication use. ADON stated the charting was a PIP (performance improvement project) they were addressing and verified staff should be attempting and charting symptoms and non-pharmacological interventions with PRN psychotropic medication use. ADON stated this was important to help the IDT see "what's working and not working" for the resident. ADON added medication may not always be needed if non-pharmacological interventions were attempted prior.	F 605			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656			7/3/25

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F 656	Continued From page 29 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan for hospice care and services was developed and/or readily available to promote continuity of care for 1 of 1 resident (R56) reviewed for hospice services. Findings include: R56's significant change in status Minimum Data Set (MDS), dated 4/10/25, identified R56 had both long-term and short-term memory	F 656	1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No lasting effect noted on R46 related to cares due to lack of comprehensive care plan for hospice not readily available. Comprehensive care plan was provided by hospice to be placed in hospice binder. The need to reassess PRN		

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F 656	Continued From page 30 impairment and demonstrated hallucinations and rejection of care behaviors. Further, the MDS outlined R56 received hospice services while a resident. On 5/28/25 at 7:19 a.m., R56 was observed lying in bed while in his room. R56 could be heard from the hallway speaking aloud and had mostly non-sensical speech, however, at times would have statements which could be understood such as, "Thank you very much, goodbye," and, "What's the subject matter?" R56 would also, at times, shout loudly with, "Help me!" A female staff member did enter R56's room and expressed staff would be down shortly to help get him up and ready for the day. R56's facility care plan, dated 4/16/25, identified R56 was at the end stage(s) of life and using hospice or palliative care services. The plan listed a goal which read, "The resident will be comfortable," along with interventions including calling hospice when new physician orders were received, coordinating with hospice and other end-of-life services, and others which read: "Hospice pastoral care visits are scheduled for: See hospice binder at nursing station," "Hospice social service visits are scheduled for: See hospice binder at nursing station," "The Hospice [sic] staff will provide bathing services on: See hospice binder at nursing station," "Medications will be ordered through: See hospice binder at nursing station," and,			F 656	psychotropics was audited to make sure the box was checked in the medication order to be reassessed on 6/18/25. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents on hospice have the potential to be affected by the same deficient practice. All hospice resident binders were checked to ensure all care plans were included and up to date. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Care Plan and Hospice policies reviewed on 6/26/25. The Care Plan policy was reviewed with staff on 7/1/25 and 7/2/25. Copy of Hospice policy faxed to all hospice teams. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Hospice binders will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025		

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F 656	Continued From page 31 "Supplies will be ordered through: See hospice binder at nursing station." The facility' care plan lacked any further specifics on these services nor how often they'd be provided for R56 while at the care center. A white-colored binder was located at the nursing station which was labeled, "Our Lady of Peace Hospice & Home Care," along with a telephone number to contact them. This binder was inspected and R56's name was recorded inside. The binder contained various medical paperwork including a POLST (Provider's Orders for Life Sustaining Treatment), hospice emergency contact information, and multiple 'summary' notes completed by hospice staff when they visited. The binder included a yellow-colored copy of the Service Agreement and Election of Hospice Benefit, dated 4/3/25, which identified a hospice registered nurse (RN), social worker (SW), and chaplain would visit along with anticipated frequencies (i.e., 1-2 times/month); however, lacked information on what services these disciplines would be doing or performing while onsite with R56. R56's medical record and hospice binder both lacked a complete, comprehensive care plan detailing what services the outside hospice agency would provide. SEE F684 FOR ADDITIONAL INFORMATION. On 5/28/25 at 9:07 a.m., licensed practical nurse (LPN)-B was interviewed, and explained they were waiting for a call back from hospice as some of R56's as-needed medication supply had expired. LPN-B stated there was no hospice aide coming in to see R56 to their recall and the hospice nurse (HRN) they'd see about "once a	F 656			

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F 656	Continued From page 32 week, if I'm lucky." LPN-B stated the HRN typically visited with R56 for a bit and then left again adding such was "what a majority of them do." LPN-B stated they couldn't recall ever seeing a hospice care plan in R56's binder of information but then added, "I can't say I've looked, either." When interviewed on 5/28/25 at 10:02 a.m., HRN stated they visited the campus once or twice a week, and the hospice SW would visit once or twice a month. HRN stated they typically obtained R56's vital signs and reviewed him for pain control when they visited. HRN stated they'd also, at times or if needed, visit with R56's family members on his condition. HRN stated the hospice care plan was usually housed in their own "electronic record" which was "just for us" with no care center staff having access to it. HRN stated a copy should have likely been printed and placed into R56's binder of information. On 5/28/25 at 1:30 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had looked into R56's hospice binder and medical record. ADON stated the care center had hospice outlined on their own care plan, however, the interventions were "somewhat generic" and mostly directed to the hospice binder for information. ADON verified the hospice care plan was not provided prior to survey and expressed it was important to have both the care center and hospice plans together and available so staff were "on the same page." A provided Care Plans - Comprehensive policy, dated 6/2022, identified an individualized, comprehensive care plan with measurable objectives and timetables would be developed for each resident. This care plan was to be	F 656			

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F 656	Continued From page 33	F 656			
F 684 SS=D	developed within seven (7) days after the completion of the comprehensive MDS. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to coordinate care with an outside hospice agency to ensure ongoing, consistent care delivery and promote comfort for 1 of 1 resident (R56) reviewed for hospice services. In addition, the facility failed to assess and appropriately monitor developing bruising to ensure healing for 1 of 1 resident (R46) reviewed who had visible bruising on their skin. Findings include: R56 R56's significant change in status Minimum Data Set (MDS), dated 4/10/25, identified R56 had both long-term and short-term memory impairment and demonstrated hallucinations and rejection of care behaviors. Further, the MDS outlined R56 received hospice services while a resident.	F 684			7/3/25

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F 684	Continued From page 34 On 5/28/25 at 7:19 a.m., R56 was observed lying in bed while in his room. R56 could be heard from the hallway speaking aloud and had mostly non-sensical speech, however, at times would have statements which could be understood such as, "Thank you very much, goodbye," and, "What's the subject matter?" R56 would also, at times, shout loudly with, "Help me!" A female staff member did enter R56's room and expressed staff would be down shortly to help get him up and ready for the day. R56's facility care plan, dated 4/16/25, identified R56 was at the end stage(s) of life and using hospice or palliative care services. The plan listed a goal which read, "The resident will be comfortable," along with interventions including calling hospice when new physician orders were received, coordinating with hospice and other end-of-life services, and multiple others including, "Hospice pastoral care visits are scheduled for: See hospice binder at nursing station," and, "Medications will be ordered through: See hospice binder at nursing station." However, the facility's care plan lacked any further specifics on these services nor how often they'd be provided for R56 while at the care center. A white-colored binder was located at the nursing station which was labeled, "Our Lady of Peace Hospice & Home Care," along with a telephone number to contact them. This binder was inspected and R56's name was recorded inside. The binder contained various medical paperwork along with a yellow-colored copy of the Service Agreement and Election of Hospice Benefit, dated 4/3/25, which identified a hospice registered nurse (RN), social worker (SW), and chaplain would visit along with anticipated frequencies (i.e., 1-2 times/month); however, lacked information on	F 684	an up to date Care Plan and calendar were included. Skin assessment performed on all residents. Anticoagulation policy reviewed on 6/26/25. Nursing educated on quality of care, skin assessments and monitoring, and anticoagulation policy on 7/1/25 & 7/2/25. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Nursing educated on quality of care, skin assessments and monitoring, and anticoagulant side effect monitoring on 7/1/25 & 7/2/25. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. “At risk for bruising” form will be audited weekly x 1 month, then monthly x 2 months. Hospice binders will be audited weekly x 1 month, then monthly x 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 684	Continued From page 35 what services these disciplines would be doing or performing while onsite. SEE F656 FOR ADDITIONAL INFORMATION. The binder contained a single, white-colored calendar page labeled, "2025 [space] April [space] 2025," along with hospice' staff names handwritten on 4/3, 4/4, 4/9, and 4/14, respectively. This calendar showed a total of three nurse visits and two social worker visits were completed. On the reverse side of the calendar, a handwritten label was made reading, "May," along with, "Mon May 5 - [staff name] SW." The entire binder lacked any further calendar(s) or direction on when hospice staff would be visiting the campus. On 5/28/25 at 9:07 a.m., licensed practical nurse (LPN)-B was interviewed, and explained they were waiting for a call back from hospice as some of R56's as-needed medications had expired and needed to be renewed. LPN-B stated R56 had been on hospice a "couple months" now and they were unsure when hospice would visit most of the time prior to them arriving adding they'd see the hospice nurse "once a week, if I'm lucky." LPN-B explained R56's as-needed lorazepam (anxiety medication) needed to be renewed before it could be given adding if staff were not "Johnny on the spot" with watching it then this would happen where the timeframe to give it would lapse. LPN-B reiterated the hospice staff would never tell care center staff prior to coming, rather, just "show up" which had been the practice since they came onboard. LPN-B stated the calendar used in the binder was for staff to write their names on when they visited, not beforehand, and expressed the hospice staff never seemed to "stay very long" when they did	F 684			

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F 684	Continued From page 36 visit. LPN-B stated they rarely, if ever, even looked in the hospice binder at the calendar or notes adding they only had it with them now to get the number to call about the expired medication. During the interview, at 9:12 a.m., hospice registered nurse (HRN) then entered into the building. LPN-B and HRN then discussed the expired medications before HRN left the desk to see R56. When interviewed on 5/28/25 at 10:02 a.m., HRN stated they visited R56 one to two times per week, and the hospice social worker would visit one or two times per month. HRN stated they couldn't recall another time when R56's medication prescriptions lapsed like had just happened, and expressed they tried to "always ask" staff when they visit if they needed anything, like prescriptions renewed, at their visits. However, HRN stated it was ultimately care center staff whom were responsible to ensure they don't lapse the medication availability. HRN stated they felt there was collaboration between hospice and the care center adding it was "good for what it is here." HRN stated R56 was their only patient at the campus and things were still being worked out adding, "It still feels like new," adding there was "always opportunity to communicate better." HRN stated they were going to adjust R56's Seroquel order today, and acknowledged the lack of a hospice care plan being readily available for the care center staff. HRN then reviewed the provided calendars in their hospice binder which was left for the care center. HRN acknowledged it lacked a May 2025 calendar (despite being almost June) and it did not outline upcoming visits for care center staff to be aware of adding, "I'm not very good at this part." HRN stated having a more routine, set	F 684			

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F 684	Continued From page 37 schedule in writing for staff to see would be "an area of opportunity, too." On 5/28/25 at 1:30 p.m., the assistant director of nursing (ADON) was interviewed, and verified they had reviewed R56's medical record. ADON explained they didn't typically work with R56's hospice agency and verified the hospice care plan had not been provided to the campus prior to survey. ADON stated one should have been adding it was important to ensure the care plans were available and "meshing together" so staff were all on the "the same page." ADON verified a calendar had also just been placed into the binder to help show when hospice would be visiting more easily adding, prior, it had been "a struggle to know exactly what day they're coming." ADON stated the hospice staff should be reviewing R56's medication supplies and prescriptions when onsite to ensure they don't lapse with availability adding, "The hospice nurse would catch this [assumed]." ADON verified the importance of coordinating care with a hospice provider adding they should be "working together to take care of this resident." A facility provided Hospice Program policy, dated 7/2017, identified the care center would have written agreements with hospice providers and those providers would be held to the same professional standards of service as other contracted agencies or individuals. The policy outlined responsibilities of both the hospice and the care center, however, the spacing to record a person designated to coordinate with the hospice was left blank and not filled out with text reading, "12. Our facility has designated _____ (Name) _____ (title) to coordinate care provided to the resident by our facility staff and	F 684			

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F 684	Continued From page 38 the hospice staff." R46 R46's quarterly Minimum Data Set (MDS) dated 4/10/25, indicated R46 had moderately impaired cognition and no hallucinations, delusions, or rejection of cares. R46 required partial and/or moderate assistance to roll left and right, required substantial/maximal assistance with upper body dressing and transfers, and was dependent with lower body dressing and toileting hygiene. R46's diagnoses included peripheral vascular disease, arthritis, hip fracture, dementia, Parkinson's Disease, and depression. R46's anticoagulant care plan, revised 4/23/25, indicated R46 was on anticoagulant therapy related to atrial fibrillation. Interventions directed staff to complete labs as ordered and report abnormal lab results to the provider and administer anticoagulant medications as ordered by physician and observe for side effects and effectiveness every shift. R46's skin integrity care plan, revised 4/23/25, indicated R46 had an impairment to skin integrity related to new colostomy and surgical wound on abdomen and surgical incision on right hip. R46 had the potential for further skin integrity concerns related to redness on coccyx and groin. Interventions directed staff to use barrier cream after each incontinent episode, keep skin clean and dry, use lotion but not to open areas, use pressure relieving/reducing cushion to protect the skin while in wheelchair and mattress to protect the skin while in bed. R46's care plan lacked resident specific	F 684			

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F 684	Continued From page 39 interventions to prevent bruising. R46's Order Summary Report printed 5/28/25, indicated: -11/18/24, apixaban (an anticoagulant medication used to treat and prevent blood clots) oral tablet 2.5 mg by mouth two times a day. -11/18/24, weekly skin check and complete the "weekly skin review assessment" in the electronic health record every Saturday day shift. -5/28/25, anticoagulant medication- monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, and nose bleeds. Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "Other/ See Nurses Notes" and progress note findings three times a day related to long term (current) use of anticoagulants. R46's progress notes indicated: -1/1/25 at 2:07 p.m., R46 had multiple bruises on bilateral upper extremity. -3/22/25 at 12:35 p.m., R46 had a bruise on back of left hand, and staff would continue to monitor. R46's assessments and other documents viewable in the electronic health record lacked information on bruising assessment and monitoring. During observation on 5/27/25 at 9:28 a.m., R46 was in bed and had bruising on both hands. During observation on 5/29/25 at 8:08 a.m., R46 sat at a dining room table. R46 had general	F 684			

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F 684	Continued From page 40 discoloration and a bruise approximately less than one inch by one inch to his left hand and general discoloration and a bruise approximately greater than one inch by one inch to his right hand. R46's right hand had a dark bluish-black scab with reddish drainage between his first and middle finger. During interview on 5/29/25 at 8:23 a.m., nursing assistant (NA)-F stated they notified a nurse when they saw a bruise on a resident. NA-F stated they worked with R46 "once in a while" and was not aware of bruising to R46. When asked about the new area on R46's right hand, NA-F stated they thought R46 bumped their hand this morning and notified the nurse right away. During interview on 5/29/25 at 1:46 p.m., registered nurse (RN)-E stated staff followed-up on bruises to residents' hands on a case-by-case basis. RN-E stated R46 was on a blood thinner, and staff should evaluate bruises for a potential cause. RN-E stated staff documented new skin concerns in risk management. RN-E stated R46 came out of their room a lot and sat in their wheelchair, and RN-E would have to review R46's progress notes and risk management documents to comment further on R46's skin or bruising. During follow-up interview on 5/29/25 at 2:31 p.m., RN-E stated they looked at RN-E's hands and offered skin protectors or gloves, and R46 declined. RN-E stated R46's hands lined up with the dining table when he sat in his wheelchair and stated R46 was able to move in their wheelchair. RN-E stated they reviewed R46's progress notes and did not see follow-up on R46's bruising. RN-E reviewed R46's risk management documents and stated on 3/5/25, R46 had a scratch from a call	F 684			

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F 684	Continued From page 41 light clip, and on 3/28/25, a skin tear was identified on R46's left forearm. RN-E did not see a risk management entry related to bruising. During interview on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON) expected bruises to be documented in risk management and staff to assess the root cause to prevent future bruises and monitor until healed to ensure the skin does not worsen. R46's skin assessments were requested from the facility. The facility provided Integrated Wound Care progress notes, which lacked documentation of bruising, and did not send any documentation related to the weekly skin assessments. The facility Prevention of Skin Breakdown policy dated 7/2/18, indicated the care plan was to be evaluated and revised based on response, outcomes, and needs of the resident. The facility policy Anticoagulation - Clinical Protocol undated, directed the staff and physician to monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686			7/3/25

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F 686	Continued From page 42 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess to help determine what, if any, additional interventions were required to promote healing and reduce the risk of complication after an in-house acquired pressure injury developed for 1 of 2 residents (R56) reviewed for pressure ulcer care. Findings include: R56's significant change in status Minimum Data Set (MDS), dated 4/10/25, identified R56 had both short-term and long-term memory impairment, demonstrated hallucinations, and had rejection of care behaviors one (1) to three (3) days during the review period. The MDS recorded R56 was enrolled in hospice care and had several medical conditions including high blood pressure, coronary artery disease (CAD), and Alzheimer's Disease. Further, the MDS contained a section labeled, "Section M - Skin Conditions," which recorded R56 was at risk of developing pressure ulcers, however, had no current pressure ulcers during the review period. R56's most recent Braden Scale For Predicting Pressure Sore Risk, dated 4/4/25, identified R56 scored a cumulative score of 19.0 which was not considered to be 'at risk' for pressure ulcer	F 686	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice No lasting effect noted related to pressure ulcer treatment for R56. Affected resident received a comprehensive skin assessment on 6/23/25. Interventions have been in place since pressure area has occurred. According to IWC notes 6/16/25 pressure area is improving. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practices. Weekly skin checks to be performed on all residents. Skin check audit performed on 6/24/25. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Pressure ulcer policy reviewed on		

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F 686	Continued From page 43 development. In addition, R56's Quarterly Resident Review, dated 4/7/25, identified a review of R56's health status (i.e., vital signs, oral status, respiratory status) which included a section labeled, "L. Skin[.]" This outlined R56 had no current, unhealed pressure injuries adding, "Does the resident have any skin integrity issues?" answered with, "2. No." However, R56's progress note, dated 4/17/25, identified R56 had irritated skin areas which included, " ... has got a reddened spot at the sacral area." The note identified R56 was assisted with repositioning and staff continued to monitor the skin integrity. A subsequent Integrated Wound Care (IWC) note, dated 5/5/25, identified R56 was being seen and treated for multiple burns but now outlined, "5/5/25: Burns to bilateral thighs are improving. Staff noticed blistering to sacrum in the last few days. There was no clear cause." The IWC note continued and listed a section labeled, "Wound(s):[.]" which recorded a pressure ulcer to R56's sacrum including, "Stage 2," and, "4.2 X 1.3 X 0 [cm]," adding further, "50% Blood blister." A subsequent section of the note labeled, "Plan," directed to apply barrier cream with pericare and as-needed; and start an offloading mattress. The note outlined factors which could affect wound healing and directed, "Medical management per primary team," and, "Optimize nutrition." An additional IWC note, dated 5/26/25, identified a timeline of R56's wound history including the developed pressure ulcer on his sacrum. The note dictation included, "5/12/25 ... His sacral ulcer has now evolved into a stage 3 with slough as base, do not suspect any further injury in the past week. Will update orders to a silicone foam	F 686	6/26/25. Nursing educated on pressure ulcer policies on 7/1/25 & 7/2/25. Comprehensive skin assessments will be completed on all new pressure ulcers. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. Weekly skin checks will be audited weekly x 1 month, then monthly x 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 686	Continued From page 44 border dressing changed M,W, F and [as needed]. Pressure reducing mattress ow [sic] in place." The timeline continued and outlined, "5/16/25 ... Burns and pressure ulcer to sacrum have improved in size." Furthermore, the timeline then outlined, "5/26/25 ... PU [pressure ulcer] to sacrum has stalled, some stool has seeped under bandage, will change POC [plan] to Triad paste without cover dressing to avoid this." On 5/28/25 at 7:36 a.m., R56's morning cares were observed with nursing assistant (NA)-A and NA-B involved. R56 was lying in bed which had an air-pressure mattress in place; along with staff helping to wash him up. R56 would converse with staff as they provided care, however, it was not always sensical to the situation including, "A bridge of bread, that's perfect for ya." R56 was assisted to turn onto his right side which exposed his coccyx and buttocks. R56 had a visible pressure ulcer present on the medial aspect of his coccyx which was approximately 50-cent piece sized, nearly symmetrical in shape, and had a dark-red colored center with lighter pink-colored peri-wound perimeter. The wound bed was not immediately visible and the wound, as a whole, had a visible white-colored, semi-hardened paste-like substance both around and in the wound. NA-A stated they thought the wound looked "a little bit better" and expressed staff often attempted to get R56 to lay down between meals, however, he was not always cooperative and would refuse at times. NA-A and NA-B stated R56 was repositioned every couple hours which had been the same both before and since the pressure injury developed adding aloud, "I think it's the same." NA-B stated the wound had different treatments being applied, too, adding aloud, "[It's] sometimes a dressing, sometimes	F 686			

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F 686	Continued From page 45 cream." NA-A and NA-B both stated they were unsure what, if any, other interventions being done to help heal the developed ulcer except R56's bed having an air mattress placed on it. NA-A then took a tube of medicated cream labeled, "Remedy Protect Zinc Oxide Paste," from R56's bedside table and applied it to R56's coccyx. NA-A then placed a new incontinence product underneath R56 and secured it before helping him to pull up the pants. NA-A and NA-B then finished R56's morning cares. R56's Medication Administration Record (MAR), dated 5/2025, identified R56's current physician-ordered medications and treatments along with staff initials to demonstrate their administration or refusal. This included an order which read, "Mighty shakes ... two times a day for weight loss," which ended on 5/12/25. These intakes were recorded and ranged from 0 (ml) to 170 ml with multiple spaces just recording, "NA [not applicable]." The MAR lacked any further supplement use. On 5/28/25 at 9:22 a.m., licensed practical nurse (LPN)-B was interviewed, and verified they provided care to R56 prior. LPN-B stated R56 developed the sacral pressure ulcer back in May 2025, and was currently getting Triad cream applied to the wound. LPN-B explained when a new pressure ulcer is identified, the staff finding it should report it to the assistant director of nursing (ADON) who would then update the "wound nurse" adding it would then be looked at and reviewed on their next visit (i.e., Mondays). LPN-B stated staff who find the wound would "in the mean time" just update the physician and get an order until that happened. LPN-B stated the floor nurse didn't usually review nutrition or do	F 686			

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F 686	Continued From page 46 any other comprehensive review of the person or their pressure ulcer risk adding, "I don't go over that with anybody." LPN-B stated R56 was "not real mobile" and used a Broda-type wheelchair for mobility adding R56 would, at times, be combative with staff and resistive to cares. LPN-B reiterated any type of comprehensive evaluation of pressure ulcer risk or determining what interventions were needed for them was not their responsibility adding aloud, "It's not my wheel house." When interviewed on 5/28/25 at 10:02 a.m., R56's hospice registered nurse (HRN) stated they were aware of R56's sacral pressure ulcer adding he developed it a few weeks prior. HRN stated they believed the ulcer was improving and "looking good" as of late. HRN recalled they believed R56 was on a nutritional supplement and expressed interventions for pressure ulcer care was always tough adding they were "always walking that line" between comfort and restorative. HRN stated they believed the sacral ulcer developed from extended periods of sitting in his wheelchair adding, "He's in his chair a lot," and further, "There's only so much repositioning you can do." HRN verified they had provided R56 with his current wheelchair and believed it had a cushion present but added, "I can follow up on that." Further, HRN stated nobody from the care center had discussed R56's cushion or what, if any, other options were available since R56 developed the ulcer. R56's medical record was reviewed and lacked evidence R56 had been comprehensively reassessed by the care center to determine what, if any, additional or proactive interventions were needed (i.e., protein supplement, different			F 686			

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F 686	Continued From page 47 wheelchair cushion) or could be used to help promote healing of the developed pressure ulcer; nor evidence the facility had reviewed R56's nutrition to determine potential nutritional interventions to promote wound healing despite the IWC note directing to "optimize nutrition." On 5/28/25 1:30 p.m., the ADON was interviewed. ADON verified R56's sacral ulcer was in-house acquired, and explained when a new ulcer is found the staff notify the provider for immediate orders and place them on the wound team listing to be seen at next visit. ADON stated a comprehensive review, like which would be done with the interdisciplinary team (IDT), would "in theory" be located in the "risk management" charting and contain the facility' investigation and reports about it. However, this was not routinely done for pressure ulcer development for some reason. ADON verified there was nothing they could locate in the "risk management" section of the record regarding R56's sacral pressure ulcer. ADON verified the record lacked a comprehensive evaluation of R56's skin risk since the ulcer developed and expressed their approach had been more "just kinda constant reminders" to staff about offloading and repositioning him, however, these were also not documented and just more verbal discussions. ADON acknowledged the need to re-assess after a pressure ulcer develops and expressed doing so was important to "help prevent further injury" adding aloud, "If it's not documented, it's not done." A facility-provided Prevention Of Pressure Ulcers policy, dated 3/2025, identified the resident should be assess for pressure ulcer risk upon admission with the assessment repeated weekly	F 686			

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F 686	Continued From page 48	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess for, and implement as appropriate, a nursing functional maintenance program to ensure 1 of 3 residents (R15) maintained and/or improved their highest level of range of motion (ROM). Findings include:	F 688			7/3/25

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F 688	Continued From page 49 R15's quarterly MDS dated 3/6/25, indicated R15 had severely impaired cognition and required staff assistance with all activities of daily living (ADLs). The MDS indicated R15 had a "Functional Limitation in Range of Motion" on all extremities. The MDS indicated R15 was not on a restorative nursing program during the look-back period (LBP). R15's care plan, dated 3/20/25, indicated R15 had an ADL "performance deficit" related to Alzheimer ' s disease and inability to perform self-cares. The care plan outlined R15's daily routine as, she prefers to remain in bed "as long as possible", getting up as close to breakfast and lunch as possible, laying back down as soon as possible after meals, and remaining in bed for dinner. The care plan did not include R15's current ROM status or specific interventions or exercises to ensure R15 maintained her ROM and prevented further decline. R15's medical record (including Tasks) was reviewed and did not include an assessment of R15's specific ROM status or interventions/exercises to ensure R15 maintained her ROM if needed. During an interview and observation on 5/27/25 at 2:09 p.m., R15 was observed lying in bed on her back, slightly reclined with no obvious contractures observed. Resident representative (RR)-A stated he commonly assisted R15 with her ADLs and had noticed that R15's legs appeared to have "stiffened up". RR-A stated he was concerned as he did not think staff were completing exercises to stop R15's leg stiffening from getting worse.	F 688	2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice. All resident care plans reviewed for functional maintenance. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Rehab policy reviewed on 6/26/25. If nursing recognizes the need for an exercise or range of motion program, they will receive orders from the provider for therapy. Education provided to nursing on 7/1/25 & 7/2/25. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. ROM programs will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 688	Continued From page 50 During an interview on 5/28/25 at 11:55 a.m., nursing assistant (NA)-E confirmed she was R15's aide for the day and stated she did not do any passive or active ROM activities with R15. NA-E stated she had not been instructed to complete these with R15 and thought the therapy department did these activities. During an interview on 5/29/25 at 8:54 a.m., registered nurse (RN)-B confirmed he was R15's nurse for the shift, and stated he was not aware of any functional maintenance program for R15 or if she had been assessed for one but recommended asking therapy about it. During an interview on 5/29/25 at 8:59 a.m., the director of rehabilitation (DOR, an occupational therapy assistant) stated her department would make recommendations for a restorative nursing program after discharge from therapy. The DOR stated the therapy department was also happy to assist in screening residents for maintenance programs if consulted by the nursing department, but this did not commonly occur. The DOR stated she did not think that they had created or been consulted to create a maintenance program for R15. During an interview on 5/29/25 at 10:08 a.m., physical therapist (PT)-A stated they do not commonly create restorative or functional maintenance nursing programs but would be willing to if asked. PT-A stated assessing for and following functional maintenance programs would help prevent a rapid decline in functional status as well as help to improve a resident ' s quality of life, especially for residents with degenerative diseases.	F 688			

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F 688	Continued From page 51 During an interview on 5/29/25 at 12:26 p.m., the assistant director of nursing (ADON) stated usually the nursing department got their nursing restorative programs for residents after a resident was discharged from therapy. The ADON stated they would then add the program to the care plan and the aides' "tasks" on the electronic health record (EHR). The ADON stated "first she has heard anything" regarding a functional maintenance program for R15 and confirmed she did not think R15 had been assessed for her specific ROM status or the need/appropriateness for a maintenance program as needed. The ADON stated usually the nursing department would consult therapy for a functional program if it was something the provider had ordered or if a resident had increased/developed contractures but was not usually completed preventatively unless requested.	F 688			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 697		7/3/25	
			1)What corrective actions(s) will be		

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F 697	Continued From page 52 review, the facility failed to complete ongoing pain assessments and timely intervention when signs of pain were observed for 1 of 4 residents (R15) reviewed for pain, with severely impaired cognition. Findings include: R15's quarterly MDS dated 3/6/25, indicated R15 had severely impaired cognition and required staff assistance with all activities of daily living (ADLs). The MDS indicated R15 was on a scheduled pain medication regimen but had not received any PRN pain medications during the look-back period (LBP). The MDS indicated R15 had "non-verbal sounds (crying, whining, gasping, moaning, or groaning)" of pain during the LBP, and these indicators occurred three to four days out of the last five days of the LBP. R15's Medical Diagnosis list dated 1/5/24, indicated R15 was diagnosed with Alzheimer's disease, pain in her thoracic spine, and "other chronic pain". R15's care plan dated 3/20/25, indicated R15 had chronic pain related to a history of fractures and chronic thoracic back pain. R15's care plan indicated the nursing assistants were to monitor, record, and report to the nurse any signs of non-verbal pain including vocalizations such as grunting, moans and yelling out, irritability, restlessness, tearing, crying, grimacing, etc. but did not include how quickly this should be completed. The care plan indicated R15 had "severe cognitive impairment", and impaired thought processes related to late-onset Alzheimer's disease and indicated R15 required assistance with all decision-making and was			F 697	accomplished for those residents found to have been affected by the deficient practice. No lasting effect noted related to pain management for R15. Pain assessed on 6/2/25 noted no pain present. Orders entered to monitor for non-verbal signs of pain BID on 6/24/25. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficiency. Orders entered for all residents to monitor for pain BID on 6/26/25. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Pain management policy reviewed on 6/26/25. Education to nursing staff on 7/1/25 & 7/2/25. All new admissions will have pain monitoring orders. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. Pain assessments will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will		

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F 697	Continued From page 53 dependent on staff for meeting all her emotional, sensory, physical, spiritual, and social needs. R15's progress notes from 4/28/25 to 5/28/25, were reviewed and did not include an indication R15's pain had been assessed during the period. R15's Medication Administration Record (MAR) dated 5/1/25 through 5/27/25, indicated R15 received the following pain medications: -one 12 micrograms/hr (mcg/hr) Fentanyl (a narcotic pain medication) patch applied every three days. -five milligrams (mg) of oxycodone (a narcotic pain medication) four times a day. -650 mg of acetaminophen (an over-the-counter pain medication) four times a day. -five mg of oxycodone every four hours as needed, which had not been administered during the period. -650 mg of acetaminophen daily as needed which had not been administered during the period R15's Pain Level record printed on 5/28/25, indicated the last pain score taken was on 3/6/25 and was 1 out of 10. During an interview on 5/27/25 at 1:38 p.m., resident representative (RR)-A stated he felt that the facility staff didn't follow R15's care plan and did not know her well enough due to the number of agency staff used. RR-A stated he had a camera in R15's room and although he didn't watch it all the time, he felt she was not getting pain intervention as often as she should because he would see her yelling out on the camera and not see anyone intervening. RR-A stated that R15 could no longer tell anyone she was in pain, but she used to often tell him her back was "killing	F 697	ensure compliance. The date of compliance is July 3, 2025.		

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F 697	Continued From page 54 her" and now he could tell she was in pain when she was yelling out. RR-A stated that RR-A had compression fractures to the vertebrae, and he was "very concerned" that her pain was not being managed when he was not at the facility. During continuous observation and interview on 5/28/25 from 9:15 a.m. to 11:44 a.m., R15 was observed lying in bed on her back with her room door open. At 9:44 a.m., R15 was observed loudly (heard from the hallway) moaning. R15 continued intermittently moaning as heard from the hallway. Nursing assistant (NA)-E and NA-F were observed intermittently passing by R15's room as she loudly moaned. At 10:34 a.m., NA-E and NA-F were observed entering R15's room and closing the door. On interview, NA-F stated they had not assisted R15 but solely were helping her roommate. At 10:46 a.m., as R15 loudly moaned, NA-E was observed entering R15's room and a few seconds later exited. At 10:50 a.m., NA-E was observed to quickly walk a few feet into R15's room as R15 loudly moaned and then walked away. R15 continued to loud moan. Unless noted above, staff were not observed to enter R15's room. During an interview on 5/28/25 at 11:55 a.m., NA-E stated she worked with a staffing agency and was not super familiar with R15 but had worked with her before. NA-E stated she had heard R15 make these moaning sounds previously and thought it was normal for her, so had not completed any nonpharmacological pain interventions for her. NA-E stated she had notified the nurse of the moaning but was not sure of the exact time she had done so. During an interview on 5/28/25 at 12:55 p.m.,			F 697			

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F 697	Continued From page 55 registered nurse (RN)-D confirmed she was R15's nurse for the shift. RN-D stated that R15 was nonverbal and was unable to tell facility staff when she was in pain. RN-D stated that R15's resident representative was very involved with her care and would sometimes call the facility and ask them to check on her because he would see signs of R15 in pain on the camera he had placed in her room. RN-D stated she could tell R15 was in pain when she was moaning, restless, moving around a lot, or making "sounds." RN-D had said that NA-E had notified her of R15 having signs of pain around noon, so she had administered her scheduled pain medication and confirmed she had not completed a formal pain assessment. RN-D stated she would expect the aides to notify her immediately if signs of pain were noticed so she could complete an assessment and intervene as needed. RN-D stated for some residents an assessment prompt was given to complete an assessment with pain medication administration, but she did not see that this was in place for R15, so she had not been completing pain assessments. RN-D stated sometimes they would put pain assessments in the progress notes but confirmed she had reviewed the medical record and was unable to find that regular pain assessments were being completed for R15. During an interview on 5/28/25 at 1:13 p.m., the assistant director of nursing (ADON) stated pain assessments were completed quarterly or as needed when as needed pain medications were given. The ADON stated if an NA had observed signs of possible pain in a resident, she would expect them to immediately notify the nurse so the resident could be assessed. The ADON stated she would expect staff to complete a	F 697			

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F 697	Continued From page 56 progress note if they had noted "something out of the ordinary" but confirmed they did not have a process for ensuring pain assessments were being completed more regularly than quarterly for residents receiving scheduled pain medications who were unable to verbally notify staff of their pain. The facility's Pain Assessment and Management policy dated 10/7/21, indicated acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. The policy indicated that staff should assess residents with stable chronic pain at least weekly.	F 697			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700			7/3/25

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F 700	Continued From page 57 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and attempt alternatives for 1 of 1 resident (R46) reviewed who had grab bars affixed to their bed. Findings include: R46's quarterly Minimum Data Set (MDS) dated 4/10/25, indicated R46 had moderately impaired cognition and no hallucinations, delusions, or rejection of cares. R46 required partial and/or moderate assistance to roll left and right, required substantial/maximal assistance with upper body dressing and transfers, and was dependent with lower body dressing and toileting hygiene. R46's diagnoses included peripheral vascular disease, arthritis, hip fracture, dementia, Parkinson's Disease, and depression. R46's Order Summary Report printed 5/28/25, indicated okay for bilateral assist bars to serve as an enable to promote independence with order date of 11/18/24. R46's bedrail care plan revised 4/14/25, indicated R46 used bedrails related to need for assistance with bed mobility. Interventions included to anticipate and meet needs, be sure call light within reach and respond promptly to all requests for assistance, educate resident/representative on benefits and risk of bed rail/grab bar use, inspect grab bar per manufacturer direction, and reassess/evaluate use of grab bar quarterly and as needed.	F 700	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No lasting effect noted related to assist bars for R46, new assessment performed on 6/23/25 indicating need for assist bars, previous attempts with pillows to assist with repositioning were unsuccessful. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficient practice. All residents with assist bars reassessed. A new assist bar assessment was created on 6/25/25 to reflect alternatives. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. New assist bar assessment reviewed with nursing on 7/1/25 & 7/2/25. Assist bar consent forms reviewed by IDT with no changes 6/25/25. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur.		

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F 700	Continued From page 58 R46's quarterly Bed Rail/Assist Bar Evaluation dated 4/5/25, indicated no bed rail or assist bar/grab bar was in use and the need for bed rails was not indicated at the time of the assessment. R46's progress notes lacked indication of risk and benefit conversation of grab bars with resident and/or representative. During observation on 5/28/25 at 8:57 a.m., nursing assistant (NA)-D and NA-H assisted R46 with cares. R46 had two grab bars affixed to bed and used them to roll from side to side while cares were performed. During interview on 5/28/25 at 1:37 p.m., NA-D stated R46 had grab bars since he was in the room and helped him with movement. Further document review of Bed Rail/Assist Bar Evaluations indicated: -11/18/24, R46 admitted on 11/18/24 and assist bar/grab bar was requested and/or currently in use. "New Admit" was indicated in the area to describe which alternative was attempted prior to request. Evaluation factors were noted, and summarized findings indicated bed rail or assist bar was indicated and served to promote independence. The resident/family notification areas were left blank. -1/3/25, indicated assist bar/grab bar was requested and/or currently in use, and the areas to describe alternatives and resident/family notification were blank. Evaluation factors were noted, and summarized findings indicated bed rail or assist bar was indicated and served to promote independence. -1/6/25, indicated assist bar/grab bar was	F 700	Assist bar assessment will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 700	Continued From page 59 requested and/or currently in use, and the areas to describe alternatives and resident/family notification were blank. Evaluation factors were noted, and summarized findings indicated bed rail or assist bar was indicated and served to promote independence. During interview on 5/29/25 at 12:30 p.m., registered nurse (RN)-E stated grab bars were assessed prior to installation and assessments were completed quarterly. RN-E reviewed the Assist Bar Evaluations and acknowledged the lack of documentation of alternatives and family notification. RN-E stated there were ongoing conversations about risks and benefits of grab bars with the resident/family and documentation of conversations would either be in the progress notes or assessments. RN-E stated grab bar assessments were important to ensure resident used the grab bars appropriately and safely. During interview and document review on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON) stated the facility had an admission consent form and education for grab bars, which included a spot to enter alternatives trialed. The ADON stated there were inconsistencies with who completed grab bar assessments. The ADON provided and reviewed R46's Side Rails/Grab Bar Informed Consent and Release form dated 11/18/24. The document identified a resident/representative signature, and the areas listed for alternatives attempted but failed and alternatives considered but not attempted were blank. The ADON stated the facility usually trialed pillows and encouraged residents to grab the edge of the bed before grab bar installation. The ADON stated grab bars were different than bed rails but still had slight risks to residents.	F 700			

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician-ordered medications were re-ordered timely to prevent delay in administration and	F 755			7/3/25
			1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice.		

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F 755	Continued From page 61 reduce the risk of complication for 1 of 4 residents (R40) observed to receive medication during the survey. Findings include: R40's annual Minimum Data Set (MDS) dated 3/21/25, indicated R40 had moderately impaired cognition and was diagnosed with kidney disease and diabetes. The MDS indicated R40 received insulin (an injection used to lower blood sugar) during the look-back period (LBP). R40's order summary dated 5/29/25, indicated R40 had orders for: -Insulin Lispro (fast-acting insulin) three times a day per sliding scale based on blood glucose level (70 - 149, zero units; 150 - 199, 2 units; 200 - 249, 4 units; 250 -299, 6 units; 300 - 349, 8 units; 350 - 399, 10 units; 400 or greater, 12 units and notify provider) -Humulin 70/30 insulin, 52 units in the morning and 44 units in the evening. During an interview and observation on 5/28/25 at 8:33 a.m., registered nurse (RN)-F was observed preparing R40's medications for administration. RN-F was observed to look through the medication card and then stated he was unable to find R40's Humulin 70/30 insulin so he would look in the fridge. RN-F then confirmed R40 did not have an extra Humulin 70/30 insulin in the fridge so he would have to call the pharmacy to order it. RN-F stated, that given the dosage of insulin that R40 received daily, he would have expected nursing staff to reorder his insulin when he had one full pen left, but after reviewing the medical record, did not see that this had occurred. RN-F stated the last time he saw that the nursing staff	F 755	No lasting effect noted on R40 related to timely reordering of medication. Medication was delivered the same day and administered per medical provider's order. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficiency. ADON reordered all medications for all residents through the Polaris Connect Portal 6/26/25. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Medication Ordering and Receiving from pharmacy policy reviewed on 6/26/25. Meeting held with Polaris Pharmacy representative to discuss concerns related to timely delivery of medications on 6/23/25. Polaris basic operations reviewed on 7/1/25 &7/2/25 with nursing staff. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. Missing medication forms will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits.		

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F 755	Continued From page 62 had requested the medication was on 5/15/25 and would have expected the nursing staff to have reordered it again since then. During subsequent interview on 5/28/25 at 1:59 p.m., RN-F stated the Humulin 70/30 insulin had arrived at 1:00 p.m., so per the provider's instructions he had given it at that time. R40's progress note dated 5/28/25 at 2:36 p.m., indicated R40's morning Humulin 70/30 insulin (combination of insulin isophane and regular, both short and intermediate-acting insulin) was not available in the morning as only 36 units were left in the pen. The note indicated the pharmacy was called and the medication was administered at 1:00 p.m. The note indicated the provider was called regarding whether the evening dose of the medication was okay to be administered. R40's progress note dated 5/28/25 at 4:18 p.m., indicated the provider had responded instructing staff to hold R40's evening Humulin 70/30 insulin. During an interview on 5/29/25 at 10:54 a.m., the outside pharmacy technician (OPT)-A stated on 5/15/25 they had sent a nine-day supply of the Humulin 70/30 insulin for R40 but had not received a request from the facility to send Humulin 70/30 insulin for R40 since 5/15/25. OPT-A stated they expected the facility to submit requests for medications at least a couple of days before running out. During an interview on 5/29/25 at 12:33 a.m., the director of nursing (DON) stated nursing staff oversaw reordering medication timely and usually a "backup" for each resident was kept for each resident to ensure doses were not missed.	F 755	5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108			
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F 755	Continued From page 63			F 755			
F 806 SS=D	The facility's Medication Ordering and Receiving from Pharmacy policy dated 5/22, indicated reordering of medications was completed by the order and delivery schedule of the pharmacy provider. The policy indicated staff were to reorder medications in advance of need, as directed by the pharmacy order and schedule to ensure an adequate supply is on hand. Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident choice with meal preferences was attempted and/or honored to promote quality of life for 1 of 1 resident (R35) reviewed who wanted to have fried eggs (i.e., runny yolk) and was told they could not have them. Findings include: The Centers for Medicare and Medicaid (CMS) State Operations Manual Appendix PP, dated 4/2025, identified the Federal regulatory requirements long-term care facilities must abide			F 806			7/3/25
					1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. No lasting effect noted on R35 related to resident preferences regarding the type of breakfast egg he consumes. The resident's' choice has been accommodated since 5/27/25. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what		

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F 806	Continued From page 64 by in accordance with Federal law. These regulations included F812 which outlined, " ... To accommodate residents choice for items such as 'sunny side up [eggs]' the facility must use pasteurized eggs only." On 5/27/25 at 8:13 a.m., an initial tour of the kitchen was completed. A series of boxes were stacked on the floor next to the Kolpak walk-in cooler which had been delivered by the food service vendor. Amongst these were two boxes labeled, "Pasteurized Eggs." R35's quarterly Minimum Data Set (MDS), dated 4/24/25, identified R35 had intact cognition and demonstrated no delusional thinking. On 5/27/25 at 9:13 a.m., R35 was observed lying in bed while in his room. R35 had a meal tray placed on a bedside table which extended across his body and on the plate was a stack of pancakes with fruit, along with one hard-boiled (whole) egg. R35 was interviewed and stated his "only complaint" about the care center was they wouldn't let him have fried eggs with a runny yolk. R35 added, "They won't let me have easy-over eggs." R35 stated it was frustrating to him as others were served them adding aloud, "It just doesn't make any sense." R35 stated he had asked for them repeatedly but the management kept telling him no adding, "They override me." R35's progress note, dated 4/10/25, was authored by the campus dietary manager (DM) and outlined they had spoken to R35 and informed him they couldn't served over-easy eggs adding, " ... all eggs will be fully cooked." The note recorded R35 accepted the information and enjoyed the food at the campus. However, the note lacked any rationale on why R35 was unable	F 806	corrective action will be taken. All residents have the potential to be affected by the same deficiency. Food committee met with the dietary manager during resident council on 6/24/25. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Dietary manager meets with all new admissions, and existing residents quarterly and as needed to record food preferences. Resident rights policy reviewed with no changes on 6/26/25. Staff educated on resident preferences and meal choice on 7/1/25 & 7/2/25. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. Resident preferences will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) The Dietary Manager and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 806	Continued From page 65 to have fried eggs despite the campus having pasteurized eggs available for use. R35's nutritional care plan, last revised 4/2025, identified R35 had potential for nutritional risk due to a history of infection, multiple sclerosis, diabetes and a high BMI (Body Mass Index). A goal was listed for R39 to maintain his weight around 200 pounds (lbs) and multiple interventions were listed to help him meet this goal including weights per order, and a protein supplement as directed/ordered. However, the care plan lacked information on why R39 was not allowed to consume fried eggs as outlined in the progress note (dated 4/10/25). The following day, on 5/28/25 at 8:29 a.m., R35 was again observed laying in bed while in his room. R35 had a meal tray placed on the bedside table which R35 expressed staff had "just brought in." The tray had a single plate which had French Toast, two hard-boiled eggs, and a small bowl of oatmeal present. A white-colored menu slip was also present on the tray which read several food categories including, "Egg: _____," and opposite the slip on the same line, "1 each." The menu slip lacked information on which type of prepared egg(s) R35 wanted. R35 reiterated he wanted fried eggs and expressed aloud, "Maybe I will have to call up Denny's [restaurant chain] or something." Immediately following this, at 8:33 a.m., the second floor main dining room was observed. The room had multiple tables present with various residents seated around them including another male resident who was eating eggs on a regular plate which had a visible yellow-colored, runny yolk smeared on the plate. When interviewed on 5/28/25 at 8:36 a.m.,			F 806			

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F 806	Continued From page 66 nursing assistant (NA)-C stated they were assigned care for R39. NA-C explained R39 typically ate breakfast in his room and thought he (R39) was usually served fried eggs. NA-C stated they were unsure why R39 had been served hard-boiled eggs for the past few days but reiterated they felt R39 was typically served fried eggs. On 5/28/25 at 10:31 a.m., cook (CK)-A was interviewed, and verified they often helped prepare the breakfast meals for residents. CK-A stated they recalled R39 wanting to have fried eggs adding staff had been "battling for a couple months" with him about it. CK-A stated they believed fried eggs were acceptable to serve as long as pasteurized eggs were used to make them which CK-A verified were available. CK-A stated R39 would eat fried eggs for every meal if allowed, and recalled DM had visited with him about it in the past. CK-A stated, to their knowledge, R39 was not allowed to have fried eggs due to the facility owner not allowing it adding, "The owner didn't want to do it." CK-A stated they were unsure of the rationale and advised the DM likely would have more information about it. When interviewed on 5/28/25 at 11:05 a.m., the assistant director of nursing (ADON) stated there had been discussion through an "email thread" about R39 wanting to consume fried eggs. ADON explained they originally had believed R39 couldn't consume fried eggs due to other regulations (i.e., F812), however, the food service vendor then corrected them saying fried eggs could be made as long as pasteurized eggs were used. ADON stated the interdisciplinary team (IDT) had discussed this just the week prior but	F 806			

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F 806	Continued From page 67 still had not "come to an ultimate decision" on how, when or if R39 would be allowed to consume fried eggs as he wanted. ADON acknowledged resident' choice being important with meal items adding, "It's their right to have choice," and staff should "do the best we can to accommodate this." On 5/28/25 at 11:29 a.m., the DM was interviewed, and verified they were aware R39 wanted to consume fried eggs with some meals. DM explained if R39 had "his way" he'd get fried eggs with each meal adding R39 had reported them to her as "comfort food." DM verified pasteurized eggs were available and expressed they were still trying to figure out how or if they'd serve them to R39 adding aloud, "It's a battle." DM expressed some of the issue was other departments not wanting R39 to have them and it created a situation where they had to decide "do we allow resident satisfaction and [or] not." DM acknowledged not being provided foods of choice could be a resident rights violation.	F 806			
F 812 SS=F	A facility' policy on meal choices was requested, however, none was received. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812			7/3/25

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F 812	Continued From page 68 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a low-temperature sanitization commercial dishwasher used in 1 of 1 main production kitchen was adequately monitored (i.e., every shift) to ensure effective chemical concentration and dishware sanitization to reduce the risk of foodborne illness. This had potential to affect all 72 residents, staff and visitors who consumed food from the kitchen. Findings include: On 5/27/25 at 8:13 a.m., an initial kitchen tour was completed of the main production kitchen located in the basement-level of the care center. The kitchen had a single CMA low-temperature commercial dishwasher placed along the wall with various chemicals positioned below in bottles and connected to the machine via clear tubing. These chemicals included rinsing aid(s) and sodium hypochlorite (used as a chemical sanitizer). Later, at 8:22 a.m., dietary aide (DA)-A was present at the machine and rinsing soiled dishware before placing it onto hard-plastic racks	F 812	1. Dishwasher temperatures were reviewed upon notification. 2. This citation has the potential to affect all residents. 3. The Dietary Manager and/ or designee will conduct re-education for all dietary staff responsible for dishwashing on proper use of the dishwashing machine; including logging temperatures, and the correct chemical concentration appropriately on 6/20/25. The Dietary manager will be educated on the policy for cleaning dishes and dish machine. 4. Audits of appropriate machine washing and sanitizing daily x1 week, then weekly x2, then monthly x2 to ensure temperatures and correct chemical concentrations are recorded accurately. Audit results will be taken to the QAPI committee for further recommendations. 5. Administrator and/or designee will ensure compliance. Date Compliant 7/3/25		

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F 812	Continued From page 69 and into the machine causing the machine to activate upon the entry door closure. DA-A stated the care center had just gotten this new dishwasher installed a few months prior and verified it was a low-temperature sanitization machine. DA-A pointed to a single gauge positioned below the machine which displayed the water temperature during each cycle. This gauge displayed a washing temperature of 126 degrees Fahrenheit (F) and a rinse temperature of 140 F. DA-A stated they checked the machine for chemical concentration using a Hydrion strip and showed this process to the surveyor. DA-A removed a strip from the packaging and placed one-half of it into pool water in the base of the machine after the dishwasher stopped. The strip turned a purple-color which DA-A compared to the packaging showing a concentration of 50 parts-per-million (PPM). DA-A stated the concentration should be "like 50 to 100 [PPM]" to ensure sanitization adding the machine was checked "every day" in the morning before cooking and food service started. DA-A provided a flow sheet labeled, "St Anthony Park Home," which was dated, "May 2025," and had columns to record the date, wash temperature, chlorine concentration (i.e., PPM), rinse temperature and staff initials. This identified only a single recording for each date (5/12 to 2/27) and only listed a PPM reading being completed/documented since 5/21 (i.e., six times) with each days' reading being recorded, "50 [ppm]." There were no other recorded ppm checks on the flow sheet. DA-A verified the flow sheet lacked any additional readings and expressed, "Maybe they [staff] forgot." DA-A reiterated the machine was only checked once a day to their knowledge for a PPM reading, and they verified the strips were the only testing mechanism used to check the PPM.			F 812			

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F 812	Continued From page 70 Later, on 5/27/25 at 2:02 p.m., dietary aide (DA)-B was interviewed. DA-B verified they worked the evening (i.e., second) shift and helped with washing dishes using the CMA commercial dishwasher in the main kitchen from the supper meal. DA-B stated the machine was just installed a few months prior and "the morning shift" was responsible to check the machine for PPM concentration. DA-B verified they do not complete any checks of the PPM using the Hydrion strips or any other mechanical indicators adding aloud, "I don't do that, no." On 5/28/25 at 11:26 a.m., the dietary manager (DM) was interviewed, and they verified the dishwasher was only checked once-a-day for ppm concentration of the sanitizing solution. DM acknowledged the flow sheets used to record this process only started having a documented PPM check on 5/21/25, and expressed it "took awhile" for staff to get used to running the machine and checking it for function and sanitization. DM stated they would adjust the flow sheet to ensure a twice-a-day check (i.e., every shift) was completed and recorded. DM stated it was important to ensure the machine was checked adequately for sanitization so as "to make sure the chemicals are at equal levels to make sure the dishes are getting sanitized." A facility provided Cleaning Dishes/Dish Machine policy, undated, outlined all flatware, dishes and cookware would be cleaned, rinsed, and sanitized after each use adding, "The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing." The policy outlined a process to ensure sanitization for both a			F 812			

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F 812	Continued From page 71	F 812			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880			7/3/25

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F 880	Continued From page 72 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report a suspected Norovirus outbreak to the State Agency (SA) as required. This had the potential to affect all 72 residents residing in the	F 880	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice.		

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F 880	Continued From page 73 facility. In addition, the facility failed to ensure a blood glucose machine was kept in good repair to ensure the surface could be adequately disinfected and for 1 of 4 residents (R40) reviewed for medication administration. The facility also failed to ensure proper hand hygiene and glove use was utilized for 1 of 2 residents (R62) observed during personal cares. Findings include: NOT REPORTING SUSPECTED NOROVIRUS OUTBREAK TO STATE AGENCY According to 2024-2025 Norovirus Information for long-term care facilities from www.health.state.mn.us, "By Minnesota state law (Minn. Rules part 4605.7050), "any pattern of cases, suspected cases, or increased incidence of any illness beyond the expected number of cases in a given period" shall be reported immediately to MDH. This includes suspected outbreaks, increases in GI illnesses, or unusual disease activity at your facility." The Antibiotic Surveillance and Symptom Tracker report, printed 5/28/24, was reviewed. The log included the following information: resident names, date of birth, unit, room numbers, onset date of symptoms, diagnostic order and results, current prescription, infections, isolation, organism, status and signs and symptoms. The report identified between 1/31/25 -2/16/25, 14 residents were suspected of Norovirus. One resident was also identified on 2/26/25 and another on 4/18/25. Recorded signs and symptoms included vomiting, diarrhea, nausea, abnormal bowel movement and GI complaints.	F 880	No lasting effect noted for R40 regarding medication administration and glucometer use. Glucometer was replaced on 5/28/25. No lasting effect noted for R62 regarding hand hygiene. All staff on unit educated on hand washing policy on 6/26/25. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the same deficiency. Hand hygiene policy reviewed with staff on 7/1/25 & 7/2/25. All glucometers inspected for cracks or cleanliness. Suspected Norovirus outbreak was reported to MDH on 6/10/25. 3) What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Infectious disease reporting policy reviewed with infection preventionist on 6/26/25. Hand hygiene policy reviewed on 6/26/25 and reviewed with all staff on 7/1/25 & 7/2/25. Education on cleaning and inspecting glucometers reviewed with nursing staff on 7/1/25 & 7/2/25. 4) How the corrective actions(s) will be		

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F 880	Continued From page 74 Isolation precautions were listed as "contact" for all residents listed for Norovirus. During an interview on 5/28/25 at 1:57 p.m., assistant director of nursing (ADON) stated she was the facilities infection preventionist (IP) and had been in the IP role for over a year. ADON stated she did all the required reporting for any suspected outbreaks in the facility. ADON stated the facility had a Norovirus outbreak in February, however she did not have any documentation that the outbreak was reported to the state agency as she did not report the outbreak and was unsure if it was required to report a Norovirus outbreak. ADON stated she thought one resident was tested for Norovirus but any residents with symptoms were treated as though they had Norovirus. During an interview on 5/29/25 at 12:52 p.m., director of nursing (DON) stated it was the facilities responsibility to report any suspected outbreak to the state agency. DON stated there was a Norovirus outbreak in February and it should have been reported. A facility policy titled Reporting Communicable Diseases, undated, indicated "the infection preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable diseases." BLOOD GLUCOSE MACHINE The Medline Evencare G2 Blood Glucose Monitoring System dated 2017, included the following cleaning instructions: Wash hands with soap and water, inspect the machine for blood debris, etc., clean the machine with a validated	F 880	monitored to ensure deficient practice will not recur. Hand hygiene, glucometer cleaning and infectious and outbreak monitoring will be audited weekly for 1 month, monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 880	Continued From page 75 disinfecting wipe, allow it to air dry, and if cracking of the plastic housing is noted, stop using the device. R40's annual Minimum Data Set (MDS) dated 3/21/25, indicated R40 had moderately impaired cognition and was diagnosed with kidney disease and diabetes. The MDS indicated R40 received insulin (an injection used to lower blood sugar) during the look-back period (LBP). R40's order summary dated 5/29/25, indicated R40 had orders for: -Insulin Lispro (fast-acting insulin) three times a day per sliding scale based on blood glucose level (70 - 149, zero units; 150 - 199, 2 units; 200 - 249, 4 units; 250 -299, 6 units; 300 - 349, 8 units; 350 - 399, 10 units; 400 or greater, 12 units and notify provider) -Humulin 70/30 insulin (combination of insulin isophane and regular, both short and intermediate-acting insulin), 52 units in the morning and 44 units in the evening. During an interview and observation on 5/28/25 at 8:13 a.m., registered nurse (RN)-F stated R40 had insulin due this morning, so he was going to check his blood sugar. RN-F was observed to take a Medline Evencare G2 blood glucose machine which had about an inch-long crack in the plastic housing on the left side of the machine, sporadic white building up on the machine, and was missing a back battery cover which was instead covered with clear medical tape. RN-F was observed to complete hand hygiene, apply gloves, and use the machine to take R40's blood glucose reading. RN-F confirmed this machine was used for the floor and not solely for R40. RN-F stated he was	F 880			

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F 880	Continued From page 76 unsure how long the machine had been cracked. During an interview on 5/28/25 at 12:45 p.m., RN-E, the unit nurse manager, stated she was unsure if the blood glucose machine was still a cleanable surface but was going to take the machine out of service and see if they had a different blood glucose machine to use instead. During an interview on 5/29/25 at 12:38 p.m., the director of nursing (DON) stated if a blood glucose machine was cracked, she would expect nursing staff to take it out of service as it was no longer a cleanable surface and could affect the accuracy of the measurements. The facility's Obtaining a Fingerstick Glucose Level policy dated 9/30/21, indicated that blood glucose monitoring equipment was to be cleaned and disinfected according to manufacturer's instructions and current infection control standards of practice. HAND HYGIENE AND GLOVE USE R62's quarterly Minimum Data Set (MDS) dated 5/2/25, indicated R62 had intact cognition and no hallucinations, delusions, behaviors, or rejection of cares. R62 had impairment to both lower extremities, required partial and/or moderate assistance for upper body dressing and to roll left and right, and was dependent on toileting hygiene and lower body dressing. R62's diagnoses included heart failure, hypertension, malnutrition, anxiety, depression, post traumatic stress disorder, respiratory failure, and chronic obstructive pulmonary disease. During observation on 5/28/25 at 11:10 a.m.,			F 880			

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F 880	Continued From page 77 nursing assistant (NA)-G wore gloves, unhooked R62's incontinent product, and completed peri-cares. NA-G disposed of R62's incontinent product soiled with urine and used the same gloves to apply a clean brief and clean bed pad. NA-G removed their gloves, did not perform hand hygiene, exited the room, and grabbed a clean gown from the floor's clean linen area. NA-G returned to R62's room with the gown, applied new gloves, and assisted R62 to apply the gown. NA-G bagged soiled linen and garbage, removed gloves, and washed their hands. During interview on 5/28/25 at 11:22 a.m., NA-G stated they changed their gloves after changing R62's incontinent product. NA-G acknowledged they did not complete hand hygiene with glove change or when they exited room to get clean gown. During interview on 5/29/25 at 1:46 p.m., registered nurse (RN)-E expected staff to change gloves and complete hand hygiene after a dirty process and before touching clean products. During interview on 5/29/25 at 3:00 p.m., the assistant director of nursing (ADON), who was the facility's infection preventionist, stated hand washing was the best form of infection prevention. The facility Handwashing/Hand Hygiene policy dated 1/18/22, directed staff to complete hand hygiene after removing gloves, before and after direct contact with resident, before moving from a contaminated body site to a clean body site during resident care, and after contact with blood or bodily fluids.	F 880			

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F 881 F 881 SS=F	Continued From page 78 Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an antibiotic stewardship program which included development of protocols and a system to monitor appropriateness of antibiotic including prophylactic antibiotic use to prevent antibiotic resistance and help prevent the spread of infectious diseases. This had the potential to affect all 72 residents residing in the facility. In addition, the facility failed to ensure an ongoing review of prophylactic antibiotic use for 1 of 1 residents (R51) reviewed for oral antibiotic use. R51 R51's admission Minimum Data Set (MDS) dated 4/21/25, indicated R51 had intact cognition and had been admitted to the facility on 4/15/25. R51's provider note dated 5/20/25, indicated R51 was diagnosed with anemia and wounds of the left and right ankle. The note did not indicate that R51 had a history of urinary tract infections or an indication of review for the continued use of cephalexin.			F 881 F 881	)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No lasting effect on R51 related to prophylactic antibiotic. Request for urology notes received on 6/5/25 – notes from 12/10/24 states resident to start on low dose prophylactic antibiotic. Provider put prophylactic antibiotic on hold on 6/6/25. Prophylactic antibiotic was discontinued on 6/19/25. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this same deficiency. Prophylactic antibiotics were added to antibiotic monitoring program. 3) What measures will be put in place or what systemic changes will you make to		7/3/25

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F 881	Continued From page 79 R51's Order Summary Report dated 5/27/25, indicated R51 had an order for cephalexin (an antibiotic) 250 milligrams (mg) daily for urinary tract infection (UTI) "prophylaxis". R51's medical record was reviewed and did not indicate that R51' s order for prophylactic cephalexin had been reviewed with indication for its continued use. During an interview on 5/27/25 at 8:46 a.m., R51 stated she had seen a urologist sometime in 2023 after she had fallen and broken her pelvis, and he had started the cephalexin because she had multiple UTIs. R51 stated thought the urologist had told her to keep taking the cephalexin "until the body heals" but did not recall being told an exact duration of use. During an interview on 5/28/25 at 1:27 p.m., the assistant director of nursing (ADON), also in the role of infection preventionist, confirmed she had reviewed R51' s medical record and was unable to find documentation that the Cephalexin had been reviewed by the provider for the appropriateness of continued use. The ADON stated she would prefer to "get rid of" prophylactic antibiotics when a resident was admitted to the facility but had been struggling with getting provider participation in reviewing these medications for residents. During an interview on 5/29/25 at 2:27 p.m., nurse practitioner (NP)-A stated R51 had been admitted with the cephalexin, and she had thought R51 had been taking the medication "for years" and she "tend[s] to leave it[those medications] alone". NP-A stated that R51 was	F 881	ensure that the deficient practice does not recur. Antibiotic stewardship policy reviewed with Infection preventionist on 6/26/25. Prophylactic antibiotics were added to antibiotic monitoring program. 4) How the corrective actions(s) will be monitored to ensure deficient practice will not recur. Antibiotics will be audited weekly for 1 month, then monthly for 2 months. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. 5) Director of Nursing and/or designee will ensure compliance. The date of compliance is July 3, 2025.		

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F 881	Continued From page 80 currently on a transitional care unit status, so she was not going to review if the continued use of the cephalexin was appropriate for R51, until she transitioned to long-term care as was her practice. NO PROPHYLACTIC ANTIBIOTIC MONITORING The Antibiotic Surveillance and Symptom Tracker report, printed 5/28/25, was reviewed. The log included the following information: resident names, date of birth, unit, room numbers, onset date, diagnostic order and results, current prescription, infection, isolation, organism, signs and symptoms and status. The report lacked prophylactic antibiotic tracking. During an interview on 5/28/25 at 1:57 p.m., assistant director of nursing (ADON) stated she was the facilities infection preventionist (IP). ADON stated she has been in the IP role for over a year. ADON stated she was not tracking any prophylactic antibiotics in the facility and verified they were not included on the antibiotic tracking sheet which was reviewed in QAPI (Quality Assurance and Performance). ADON stated she was currently not reviewing prophylactic antibiotics and was not able to state the number of residents on prophylactic antibiotics. ADON stated she had not determined where or how she was going to track them. ADON stated she relied on the pharmacy to review the prophylactic antibiotics but was unsure how this was completed. ADON stated it was important to monitor prophylactic antibiotics as "according to a	F 881			

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F 881	Continued From page 81 lot of people they are not effective." During an interview on 5/29/25 at 1:56 p.m., consulting pharmacist (CP)-A stated that during her monthly audits of resident charts, she reviewed antibiotics to ensure they were the appropriate dose for the resident. CP-A stated she did not review for the duration of the antibiotic and stated, "I would leave it up to the provider to determine how long the resident should be on a prophylactic antibiotic". During an interview on 5/29/25 at 12:51 p.m., director of nursing (DON) stated it was important to track prophylactic antibiotics to make sure they were appropriate for why they were prescribed. A facility policy titled Antibiotic Stewardship Policy, dated 10/4/21, indicated "The Infection Control Nurse will complete monthly chart reviews of all ordered and administered antimicrobials for the residents. The data will be recorded and presented at the Quarterly Quality Assurance Committee Meeting. A review of possible trends will be discussed at this time. The Consulting Pharmacist will complete a monthly review for indications and justification of use to verify that antibiotics are used in accordance with CDC recommended guidelines."			F 881			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 28, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Anthony Park Home, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2025

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: The St Anthony Park Home was constructed at three different times. The original building was built in the 1900's, is 3 stories, with a basement and was determined to be of a Type II (111) construction with a wood frame roof system that meets the exception to "The Life Safety Code" NFPA 101 (2000 edition) Section 16.1.6.2. In 1960 an addition was constructed to the west of original building, which was 1-story, with a basement, and was determined to be Type II	K 000			

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K 000	Continued From page 2 (111) construction. In 1999 a 2nd and 3rd floor were constructed over the 1960 addition that are separated with a 2 hour fire barrier from the 1900 original building and are Type II (111) construction. The building is divided into 11 smoke zones (3 each level except the basement) by at least 1 hour fire barriers. Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 72 at the time of the survey.	K 000			
K 225 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 225		7/3/25	

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K 225	Continued From page 3 Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.3, 7.1.3.2.3, and 7.2.2.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/28/2025, at 9:05 AM, it was revealed by observation that there were alcohol hand rub stations installed on each level of each stairwell. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 225	The alcohol hand rub stations (ABHR) installed on each level of each stairwell were removed on May 30, 2025. A task to ensure all stairwells within the building are free of alcohol hand rub stations was created within the facilities TELS system. Maintenance Director and Environmental Director have been educated on the NFPA 101 (2012), Life safety code, section 7.2.2.5.3 (Usable Space) and 7.2 (Stairwell Alcohol). Keeping all areas of stairwell free of facility equipment, and storage of ABHR. Inspections will be conducted 1x week for 4 weeks, 1x month for a month. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits. The Director of Maintenance and/or designee will ensure compliance. Date of compliance is July 3, 2025		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920			7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/28/2025	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 920	Continued From page 4 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/28/2025, at 9:30 AM, it was revealed by observation that there was an extension cord was plugged into a power strip in the Boiler Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 920	On May 28, 2025, the Maintenance Director corrected the deficient practice by removing the extension cord in the boiler room. Facility was checked to ensure extension cords were not in use for permanent reasons and all power strips meet UL 1363A or UL 60601-1 standards. All staff will be educated on extension cord usage within the facility and ensure no extension cords are used to power devices. Inspections will be conducted 1x week for 4 weeks, 1x month for a month, then annually thereafter. Audit review and analysis will be brought to QAPI to determine ongoing frequency and duration of audits.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/26/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245063	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN 55108		
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K 920	Continued From page 5	K 920	The Environmental Director and/or designee will ensure compliance. The actual date of completion is July 3, 2025.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245063	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 5/28/2025
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 351	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/28/2025, at 9:40 AM, it was revealed by observation that there were wires in contact with the sprinkler system in the Laundry and In Service Rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			
	K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have an isolated impact on the residents within the facility.		

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245063	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 5/28/2025
NAME OF PROVIDER OR SUPPLIER ST ANTHONY PARK HOME INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2237 COMMONWEALTH AVENUE SAINT PAUL, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 712	Continued From Page 1 Findings include: On 05/28/2025, at 8:45 AM, it was revealed by a review of available documentation that the facility had exceeded the allowable 3 months between fire drills for the night shift between the 2nd quarter and the 3rd quarter of 2024. An interview with the Mainteance Director verified this deficient finding at the time of discovery.			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 18, 2025

Administrator
St. Anthony Park Home Inc 2237
COMMONWEALTH AVENUE
SAINT PAUL, MN 55108

RE: CCN: 24G527
Cycle Start Date: May 29, 2025

Dear Administrator:

On July 14, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us