Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 25, 2024

Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

RE: CCN: 245310
Cycle Start Date: August 15, 2024

Dear Administrator:

On October 21, 2024, 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.

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

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Electronically delivered
August 26, 2024

Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

RE: CCN: 245310
Cycle Start Date: August 15, 2024

Dear Administrator:

On August 15, 2024, 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 November 15, 2024 (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 February 15, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(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 8/12/24 through 8/15/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 8/12/24 through 8/15/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H53106646C (MN105049/MN00105791) and H53106647 (MN103905). The following complaints were reviewed: H53106645C (MN102269) with a deficiency cited at F625. 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		

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

Electronically Signed | 09/04/2024

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 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		10/3/24

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F 584	Continued From page 2 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the dining room floor for 1 of 3 dining rooms was clean and sanitary. Findings include: During observation on 8/12/24 at 12:17 p.m., the dining room floor of the Villa unit had copious amounts of dried food and spilled liquids and was very sticky upon walking on it. During observation on 8/12/24 at 1:30 p.m., all the residents in the Villa unit were in the dining room waiting to go to McDonalds for lunch and the floor was observed to be visibly soiled and sticky. During interview on 8/13/24 at 7:49 a.m., licensed practical nurse (LPN)-A verified the dining room floor (Villa unit) was visibly soiled, had many areas of dried food/liquid spills, and was sticky. LPN-A stated housekeeping came every morning at 8:00 a.m. and mopped the floor. -At 9:37 a.m. environmental services (ES)-A finished mopping the dining room floor, put out wet floor signs, and left the unit. Surveyor observed numerous sticky spots and spills of juice that still remained on the floor.	F 584	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. The dining room floor was deep cleaned on 8/13/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The other dining rooms within the community were verified as clean during the survey process. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. The housekeeper responsible for the Villa neighborhood has been educated, retrained, and has demonstrated appropriate mopping technique. All staff have been educated on the TELS system to put in a work order/housekeeping request if there are areas that need further attention or deep	

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F 584	Continued From page 3 During observation and interview on 8/13/24 at 10:03 a.m., the director of environmental services verifed the dining room floor was visibly dirty, sticky and there was more then one day of built up dirt/food spills stating "I don't know what happened to this floor." During interview on 8/14/24 at 8:49 a.m. environmental services (ES)-B stated they cleaned the dining room floors on each unit daily. They come in the morning and clean the tables, then after lunch they sweep and mop the dining room floors. During interview on 8/14/24 at 12:21 p.m. nursing assistant NA-C stated the dining room floor (Villa unit) was "usually pretty sticky and dirty." The floor cleaning schedule (undated) indicated dining rooms/kitchen serving areas were mopped 2 times per day, in the morning and after lunch. The sign off sheets for documenting whether the floor had been cleaned or not were requested but not received. A facility policy regarding cleaning was requested but not received.	F 584	cleaning if there is excess build up. The housekeeping daily cleaning checklist is being documented and verified by the Environmental Services Director. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. EVS Director/Designee will audit each of the dining rooms within community 1x per week for 4 weeks to assure cleanliness. The results of this audit will be reported to QAPI. 5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	
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	F 656		10/3/24

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F 656	Continued From page 4 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 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:	F 656		

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F 656	Continued From page 5 Based on interview and document review, the facility failed to ensure a comprehensive and individualized care plan was developed for 1 of 3 residents (R88) reviewed for psychotropic medication use. Findings include: R88's admission MDS dated 7/24/24, indicated R88 had moderate cognitive impairment and diagnoses of sepsis, metabolic encephalopathy (change in how the brain works due to an underlying condition), delirium related to known physiological condition (a temporary mental state characterized by confusion, incoherent speech, and hallucinations), and age-related cognitive decline. Furthermore, R88's MDS indicated R88 had received an antipsychotic medication. R88's care plan revised on 8/12/24 at 3:45 p.m., (after the start of survey) indicated R88 used quetiapine for delirium. Interventions included to administer medication as ordered, ask for a possible dose reduction every three months, and monitor for side effects. Interventions further included monitoring behaviors every shift and document. R88's care plan lacked non-pharmacological or personalized interventions were in place to support any signs of delirium or delusions. R88's nursing task sheet no date, lacked indication R88 had behaviors or confusion. When interviewed on 8/14/24 at 12:33 p.m., nursing assistant (NA)-B stated R88 was confused at times but did not really have any behaviors or outbursts. NA-B further	F 656	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R88 discharged from the community on 8/21/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents that receive an antipsychotic medication will be reviewed and updated as needed to include individualized interventions. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All nursing associates have been educated on expected documentation related to monitoring for behaviors and documenting non pharmalogical interventions. All Clinical Manager and MDS personnel have been educated related to the need for individualized, person centered care and care plans. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/Designee will audit 5 residents who are taking antipsychotic medications to ensure individualized interventions and	

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F 656	Continued From page 6 acknowledged there were no alerts on the task sheet identifying any behavioral concerns for R88 and wasn't aware of any interventions. When interviewed on 8/14/24 at 1:00 p.m., registered nurse (RN)-A stated if a resident was experiencing some anxiety or getting agitated, we use distraction by going for a walk or their mind on something else and it would depend on the situation. RN-A further stated they were not aware of any behaviors for R88 or personalized interventions that were in place. When interviewed on 8/15/24 at 10:06 a.m., the Director of Nursing (DON) stated the care plan was developed from the MDS nurse and the unit's nurse manager. DON verified R88's care plan lacked individualized interventions and furthermore expected care plans to be individualized to each resident. A facility policy titled Comprehensive Assessment and Care Planning revised 9/2023, directed an all-person-centered care plan interventions will by implemented by qualified personal and may be communicated through the electronic health record, profile, assignment sheets or verbal communications.	F 656	care plans are in place for 4 weeks. Results of this audit will be reviewed by QAPI. 5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate	F 676		10/3/24

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F 676	Continued From page 7 that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide routine showers for 1 of 1 residents (R90) reviewed for activities of daily living (ADLs). Findings include: R90's admission Minimum Data Set (MDS) dated	F 676	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R90 received a shower on 8/9 and 8/16 in conjunction with her OT treatment plan.	

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F 676	Continued From page 8 7/31/24, indicated R90 was cognitively intact and had diagnoses of cellulites (skin infection) of right lower limb, lymphedema (swelling from due to lymphatic system problem), and fracture of right foot 5th toe. R90's admission MDS further indicated R90 did not reject cares, required substantial assistance for lower body dressing, supervision or touching assistance for personal hygiene, and had not been assess for bathing showering assistance due to medical/safety concerns. R90's care plan dated 7/28/24, indicated R90 had difficulty with bathing related to decline in mobility, lymphedema, and leg wounds. Interventions included staff assist with bathing weekly. R90's nursing care sheet no date, provided at survey exit indicated R90's bath day was on Monday. R90's nursing order dated 7/25/24, indicated R90's bath day was once a day on Monday morning. R90's treatment administration record (TAR) for 8/1/24-8/13/24, indicated R90 had not received a bath on 8/5/24 or 8/12/24. The TAR indicated the reason the bath was not administered was shower day was Tuesday. R90's point of care documentation dated 7/25/24-8/13/24, lacked indication R90 had a shower or bath. When interviewed on 8/12/24 at 12:35 p.m., R90 was seated in the recliner chair in their room. R90 stated when admitted, she hadn't had a shower in almost 2 weeks and had to complain a	F 676	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All Transitional Care Unit Residents have been audited to ensure the nursing order, Treatment Administration Record, and care delivery guide match to ensure community associates are aligned with expected duties related to shower days. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All nursing associates have been educated on customer service related to meeting resident requests including additional showers being provided if requested. All Clinical Managers and the therapy department have been educated on communicating changes in shower schedules and updating the care delivery guides based on individualized goals and treatments of each resident. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/Designee will audit five residents per week to ensure nursing order, Treatment Administration Record, care delivery guide, and documentation of task completed related bathing of residents for 4 weeks. The results of this audit will be reported to QAPI.	

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F 676	Continued From page 9 lot to get one. R90 stated she was supposed to be on a schedule now, but not sure as she had not had one since. R90 did not know what day it was supposed to be or when the next one was. When interviewed on 8/14/24 at 6:41 a.m., nursing assistant (NA)-A stated resident bath days were found on the care sheets. NA-A verified R90's bath day on the care sheet was on Tuesday mornings. A follow up interview on 8/14/24 at 11:35 p.m., R90 stated a shower was not offered on Monday 8/12/24 or Tuesday 8/13/24. R90 further stated she found out the shower was supposed to happen on Monday but had not. When R90 asked about it on Tuesday, staff told her it was not her bath day and had not received one. When interviewed on 8/14/24 at 12:33 p.m., NA-B stated resident shower days were listed on the care sheet. NA-B stated if a resident refused a bath or shower, it would be documented in the POC documentation, and the nurse would be notified. NA-B pulled out the care sheet and verified R90's shower day was Tuesday. NA-B reviewed R90's POC documentation and verified there had been no bathing/shower documentation the past few weeks. When interviewed on 8/14/24 at 1:00 p.m., registered nurse (RN)-A stated resident bath days were located on the care sheets as well as a nursing order. RN-A further stated sometimes the days were changed per resident request. RN-A verified the nursing documentation indicating R90 had not had a shower or bath the past 2 Mondays as the bath day was on Tuesday. RN-A also verified the care sheet indicated the bath day was on Tuesday. RN-A was not sure if	F 676	5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	

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F 676	Continued From page 10 R90 had been given a bath or shower and wasn't sure why the order and care sheet were different. RN-A stated the care sheet, or the order needed to be updated and match up, so showers were not missed. When interviewed on 8/15/24 at 10:06 a.m., the Director of Nursing (DON) stated upon admission residents were assigned a specific bath day by the unit managers. DON further verified the NAs would document in POC when the shower or bath was completed, and the nurse would document it as a treatment. DON acknowledged there was some miscommunication around R90's shower days and verified the shower day should be on Mondays and coordinated with occupational therapy as they were managing R90's edema wraps. A facility policy titled Activities of Daily Living dated 2021, directed staff to provide care appropriate to maintain their ability to maintain or improve their ability to carry out ADLs. Furthermore, the policy directed staff to assist residents who are unable to carry out ADL's independently including bathing.	F 676		
F 684 SS=E	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.	F 684		10/3/24

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F 684	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure vitals signs were taken as ordered for 1 of 3 residents (R77) reviewed for antipsychotic medication use and the facility failed to ensure resident's weights were monitored as ordered for 1 of 1 residents (R82) reviewed for nutrition. In addition, the facility failed to monitor skin alterations for 1 of 1 resident (R4) with facial bruising and failed to administer medications per doctor's order for 1 of 1 resident (R65) who repeatedly did not receive scheduled medications due to sleeping. Furthermore, the facility failed to ensure skin assessments were accurately documented for 3 of 3 residents (R90, R36, R88) reviewed for non-pressure skin altercations. Findings include: R77 R77's quarterly Minimum Data Set (MDS) dated 6/5/24, indicated R77 had severe cognitive impairment and received antipsychotic medications. R77's diagnoses included dementia, Alzheimer's disease, edema, vertigo, and asthma. R77 required substantial to full assistance with most activities of daily living (ADLs). R77's MDS further indicated no rejection of care behaviors exhibited by R77. R77's care plan (CP) indicated R77 was at risk for complications from psychotropic drug use and instructed staff to monitor vital signs weekly and as necessary. The CP further indicated R7 was at risk for falls related to needing assistance with most cares and instructed staff to monitor vital	F 684	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R77 had a full set of vitals taking on 8/14/2024 and all were within normal limits. R82 had a weight taken on 8/13. Provider was updated. Weight was stable based on resident interview. R4s facial bruise has resolved. R65 medication regimen was reviewed by the provider on 8/13/2024. R90 had a skin assessment updated on 8/15. R36 had a skin assessment updated on 8/12. R88 has discharged from the community. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents within the community have been audited to ensure an accurate set of vitals have been obtained. All residents on the transitional care unit have been audited to ensure they have an accurate weekly weight. No additional residents have been noted to have facial bruising. R4 had a nurse's order to monitor the bruise, however, the order had a stop date prior to healing. It is the expectation that all bruises are monitored until healed. The MAR for "medications not given" has been reviewed for the last 60 days.	

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F 684	Continued From page 12 signs per protocol. R77's provide order included: -olanzapine tablet; 5mg; amt: 5mg; oral at bedtime HS med pass dated 4/16/24 -BHCI Standing Orders dated 12/6/23 -Monitor for side effects r/t use of antipsychotic medication to include but not limited to ...tachycardia [fast heart rate] dated 12/8/23." R77's vital signs report dated 12/6/23 through 8/14/24, indicated prior to 8/14/24, the most recent vital signs taken on 3/5/24 included temperature 97.6, Pulse 69, reparations 18, blood pressure 127/79 and O2 saturation 95%. R77's progress note (PN) dated 5/7/24 at 8:33 a.m., indicated, "patient has one episode of emesis, which was resolved after drinking ginger ale, the patient's vital signs bp 134/67, resp 16, temp 98, O2 97% at RA [room air], pulse 76, Staff will continue to monitor patent [sic]." R77's PN lacked evidence of any further vitals signs between 3/5/24 and 8/14/24. R77's medical doctor (MD) note dated 6/24/24, indicated, "Vitals: BP 127/79 | Pulse 69| Temp 97.6 F | Resp 18| ...SpO2 95%." R77's nurse practitioner (NP) note dated 8/9/24, indicated, "Vitals: BP 127/79 | Pulse 69| Temp 97.6 F | Resp 18| ...SpO2 95%." The NP note further indicated, "Bilateral leg edema ...no plan for diuretic with SBP's [systolic blood pressure] 120 and fall risk." During interview on 8/14/24 at 10:23 a.m., licensed practical nurse (LPN)-A stated any	F 684	Providers have been updated as appropriate and nurses who have documented meds not given due to resident sleeping have received education. All residents who have admitted to the community within the last 30 days have had their skin observation assessment reviewed and compared to their treatment order and plan of care. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All nursing associates have been provided education related to the expectation of obtaining a full set of vitals and weights on bath days or to document a refusal of care. All nursing associates have been provided education that if a fall with bruising occurs an order to monitor until bruise resolves is the appropriate order to enter. All nurses have been educated that medications are to be given as prescribed by the provider. The process if a resident is sleeping is to re-approach, then wake the resident up, and if the resident continues to sleep document a refusal of care. All nurses have been educated on the expectation of the skin observation assessment to be completed within 72 hour of admission and weekly for the first 4 weeks after admission and that	

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F 684	Continued From page 13 resident receiving antipsychotic medications would have behavior and side effect monitoring completed regularly. LPN-A stated orthostatic blood pressure changes could be a side effect of these medications and should be monitored. LPN-A stated vital signs should be taken weekly on all residents unless they had orders for more frequent monitoring. LPN-A stated facility protocol indicated vital signs were taken weekly on shower days and that even if a resident refused a shower, vital signs should still be taken. LPN-A confirmed R77 did not have any vital signs documented since 3/5/24 and stated R77 should have had vital signs taken weekly within that time. During interview on 8/14/24 at 10:40 a.m., registered nurse (RN)-F stated would expect blood pressures along with all other vital signs to be completed weekly on shower days unless ordered more frequently. RN-F looked at R77's medical record and confirmed no vital signs documented in the vital sign tab since 3/5/24 and only one other set of vital signs documented in progress notes on 5/7/24. RN-F further stated any refusals by the resident should be documented in the medical record. During interview on 8/14/24 at 11:52 a.m., director of nursing (DON) stated the expectation was for all residents to have a full set of vital signs completed and documented weekly on shower days unless a medical condition required more frequent monitoring. DON further stated R77 should have had vital signs completed weekly and confirmed they had only been checked and documented once in a progress note since 3/5/24. DON stated vital signs should be documented in the vital signs tab, so providers and other staff reference that location for the	F 684	associates have the option for two nurses to complete the assessment together to ensure accuracy if needed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/designee will audit 5 residents per week on their bath day to ensure a full set of vitals is taken or a refusal of care is documented DON/Designee will audit 5 residents per week on the transitional care unit to ensure a weight is being taken weekly. DON/designee will audit 3 falls per week to ensure an appropriate event is completed if the resident sustains an injury, bruise, or skin tear to ensure community continues to monitor. DON/designee will audit 5 residents per week to ensure the MAR is accurate and the residents are receiving the medications ordered per the providers order. DON/designee will audit 5 residents per week who are within 30 days of their admission date to ensure the skin observation assessment matches the plan of care established as well as the resident's actual skin condition.	

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F 684	Continued From page 14 most recent vitals to assist in completing resident assessments and writing progress notes. Facility standing orders dated 7/23, indicated vital signs should be taken weekly for all residents residing in the long-term care community. R82 R82's admission MDS dated 7/25/24, indicated R82 was cognitively intact, had not had a weight change in the last six months prior to admission, and did not reject cares. The MDS indicated R82's diagnoses included high blood pressure, thyroid disease, and depression. R82's face sheet printed 8/13/24, indicated R82 was admitted to the facility on 7/19/24. R82's CP dated 7/22/24, indicated R82 was at risk for nutritional status due to multiple diagnoses and instructed staff to monitor weight weekly. R82's provider order dated 7/20/24, indicated, "Weight [sic] patient: per facility protocol." R82's initial nutritional assessment dated 7/22/24, indicated R82's admission weight was lower than usual body weight and listed goals included monitoring weights per orders. R82's progress notes dated 7/20/24 through 8?13/24, indicated, "Weight Gain or Loss: No" 19 times. R82's weight report for 7/19/24 through 8/13/24, indicated only one weight documented for R82 of 142.8 on 7/20/24. R82's medical record lacked	F 684	5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	

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F 684	Continued From page 15 evidence of any other weights taken or documented during that time. During interview on 8/12/24 at 2:33 p.m., R82 stated felt like she was losing weight but was not sure since she had only been weighed once just after admission to the facility. During interview on 8/13/24 at 1:10 p.m., nursing assistant (NA)-G stated nursing assistants weighed residents weekly on shower days unless they had orders for daily weights. NA-G stated NAs had access to enter the weight into the medical record. During interview on 8/13/24 at 2:04 p.m., RN-C stated the facility protocol was to complete weekly weights on shower days unless more frequent weights were ordered. RN-G stated weights would be done even if the resident refused a shower. RN-G confirmed R82 had only been one time since admission. During interview on 8/14/24 at 8:44 a.m., registered dietician (RD) stated expectation that residents without medical conditions like congestive heart failure (CHF) which would require daily weight monitoring, would be weighed at least weekly. RD stated R82 should have been weighed weekly per protocol and confirmed that had not been done. During interview on 8/14/24 at 11:46 a.m., DON stated expectation was for residents would be weighed according to the provider orders or per protocol. Facility protocol was for weekly weights on bath days. DON stated weights should still be completed even if the resident refused a bath.	F 684		

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F 684	Continued From page 16	F 684		

Facility standing orders dated 7/23, indicated residents admitted for a short stay (transition care unit) without CHF, "obtain weekly weight unless directed otherwise."

Skin monitoring

R4's quarterly Minimum Data Set (MDS) dated 5/7/24, indicated severe cognitive impairment, disorganized thinking, and wandering. It further indicated diagnoses of dementia, falls, restlessness, and agitation. R4 requred partial to moderate assistance with transfers and had no falls since admission.

R4's care plan dated 8/2/24, indicated an alteration in skin integrity as evidenced by abrasions and bruises on face, forehead, nose, and around the eyes. It further indicated an intervention to monitor the site until healed/resolved.

During observation on 8/12/24 at 2:30 p.m., R4 was sitting in the dining room in her wheelchair. The left side of her forehead had yellowish/green bruising and under her right eye was a dark purple bruise. There were two red marks on the bridge of her nose and several small scratches on the right side of her forehead with dried blood.

R4's progress note dated 8/6/24, indicated the interdisciplinary team (IDT) met to review resident's fall. "According to staff, resident was in the wheelchair in dining room area prior to fall. Fall happened in the family room, resident either propelled herself to the family room or was assisted/wheeled towards the family room by one of the MR# 8105-01 (D.N.) came and informed

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F 684	Continued From page 17 the writer that resident is on the floor in the family room. When the staff went to the family room where resident, observed MR# 1039-01 (J.B.) pushing [R4's] wheelchair from the family room towards to the dining room.[R4] was on the floor on her face, and her forehead & nose has abrasions. The staff helped the resident to sit and assessed the resident. Assessment done the resident's [range of motion] ROM x 3 done without pain/limitations or shortening. Resident was complaining of pain in her left hand middle finger. The finger was bruised had no rotation/deformity or shortening observed. The resident is alert and orient to her name & pain per baseline. Vital signs [VS] checked and noted in matrix care.The resident does not usually ambulate but can stand and pivot, with transfers and utilizes wheelchair (w/c) for mobility. The resident may have slid or fell out of the w/c, whilst propelling herself or being wheeled by the other resident (J.B) who likes to assist other resident's on the unit, resulting in a fall. Resident has cognition impairment, contributing to poor safety awareness and limitation. Immediate intervention staff applied ice pack on forehead and right hand middle finger and did not swell. Call was placed to Fairview and talked to medical doctor (MD), on-call provider, updated on fall with injuries. The doctor gave the following orders: 3 view x-ray on left hand tomorrow and ok to send the patient to hospital for CT scan for bleeding or monitor per the facility's protocol per the family decision. The writer also talked to the resident's daughter before received doctor's order. Staff also called the resident's family after getting the orders from the doctor and left the message. X-ray result did not show any fractures, staff continues to monitor resident due to unwitnessed, the VS and neuro check are on going per facility's protocol.	F 684		

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Resident's condition remains stable and at baseline, bruising resolving without any complications." R4's progress notes lacked indication of monitoring skin alterations/bruising after 8/6/24.

Medication not administered

R65's quarterly Minimum Data Set (MDS) dated 8/7/24, indicated severe cognitive impairment and diagnoses of dementia, unspecified convulsions, and pain. It further indicated R65 required substantial assistance with activities of daily living (ADL), mobility, and no rejection of care behaviors were exhibited.

R65's physician's orders indicated:
-2/13/24 Methadone 2.5 milligrams (mg), give 2.5 mg at bedtime for pain.
-8/3/23 Levetiracetam (Keppra) 100 mg/milliliters (ml) by mouth, give 7.5 ml twice a day for unspecified convulsions.

R65's medication administration record (MAR) for the months of July and August (2024) indicated the following:
Keppra
-7/17/24 and 7/31/24 documented as not administered because the resident was sleeping,
Methadone
-8/7/24 documented as not administered because the resident was sleeping.

R65's progress notes lacked any indication R65 had not received his medications.

During interview on 8/14/24 at 7:30 a.m., licensed practical nurse LPN-A stated if a resident was

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F 684	Continued From page 19 sleeping when it was time to administer their medication(s), they would wait awhile and re-approach. If they were sleeping the whole shift, they would wake them up to take their medication(s). If the medications were not administered for some reason, LPN-A would call the doctor, the family and the supervisor to let them know. During interview on 8/14/24 at 8:10 a.m., registered nurse (RN)-E stated if a resident was sleeping when it was time to administer their medications, they would keep trying to give the medications and if the resident slept through the entire shift they would wake them up. If the resident refused to take their medications or didn't take them for any reason, RN-E would contact the provider. During interview on 8/14/24 1:51 p.m., clinical manager registered nurse (RN)-F stated if a resident was sleeping when it was time to administer their medications, staff should reapproach later and wake them up to take their medications if they sleep the entire shift stating sleeping was not considered a good reason to not give medications. Also, nurses were responsible for monitoring and documenting skin alterations (such as bruising) until they have resolved. During interview on 8/15/24 at 8:41 a.m., the director of nursing (DON) stated if a resident was sleeping when it was time to take their medications, the nurse should re-approach the resident. If they don't administer the patients medication during the shift they should pass it on to the on coming nurse during report. The DON declined to answer if a sleeping was an appropriate reason for not administering a	F 684		

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residents medications. The DON further stated nurses were responsible for documenting and monitoring skin alterations, and it should be monitored until it's resolved. It only needs to be documented on if there are any changes.

A policy regarding medication administration was requested and received, however did not address the process for what to do if a resident didn't receive their medications for reasons other then a refusal.

Skin assessments

R90

R90's admission Minimum Data Set (MDS) dated 7/31/24, indicated R90 was cognitively intact and had diagnoses of sepsis (whole body response to an infection) R90's admission MDS further indicated R90 was not at risk for pressure injury and had no pressure injuries, venous ulcers, or other skin concerns. However, R90 required application of nonsurgical dressings other than the feet.

R90's face sheet printed 8/13/24, indicated R90 had diagnoses of cellulitis (skin infection) to the right lower extremity, open wounds to right lower leg, lymphedema, and a right 5th toe fracture.

R90's hospital discharge summary dated 7/25/24, indicated R90 had chronic right leg wounds, and had stubbed the right toe in the shower and the right hallux was open and bleeding was noted.

A review of R90's provider and nursing orders

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indicated:
-on 7/25/24, R90 required a surgical shoe to the right foot when out of bed and with activity.
-on7/25/24, R90 required wound care to the right hallux nail bed once daily. This order was discontinued on 8/12/24.
-on 7/29/24, R90 required wound care for the right lower extremity anterior and posterior wounds on Monday, Wednesday, and Fridays.

R90's wound observation notes dated 7/30/24, indicated on 7/26/24, three venous wounds were identified on R90's right shin and right calf. All three were identified as present on admission.

R90's skin observation assessment dated 7/25/24, indicated R90 had edema that required lymphedema wraps. Furthermore, the assessment indicated R90 had a diabetic foot ulcer and other open areas on the foot. R90's assessment lacked indication R90 had venous ulcers that required nonsurgical dressings applied or required an operative shoe when out of bed.

R90's skin observation assessment dated 8/1/24, indicated R90 had surgical wounds and surgical wound care. 90's assessment lacked indication R90 had edema that required lymphedema wraps, venous wounds that required dressings applied, an open area of the foot that required a dressing applied or required an operative shoe when out of bed.

R90's skin observation assessment dated 8/8/24, indicated R90 had edema and an infection of the foot that required dressings, and had no pressure injury but required pressure injury wound care. R90's assessment lacked indication R90 had venous ulcers that required dressings applied,

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F 684	Continued From page 22 required lymphedema wraps, or required an operative shoe when out of bed. R90's care plan dated 7/28/24, indicated R90 had venous stasis wounds in the right lower extremity. Interventions directed staff to monitor R90's pressure ulcer in the right lower extremity and provide treatments as ordered. An observation on 8/14/24 at 11:58 p.m., registered nurse (RN)-A and occupational therapist (OT)-A entered R90's room to remove and replace R90's lymphedema wraps and provide wound care. R90 was sitting in the recliner chair and had on operative shoe on the right foot and had lymphedema wraps on both legs with the right one extending over the knee. The operative shoe and lymphedema wrap to the right leg was removed. R90 had two wounds on the right shin and one on the right calf. Wound care was provided per orders. RN-A stated the right hallux wound was now closed and no longer required wound care. When interviewed on 8/12/24 at 12:31 p.m., R90 was seated in their recliner with legs elevated and positioned with pillows. An operative shoe was on R90's right foot. R90 stated they had the wounds before admission to the facility and they had become infected. R90 stated she thought they started as bruises and then opened. R90 further stated their toe was better after the dressing change earlier in the day. R36 R36's admission MDS dated 7/19/24, indicated R36 was cognitively intact and had diagnoses of a spleen laceration and perforation of the	F 684		

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F 684	Continued From page 23 intestine with surgical treatments, stroke with hemiparesis (weakness, loss of movement) of the left side and frail skin. Furthermore, R36's MDS indicated R36 had surgical wounds and skin tears that required treatment. R36's hospital discharge summary dated 7/13/24, indicated R36 had a closed surgical incision that could be covered with gauze and changed daily or left open to air. R36 also had a right arm skin tear and right knee abrasion that was covered with a foam dressing to be changed weekly and as needed. A skin integrity event dated 7/22/24, indicated R36 had obtained a skin tear on 7/18/24 to the left lateral leg during a transfer and on 7/22/24, two skin tears were identified from an unknown cause on the left knee and left thigh. A review of R36's provider and nursing orders indicated: -on 7/23/24, R36's required monitoring of the abdominal surgical incision that was open to air. -on 7/23/24, R36 required dressing changes every 5 days with a foam dressing to the right knee, right lateral shin, and left thigh. A dressing change was also required to left shin for brace protection only. -on 8/1/24, R36 required monitoring of skin tear site that was secured with steri-strips and open to air to right medial calf and left knee. R36's skin observation assessment dated 7/29/24, indicated R36 utilized a brace or splint, had skin tears, and surgical wounds. R36's assessment lacked indication R36 required application of nonsurgical dressings for the skin tears.	F 684		

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F 684	Continued From page 24 R36's skin observation assessment dated 8/5/24, indicated R36 had skin tears and surgical wounds. R36's assessment lacked indication R36 required application of dressings to the skin cares or utilized a brace or splint. R36's skin observation assessment dated 8/12/24, indicated R36 utilized a brace or splint and had surgical wounds. R36's assessment lacked indication R36 had skin tears that required application of dressings. R36's care plan dated 7/25/24, indicated R36 had skin tears on both lower extremities. Interventions included to monitor for healing, follow treatments of steri-strips and mepelix dressings. R36's careplan lacked indication R36 utilized braces for the left upper and lower extremity. An observation on 8/12/24 at 1:31 p.m., R36 was seated in the recliner chair. R36 had a brace on the left shoulder and one on the left foot. A foam dressing was observed on the left thigh. R36 had sleeves placed on both arms. R36 stated he had several skin tears, and his skin was very frail. R88 R88's admission MDS dated 7/24/24, indicated R88 had moderate cognitive impairment and diagnoses of sepsis, liver abscess, and presence of a hepatic drain (device used to drain liver abscess). Furthermore, R88's MDS indicated R88 had surgical incisions that required wound care. R88's hospital discharge summary dated 7/18/24,	F 684		

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F 684	Continued From page 25 indicated R88 had a hepatic drain but lacked indication R88 had surgical incisions. A review of R88's provider and nursing orders indicated: -on 7/18/24, R88 hepatic drain care directed staff to change the dressing around the drainage tube as needed. This order was discontinued on 8/12/24. -on 8/6/24, R88's hepatic drain site (now removed) required a gauze and tape dressing to be in place for 7 days and to be changed daily and as needed. This order was discontinued on 7/12/24. R88's skin observation assessment dated 7/23/24, indicated R88 had no surgical wounds, and did not require dressings or treatments. R88's assessment lacked evidence a drain was in place that required treatment. R88's skin observation assessment dated 7/25/24, indicated R88 had no open areas or surgical wounds and did not require dressings or treatments. R88's assessment lacked evidence a drain was in place that required treatment. R88's skin observation assessment dated 8/1/24, indicated R88 had no pressure ulcers, open areas, or surgical wounds and did not require dressings or treatments. R88's assessment lacked evidence a drain was in place that required treatment. R88's skin observation assessment dated 8/8/24, indicated R88 had no pressure ulcers, open areas, or surgical wounds. R88 did require surgical wound care. R88's assessment further indicated R88 had an infection of the foot.	F 684		

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F 684	Continued From page 26 R88's care plan dated 7/22/24, indicated R88 had an actual infection. Interventions included to assess all wounds for signs of infection. R88's care plan lacked indication R88 had a drain that required treatment. When interviewed on 8/12/24 at 12:14 p.m., R88 was seated at the edge of the bed. R88 stated they had no skin issues, other than a site where she had a drain placed. R88 further stated the drain was placed to drain fluid from an infection and had been removed sometime last week. R88 lifted their shirt some to reveal gauze and tape on the right side of the abdomen. When interviewed on 8/13/24 at 12:54 a.m., RN-D stated a skin assessment was completed upon admission and any wounds or open areas, including skin tears, were measured, and documented in the wound observation note. A skin observation was also completed weekly for the first few weeks after admission. The skin observation assessment was a visual observation of the skin to identify any skin issues. The assessment also indicated risks for skin breakdown and interventions in place. RN-D reviewed R90's wound observation assessments and skin observation assessments and verified the inconsistent documentation. RN-D stated R90 did not have any surgical wounds, diabetic ulcers, or foot infection. RN-D reviewed R88's skin observation assessments and verified the drain was not documented. RN-D wasn't sure if drains were documented or not, but acknowledged a dressing was used. RN-D further stated R88 did have an infection, but it was not in their feet. RN-D stated R36 had very fragile skin and had	F 684		

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F 684	Continued From page 27 skin tears and a surgical incision. RN-D reviewed R36's skin observations and verified they were not accurate and missing information. RN-D nurses likely complete the skin observations with what they know or what they think is going on by looking at the resident and wasn't sure if other areas of the chart were reviewed. When interviewed on 8/15/24, the Director of Nursing (DON) stated when residents were admitted, a skin assessment was completed during the first 72 hours. Then a skin assessment was completed weekly for an additional 4 weeks. DON expected the skin assessments to accurately reflect what skin altercations the resident had. Furthermore, this was important to help determine further interventions and provide an accurate plan of care. A facility policy titled Prevention and Treatment of Skin Breakdown dated 9/2018, directed staff to complete a skin risk assessment upon admission and weekly for 4 weeks after. The residents care plan was then implemented and updated based on the resident's skin assessment, areas of risk, Braden evaluation, provider assessment and preferences.	F 684		
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	F 688		10/3/24

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F 688	Continued From page 28 §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 interview, observation, and document review, the facility failed to implement a walking program as written to prevent potential decrease in mobility for 1 of 1 resident (R73) reviewed for walking programs. Findings include: R73's quarterly Minimum Data Set (MDS) assessment dated 8/8/24, identified she had intact cognition with a Brief Interview of Mental Status (BIMS) score of 15/15, and no behaviors or rejection of care. R73 had no hearing difficulty in normal conversation, had clear speech, responded adequately to simple, direct communication only, and may miss some part of a message but comprehended most conversation. Functional physical impairments of upper and lower extremities were present, a wheelchair was normally used, and a cane was not identified as having been used. R73's walking ability was left blank, however she required partial to moderate assistance for chair to bed transfers, sit to stand and sit to laying down and was independent with wheelchair mobility. Diagnoses included stroke and aphasia (impaired	F 688	F688-ROM/Mobility (Nursing) 1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R73's walking program has been reviewed and modified as appropriate and is implemented and documented upon. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with a restorative or maintenance programs have been reviewed and modified as appropriate. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All nursing staff have been educated related to the expectation of charting related to completion of tasks or	

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F 688	Continued From page 29 communication after a stroke). R73's Activities of Daily Living Care Area Assessment (ADL CAA) dated 11/9/23, was triggered due to assist needed with cares and mobility due to stroke, right sided weakness, and aphasia. R73's undated nursing assistant care sheet identified a walking program was in place to and from meals, using contact guard assist with right AFO, gait belt and quad cane. Family not able to ambulate with resident. Ask yes/no questions or use communication board. R73's care plan interventions with a start date of 4/1/24, also identified a walking program with meals at 10:30 a.m., 4:30 p.m., and 7:00 p.m., was in place. Use contact guard assist (CGA) which is hands on assist to steady the resident's balance; a gait belt, right AFO (ankle foot orthotic) and quad cane in the hallway. The care required sign off in Point of Care (POC) system which is the nursing assistant documentation software. R73's care plan interventions with a start date of 3/8/24, identified to ask yes/no questions or use communication board. R73's POC documentation from 4/1/24 through 8/15/24, identified walking in the corridor (hallway) in accordance with the walking program, occurred at the following frequency: 4/1/24 through 4/30/24: once out of 30 days. 5/1/24 through 5/31/24: none. 6/1/24 through 6/30/24: three times in 30 days. 7/1/24 through 7/31/24: none. 8/1/24 through 8/15/24: once out of 15 days. R73's POC documentation had not supported the	F 688	documented refusals. Residents with restorative or maintenance programs that are not currently being documented as completed follow up education has been provided to appropriate staff. Clinical Managers and the therapy department have been educated related to coordination of care when setting up restorative programs. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/Designee will audit five residents per week to ensure restorative program is being offered, carried out as ordered, and documented in the medical record for 4 weeks. The results of this audit will be reported to QAPI. 5. Date when the corrective action will be completed: This deficient practice will be completed on 10/3/2024.	

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ambulation program was carried out as ordered.

R73's outpatient physical therapy note dated 7/30/24, identified to please walk using her quad cane every day, needs assistance.

R73's active orders dated 7/30/24, identified please walk using her quad cane every day (needs assistance).

During an interview on 8/12/24 at 12:41 p.m., R73 stated "no" when asked if staff walk with her every day and stated "yes" when asked if she'd like to walk more often.

During an observation on 8/12/24 at 5:00 p.m., R74 was not offered an opportunity to walk at the evening meal.

During an observation on 8/13/24 at 11:00 a.m., R74 was not offered an opportunity to walk at the brunch meal.

During an interview on 8/13/24 at 1:11 p.m., nursing assistant (NA)-D stated if a resident was on an ambulation program it would be on the care sheets and in POC charting to sign off. NA-D stated R73 was in her care today and she had not walked her to brunch meal as ordered on the care sheet and care plan, because she had not noticed it on the assignment sheet. NA-D stated the nursing assistants would document walking programs and not the registered nurses (RN) or licensed practical nurses (LPN).

During an interview on 8/13/24 at 2:04 p.m., NA-E stated R73 could walk, but she had not seen her walking with nursing assistants lately. NA-E stated the nursing assistants document walking

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programs they carried out, and not the RNs or LPNs.

During observations on 8/14/24, at 8:36 a.m. through 9:31 a.m., NA-F completed R73's morning cares, and stated R73 would self-propel in her wheelchair to brunch. At 10:35 a.m., R73 started to self-propel in her wheelchair to the brunch meal. An unidentified staff pushed her in the wheelchair the rest of the way. At 11:57 a.m., R73 self-propelled in her wheelchair back to her room. An opportunity to walk to and from her meal was not offered as identified in the care plan and care sheet.

After surveyor asked if R73 wanted to walk and if it was ok to observe the walking program, on 8/14/24 at 12:00 p.m., R73 went up to NA-F and indicated she wanted to walk. NA-F assisted R73 with a gait belt and her quad cane, walked down the hallway and partway back for a total of about 10 minutes with 125 feet. NA-F stated there was not always the opportunity to walk with R73 due to being busy.

During an interview on 8/14/24 at 12:00 p.m., licensed practical nurse (LPN)-B stated the nursing order dated 7/30/24, for the walking program was an acknowledgement of the order, and not an order for nursing to complete the walking program. The nursing assistants were responsible to complete walking programs and document in POC. LPN-B stated she had seen R73 do her walking program in the hallway before but was not sure how recently she last saw it completed.

During an interview on 8/14/24 at 12:30 p.m., the facility's physical therapy assistant (PTA) stated

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F 688	Continued From page 32 R73 they had worked with R73 in house, she had a walking program in place with nursing staff, and it was important to complete as ordered so the resident could achieve their highest level of functioning. R73 was now discharged to an outpatient physical therapy department. During an interview on 8/14/24 at 12:41 p.m., the outpatient physical therapist (PT)-B, stated she was told a walking program was already in place with the facility prior to transferring to outpatient. PT-B stated the ambulation program should be carried out daily as written, as they were trying to get R73 to tolerate up to 30 minutes of exercise. The PT-B stated R73 walked a distance ranging from 100 feet to around 200 feet at the outpatient facility. During an interview together with the director of nursing (DON) and regional registered nurse (RRN) on 8/15/24 at 11:00 a.m., the DON stated walking programs were usually established when a resident was done with physical therapy. The DON stated he expected walking programs to be completed as ordered. The RRN stated the TAR documentation from 7/30/24 through 8/15/24 identified the ambulation program had been completed by the nurses, even though the nursing assistant documentation was not in place. (However, that did not explain the lack of documentation from 4/1/24 through 7/29/24, on the care planned walking program.) The DON reviewed the POC documentation report and acknowledged the lack of documentation on the walking program. The DON also verified the nursing assistant care sheet identified the ambulation program was currently in place. During an interview on 8/15/24 at 11:33 a.m.,	F 688		

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F 688	Continued From page 33 LPN-C stated the nursing assistants documented on the walking programs and activities of daily living (ADLs) they carried out, and the RNs or LPNs did not document on the NA's behalf. During an interview on 8/15/24 at 11:40 a.m., RN-G also stated the nursing assistants documented in POC on the walking programs and activities of daily living (ADLs) they were assigned to complete, and the RNs or LPNs did not document on the NA's behalf. During an interview on 8/15/24 at 11:46 a.m., the MDS RN-H stated if ambulation occurred during the lookback period, it would be documented on the MDS, she used the nursing assistant charting in POC, the nursing assessments for the MDS section GG, and interviews to guide the MDS information. The facility's ADL policy dated 6/2021, identified care and services would be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with mobility (transfer and ambulation, including walking). Additionally, the resident's response to interventions would be documented, monitored, evaluated, and revised as appropriate.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/3/24

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F 689	Continued From page 34 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure behaviors of potential wandering were comprehensively assessed for 3 of 3 residents (R15, R4, R21) and failed to assess for resident safety in the community for 1 of 1 resident (R15). The facility further failed to implement care planned interventions for 1 of 1 resident (R77) who wanders. Findings include: R15's admission Minimum Data Set dated 7/9/24, indicated R15's preferred language was Hmong, did not need an interpreter, had difficulty hearing in some environments such as when speaking softly or a noisy setting and required a hearing device, a brief interview for mental status (BIMS) should have been conducted, however was not conducted, did not have hallucinations or delusions, did not exhibit wandering behavior, and did not reject care. Additionally, R15 used a cane, required partial to moderate assistance with toileting, showering, upper and lower body dressing, hygiene, and donning/doffing footwear. R15 required partial to moderate assist with sitting to standing safely and required supervision or touching assistance to ambulate 10 feet. R15 was incontinent of bowel and bladder, had an anxiety disorder, cardiogenic shock (the heart cannot pump enough blood to the brain and other organs), acute respiratory failure with hypoxia (the body doesn't have enough oxygen at the tissue level), acute pulmonary edema (a condition	F 689	689- Free of Accident Hazards/Supervision/Devices (Social Services)) 1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R15 discharged to The Villas of St. Paul per his preference related to a Hmong population. R4 had an updated elopement risk assessment completed R21 had an updated elopement risk assessment completed R77 had an updated elopement risk assessment completed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the community have been audited and any elopement risk assessments that were dated more than 1 year ago have been updated and completed. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All social services staff have been educated to complete the elopement risk assessment upon admission, annually, with any elopement attempt or change of	

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F 689	Continued From page 35 where too much fluid builds up in the lungs), acute on chronic combined systolic and diastolic heart failure, had a defibrillator, had a life expectancy of less than 6 months, took an antipsychotic and antianxiety medication, was on hospice and did not use restraints. R15's face sheet indicated R15 was not responsible for himself, and family member (FM)-B was R15's primary emergency contact. Additionally, R15 had the following diagnoses: restlessness and agitation, generalized edema, and other encephalopathy (a disease in which the functioning of the brain is affected by an agent or condition). R15's care area assessment (CAA) dated 7/9/24, indicated R15 triggered for falls due to needing assist with cares, mobility, transferring, toileting, incontinence, and diagnoses that included cardiogenic shock, congestive heart failure, and toxic metabolic encephalopathy (can lead to altered consciousness, going from delirium to coma). R15's CAA dated 7/10/24, indicated R15 took antipsychotic medications as needed for restlessness and agitation, and lorazepam for anxiety. R15's care plan dated 7/3/24, indicated R15 was on hospice with an expected decline in condition and the following hospice staff visited: nursing and nursing assistants weekly, social services and chaplain monthly, and volunteers. R15's care plan dated 7/3/24, indicated R15 did not want resuscitation and interventions included healthcare directives signed by appropriate	F 689	condition. All social service staff have been educated to individualize care plans and care delivery guides to include appropriate interventions related to redirection if a resident displays symptoms of wandering or exit seeking. All HUCs, Admissions personnel, Clinical Managers, and management team have been educated that all residents on our secured memory care neighborhood are an inherent elopement risk and thus should have a picture placed in the front desk elopement risk book along with anyone else that is high risk per the elopement risk assessment. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DSS/designee will audit 5 residents per week to ensure the elopement risk assessment is completed, care planned interventions are in place and picture is within the elopement book as appropriate. This audit will be conducted for 4 weeks. The results of this audit will be reported to QAPI. 5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	

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F 689	Continued From page 36 individuals (physician, resident, family, legal representative). R15's care plan dated 7/6/24, indicated R15 had a self-care deficit and was at risk for falls. Interventions indicated R15 required assist of 1 staff for transfers using a gait belt and walker, and preferred staff to assist him in "wheeling" long distances. R15's care plan lacked information whether R15 was safe to go out in the community. R15's care sheet dated 8/9/24, indicated R15 was impulsive, spoke English and staff needed to anticipate needs. The care sheet lacked information R15 was safe to go out in the community. R15's Provider Orders for Life-Sustaining Treatment (POLST) form indicated R15 did not want to be resuscitated and under documentation of discussion indicated 6 check boxes that included the following: Patient (Patient has capacity), court-appointed guardian, other surrogate, parent of minor, health care agent, and health care directive. The only check box marked was, "health care agent" and was signed by FM-B. Additionally, the POLST included instructions that a person with capacity, or the valid surrogate of a person without capacity, could void the form and request alternative treatment. R15's physician orders indicated the following order: 8/4/24, monitor the placement of wander guard and was discontinued on 8/12/24.	F 689		

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F 689	Continued From page 37 R15's medication administration record (MAR) and treatment administration record (TAR) dated 8/4/24, through 8/12/24, indicated to monitor the placement of the wander guard every shift. Under comments on the MAR and TAR, indicated on 8/6/24 at 5:36 p.m., "no wander guard", on 8/7/24 at 3:30 a.m., resident removed wander guard, on 8/7/24 at 8:40 p.m., "not on", 8/8/24 at 1:55 a.m., "resident removed", on 8/9/24 at 3:11 a.m., "resident removed", 8/9/24 at 2:37 p.m., "does not have a wander guard on", on 8/10/24 at 2:50 a.m., indicated "no on" and on 8/12/24 at 1:47 p.m., indicated "discontinued". R15's cardiology note dated 6/17/24, indicated R15 was unable to participate in decision-making process. R15's nurse practitioner (NP) note dated 6/18/24, indicated FM-B asked for help in determining R15's capacity to make complex decisions if R15 improved enough to engage in discussions regarding goals and plan of care and gave an example of potential vulnerability to financial exploitation by unknown people in R15's home country where R15 intermittently sent significant amounts of money. Further, R15 demonstrated limited understanding. Last, under a heading, "Decision Making Capacity" indicated R15 required surrogate decision making due to critical illness and was unclear if R15 had decision-making capacity at baseline per daughter. R15's physician discharge to facility note dated 7/2/24, indicated R15 was unable to verbalize understanding of his condition and treatment plan due to being disoriented and the diagnosis and	F 689		

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F 689	Continued From page 38 treatment plan was discussed with FM-B. R15's NP-D progress note dated 7/16/24, indicated R15 was independent with activities of daily living (ADLs), was ambulatory and R15's review of systems was limited due to cognitive impairment. R15's Application of a Health Officer or Peace Officer for Emergency Admission form dated 8/4/24 at 1:15 p.m., indicated R15 was trying to walk 11 miles in 71-degree heat in a winter jacket. R15 was on hospice and tried to assault staff and refused to return and staff wanted R15 to go to the hospital. R15's emergency department note dated 8/4/24, indicated R15 eloped to go to the Hmong market and the police were contacted and intercepted R15 two blocks away. Further, staff indicated R15 had to come to the hospital but did not elaborate and per EMS, family resided out of state except a daughter who was the power of attorney but R15 did not have contact with, and had organized thought content and processes, additionally FM-B was contacted and wanted R15 admitted for a psychiatric evaluation for capacity. It was explained to FM-B capacity could be completed outside the hospital and better in a legal setting versus a medical setting. R15's NP-D progress note dated 8/13/24, indicated R15 had dementia without behavioral disturbances, had cognitive limitations, and eloped on 8/4/24, attempting to ambulate to the store to purchase Hmong medications. Additionally, review of systems was limited secondary to cognitive impairment.	F 689		

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F 689	Continued From page 39 OBSERVATION FORMS: R15's Clinical Documentation Admission form dated 7/3/24 at 12:14 p.m., indicated staff could not identify whether R15 had an advanced directive due to a level of cognitive impairment. R15's Clinical Documentation Functional Abilities form dated 7/3/24 at 12:21 p.m., indicated ambulating 10 feet was not attempted due to a medical condition or safety concern. Additionally, ambulating 50 feet and 150 feet was not attempted because R15 did not perform this activity prior to the current illness, exacerbation, or injury further, the ability to ambulate 10 feet on uneven surfaces, or go up and down a curb and or up and down one step was not attempted due to environmental limitations. R15's Self-Administration of Medication form dated 7/7/24, indicated R15 was not appropriate to self-administer medications and R15's cognitive status was identified as "moderately impaired-decisions poor; cues/supervision was required." R15's Long Term Care Social Service form dated 7/10/24 at 5:18 p.m., indicated R15 had minor forgetfulness, a vision or hearing problem that impaired communication, distorted and misrepresented events, did not fully understand physical limitations. R15's Notice of Resident/Patient Transfer or Discharge form dated 8/4/24 at 2:38 p.m., indicated R15 was involuntarily transferred to the hospital on 8/4/24, because R15's welfare and needs could not be met in the facility.	F 689		

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F 689	Continued From page 40 R15's Resident Transfer Form dated 8/4/24 at 2:57 p.m., indicated FM-B was R15's health care proxy (someone designated to make medical decisions if a person is unable to themselves) was notified. Under the heading, "Reason for Transfer" "What Happened" indicated R15 eloped and attempted to hit staff. Further, "Primary Clinical Reason for Transfer" indicated a check box for "other" and identified acute chronic combined systolic and diastolic failure. Additionally, the form indicated R15 was alert and oriented and followed instructions, ambulated with a cane but did not indicate the distance R15 could ambulate, and was identified as not applicable under impairments including hearing and cognitive and a behavior started 8/4/24, when R15 went outside the building and tried to hit staff. R15's Social Services Elopement Risk form in progress dated 8/14/24 at 1:32 p.m., R14 exhibited combativeness, resisting redirection from staff, had a recent move to the facility, terminal illness, and preventative action taken included wanderguard, photograph posted and a check box indicating "social services" were marked in the check boxes. EVENTS: R15's Safety Events Elopement form dated 8/4/24 at 7:57 p.m., indicated R15 eloped and was found near McDonald's in Silverlake and had not exhibited any of the following: anger regarding facility placement, combativeness, elopement attempts in the past, failure to return from outings and appointments, packing belongings, removing devices such as wanderguards, and tabs alarm, repeatedly opening doors, resisting redirection	F 689		

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F 689	Continued From page 41 from staff, verbalizing statements about leaving, verbally abusive, wandering with no rational purpose and attempting to open doors. Further, the form indicated R15 was going to get Hmong medications and did not have any changes in mental status of a new onset which included agitation, anxiety, confusion, lethargy, resistiveness, restlessness, sleepiness, slurred speech. The form indicated "None of above" under the heading, "Possible Contributing Factors" that included anxiety and terminal illness. The form indicated there were no recent changes in medications, or new medications and under interventions to indicate measures taken which included door alarm bands such as a wanderguard, indicated "none of above." Further, the police were contacted and R15 was transferred to the hospital. Under a heading, "Notes" indicated on 8/5/24 at 6:55 a.m., R15 was in bed sleeping and staff continued to observe R15 every 15 minutes. CARE CONFERENCE: R15's care conference notes last updated by the director of social services dated 7/16/24, indicated R15 scored a 6 out of 15 on the brief interview for mental status (BIMS) which indicated R15 had severe cognitive impairment. Further, R15 ambulated independently with the use of a single end cane and was assisted with ADLs and was not compliant with taking diuretic medications. R15's family reported R15 was uncomfortable with the swelling in his legs. PROGRESS NOTES: R15's progress notes dated 7/3/24 at 2:16 p.m., indicated R15 was alert to self, unable to	F 689		

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F 689	Continued From page 42 communicate needs and was alert and oriented times 2. R15's progress notes dated 7/6/24 at 9:27 p.m., indicated R15 required assist of 1 with transfers, toileting, and ADLs. R15's progress notes dated 7/23/24 at 3:44 p.m., indicated hospice would have a discussion to locate a place that could accommodate R15 and R15 insisted on taking a Hmong medication from the market. R15's progress notes dated 8/4/24 at 1:20 p.m., indicated R15 went to the nurse's station around 11:40 a.m. to ask for the phone and did not understand what they were communicating due to a language barrier and after about 10 minutes, the supervisor received a call that R15 was outside on the right side of the building. The supervisor went outside to check immediately but did not locate the resident and followed protocol of searching for the resident. R15 was seen walking faster towards the intersection by McDonalds and therapy staff reached R15 first before the supervisor arrived. R15 stated he was going to go and get his Hmong medication for his legs. The note further indicated R15 was resistive and unable to be redirected after multiple attempts and kept following the way to board the bus and later became agitated and tried to hit staff multiple times. The police were contacted and were unable to redirect R15 and stood firm he was not going back to the facility. A family member was contacted who did not want to talk with R15 and the facility decided to send R15 to the hospital. R15's progress notes dated 8/4/24 at 7:19 p.m.,	F 689		

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F 689	Continued From page 43 indicated R15 returned from the hospital around 6:00 p.m. after an incident when the resident left the facility unaccompanied. To make sure the incident was not repeated, the nurse spoke with FM-B regarding wearing a wanderguard and planned to discuss issues of wearing a wanderguard by a resident with no diagnosis of a cognitive impairment on 8/5/24, with the director of social services and a wanderguard was placed on R15's right wrist and was on 15-minute checks. R15's hospice progress note dated 8/4/24 at 9:00 p.m., indicated the hospice nurse contacted the interpreter and R15 stated he wanted an herbal supplement for his kidneys because the medications were not working. R15's daughter was updated and stated 1 pill was $300.00 and could not get the medication. R15's progress notes dated 8/5/24 at 6:55 a.m., indicated staff observed R15 every 15 minutes. R15's progress notes dated 8/7/24 at 1:51 p.m., indicated on 8/4/24, R15 walked on foot to the bus station near McDonalds, about 10 minutes away from the facility and the supervisor and team of nurses and therapists located R15 at the bus station near McDonalds. FM-B agreed to a wanderguard placement to alert staff when R15 attempted to leave the facility. Further, the note indicated R15 did not elope was alert and oriented x 3 and knew the route to the bus station. R15's progress notes dated 8/7/24 at 4:39 p.m., and recorded as a late entry on 8/12/24 at 8:44 a.m., by the social services director indicated the following: "Writer called and spoke with daughter regarding medication that resident has been	F 689		

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F 689	Continued From page 44 asking for. Family reports that resident has taken the medication previously, but it is not easily sourced and not readily available through traditional means of purchasing medication. Resident is requesting this medication to help them to feel comfortable as the medication aligns with medicine in their culture. To align with resident's cultural beliefs and to respond to person centered care, writer and family will continue to discuss ways that this medication can be provided to the resident. According to the matrix care chart review and weekend supervisor, at 11:40 a.m., the patient requested a telephone at the nurses' station and made a call to a family member. The patient then left the building through the main entrance, despite attempts by the receptionist to redirect them back inside. The patient walked on foot to the bus station near McDonalds, about 10 minutes away from the facility, expressing an intention to obtain traditional medicine from a Hmong store. The receptionist promptly informed the building supervisor of the event. The supervisor and a team of nurses and therapists quickly located the patient at the bus station near McDonalds. Despite multiple attempts by staff members to redirect [R15] back, he became agitated and threatened physical violence. As efforts continued unsuccessfully, emergency services were called for assistance." R15's progress note dated 8/12/24 at 8:59 a.m., indicated the wanderguard was discontinued and was not appropriate to wear a wanderguard at this time. Further the note indicated R15 was alert and oriented times three. During interview on 8/12/24 at 5:40 p.m., registered nurse (RN)-I stated she thought R15	F 689		

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F 689	Continued From page 45 tried to run away last week. During interview on 8/13/24 at 11:37 a.m., FM-B stated she spoke with the social services director (SSD)-B about 3 days after incident who did not have much to say about the incident other than they put a wanderguard on R15. FM-B stated she was not sure if R15 still had the wanderguard, SSD-B mentioned R15 cut off the wanderguard. FM-B stated she understood R15 wanted to purchase a supplement that could only be purchased in the Hmong village and was walking with a cane and had a winter jacket on. FM-B stated she told the SSD-B R15 had the intention of doing this and SSD-B reassured FM-B someone was by the door all the time. FM-B stated the nurse contacted her and told her R15 left the facility and wanted her to tell R15 to go back and when FM-B tried to talk with R15, he would not listen, and the police were called. FM-B stated the police were unable to get R15 to come back and the nurse stated they were going to take R15 to the hospital because R15 tried to assault a staff member. FM-B further stated the physician contacted her and stated R15 was breathing ok and was confused because she thought R15 would be having a psychological evaluation. FM-B stated she did not think R15 could make sound reasonable decisions for himself, but was told due to no impairment, R15 could make decisions for himself. During interview on 8/13/24 at 2:05 p.m., nursing assistant (NA)-H stated she looked at the care sheet and stated she was not working and when she came back to work heard R15 tried to escape and stated she needed to check to see if R15 had a wanderguard on and stated she would ask the nurse. NA-H further stated R15 asked her where	F 689		

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F 689	Continued From page 46 he was, and NA-H wrote the name and address down and gave it to R15. During interview on 8/13/24 at 2:16 p.m., nursing assistant (NA)-I stated she thought R15 tried to escape and added he couldn't go anywhere because people were out there and further stated R15 only left once and stated everybody went to locate R15. During interview and observation on 8/13/24 at 2:30 p.m., the interpreter was contacted and R15 stated he had been at the facility a long time and wanted to move out of the hospital and was unable to identify what facility R15 was at. R15 further stated the wanderguard did not help his illness and stated he would just take off the wanderguard. R15 stated he wanted to move to a Hmong facility where R15 could get medication to help his legs and stated he did not know the name of the medication but stated it was a Chinese medication. R15's feet were swollen and was wearing a pair of thong sandals. During observation on 8/14/24 at 8:33 a.m., R15 was searching through his phone and did not acknowledge presence. R15 had a thick green winter jacket located on the top of the dresser and was trying to make a phone call. During interview on 8/14/24 at 8:38 a.m., registered nurse (RN)-E stated she looked at the care plan to know what kind of cares a resident required and stated they complete a clinical assessment and ask a few questions that they are safe and a resident's memory is ok to determine whether they can do something or not and stated she thought the social worker completed a cognitive assessment. RN-E further	F 689		

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F 689	Continued From page 47 stated if a resident wandered, they placed a wanderguard and added she did not work in the locked unit. RN-E stated if a resident tried to leave, they call 911 and if they refuse to come back, they call 911 for help and then put an assessment in the computer and added it had not happened to her before. RN-E stated if a resident went out, they completed a safety check, and it would be on the resident's care plan on when to check on the resident and expected care plan interventions to know if a resident wandered. RN-E stated management added the form in the electronic medical record, and then the staff nurse completed the assessment. RN-E further stated she knew R15 was not going to make another attempt because R15 was not talking about leaving and would be a concern if R15 talked about wanting the Hmong medication. When asked why the facility placed a wanderguard if R15 was alert and oriented, RN-E stated R15 was trying to leave and wanted to get Hmong medication. During interview on 8/14/24 at 10:05 a.m., licensed practical nurse (LPN)-D stated she looked to the care plans to know what kind of cares a resident required and stated she would have to ask if there was any kind of assessment because she didn't complete assessments. LPN-D stated the care plan sometimes had information on decision making capacity and stated it was also on the Facesheet. LPN-D stated she would have to ask her supervisor what the process was if a resident eloped because she had never come in contact with a resident who eloped and added in the memory care unit they used wanderguards and the unit was locked and stated one resident on this unit tried to elope about two or three weeks ago, but could not recall	F 689		

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F 689	Continued From page 48 the resident's name or room number and stated she thought they went out to look for the resident and informed the supervisor the resident refused to come in and they contacted the police. LPN-D stated they had to monitor the resident every 15 minutes and thought they applied a wanderguard. During interview on 8/14/24 at 10:19 a.m., when asked how she knows a resident was safe to leave the facility alone, registered nurse (RN)-F stated most of their residents could not leave the facility, some could go for appointments and stated she did not know if there was any kind of an assessment to make that determination and would have to go and check. RN-F stated they assess if someone can go in the community in the transitional care unit and further stated she would have to check into that. RN-F stated when a resident eloped, staff look for the resident and they are alerted to an elopement by an overhead, additionally they check all rooms, med rooms, bathrooms, and contact 911. RN-F stated when the resident is found, they complete an elopement event, update the family, and physician, and apply a wanderguard to make sure they don't do it again. RN-F further stated they completed an Elopement Risk assessment under the Observations tab. The form identifies if the resident experienced changes, a description of the resident's elopement risk and any preventative action. RN-F further stated they took a picture of residents at risk and placed the pictures in a book downstairs and was not sure if R15 had a picture downstairs and stated she would have to check on that. When asked if R15 should have an assessment to determine whether R15 was at risk for elopement, RN-F stated yes and no and added to be on the safe side it would be better to have an assessment.	F 689		

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F 689	Continued From page 49 RN-F further stated therapy completed cognition screens to determine if a resident could make their own decisions, but stated R15 was on hospice and stated social services might determine if R15 could make his own decisions. RN-F verified R15 did not have an elopement risk assessment completed in the Observations form and stated they placed a wanderguard and was discontinued per R15's progress notes. RN-F stated she would check with the director of social services because she did not see anything in R15's chart for an elopement assessment. RN-F further stated if a resident left the facility, they usually completed a care plan with interventions. During interview on 8/14/24 at 10:42 a.m., the social services director (SSD)-B stated they had care conferences and completed a BIMS interview to help determine whether a resident was able to make their own decisions and ultimately it was up to the court system and was done through a guardianship and stated it was documented under resident notes. Additionally, it was a court decision along with the physician's opinion. If a resident was admitted to the facility and they did not know whether a resident could make their own decisions they ask for health care directives and if that is not provided, would speak with the resident. SSD stated they have therapy complete an evaluation to determine if someone was safe to leave and if a resident eloped, they call a Mr. Lost code and notify the police, administrator, and director of nursing. SSD-B stated an elopement risk assessment is completed within the first 48 hours after admission by the social worker and then after that the interdisciplinary team completed the assessment. SSD-B viewed R15's chart and verified R15 did not have an initial assessment	F 689		

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F 689	Continued From page 50 completed and stated R15 should have had an assessment completed. SSD-B stated he did not know whether an assessment should be completed after a resident eloped. SSD-B stated R15 could make decisions with the help of his family and further added if R15 puts his safety at risk they follow what they need to follow to ensure R15 is safe and stated R15 had an elopement attempt. R15 went to the bus stop to go to the Hmong village to get a medication. SSD-B further stated the purpose of the elopement risk was to provide information to staff for residents at high risk and they provide information to the front desk. SSD-B stated he would have to check whether there should be a care plan for elopement and added R15 hadn't made other attempts and R15's BIMS was a 6 out of 15 which indicated severe cognitive impairment and added R15 had not expressed wanting to leave and did not know he would have a concern of R15 leaving again. SSD-B further stated he did not have information whether R15 could make his own decisions and later stated they would approach that R15 was able to make his own decisions with support of family. When asked why a wanderguard was placed if R15 was able to make his own decisions, SSD-B stated it was applied for his safety because the decision R15 made put him in an unsafe position and was since taken off and stated it would be important to have an elopement risk on any patient to see what their potential for elopement was. During interview on 8/14/24 at 11:04 a.m., occupational therapists (OT)-H and OT-I stated they completed a cognitive assessment on every resident to determine their general baseline. The cognitive screens completed were Short Blessed Test and based on that score may do a SLUMS	F 689		

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F 689	Continued From page 51 assessment that looked more at memory and sequencing, and they also had a cognitive performance test for medication management, choosing the appropriate clothing based on the weather outside and added they were more in depth that the BIMS. OT-H and OT-I verified R15 was not seen by therapy and verified there were no therapy notes in R15's medical record and stated R15 was on hospice so did not have any therapy orders and verified there was no cognitive assessment completed through therapy. During interview and observation on 8/14/24 at 11:09 a.m., R15 was not located in the elopement book and front desk staff (FDS)-J verified R15 did not have a photograph in the elopement book. During interview on 8/14/24 at 12:23 p.m., hospice social worker (HSW)-C stated he visited monthly and was looking for different placement for R15 and stated R15 enrolled in hospice on 7/3/24. HSW thought R15 could make his own decisions and stated he didn't have firsthand knowledge of R15's elopement and stated the note indicated R15 returned from the hospital after leaving the facility. During interview on 8/14/24 at 12:07 p.m., nurse practitioner (NP)-D stated R15 was a newer resident who spoke English ok, was on hospice, had edema to his legs but refused medications and eloped a few weeks ago. NP-D further stated R15 could make needs known, can make a choice such as applying lotion, but could not make medical or financial decisions and they would look to R15's family and added R15 had dementia and did not want his patient eloping and expected the facility complete a risk assessment and stated he thought R15 cut off his	F 689		

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F 689	Continued From page 52 wanderguard and stated he expected staff should have completed an assessment to determine R15 was safe and stated he was surprised they didn't get a plan put into place and stated it was an issue for the safety of the person if he doesn't have a wanderguard in place and is not in a secure unit and assumed the facility did something to ensure R15 was safe. During interview on 8/14/24 at 1:10 p.m., a policy on wandering and elopement was requested from the administrator. During interview on 8/15/24 at 9:26 a.m., the director of nursing (DON) stated the process to determine whether a resident was capable of making their own decisions was an ethical question and they had to assess mental capacity and stated it went through social services to see if a resident was capable and added it was an IDT approach and medical doctors and stated it depended if they came to the facility and had power of attorney documentation and if they didn't have documentation on file they question if it warrants getting the ombudsman or an attorney for a person or family member to be the decision maker and they would go through a process. DON further stated if they were assisting family members it was documented in a care conference and progress note or the social worker would enter a progress note. The DON stated they reviewed orders when a resident comes from the hospital and discharge summaries and stated either the DON or managers went through the resident's medical record to be on the safe side to know what was needed for a person just in case it was not in the orders and stated therapy staff also go through the history and physical. DON stated the	F 689		

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F 689	Continued From page 53 elopement assessment was completed upon admission and was reassessed periodically quarterly. DON stated the purpose of the elopement assessment was to establish whether a resident was at risk for leaving the facility with out staff knowledge or going out unsafely depending on their cognitive status. The DON further stated R15 was alert and oriented to the situation and can dial numbers and will tell you what he is going to do and stated R15 could go on an unsupervised leave. The DON stated R15 went out the front door and staff were called, saw R15 walking and stopped at the bus stop and other staff followed R15 and tried to redirect him. The DON further stated he instructed staff to contact the police because R15 was aggressive and the best thing they could do was send R15 to the emergency room. The DON stated this was not the first time R15 asked for medication, and they were working on a process to help get the supplement and stated R15 had not attempted to leave since. The DON stated they tried to stop R15 because everyone went by orders and information that was relayed to him. Contrary to documentation, the DON stated staff went with R15 and R15 did not walk alone and further stated they planned to monitor R15 and make sure he was checked on every shift. R4 R4's quarterly Minimum Data Set (MDS) dated 5/7/24, indicated severe cognitive impairment, disorganized thinking, and wandering with a diagnoses of dementia, restlessness, and agitation. It further indicated R4 required partial to moderate assistance with transfers.	F 689		

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F 689	Continued From page 54 R4's last elopment risk assessment was dated 7/13/21, and was at moderate risk for elopement. R4's care plan dated 5/8/24, indicated R4 was having a tough time adjusting to a secure memory care unit, and may exhibit behaviors including crying, making angry statements about wanting to hurt herself or others, hitting/kicking caregivers, and refusing cares. It was taking awhile to adjust to many recent changes: environment, recent hospitalization, and dignoses of depression, dementia, and delirium. It further indicated the following interventions: -approach in a calm manner and explain what you intend to do. -redirect -offer aromatherapy as needed -remove from the situation -provide 1:1 -hand massage -healing music -encourage the use of therapy doll as needed. During observation on 08/12/24 at 12:18 p.m., R4 was sitting in her wheelchair by the exitdoor. When the social services director (SSD) came through the door, R4 stated "don't leave me." The SSD attempted to push her in her wheelchair down the hallway but after a few steps she put her feet down and wouldn't let him push her any farther. SSD continued walking down the hallway and R4 self propelled her wheelchair back to sit in front of the exit door again. During interview on 8/14/24 at 12:21 p.m. nursing assistant (NA)-C stated there's days where R4 will sit by the exit door and push on it in attempt to get it open and when staff approach her she would say she's looking for her kids. It usually	F 689		

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F 689	Continued From page 55 happened in the morning. Staff try to redirect her, offer her an activity or use aromatherapy to keep her calm. R21 R21's annual Minimum Data Set (MDS) dated 5/20/24, indicated moderately impaired cognition and diagnosis of unspecified signs and symptoms involving cognitive functions and awareness. It further indicated R21 required staff assistance with activities of daily living (ADL) and mobility. R21's last Elopement Risk Assessment was completed on 6/22/23. R21's care plan dated 5/23/24, indicated R21 has difficulty adjusting to her current situation due to diagnoses of anxiety, cognitive deficits, and poor safety awareness. R4 would like to be independent even though she has physical limitations. Staff report she is adamant with her daily routine. She will ask staff to direct her to the bus or train, aske to go home, ask where the kids are, and state let's go upstairs and get the kids. It further indicated the following interventions: -resides in a secured memory unit -engage me into different diversional activities to assist me to adjust to my situation as needed -use aromatherapy every shift if able to tolerate it based on the facility policy -redirect me when I have difficulty thinking clearly, which is evidenced by incoherent thought process and saying things that may not be accurate. -ok for staff to keep me at the nurses station to ensure my safety -use in house psychology to allow me to adjust to my new situation as needed.	F 689		

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F 689	Continued From page 56 During interview on 8/14/24 at 7:30 a.m. licensed practical nurse (LPN)-A stated the social worker (SW) was responsible for filling out the resident elopement risk assessments, but any nurse could do it. It should be filled out upon admission but didn't know how often they are supposed to be filled out after that. LPN-A also wasn't sure if every resident needed an elopement risk assessment completed following the one on admission or if it was just for residents who have exhibited that behavior. During interview on 8/14/24 at 8:10 a.m., registered nurse (RN)-E stated an Elopement Risk Assessment only needs to be completed if the resident is exhibiting that behavior and nurses were responsible for completing them. During interview on 8/14/24 at 1:51 p.m., clinical manager RN-F stated she wasn't sure if residents were required to have an Elopement Risk Assessment, who was responsible for completing them, or how often they needed to be done. During interview on 8/15/24 T 9:44 a.m., the social services director (SSD) stated all residents should receive an Elopement Risk Assessment upon admission (completed by social services) and then ongoing it should be completed annually and when there's a significant change in status. Social services works with nursing on the Elopement Risk Assessments when their is a significant change in status and for the annual assessments. The SSD also verified R4's last Elopement Risk Assessment was completed on 7/13/21 and R21's was on 6/22/23. During an interview on 8/15/24 at 8:41 a.m. the	F 689		

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BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(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
F 689	Continued From page 57 director of nursing (DON) stated all residents were required to have an Elopement Risk Assessment completed upon admission and with quarterly assessments and social serivices was responsible for completing them. R77 R77's quarterly Minimum Data Set (MDS) dated 6/5/24, indicated severely impaired cognition and diagnoses of dementia (unspecified severity, with agitation, Alzheimer's disease, restlessness and agitation. It further indicated R77 required staff assistance with activities of daily living (ADL) and was independent with mobility. R77's most recent Elopement Risk Assessment was dated 3/7/24, and indicated a low risk for elopement. R77's care plan dated 12/14/23, indicated R77 was at risk for elopement as evidenced by wandering aimlessly and impaired safety awareness. It further indicated the following interventions: -try to determine the reason for elopement, -apply an alarm for alarm doors, -fall risk assessment, -check R7's location every shift, -provide distraction by offering pleasant diversions, -keep a picture of R77 at the front desk. -document all of my incidents of wandering. -identify a pattern of wandering: Is my wandering purposeful, aimless, or escapist? -maintain log of interventions that work to control my wandering -make sure all staff are aware of my elopement	F 689		

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F 689	Continued From page 58 risk -observe me for fatigue and weight loss -outside secure courtyard for safe walking -personalize my room with clock, calendar, signs, or pictures -place identification band on me -place me in a closed unit if appropriate -provide me with a safe walking path -provide me with structured and supervised walking activities -reorient me to person, place, and time prn -staff to accompany me to: Beauty salon, appointments, church services. -toileting schedule R77's care plan dated 12/07/2023, also indicated R77 was at risk for elopement related to a diagnoses of Alzheimer's with agitation as evidenced by ambulating independently, wanders on the unit, and goes up to all doors and attempts to open them. It further indicated R77 resided in a secured memory unit. with interventions to keep a picture at the receptionist desk in the elopement book, educate family and staff on elopement risk, have a picture of R77 available in computer, keep residents room personalized with personal possessions, offer/encourage involvement in facility activities, and to monitor and report changes in residents mental status. During observation on 8/12/24 1:32 p.m. R77 was walking up and down the hallway, stopped at other residents rooms but didn't go in. Then she went to the patio door and stood and looked out and to the exit door which leads to another unit and stood and looked out the window of the door for a minute and then walked back down the hallway.	F 689		

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F 689	Continued From page 59 During observation on 8/15/24 at 9:28 a.m., R77 was standing in the dining room and did not have an identification band on. During observation and interview on 8/14/24 at 1:00 p.m., front desk staff (FDS) and surveyor looked in the elopement book at the front desk for pictures of the residents who were at risk for elopement and there wasn't a picture of R77 in the book. The receptionist also verified R77's picture was not in the book, stating only residents who wear a wanderguard were in there. During interview on 8/15/24 at 9:55 a.m. the clinical manager registered nurse (RN)-F stated residents who are at risk for elopement should have that included in their care plan and would expect staff to be following the care plan. RN-F further stated the nurses and herself (as the clinical manger) were responsible for ensuring the care plan and interventions were being followed. A facility policy regarding care area assessment and care planning dated 9/27/23, indicated all person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. A policy, Elopement dated 9/2023, indicated the purpose of the policy was to provide a safe and least restrictive environment for residents and to maintain the safety of residents who are at risk of wandering and or active elopement. The nurse or social services will evaluate each resident's potential for wandering upon admission and as needed. The nurse or social services identifies necessary interventions for each resident in their	F 689		

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F 689	Continued From page 60 care plan, assessment, and or abuse prevention plan. The registered nurse will provide necessary training on interventions and techniques for each resident. These may include but are not limited to medic alert bracelet or necklace, business cards to keep in purse, wallet, or pocket as appropriate. A current photograph of each resident at risk for inappropriate wandering and or elopement and a description of any unique identifiers will be in the electronic health record and may be kept in another specified area. Nursing and social services partners with the resident's family and friends to support resident safety regarding wandering and or elopement such as asking them to contact the community when they escort the resident on an outing. When an active attempt by a resident to elope, an associate is to stay with the resident, attempt to prevent their departure in a respectful manner, get help from other associates, instruct another associate to inform the charge nurse or DON, if the resident refuses to return to the community with the associate, associate will notify other associates in the community and then call for assistance e.g. 911, family, whichever is deemed appropriate to the situation. The registered nurse or social services will re-assess the resident and determine if changes need to be made to the resident's care plan and or new interventions added to the abuse prevention plan to prevent future elopement attempts. The resident's care plan must be reviewed and revised to reflect the elopement and a prevention plan developed.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are	F 699		10/3/24

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F 699	Continued From page 61 trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess past trauma and implement individualized care plan interventions utilizing a trauma-informed approach for 1 of 1 (R47) resident reviewed who had post-traumatic stress disorder (PTSD) symptoms. Findings include: R47's quarterly Minimum Data Set (MDS) dated 7/16/24, identified intact cognition, and was dependent on staff for eating, lower body dressing, and toileting assistance. Required substantial to maximal assistance with shower, bathing, and upper body dressing. Diagnoses included depression and bipolar disorder. R47's Activities of Daily Living (ADL) Care Area Assessment (CAA) worksheet dated 1/16/24, identified psychosocial well-being triggered due to six or more activities flagged as not important at all. R47 was admitted to skilled nursing facility with bipolar disorder and had a diagnosis of depression so changes in mood was expected. R47's trauma screening dated 1/20/22, identified she had been through life threatening or traumatic events and wanted to be left alone if angry or upset. The sections for triggers that make this worse or things to help manage difficult	F 699	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R47 trauma informed assessments and care plans have been updated to include individualized interventions. R47’s care delivery guide has been updated to reflect preference for male care givers. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents are to have trauma informed assessments. Any resident that has an assessment over a year old has been updated with individualized goals and interventions listed in their plan of care and on NAR care delivery guides as appropriate. 2. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. The social services department along with	

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F 699	Continued From page 62 times was left blank. R47's medical record lacked additional follow up trauma screenings. R47's care plan dated 8/12/24, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization. R47's nursing orders dated 8/1/24, identified: per patient request, no male nursing assistants were allowed to provide care. R47's Associated Clinic of Psychology (ACP) note dated 8/6/24, identified the patient requested a visit due to PTSD symptoms. There was an incident where a male provided personal cares and she began having flashbacks of childhood abuse. R47 discussed circumstances from foster care and childhood trauma, she also reported nightmares one to three times per week and day-time flashbacks. R47 felt safe at the facility if cares were not provided by male nursing assistants. R47 responded well to trauma informed CBT (cognitive behavioral therapy) during the session. During an interview on 8/13/24 at 1:11 p.m., nursing assistant (NA)-D was not aware of R47's PTSD or if she could have male caregivers. NA-D reviewed R47's nursing assistant care sheet, which had not identified any triggers or approaches related to PTSD. During an interview on 8/13/24 at 1:22 p.m., R47 stated she deals with PTSD and had not talked about it until recently, when she was re-traumatized after having a male caregiver. She stated she had no male caregivers before by chance, however, after she had one, she asked	F 699	the clinical management team and MDS department has been educated on the facility policy related to updating care plans in an individualized manner. The social services department along with clinical management team and the MDS department have been educated on the expectation to communicate with one another as new information comes to light related to our residents and how this can and should trigger updated assessments and care plans. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DSS/designee will audit 5 residents per week to ensure the trauma informed assessment are complete and the care plan includes goals and interventions related to the resident's individualized situation and that appropriate approaches carry through to the care delivery guide as appropriate. 5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	

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F 699	Continued From page 63 to not have male caregivers going forward. R47 stated if she had no males and staff approached her with kindness and understanding, she would continue to feel safe. R47 stated she deals with PTSD and talked to her counselor about it, and she would be comfortable speaking with the facility's social services director about trauma informed care. During an interview on 8/13/24 at 2:04 p.m., NA-F stated she knew R47 could not have male caregivers, because R47 had told her about it when she had the male caregiver. After, R47 would ask NA-F if any males were working that day, and NA-F would ensure they would not work with R47. NA-F reviewed the care sheet and agreed it lacked triggers or approaches related to PTSD, and it might be helpful so all caregivers could be made aware. During an interview on 8/14/24 at 1:31 p.m., the ACP SW-A stated R47 had not brought up PTSD before in their sessions, but after she had a male caregiver and requested an ACP visit, she was "clearly" exhibiting PTSD during their visit. SW-A stated R47 had some underlying PTSD, and she would expect the facility to follow up with trauma informed care based off the facility protocol. During an interview on 8/14/24 at 1:49 p.m., licensed practical nurse (LPN)-B stated she never knew about R47's PTSD until she spoke up about it after a male nursing assistant was assigned. LPN-B stated she then had the order added to the nursing administration records. LPN-B agreed the trauma triggers or preferred trauma informed care approaches were not listed on the care plan or nursing assistant care sheets, and it would be helpful to have the information easily accessible	F 699		

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F 699	Continued From page 64 to reference. LPN-B stated social services completed trauma assessments. During an interview on 8/14/24 at 2:00 p.m., the facility's social services director (SSD) stated he was aware of R47's PTSD which she discussed with her counselor and other facility staff. The SSD was unsure how often trauma screenings needed to be completed at the facility. The SSD stated if PTSD symptoms were new, a new trauma screening should be completed to reassess trauma triggers, approaches, and add interventions to the care plan to help minimize re-traumatization. The facility policy titled Trauma Informed Care, revised on 5/28/24, identified residents that have a history of trauma would be assessed, and have goals and interventions added to their care plan to address potential triggers and approaches to minimize or eliminate the effect of the trigger on the resident. If the trauma survivor was reluctant to share history, the facility was still responsible to try to identify triggers which may cause re-traumatization and develop care plan interventions which minimized or eliminated the effect of the trigger.	F 699		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure assistance to a family	F 745	1. How corrective action will be accomplished for the residents who have	10/3/24

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F 745	Continued From page 65 member with determining mental capacity for 1 of 1 resident (R15) reviewed for social services. Findings include: R15's admission Minimum Data Set dated 7/9/24, indicated R15's preferred language was Hmong, did not need an interpreter, had difficulty hearing in some environments such as when speaking softly or a noisy setting and required a hearing device, a brief interview for mental status (BIMS) should have been conducted, however was not conducted, did not have hallucinations or delusions, did not exhibit wandering behavior, and did not reject care. Additionally, R15 used a cane, required partial to moderate assistance with toileting, showering, upper and lower body dressing, hygiene, and donning/doffing footwear. R15 required partial to moderate assist with sitting to standing safely and required supervision or touching assistance to ambulate 10 feet. R15 was incontinent of bowel and bladder, had an anxiety disorder, cardiogenic shock (the heart cannot pump enough blood to the brain and other organs), acute respiratory failure with hypoxia (the body doesn't have enough oxygen at the tissue level), acute pulmonary edema (a condition where too much fluid builds up in the lungs), acute on chronic combined systolic and diastolic heart failure, had a defibrillator, had a life expectancy of less than 6 months, took an antipsychotic and antianxiety medication, was on hospice and did not use restraints. R15's face sheet indicated R15 was not responsible for himself, and family member (FM)-B was R15's primary emergency contact. Additionally, R15 had the following diagnoses: restlessness and agitation, generalized edema,	F 745	found to have been affected by the deficient practice. R15 discharged to The Villas of St. Paul per his preference related to a Hmong population. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents on hospice have been reviewed and if they do not have a documented decision maker social services have reached out to family about the process for obtaining the power of attorney. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. If a resident signs onto hospice services the Social Services Director will verify a decision maker is identified in Matrix. If one is not the social services director will inform the family the process for obtaining a power of attorney. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DSS/designee will audit 3 hospice residents per week to ensure a decision maker is identified in the event the resident is not capable to make their own decision.	

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F 745	Continued From page 66 and other encephalopathy (a disease in which the functioning of the brain is affected by an agent or condition). R15's care plan dated 7/3/24, indicated R15 was on hospice with an expected decline in condition and the following hospice staff visited: nursing and nursing assistants weekly, social services and chaplain monthly, and volunteers. R15's care plan dated 7/3/24, indicated R15 did not want resuscitation and interventions included healthcare directives signed by appropriate individuals (physician, resident, family, legal representative). R15's care plan lacked information whether R15 could make his own decisions. R15's care sheet dated 8/9/24, indicated R15 was impulsive, spoke English and staff needed to anticipate needs. R15's Provider Orders for Life-Sustaining Treatment (POLST) form indicated R15 did not want to be resuscitated and under documentation of discussion indicated 6 check boxes that included the following: Patient (Patient has capacity), court-appointed guardian, other surrogate, parent of minor, health care agent, and health care directive. The only check box marked was, "health care agent" and was signed by FM-B. Additionally, the POLST included instructions that a person with capacity, or the valid surrogate of a person without capacity, could void the form and request alternative treatment. R15's medication administration record (MAR)	F 745	5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024.	

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F 745	Continued From page 67 and treatment administration record (TAR) dated 8/4/24, through 8/12/24, indicated to monitor the placement of the wander guard every shift. Under comments on the MAR and TAR, indicated on 8/6/24 at 5:36 p.m., "no wander guard", on 8/7/24 at 3:30 a.m., resident removed wander guard, on 8/7/24 at 8:40 p.m., "not on", 8/8/24 at 1:55 a.m., "resident removed", on 8/9/24 at 3:11 a.m., "resident removed", 8/9/24 at 2:37 p.m., "does not have a wander guard on", on 8/10/24 at 2:50 a.m., indicated "no on" and on 8/12/24 at 1:47 p.m., indicated "discontinued". R15's cardiology note dated 6/17/24, indicated R15 was unable to participate in decision-making process. R15's nurse practitioner (NP) note dated 6/18/24, indicated FM-B asked for help in determining R15's capacity to make complex decisions if R15 improved enough to engage in discussions regarding goals and plan of care and gave an example of potential vulnerability to financial exploitation by unknown people in R15's home country where R15 intermittently sent significant amounts of money. Further, R15 demonstrated limited understanding. Last, under a heading, "Decision Making Capacity" indicated R15 required surrogate decision making due to critical illness and was unclear if R15 had decision-making capacity at baseline per daughter. R15's physician discharge to facility note dated 7/2/24, indicated R15 was unable to verbalize understanding of his condition and treatment plan due to being disoriented and the diagnosis and treatment plan was discussed with FM-B.	F 745		

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F 745	Continued From page 68 R15's NP-D progress note dated 7/16/24, indicated R15 was independent with activities of daily living (ADLs), was ambulatory and R15's review of systems was limited due to cognitive impairment. R15's Application of a Health Officer or Peace Officer for Emergency Admission form dated 8/4/24 at 1:15 p.m., indicated R15 was trying to walk 11 miles in 71-degree heat in a winter jacket. R15 was on hospice and tried to assault staff and refused to return and staff wanted R15 to go to the hospital. R15's emergency department note dated 8/4/24, indicated R15 eloped to go to the Hmong market and the police were contacted and intercepted R15 2 blocks away. Further, staff indicated R15 had to come to the hospital but did not elaborate and per EMS, family resided out of state except a daughter who was the power of attorney but R15 did not have contact with, and had organized thought content and processes, additionally FM-B was contacted and wanted R15 admitted for a psychiatric evaluation for capacity. It was explained to FM-B capacity could be completed outside the hospital and better in a legal setting versus a medical setting. R15's NP-D progress note dated 8/13/24, indicated R15 had dementia without behavioral disturbances, had cognitive limitations, and eloped on 8/4/24, attempting to ambulate to the store to purchase Hmong medications. Additionally, review of systems was limited secondary to cognitive impairment. OBSERVATION FORMS:	F 745		

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F 745	Continued From page 69 R15's Clinical Documentation Admission form dated 7/3/24 at 12:14 p.m., indicated staff could not identify whether R15 had an advanced directive due to a level of cognitive impairment. R15's Self-Administration of Medication form dated 7/7/24, indicated R15 was not appropriate to self-administer medications and R15's cognitive status was identified as "moderately impaired-decisions poor; cues/supervision was required." R15's Long Term Care Social Service form dated 7/10/24 at 5:18 p.m., indicated R15 had minor forgetfulness, a vision or hearing problem that impaired communication, distorted and misrepresented events, did not fully understand physical limitations. R15's Notice of Resident/Patient Transfer or Discharge form dated 8/4/24 at 2:38 p.m., indicated R15 was involuntarily transferred to the hospital on 8/4/24, because R15's welfare and needs could not be met in the facility. R15's Resident Transfer Form dated 8/4/24 at 2:57 p.m., indicated FM-B was R15's health care proxy (someone designated to make medical decisions if a person is unable to themselves) was notified. Under the heading, "Reason for Transfer" "What Happened" indicated R15 eloped and attempted to hit staff. Further, "Primary Clinical Reason for Transfer" indicated a check box for "other" and identified acute chronic combined systolic and diastolic failure. Additionally, the form indicated R15 was alert and oriented and followed instructions, ambulated with a cane but did not indicate the distance R15 could ambulate, and was identified as not	F 745		

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F 745	Continued From page 70 applicable under impairments including hearing and cognitive and a behavior started 8/4/24, when R15 went outside the building and tried to hit staff. R15's Social Services Elopement Risk form in progress dated 8/14/24 at 1:32 p.m., R15 exhibited combativeness, resisting redirection from staff, had a recent move to the facility, terminal illness, and preventative action taken included wanderguard, photograph posted and a check box indicating "social services" were marked in the check boxes. CARE CONFERENCE: R15's care conference notes last updated by the director of social services dated 7/16/24, indicated R15 scored a 6 out of 15 on the brief interview for mental status (BIMS) which indicated R15 had severe cognitive impairment. PROGRESS NOTES: R15's progress notes dated 7/3/24 at 2:16 p.m., indicated R15 was alert to self, unable to communicate needs and was alert and oriented times 2. R15's progress notes dated 8/4/24 at 1:20 p.m., indicated R15 went to the nurse's station around 11:40 a.m. to ask for the phone and did not understand what they were communicating due to a language barrier and after about 10 minutes, the supervisor received a call that R15 was outside on the right side of the building. The supervisor went outside to check immediately but did not locate the resident and followed protocol of searching for the resident. R15 was seen	F 745		

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F 745	Continued From page 71 walking faster towards the intersection by McDonalds and therapy staff reached R15 first before the supervisor arrived. R15 stated he was going to go and get his Hmong medication for his legs. The note further indicated R15 was resistive and unable to be redirected after multiple attempts and kept following the way to board the bus and later became agitated and tried to hit staff multiple times. The police were contacted and were unable to redirect R15 and stood firm he was not going back to the facility. A family member was contacted who did not want to talk with R15 and the facility decided to send R15 to the hospital. R15's progress notes dated 8/4/24 at 7:19 p.m., indicated R15 returned from the hospital around 6:00 p.m. after an incident when the resident left the facility unaccompanied. To make sure the incident was not repeated, the nurse spoke with FM-B regarding wearing a wanderguard and planned to discuss issues of wearing a wanderguard by a resident with no diagnosis of a cognitive impairment on 8/5/24, with the director of social services and a wanderguard was placed on R15's right wrist and was on 15-minute checks. R15's hospice progress note dated 8/4/24 at 9:00 p.m., indicated the hospice nurse contacted the interpreter and R15 stated he wanted an herbal supplement for his kidneys because the medications were not working. R15's daughter was updated and stated 1 pill was $300.00 and could not get the medication. R15's progress notes dated 8/7/24 at 1:51 p.m., indicated on 8/4/24, R15 walked on foot to the bus station near McDonalds, about 10 minutes	F 745		

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F 745	Continued From page 72 away from the facility and the supervisor and team of nurses and therapists located R15 at the bus station near McDonalds. FM-B agreed to a wanderguard placement to alert staff when R15 attempted to leave the facility. Further, the note indicated R15 did not elope was alert and oriented x 3 and knew the route to the bus station. R15's progress notes dated 8/7/24 at 4:39 p.m., and recorded as a late entry on 8/12/24 at 8:44 a.m., by the social services director indicated the following: "Writer called and spoke with daughter regarding medication that resident has been asking for. Family reports that resident has taken the medication previously, but it is not easily sourced and not readily available through traditional means of purchasing medication. Resident is requesting this medication to help them to feel comfortable as the medication aligns with medicine in their culture. To align with resident's cultural beliefs and to respond to person centered care, writer and family will continue to discuss ways that this medication can be provided to the resident. According to the matrix care chart review and weekend supervisor, at 11:40 a.m., the patient requested a telephone at the nurses' station and made a call to a family member. The patient then left the building through the main entrance, despite attempts by the receptionist to redirect them back inside. The patient walked on foot to the bus station near McDonalds, about 10 minutes away from the facility, expressing an intention to obtain traditional medicine from a Hmong store. The receptionist promptly informed the building supervisor of the event. The supervisor and a team of nurses and therapists quickly located the patient at the bus station near McDonalds.	F 745		

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F 745	Continued From page 73 Despite multiple attempts by staff members to redirect [R15] back, he became agitated and threatened physical violence. As efforts continued unsuccessfully, emergency services were called for assistance." R15's progress note dated 8/12/24 at 8:59 a.m., indicated the wanderguard was discontinued and was not appropriate to wear a wanderguard at this time. Further the note indicated R15 was alert and oriented times three. During interview on 8/13/24 at 11:37 a.m., FM-B stated she spoke with the social services director (SSD)-B about 3 days after incident who did not have much to say about the incident other than they put a wanderguard on R15. FM-B stated she was not sure if R15 still had the wanderguard, SSD-B mentioned R15 cut off the wanderguard. FM-B stated she understood R15 wanted to purchase a supplement that could only be purchased in the Hmong village and was walking with a cane and had a winter jacket on. FM-B stated she told the SSD-B R15 had the intention of doing this and SSD-B reassured FM-B someone was by the door all the time. FM-B stated the nurse contacted her and told her R15 left the facility and wanted her to tell R15 to go back and when FM-B tried to talk with R15, he would not listen, and the police were called. FM-B stated the police were unable to get R15 to come back and the nurse stated they were going to take R15 to the hospital because R15 tried to assault a staff member. FM-B further stated the physician contacted her and stated R15 was breathing ok and was confused because she thought R15 would be having a psychological evaluation. FM-B stated she did not think R15 could make sound reasonable decisions for	F 745		

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F 745	Continued From page 74	F 745		

himself, but was told due to no impairment, R15 could make decisions for himself.

During interview and observation on 8/13/24 at 2:30 p.m., the interpreter was contacted and R15 stated he had been at the facility a long time and wanted to move out of the hospital and was unable to identify what facility R15 was at. R15 further stated the wanderguard did not help his illness and stated he would just take off the wanderguard. R15 stated he wanted to move to a Hmong facility where R15 could get medication to help his legs and stated he did not know the name of the medication but stated it was a Chinese medication. R15's feet were swollen and was wearing a pair of thong sandals.

During interview on 8/14/24 at 8:38 a.m., registered nurse (RN)-E stated she looked at the care plan to know what kind of cares a resident required and stated they complete a clinical assessment and ask a few questions that they are safe and a resident's memory is ok to determine whether they can do something or not and stated she thought the social worker completed a cognitive assessment.

During interview on 8/14/24 at 10:05 a.m., licensed practical nurse (LPN)-D stated the care plan sometimes had information on decision making capacity and stated it was also on the Facesheet.

During interview on 8/14/24 at 10:19 a.m., when asked how she knows a resident was safe to leave the facility alone, registered nurse (RN)-F stated most of their residents could not leave the facility, some could go for appointments and stated she did not know if there was any kind of

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F 745	Continued From page 75 an assessment to make that determination and would have to go and check. RN-F stated they assess if someone can go in the community in the transitional care unit and further stated she would have to check into that. RN-F further stated therapy completed cognition screens to determine if a resident could make their own decisions, but stated R15 was on hospice and stated social services might determine if R15 could make his own decisions. During interview on 8/14/24 at 10:42 a.m., the social services director (SSD)-B stated they had care conferences and completed a BIMS interview to help determine whether a resident was able to make their own decisions and ultimately it was up to the court system and was done through a guardianship and stated it was documented under resident notes. Additionally, it was a court decision along with the physician's opinion. If a resident was admitted to the facility and they did not know whether a resident could make their own decisions they ask for health care directives and if that is not provided, would speak with the resident. SSD-B stated R15 could make decisions with the help of his family and further added if R15 put his safety at risk they follow what they need to follow to ensure R15 is safe and stated R15 had an elopement attempt. R15 went to the bus stop to go to the Hmong village to get a medication. SSD-B further stated R15's BIMS was a 6 out of 15 which indicated severe cognitive impairment. SSD-B further stated he did not have information whether R15 could make his own decisions and later stated they would approach that R15 was able to make his own decisions with support of family. When asked why a wanderguard was placed if R15 was able to make his own decisions, SSD-B stated it was	F 745		

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F 745	Continued From page 76	F 745		

applied for his safety because the decision R15 made put him in an unsafe position and was since taken off and stated it would be important to have an elopement risk on any patient to see what their potential for elopement was.

During interview on 8/14/24 at 11:04 a.m., occupational therapists (OT)-H and OT-I stated they completed a cognitive assessment on every resident to determine their general baseline. The cognitive screens completed were Short Blessed Test and based on that score may do a SLUMS assessment that looked more at memory and sequencing, and they also had a cognitive performance test for medication management, choosing the appropriate clothing based on the weather outside and added they were more in depth than the BIMS. OT-H and OT-I verified R15 was not seen by therapy and verified there were no therapy notes in R15's medical record and stated R15 was on hospice so did not have any therapy orders and verified there was no cognitive assessment completed through therapy.

During interview on 8/14/24 at 12:23 p.m., hospice social worker (HSW)-C stated he visited monthly and was looking for different placement for R15 and stated R15 enrolled in hospice on 7/3/24. HSW thought R15 could make his own decisions and stated he didn't have firsthand knowledge of R15's elopement and stated the note indicated R15 returned from the hospital after leaving the facility.

During interview on 8/14/24 at 12:07 p.m., nurse practitioner (NP)-D stated R15 was a newer resident who spoke English ok, was on hospice, had edema to his legs but refused medications and eloped a few weeks ago. NP-D further

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F 745	Continued From page 77 stated R15 could make needs known, can make a choice such as applying lotion, but could not make medical or financial decisions and they would look to R15's family and added R15 had dementia and did not want his patient eloping. During interview on 8/15/24 at 9:26 a.m., the director of nursing (DON) stated the process to determine whether a resident was capable of making their own decisions was an ethical question and they had to assess mental capacity and stated it went through social services to see if a resident was capable and added it was an IDT approach and medical doctors and stated it depended if they came to the facility and had power of attorney documentation and if they didn't have documentation on file they question if it warrants getting the ombudsman or an attorney for a person or family member to be the decision maker and they would go through a process. DON further stated if they were assisting family members it was documented in a care conference and progress note or the social worker would enter a progress note. The DON stated they reviewed orders when a resident comes from the hospital and discharge summaries and stated either the DON or managers went through the resident's medical record to be on the safe side to know what was needed for a person just in case it was not in the orders and stated therapy staff also go through the history and physical. The DON further stated R15 was alert and oriented to the situation and can dial numbers and will tell you what he is going to do and stated R15 could go on an unsupervised leave. The DON stated R15 went out the front door and staff were called, saw R15 walking and stopped at the bus stop and other staff followed R15 and tried to redirect him. The	F 745		

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F 745	Continued From page 78 DON further stated he instructed staff to contact the police because R15 was aggressive and the best thing they could do was send R15 to the emergency room. The DON stated this was not the first time R15 asked for medication, and they were working on a process to help get the supplement and stated R15 had not attempted to leave since. A job description, Social Services Designee dated February 2019, indicated the social services designee coordinates the overall interdisciplinary plan of care for a resident, from admission to discharge. Acts as a liaison between resident/family and healthcare personnel to ensure necessary care is provided promptly and effectively. Under a heading, Key Result Areas, and Essential Functions of the Job, indicated assist residents/patients with financial and legal matters i.e. POA (power of attorney), applying for medical assistance, referrals to lawyers, referrals to funeral homes for preplanning arrangements, guardian/conservator. A job description, Social Worker, dated February 2019, indicated the job summary which included, identify the need for medically related social services and pursue the provision of these services. This position is responsible for identifying the psychological, social and emotional needs of residents and devising and implementing services/interventions to meet those needs including collaboration with outside community resources. Under the heading, Key Result Areas/Essential Functions of the Job, indicated provide support and advocate for resident/patient and/or family, assist residents/patients with financial and legal matters i.e. POA, applying for Medical Assistance,	F 745		

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F 745	Continued From page 79 referrals to lawyers, referrals to funeral homes for preplanning arrangements, guardian/conservator. A policy, Provision of Social Services, dated 11/28/17, indicated the purpose of the policy was to provide medically-related social services to residents and assures that the needs are met by appropriate disciplines. Further, "Medically-related Social Services" means services provided by the facility's staff to assist residents in attaining, maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services might include: Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, and referrals to funeral homes for preplanning arrangements). Assisting residents with advance care planning, including but not limited to completion of advance directives.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756		10/3/24

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F 756	Continued From page 80 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the provider's response to the initial medication review was followed and failed to ensure monitoring was in place for 1 of 3 residents (R88) reviewed for antipsychotic medication use. Findings include: R88's admission MDS dated 7/24/24, indicated R88 had moderate cognitive impairment and diagnoses of sepsis, metabolic encephalopathy (change in how the brain works due to an underlying condition), delirium related to known physiological condition (a temporary mental state	F 756	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R88 discharged from the community on 8/21/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents who are on an antipsychotic medication have been identified and the pharmacists and provider have worked in	

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F 756	Continued From page 81 characterized by confusion, incoherent speech, and hallucinations), and age-related cognitive decline. Furthermore, R88's MDS indicated R88 had received an antipsychotic medication. R88's interim medication regimen review dated 7/20/24, indicated a pharmacist recommendation to the physician was sent. The recommendation stated R88 was taking the antipsychotic medication quetiapine for delirium however lacked an allowable diagnosis to support use. The recommendation included a list of allowable diagnoses for the provider to choose from. Nurse practitioner (NP)-A circled the diagnoses of delusional disorder (a type of psychiatric disorder involving one or more delusions or beliefs that something that is not true) and signed off on the recommendation on 8/6/24. R88's nursing and provider orders were reviewed on 8/13/24, indicated: -An order dated 7/18/24, indicated R88 required quetiapine 12.5 milligrams (mg) at bedtime for delirium due to known physiological condition. The order had not been updated to reflect the indication was for delusional disorder. -R88's orders lacked indication R88 was monitored for target behaviors or side effects related to quetiapine use. R88's face sheet printed 8/14/24, indicated R88's diagnoses list was not updated to delusional disorder. R88's care plan revised on 8/12/24 at 3:45 p.m., (after the start of survey) indicated R88 used quetiapine for delirium. Interventions included to	F 756	tandem to obtain an appropriate diagnosis for each medication. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All nurses and HUCS have been educated that pharmacy reports must be reviewed and if a provider would like a diagnosis added based on pharmacy recommendation it must be transcribed in Matrix. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/Designee will audit 5 residents per week to ensure residents pharmacy recommendations are reflected in the plan of care. 5. Date when the corrective action will be completed: This deficient practice will be corrected on 10/3/2024	

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F 756	Continued From page 82 administer medication as ordered, ask for a possible dose reduction every three months, and monitor behavior every shift and document. R88's care plan did not indicate what behaviors to monitor. When interviewed on 8/14/24 at 2:19 p.m., the consulting pharmacist (CP) stated for newly admitted residents, an initial pharmacy review was a day or two after admission. The initial review was about ensuring proper diagnoses for medications and looking to see if there were any major interactions. With transitional care residents they may not be at the facility long, so it was important to see them to ensure things were in place. CP acknowledged there wasn't monitoring in place for any target behaviors, and stated there wouldn't need to be as the dose of quetiapine was low and administered at night. Likely it would only be helping R88 sleep. When interviewed on 8/15/24 at 10:06 a.m., the Director of Nursing (DON) stated upon admission there were order sets that were used to ensure residents recieved the moitoring needed for high risk medications. DON verified there was not monitoring in place for R88's quetiapine. The CP, or another pharmacist do an initial review. If recommendations were made, they were placed in the chart. If it was an order the nurse or unit coordinator would change. For the diagnoses, that was up to health information management should have changed the diagnoses and order. DON further stated there was likely someone covering for them when on vacation and missed that step. DON expected the provider's response to the pharmacy recommendation to be reflected in the medical record when it was received.	F 756		

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F 756	Continued From page 83 A facility policy titled Medication Monitoring Medication Regimen Review dated 12/2017, directed the CP identifies irregularities through a variety of sources including behavior monitoring information. The policy also directed the staff to ensure there was a written diagnosis, indication or documented objective findings to support each order and the duration of therapy was indicated and appropriate for the resident. Furthermore, the policy directed recommendations were acted upon and documented by facility staff and or the prescriber.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §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: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic 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	F 758		10/3/24

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F 758	Continued From page 84 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 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 interview and record review the facility failed to ensure 1 of 3 residents (R88) who received antipsychotic medications had an appropriate indication and diagnoses for the medication. Furthermore, the facility failed to ensure staff were monitoring resident behaviors related to the antipsychotic medication and utilizing non-pharmacological approaches to ensure the antipsychotic medication was necessary. Findings include:	F 758	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R88 discharged from the community on 8/21/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents that receive an antipsychotic	

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F 758	Continued From page 85 R88's admission MDS dated 7/24/24, indicated R88 had moderate cognitive impairment and diagnoses of sepsis, metabolic encephalopathy (change in how the brain works due to an underlying condition), delirium related to known physiological condition (a temporary mental state characterized by confusion, incoherent speech, and hallucinations), and age-related cognitive decline. Furthermore, R88's MDS indicated R88 had received an antipsychotic medication. R88's hospital discharge summary dated 7/18/24, indicated recommendations for the outpatient provider. The recommendation was to consider stopping quetiapine (antipsychotic medication). R88 required Seroquel due to delirium related to metabolic encephalopathy and R88's mental status was improving. An order dated 7/18/24, indicated R88 required quetiapine 12.5 milligrams (mg) at bedtime for delirium due to known physiological condition. R88's orders lacked indication R88 was monitored for target behaviors, had non-pharmacological interventions in place for target behaviors, or monitoring side effects related to quetiapine use. R88's care plan revised on 8/12/24 at 3:45 p.m., (after the start of survey) indicated R88 used quetiapine for delirium. Interventions included to administer medication as ordered, ask for a possible dose reduction every three months, and monitor behavior every shift and document. R88's care plan did not indicate what behaviors to monitor. R88's provider note dated 7/19/24, indicated R88 was seen for follow up from the hospital, was	F 758	medication will be reviewed and updated as needed to include individualized interventions and monitoring for behaviors. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All nursing associates have been educated on expected documentation related to monitoring for behaviors and documenting non pharmacological interventions. All Clinical Manager and MDS personnel have been education related to individualized, person centered care and care plans. All nurses and HUCS have been educated that Antipsychotic medications need to have an appropriate diagnosis. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/Designee will audit 5 residents who are taking antipsychotic medications to ensure individualized interventions and care plans are in place along with behavior monitoring and a corresponding diagnosis for the medication for 4 weeks. Results of this audit will be reviewed by QAPI. 5. Date when the corrective action will be completed:	

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F 758	Continued From page 86 pleasant, confused, and oriented. R88 had some anxiety and difficulty word finding but appeared healthy. R88's provider notes further indicated to continue quetiapine. with a possible psychiatry consult and/or discontinuation of quetiapine. R88's interim medication regimen review dated 7/20/24, indicated a pharmacist recommendation to the physician was sent. The recommendation stated R88 was taking the antipsychotic medication quetiapine for delirium however lacked an allowable diagnosis to support use. The recommendation included a list of allowable diagnoses for the provider to choose from. Nurse practitioner (NP)-D circled the diagnoses of delusional disorder (a type of psychiatric disorder involving one or more delusions or beliefs that something that is not true) and signed off on the recommendation on 8/6/24. R88's provider note dated 8/7/24, indicated R88 appeared healthy, was pleasant and had some cognitive limitations and trouble sleeping. R88's note indicated the plan was to continue quetiapine and refer to ACP for cognitive therapy. R88's provider note had not identified behaviors associated with delusional disorder. R88's medical record lacked indication R88 had monitoring for behaviors related to delirium or delusional behaviors, lacked indication non-pharmacological interventions were placed for delirium or delusional behaviors, and lacked evidence R88 had experienced behaviors related to delirium or delusions. When interviewed on 08/12/24 at 12:14 p.m., R88 stated they were recently admitted for infection in the liver. R88 stated they didn't remember much	F 758	This deficient practice will be corrected on 10/3/2024.	

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F 758	Continued From page 87 about the hospital stay as they were "pretty out of it" from the infection. R88 was going to be going to an assisted living soon and was feeling much better. When interviewed on 8/14/24 at 12:33 p.m., nursing assistant (NA)-B stated R88 was confused at times but did not really have any behaviors. NA-B further stated R88 did not have any outbursts or hallucinations that she was aware of. When interviewed on 8/14/24 at 1:00 p.m., registered nurse (RN)-A stated when residents were admitted from the hospital, there was a lot of information that comes with them. If the information or in a verbal report, we are made aware of any behaviors we would review the medications and talk to the provider if needed. If a resident was experiencing some anxiety or getting agitated, we use distraction by going for a walk or their mind on something else and it would depend on the situation. RN-A stated R88 had some forgetfulness and tends to be repetitive in what they tell you, and for the most part was alert and oriented to person, place, and time. RN-A verified R88 had no delusions or hallucinations. RN-A verified R88 was on quetiapine for delirium. RN-A wasn't sure and thought maybe in the hospital R88 experienced that, but there was no delirium at the facility. RN-A verified there were no monitoring for behaviors related to quetiapine and stated there should be some behavior monitoring in place. When interviewed on 8/14/24 at 2:19 p.m., the consulting pharmacist (CP) stated for newly admitted residents, an initial pharmacy review was a day or two after admission. The initial	F 758		

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F 758	Continued From page 88 review was about ensuring proper diagnoses for medications and looking to see if there were any major interactions. With transitional care residents they may not be at the facility long, so it was important to see them to ensure things were in place as often antipsychotic medications may be started in the hospital and were no longer needed. After reviewing the recommendation from pharmacist-A, CP stated it was likely R88 had delirium in the hospital and would have pushed the signed recommendation back to the nurse practitioner for discussion as R88 did not have a diagnosis which the delusional disorder stemmed from. CP acknowledged there wasn't monitoring in place for any target behaviors, and stated there wouldn't need to be as the dose of quetiapine was low and administered at night. Likely it would only be helping R88 sleep. CP stated it was difficult as the provider and staff just don't know the patient well enough at the time of the recommendation to determine if the quetiapine was no longer needed. CP further stated interdisciplinary behavior rounds were coming up next week and likely it would be discontinued. On 8/15/24 at 8:25 a.m., NP-D's office was contacted to interview NP-D. NP-D had not returned the call. When interviewed on 8/15/24 at 10:06 a.m., the Director of Nursing (DON) stated upon admission the if a resident was taking an anti-psychotic medication an order set was entered to ensure there was behavior and side effect monitoring in place. DON further stated the interdisciplinary team meets to discuss all resident on anti-psychotics monthly. This was where behaviors were reviewed to determine if the	F 758		

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F 758	Continued From page 89 medication was required or effective. DON verified R88 was taking quetiapine for delusional disorder as indicated by the provider's pharmacy recommendation. DON stated delusional monitoring would include hallucinations and increased confusion and should be documented in the treatment record. DON confirmed an order to monitor R88's behaviors related to quetiapine use was not ordered and was not implemented into the care plan. R88's orders and care plan also lacked non-pharmacological interventions for staff to attempt if R88 had any delusional behaviors. as an order the nurse or unit coordinator would change. For the diagnoses, that was up to health information management should have changed the diagnoses and order. DON further stated there was likely someone covering for them when on vacation and missed that step. DON expected the provider's response to the pharmacy recommendation to be reflected in the medical record when it was received. DON expected staff to be monitoring R88 for any behaviors related to delusions and ensure documentation was completed. This was important to ensure the medication was appropriate and needed. A facility policy titled Psychotropic Medication Use revised 9/2023, directed nursing to collaborate with the medical provider to ensure the lowest possible dose of an a psychotropic medication was given for the shortest period of time. Furthermore, when psychotropic medications were ordered, the interdisciplinary team identifies target behaviors and implements a care plan with both non-pharmacological and pharmacological interventions.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		10/3/24

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F 812	Continued From page 90 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. (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 refrigerated food items were properly stored, labeled, and dated and disposed after expiration date. Furthermore, the facility failed to ensure the use of hair restraints. This deficient practice had the potential to affect all residents who receive food from the kitchen. Findings include: Food Storage: During the initial kitchen observation on 8/12/24 at 12:06 p.m., the refrigerator contained the following:	F 812	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. All items not labeled and dated were thrown away per policy at the time of the survey. Hairnets and beard protectors are being worn per policy. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All kitchenettes of the community were inspected to ensure expired items were	

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F 812	Continued From page 91 a gallon of 1% milk with a best by date of 8/11/24 and the dietician stated needed to be thrown out. Hair Restraints: During interview and observation on 8/12/24 at 12:23 p.m., cook (C)-A had uncovered facial hair and was preparing food in the Robot Coupe food processor and was observed not wearing a beard guard/restraint or net. At 12:25 p.m., the dietician verified C-A was not wearing a beard net and stated he should have one on and stated she would have to look at the policy. Kitchenettes: During the observation of the Villa kitchenette on 8/12/24 at 12:29 p.m., contained the following: 1 nutrition supplement that was opened and undated. The dietician verified there was no date and the supplement indicated to consume within four days and stated it should be tossed because there was no open date to know when the supplement should be tossed. two containers, one undated and the other dated 8/2/24. One was a container of bread and strawberries and the other a container with strawberries. The dietician stated they were a resident's food items and stated food items should only be in the refrigerator a total of 5 days. During the observation of the transitional care unit (TCU) kitchenette on 8/12/24 at 12:38 p.m., contained the following: 1 nutritional shake that was almost empty and undated the dietician verified indicated on the container to toss after four days and verified there was no date identified of when the container was	F 812	discarded and food was properly labeled and stored. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All dietary staff have been educated on the community policy in that the dietary department is responsible for the contents of all kitchenettes and refrigerators on the neighborhoods as well as in the kitchen including the resident refrigerator. All residents and families have been made aware of labeling and dating expectation. All dietary staff have been educated on hairnets and beard protectors being worn. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. The CDM/designee will audit all refrigerators weekly for 4 weeks for proper storage including labels and dates. The CDM/designee will audit employee appearance/appropriate hair protection one time per week for 4 weeks. The results of these audits will be reported to QAPI. 5. Date when the corrective action will be completed: This will be corrected on 10/3/2024.	

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F 812	Continued From page 92 opened. During interview on 8/15/24 at 8:58 a.m., the dietary manager (DM) stated they provided beard nets and expected food to be labeled and dated and resident food items to be labeled and dated and stored in resident refrigerators. Further DM stated the kitchen provided supplements, but it was nursing's responsibility to label and date items as they open them and toss items when they are expired or by the directions on the container. A policy, Food Storage, dated 1/2024, indicated all products are labeled and dated with the receiving date. Once opened, products are covered to prevent contamination and dated with an open date. A policy, Personal Hygiene, undated, indicated team members must consistently demonstrate appropriate personal hygiene practices. Wear a hairnet or cap to restrain all hair, for anyone with facial hair, wear a beard and mustache restraint. A policy, Food Brought into Resident's/Patient's Room From Outside Sources dated 1/2024, indicated any food or beverage brought into the facility for resident/patient consumption will be checked by a staff member before being accepted for storage. Foods or beverages brought in from the outside will be labeled with the resident's/patient's name and room number. Nursing will date the food with the date the item was brought to the facility for storage. All cooked or prepared food brought in for a resident/patient and stored in the unit's pantry refrigerator or personal room refrigerator will be dated when accepted for storage and discarded after 24	F 812		

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F 812	Continued From page 93 hours.	F 812		
F 880 SS=E	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 §483.70(e) 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; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		10/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(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
F 880	Continued From page 94 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 observation, interview and record review, the facility failed to ensure enhanced barrier precautions (measures intended to prevent the spread of multidrug-resistant organisms) were implemented for 2 of 3 residents (R83 and R24) observed for enhanced barrier precautions, and failed to ensure appropriate hand hygiene during assist with	F 880	1. How corrective action will be accomplished for the residents who have found to have been affected by the deficient practice. R83 and R24 have had no impact to their current health status as a result of this deficient practice. Both residents have	

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F 880	Continued From page 95 activities of daily living (ADLs) for 1 of 2 resident (R24). Last, the facility failed to ensure ice packs were stored separately from food storage in two unit refrigerators. This had the potential to impact the residents who resided on those units. Findings include: R83's admission Minimum Data Set (MDS) dated 7/22/2024 indicated the use of an indwelling catheter (a thin, hollow tube that is inserted into the bladder through the urethra to collect and drain urine. R83's medical diagnosis form in the electronic medical record dated 7/16/2024 indicated the following diagnosis: Encounter for palliative care (comfort cares), acute cystitis with hematuria (a medical condition that causes bleeding in the bladder and blood to appear in the urine), Urinary tract infection (an illness in any part of the urinary tract), site not specified , other acute kidney failure, and encounter for fitting and adjustment of urinary device. R83's physician orders dated 7/11/24 indicated the following: "urinary drain care The reason for the drain is : urinary incontinence and end of life care. The type of drain is: Foley 14 Fr., Placement date: 7/11/2024. Care instructions: per facility protocol. Change Foley cath leg bag , drainage bag, extension tubing Q 2 weeks. Empty Foley bag q shift and document output. Change Foley cath Q month." R83's plan of care reviewed on 8/14/24 at 8:00 a.m. did not include interventions regarding the Foley catheter or Enhanced Barrier Precautions.	F 880	been free from any new infections and the practice was immediately corrected at the time of the survey. Ice packs were removed from unit refrigerators at the time of survey. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. This deficient practice was corrected at the time of the survey. All residents were audited for EBP signage and appropriate PPE available. The associate identified at NA J was provided immediate education related to hand hygiene for washing hands at appropriate times during cares. No additional ice packs found in food storage refrigerators. 3. What measures will be put into place or system changes made to ensure that the deficient practice will not recur. All associates will be educated on the basic fundamentals of hand hygiene. When to wash hands and when to don/doff gloves. All licensed nurses will be educated on enhanced barrier precautions and expectation that EBP be implemented by any nurse for PM, NOC, or weekend changes of condition. All associates will be educated on the proper storage for Ice packs.	

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F 880	Continued From page 96 Random observations on 8/12/24 and 8/13/24, no enhanced barrier precaution signage was noted outside of R83's room. Observation on 8/14/24 at 7:25 a.m., R83's room door was closed, and no sign was noted outside of the door. Staff was noted to knock on the door and go into the room. Interview on 8/14/24 at 7:27 a.m., nursing assistant (NA) - H indicated any resident with a catheter is on precautions, and the staff are made aware by the signage on the door and in morning report. NA-H verified R83 had a catheter and no signs were on the door. Interview on 8/14/24 at 7:30 a.m., Registered nurse (RN) - E verified R83 did not have a sign on the door, and that is how the staff know who is on precautions. Observation on 8/14/24 at 7:49 a.m., RN-L was observed to put up an Enhanced Barrier Precaution sign outside of R83's door. When interviewed she indicated she was working with RN-K who is the new infection preventionist and was told to put the signage up. Interview on 8/14/24 at 7:55 a.m., RN-K indicated she was the new infection preventionist and did not know why there was no sign previously and indicated she would investigate it. Interview on 8/14/24 at 10:53 a.m., RN-J indicated she is the current infection preventionist and RN-K was learning the job. RN-J indicated any nurse on the floor can put up the signage for precautions, no matter what kind of precautions,	F 880	4. Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. The DON/designee will audit 5 residents a week on enhance barrier precautions to ensure the appropriate PPE and signage is in place as well as staff following appropriate procedures. The DON/designee will audit 5 associates a week providing daily cares to ensure appropriate hand hygiene procedures. The Dietary Manager/designee will audit 2 refrigerators a week to ensure no Ice pack storage with food. The results of this audit will be reported to QAPI. 5. Date when the corrective action will be completed: This will be corrected on 10/3/2024.	

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F 880	Continued From page 97 and she would look into why there was no signage by R83's room. As of 08/15/24 at 10:11 AM no information received regarding why R83 did not have a signage up and was not on Enhanced Barrier Precautions since admission to the facility R24 R24's quarterly Minimum Data Set (MDS) dated 6/25/24, indicated intact cognition, had a wheelchair, was dependent for toileting hygiene, lower body dressing, and transferring, and required substantial assistance with showering and bathing, and upper body dressing. Further R24 had an indwelling catheter. R24's Facesheet indicated R24 had the following diagnoses: spastic quadriplegic cerebral palsy, muscle weakness, urinary tract infection, bladder disorder, and encounter for attention to other artificial openings of urinary tract supra pubic, and a neuromuscular dysfunction of bladder. R24's physician's orders indicated the following orders: 3/3/22, catheter change once a month on the 27th of the month Conde 16 FR and 15 cubic centimeters (CC) sterile water. 5/28/24, patient is on enhanced barrier precautions (EBP) due to urinary catheter. R24's care plan dated 6/28/24, indicated R24 required EBP due to diagnoses of spastic quadriplegic cerebral palsy, presence of indwelling urinary catheter device and had the following interventions: assess resident for EBP	F 880		

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F 880	Continued From page 98 need and implement precautions according to facility protocol, assure residents are not restricted to their rooms or limited to participation in group activities, monitor for signs and symptoms of infection, post clear signage on the door or wall outside the resident room indicating the type of precautions and required personal protective equipment (PPE), provide education to staff, residents, and visitors as needed, staff to apply gloves and gowns prior to facility-identified high-contact care activities, discard PPE in designated location following activities, and sanitize hands after PPE removal. R24's care plan dated 6/28/24, indicated R24 had an alteration in ADLs and interventions included: assist of one for grooming, dressing, and bathing. R24's care plan dated 6/28/24, indicated R24 had an alteration in mobility and required an assist of two with transfers using the ceiling lift. During observation and interview on 8/14/24 between 8:59 a.m., and 9:29 a.m., nursing assistant (NA)-J washed hands and donned gloves to assist R24 with cares. At 9:03 a.m., NA-J assisted in untying R24's gown and gave the wash rag to R24 to wash her face. At 9:08 a.m., NA-J turned R24 to pull R24's shirt down. NA-J cleaned the catheter tip with an alcohol wipe and removed gloves and sanitized hands and donned new gloves. At 9:11 a.m., NA-J moved R24's gown to take off the catheter bag. At 9:13 a.m., NA-J put vinegar in the catheter bag and took a cup and water from the faucet to pour into the catheter bag to clean the bag and put the catheter bag in a garbage bag and hung it up in the bathroom. NA-J doffed gloves and rinsed hands in the sink, however did not use soap and	F 880		

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F 880	Continued From page 99 then took out gloves and tried to don the gloves. Moisture was observed through the gloves and NA-J took off the gloves and threw them away and grabbed new gloves and donned the new gloves without properly cleansing hands. At 9:16 a.m., NA-J removed her gloves and got a basin and placed it on the table and rinsed hands and again did not use soap or sanitizer and dried her hands and grabbed gloves. At 9:18 a.m. NA-J assisted in donning R24's pants and turned R24 to pull up R24's pants. At 9:22 a.m., NA-J doffed her gloves and used hand sanitizer and did not apply gloves and assisted R24 with a transfer into R24's wheelchair with the help of another staff person. At 9:24 a.m., NA-J donned gloves and put the lift up in the air and to the corner of the room. During interview at 9:29 a.m., NA-J verified she did not always use soap when she cleansed hands at the sink and further stated she did not need to use gloves to transfer R24 and stated R24 was on EBP because of the catheter. Additionally, NA-J verified hands were not completely dry when cleansing hands. Signage for EBP was located outside R24's door. During interview on 8/14/24 at 9:33 a.m., registered nurse (RN)-F stated if a resident was on EBP, staff donned gloves and gowns when completing cares and further stated PPE was required during transfers and stated if staff were sanitizing their hands at the sink, she expected soap to be used and stated hands should be dry before donning gloves. RN-F stated they didn't want to transmit drug resistant organisms because it could take a long time to heal and take a toll on residents. RN-F verified R24 was on EBP and expected PPE to be donned and hands washed with soap.	F 880		

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F 880	Continued From page 100 During observation on 8/12/24 at 12:32 p.m., the Villa kitchenette an ice pack was located in the freezer that indicated, thermal soft gel and indicated it was the property of facility therapy. The ice pack was located in the freezer next to popsicles and vanilla ice cream, and ice cream sandwiches. The dietician stated she would pull the ice pack out of the freezer. During observation on 8/12/24 at 12:38 p.m., the freezer in the transitional care unit (TCU) contained a thermalsoft Gel hot and cold therapy pack that indicated it was the property of facility therapy. The ice pack was located next to ice cream and ice cream sandwiches, a package of lasagna, and cinnamon french toast bites. The dietician stated she planned to leave it on top of the freezer and stated she probably would not have put the ice pack in the freezer and was not sure why it was in there. During interview on 8/12/24 at 12:43 p.m., registered nurse (RN)-J stated they had separate freezers for ice packs and stated the ice packs should not be in these freezers because it was not sanitary to have mixed with the food. At 12:45 p.m., RN-J brought the ice pack from the TCU down to a room and placed it in the freezer that only contained ice packs. During interview on 8/15/24 at 9:05 a.m., the director of nursing (DON) stated staff could use hand sanitizer, or could go to the sink and use soap and water and if they went to the sink, should wash for about 30 seconds and stated hands should be dry or it would be difficult to apply gloves. Further, the DON stated staff should wear the gown and gloves during transfers or repositioning and when working directly with a	F 880		

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F 880	Continued From page 101 resident and expected staff to use soap and water. The DON also stated he thought the ice packs were an isolated incident and was informed the ice packs were located in two different kitchenettes and requested a policy on ice pack storage, however was not received. Review of the Benedictine Health System Policy titled Enhanced Barrier Precautions revised 3/28/24 indicated the following: Purpose: Enhanced Barrier Precautions (EBP) is a strategy in nursing homes to decrease transmission of CDC-targeted and other epidemiologically important multidrug-resistant organisms (MDROs). EBP will be used for residents actively infected or colonized with CDC-targeted and other epidemiologically important MDROs. Additionally, residents at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing will be required to use EBP. Policy: It is the policy of the community to protect residents and associates from the transmission of infectious diseases through use of appropriate precautions during resident care. Procedure: Enhanced Barrier Precautions (EBP) expands the use of Personal Protective Equipment	F 880		

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F 880	Continued From page 102 (PPE) beyond situations in which exposure to blood and body fluids is anticipated. It also refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The policy further stated: When to use: Enhanced Barrier Precautions: All residents with any of the following: · Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply · Infection with an additional epidemiologically important MDRO when Contact Precautions do not otherwise apply · Chronic wounds (e.g. pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers), regardless of MDRO colonization status · Indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes tracheostomy/ventilator), regardless of MDRO colonization status. PPE used for the following situations: During high-contact resident care activities: · Dressing · Bathing/showering · Transferring · Providing hygiene · Changing linens · Changing briefs or assisting with toileting · Indwelling medical device care or use: central line, urinary catheter, feeding tube tracheostomy/ventilator	F 880		

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F 880	Continued From page 103 · Chronic wound care: any skin opening requiring a dressing (excludes shorter lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage) Required PPE included: Gloves and gown prior to the high contact care activity (Change PPE before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray) A policy, Hand Hygiene, dated 9/2023, indicated infection prevention begins with basic hand hygiene. Hand hygiene means cleaning hands using either handwashing (washing hands with soap and water), or antiseptic hand rub (alcohol-based hand sanitizer, including foam or gel). Times to perform hand hygiene are, but not limited to when arriving for work, before and after direct resident contact, before and after assisting a resident with personal cares, before and after handling peripheral vascular catheters and other invasive devices, upon an dafter coming in contact with a resident's intact skin, such as when taking vitals or after assisting with lifting, before and after assisting a resident with toileting wash hands with soap and water, after handling soiled or used linens, dressing, bedpans, catheters and urinals, after removing gloves or aprons. Further, the technique for washing hands with soap and water indicated to wet hands with water, holding hands downward in the sink, apply the soap, rub hands together vigorously for 20 seconds, covering all surfaces of hands, including palms, backs, fingers, between fingers, and under nails.	F 880		

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	245310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 13, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Health Center Innsbruck, 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	K 000		

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

Electronically Signed | 09/03/2024

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 IS NOT REQUIRED. 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. Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at three different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1991 an addition was constructed to the north and was determined to be of Type II(222) construction. In 2005 the Transitional Care Unit (TCU) was	K 000		

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	245310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	**1101 BLACK OAK DRIVE** **NEW BRIGHTON, MN 55112**

(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 000	Continued From page 2 added to the north that was determined to be of Type V(111) construction. The facility has a capacity of 105 beds and had a census of 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space	K 222		9/30/24

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K 222	Continued From page 3 is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. This deficient finding could have a widespread impact on the residents within the	K 222	The maintenance team of the community has been working to address the ease of opening this door. The hinges have been moved and the door is swinging more freely than on the day of observation. However, the door still scrapes the concrete. Empire	

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K 222	Continued From page 4 facility. Findings include: On 08/13/2024, between 12:30 PM and 3:00 PM, it was revealed by observation the emergency exit door of compartment #4 would not open without force and would not close and latch on its own. An interview with Director of Environmental Services verified this deficient finding at the time of discovery	K 222	door and glass has been contacted on 9/3/2024 to obtain a quote for an entire new door to address this concern. The community will follow through to order a new door as the concrete outside of this door has shifted and is the source of this concern. The timeframe for fabrication of a new door is unknown at this time but will be corrected.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1 through 19.3.1.6). This deficient finding could have a widespread impact on the residents within the facility. Findings Include:	K 311	The ceiling tiles of the community were reinstalled on 8/21/2024. Communication with Larson Building, the general contractors of the remodel were educated on the expectation of ceiling tiles being in place per fire code at the “owner, architect, and contractor” meeting that is held on Tuesdays each week. Visual rounds and inspections are conducted M-F while	9/11/24

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K 311	Continued From page 5 On 08/13/2024, between 12:30 PM and 3:00 PM, observations and staff interview revealed that several ceiling tiles had been removed in the corridor for construction observations. This condition would delay the activation of the fire alarm and sprinkler system in the event of an emergency. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 311	construction is ongoing. A documented audit will be conducted weekly and results will be reported to QAPI to ensure deficient practice is corrected. This concern is resolved.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		9/11/24

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K 324	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain commercial cooking equipment per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Wet Chemical Extinguishing Systems, section 4.3.1.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 08/13/2024 between 12:30 and 3:00 PM, it was revealed by observation that the discharge nozzles in the kitchen hood extinguishing system did not line up with the kitchen cooking equipment it was designed to cover. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 324	The stove was moved on 8/24/2024 to ensure it aligned with the discharge nozzles of the kitchen hood. The Dietary Director was made aware of the fire code and will complete visual inspections to ensure equipment stays in place. A documented audit will be conducted weekly and results will be reported to QAPI to ensure deficient practice is corrected.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		9/4/24

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K 918	Continued From page 7 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. This deficient findings could have a widespread impact on the residents within the facility.	K 918	Pioneer critical power was contacted and the 4 hour load test was completed on 8/23/2024 with no issues detected. Pioneer critical power is our contracted vendor for generator performance and has been made aware of expectations to complete all testing timely to avoid fire code concerns.	

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K 918	Continued From page 8 Findings include: On 08/13/2024, between 12:00 PM and 3:00 PM, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 918		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/13/2024, between 12:00 PM and 3:00 PM,	K 926	The community contacted Northwest Respiratory our contractor for oxygen delivery on 8/21/2024 to discuss fire code and findings. Northwest Respiratory was able to supply community with neoprene gloves, an apron, and face shield. Which are now available in the oxygen fill room. The community will provide education as a part of our plan of correction. A documented audit to ensure PPE is available and worn will be conducted	9/30/24

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K 926	Continued From page 9 it was revealed by observations that none of the oxygen filling rooms, had the necessary PPE for staff protection. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 926	weekly and results will be reported to QAPI to ensure deficient practice is corrected. This will be corrected by 9/30/2024.	