STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155355	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Bend Nursing and Rehabilitation	4600 W Washington Ave South Bend, IN 46619

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44111 Based on observation, interview and record review, the facility failed to ensure a resident's surgeon was notified of a surgical wound change in condition and was notified of the need for treatment orders for 1 out 3 residents reviewed for skin condition. (Resident 42) Finding includes: During an observation and interview, on 12/3/2024 at 9:41 A.M., Resident 42 indiated she was supposed to have gotten her dressing changed daily, but it had not been done for the past two days. She indicated she had requested the evening shift staff to complete it, but no one had came to change the dressing. The dressing on her left above the knee amputation site was dated 11/30/2024. The dressing was loose and a large amount of reddish-brown thick drainage was noted when the resident pulled back the edge of the dressing, the center of the wound had an opened area and the tissue around the wound and incision was red. A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. Resident 42 had been admitted to the facility, on 10/30/2024, following a hospitaliaztion for a left above the knee amputation revision and treatment of a wound infection. An Admission skin assessment of her surgical wound, dated 10/30/2024, indicated the surgical incision was 22 centimeters (cm) in length by 2.5 cm in width. The wound edges were well approximated with 26 sutures visible. There was no documentation of any redness or drainage. A current Care Plan, initiated on 10/30/2024 related to the surgical wound, indicated to notify the MD of any worsening, changes in wound or signs of infection (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Admission phyisican's orders, dated 10/30/2024 included an order for a wound vac at 125 mm/hg continuous suction was to be applied to the left stump wound. The wound was to be cleansed and packed with black foam, covered with a drape and changed three times a week, on Mondays, Wednesdays and Fridays. A Nursing Progress Note, dated 11/1/2024 at 12:52 P.M., indicated an order was received to discontinue the wound vac to the surgical site. A new physician's order was received on 11/1/2024 to cleanse the left stump with wound wash and cover the wound with an ABD dressing, daily. On 11/4/2024 a physician's order was received to discontinue the wound treatment. On 11/6/2024, a new treatment order was received to apply iodine 2% to the left stump and cover the wound with an ABD dressing daily. A Physician's Order, dated 11/7/2024 changed the treatment to the following: apply an island dressing to the left stump daily A Wound Assessment Report, dated 11/20/2024, indicated the surgical wound measured 0.10 centimeters (cm) in length, 22.00 in width, the wound center had 100% epithelial (a type of healed skin) tissue, there was no exudate (drainage) and the treatment was to [NAME] the dressing daily and apply a bordered gauze dressing. A SBAR (Situational Background Assessment Report) form, dated 11/26/2024 at 2:55 P.M., indicated there was a wound infection and worsened incision site and the physician had been notified. A Wound Assessment Report, dated 11/27/2024, indicated the surgical wound measured 2.00 cm length, 16. 00 cm width, L, 0.00 cm depth, severity full thickness (the wound extended through the full thickness of the top layer of skin), had a moderate amount of purulent (thick, cloudy pus) exudate. The treatment order was changed, on 11/27/2024 to the following:- cleanse the surgical site with wound wash, use skin prep around the peri wound and apply xeroform to the wound bed, cover with an ABD and kerlix daily. During an interview on 12/3/2024 at 10:15 A.M., LPN 2 indicated that Resident 42's wound had dehisced (split open) and had shown signs and symptoms of an infection the previous week and she had notified the surgeon. She indicated she had filled out a Situation Background Assessment Recommendation (SBAR) form and the facility's wound team had looked at the wound. She was not aware if the surgeon had called back and she had not followed up to ensure the surgeon had received the notification and/or had given any treatment recommendations. During a phone interview on 12/5/2024 at 12:25 P.M., LPN 2 indicated that she had not called the surgeon's office to report the signs and symptoms of a wound infection for Resident 42 before 11/26/2024. She did not recall to whom she had spoke with at the surgeon's office. She indicated the facility's wound team had seen Resident 42 on 11/27/2024 and she thought they had taken care of getting ahold of the surgeon for any new orders that were decided. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 12/5/2024 at 1:37 P.M., the unlicenced office staff from the surgeon's office indicated they had not received a call from the nursing facility regarding a change in condition of Resident 42's wound on 11/26/2024 or 11/27/2024. She indicated every time anyone calls it was documented in their chart. She indicated they had received a call from the DON on 11/8/2024 and the following orders were: given- do not remove the sutures, okay to discontinue incisional wound vac, daily dry dressing change. During an interview on 12/5/2024 at 2:33 P.M., the ADON indiated wound rounds were completed every Wednesday, and the team was made up of the DON, ADON, clinical educatior the Nurse Practitioner (N.P.). The N.P. had assessed the wound and made recommendations. Since Resident 42 had a surgeon, he would have been notified of the N.P,'s recommendations via a fax. She indicated she did not know who had faxed the surgeon or told her an order had been received back from the surgeon. The ADON had transcribed the order but did not see the fax. She indicated they do not keep the faxed copies of orders to scan into the electronic medical record. She could not confirm the surgeon had given the treatment order received on 11/27/2024. During an interview on 12/5/2024 at 3:50 P.M., with the Clinical Certified Medical Assistant (CCMA) from the surgeon's office, she indicated she had not received a call from the facility about a change in condition on 11/26/2024 or a fax about a recommendation for a different treatment for Resident 42's wound, on 11/27/2024. She indicated the only communication documented in Resident 42's office chart was received was on 11/8/2024 from the DON indicating the facility had removed the wound vac and needed an order to discontinue the wound vac. The surgeon had then wrote an order, on 11/8/2024, indicating the following: do not remove sutures, okay to discontinue incisional wound vac, daily dry dressing changes. She indicated all calls and faxes were documented in the patient's charts when they were received. During a phone interview, dated 12/6/2024 at 9:06 A.M., RN 3 indicated when Resident 42 had been due for a dressing change with the wound vac, she had asked the DON for assistance. The DON had recommended calling the doctor to see if she could get the wound vac treatment discontinued. RN 3 indicated she had called the facility's doctor and he had given the order to discontinue the wound vac. She did not think to call Resident 42's surgeon. During a phone interview, dated 12/9/2024 at 11:22 A.M., the Manager of the surgeons office indicated she had reviewed all of Resident 42's chart and confirmed the surgeon had not been notified of the change in condition of the wound or made any new treatment orders, except on 11/8/2024, nor had he discontinued any subsequent orders or made any of the treatment changes: Although there were treatment changes provided but by the facility's Nurse Practioner and/or the facility's physician, the surgeon was not notified of the change in condition of the surgical wound and need to alter treatment. On 12/5/2024 at 8:53 A.M., the DON indicated that the facility did not have a policy regarding following physician orders as it was just the standard of practice. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 12/9/2024 at 10:00 A.M., the Administrator provided a policy titled, Resident Change of Condition Policy, revised on 2018, and indicated the policy was the one used currently by the facility. The policy indicated .It is the policy of this facility that all changes in residents condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention take place. a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly. Non-urgent changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening. b. The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant changed in the resident's condition is noted. c. If unable to reach the physician or physician or family/responsible party, all calls to physicians or exchanges and family/responsible party requesting callbacks will be documented in the medical record. d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow up. e. If unable to contact attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition. f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response. g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized . 3.1-5(a)(3)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47419 Based on interview and record review, the facility failed to provide a copy of the Notice of Transfer/Discharge form when residents were transferred and admitted to an acute care facility for 2 of 2 residents reviewed for hospitalization . (Residents 4 and 16) Findings include: 1. A record review was completed on 10/3/2024 at 2:10 P.M. for Resident 4. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, respiratory failure and heart failure. A Significant Change Minimum Data Set (MDS) assessment, dated 10/23/2024, indicated Resident 4's cognition was intact. On 10/5/2024 at 6:15 P.M., Nursing Progress notes indicated Resident 4 was found unresponsive. After an assessment and notification to the physician, Resident 4 was sent to the emergency room . Her husband was notified by phone of the transfer but the record lacked documentation that the Notification of Transfer/Discharge form was provided to the resident or her husband. During an interview on 12/05/24 at 2:16 P.M., the ED indicated there was no documentation of the transfer paperwork, including the Transfer/Discharge form for Resident 4. 48145 2. During an interview on 11/3/2024 at 10:31 A.M., Resident 16 indicated she had been to the hospital in the last four months. A Nursing Progress note, dated 9/19/2024 at 6:30 P.M., indicated Resident 16 was sent to the Emergency Department (ER) due to lower back pain and vomiting. A Nursing Progress note, dated 9/19/2024 at 7:49 P.M., indicated the Director of Nursing, Resident 16's family and the Primary Care Physician had been notified of the resident's transfer to the ER. A Nursing Progress note, dated 9/20/2024 at 6:25 A.M., indicated Resident 16 was admitted to the hospital. A Nursing Progress note, dated 10/4/2024 at 7:48 P.M., indicated Resident 16's family was concerned about the resident's health and requested the resident be sent to the hospital for evaluation. A Nursing Progress note, dated 10/4/2024 at 8:00 P.M., indicated after assessing the resident, the nurse called Emergency Services and the resident had been transported to the hospital. The record lacked the documentation that a transfer/discharge assessment and forms had been completed in conjunction with Resident 16's transfer to the hospital on 9/20/2024 and 10/4/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 12/5/2024 at 2:16 P.M., the Administrator (ED) indicated the record lacked copies of transfer paperwork, which included the notice of transfer and bed hold policy paperwork. On 12/5/2024 a policy was requested regarding documentation of a transfer/discharge assessment and one was not provided prior to the survey exit. 3.1-12(a)(6)(A)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 47419 Based on interview and record review, the facility failed to provide a copy of the Bed Hold Policy to residents when admitted to the hospital for 2 of 2 residents reviewed for hospitalization . (Residents 4 and 16) Findings include: 1. A record review was completed on 10/3/2024 at 2:10 P.M. for Resident 4. Diagnoses included, but were not limited to chronic obstructive pulmonary disease, respiratory failure and heart failure. A Significant Change Minimum Data Set (MDS) assessment, dated 10/23/2024, indicated Resident 4's cognition was intact. On 10/5/2024 at 6:15 P.M., Nursing Progress Notes indicated Resident 4 was found unresponsive. After an assessment and notification to the physician, Resident 4 was sent to the emergency room . Her husband was notified by phone of the transfer but the record lacked documentation that the Bed Hold Policy was provided to the resident or her husband. During an interview on 12/05/24 at 2:16 P.M., the ED indicated there was no documentation of the transfer paperwork, including the Transfer/Discharge form for Resident 4. 48145 2. During an interview on 11/3/2024 at 10:31 A.M., Resident 16 indicated she had been to the hospital in the last four months and did not recall receiving a bed hold policy. A Nursing Progress note, dated 9/19/2024 at 6:30 P.M., indicated Resident 16 was sent to the Emergency Department (ER) due to lower back pain and vomiting. A Nursing Progress note, dated 9/19/2024 at 7:49 P.M., indicated the Director of Nursing, Resident 16's family and Primary Care Physician were notified the resident was being transferred to the ER. A Nursing Progress note, dated 9/20/2024 at 6:25 A.M., indicated Resident 16 was admitted to the hospital. A Nursing Progress note, dated 10/4/2024 at 7:48 P.M., indicated Resident 16's family was concerned about the resident's health and requested the resident be sent to the hospital for evaluation. A Nursing Progress note, dated 10/4/2024 at 8:00 P.M., indicated after assessing the resident, the nurse called Emergency Services and the resident was transported to the hospital. The record lacked the documentation that a bed hold policy was provided to the resident in conjunction with Resident 16's transfer to the hospital on 9/20/2024 and 10/4/2024. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 12/5/2024 at 2:16 P.M., the Administrator (ED) indicated the record lacked copies of transfer paperwork, which included the notice of transfer and bed hold policy paperwork. On 12/5/2024 at 2:30 P.M., the ED provided the policy titled, Bed Hold Policy, dated 11/2017 and indicated it was the policy currently being used by the facility. The policy indicated Purpose of Policy: Provide guidance to facility staff for holding a bed for a resident transfer. 2. The residents will be provided the bed hold policy at the time of the hospital transfer or therapeutic leave. 4. The facility staff will document the notification to the resident and resident representative of the bed hold policy on the Emergency Resident Transfer Form 3.1-12(25)(A)(B)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48145 Based on interview and record review, the facility failed to have Care Plan meetings with residents and/or their representatives timely for 2 of 3 residents whose Care Plan meetings were reviewed. (Residents 47 & 38) Findings include: 1. During an interview on 12/03/2024 at 2:13 P.M., Resident 47 indicated he had not been to a Care Plan meeting with the staff. Resident 47's record review was completed on 12/4/2024 at 1:23 P.M. Resident 46 had a Minimum Data Set (MDS) assessment completed on the following dates: -11/19/2024 Quarterly MDS assessment -8/21/2024 Significant Change MDS assessment -5/31/2024 Quarterly MDS assessment -5/14/2024 Quarterly MDS assessment -3/19/2024 Annual MDS assessment -1/2/2024 Quarterly MDS assessment There was no documentation a Care Plan meeting with Resident 47 had been conducted following any of the MDS assessments, except after the 2/18/2024 Annual MDS assessment. During an interview on 12/5/2024 at 2:34 P.M., the Social Services Director indicated she had met with Resident 47 regularly, but had not had a Care Plan meeting with him following his MDS assessments. During an interview on 12/6/2024 at 8:45 A.M., the Executive Director indicated Resident 47 had not received Care Plan meetings regularly after his MDS assessments. 47419 2. During an interview on 12/4/2024 at 10:45 A.M., Resident 38 indicated she had not met with staff about her care plan in a long time. A record review was completed on 10/5/2024 at 2:30 P.M. for Resident 38. Diagnoses included, but were not limited to, hypertension, general anxiety disorder and depression. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Annual Minimum Data Set (MDS) assessment, dated 11/6/2024, indicated Resident 38's cognition was intact. Resident 38's record lacked the documentation a Care Plan meeting had been conducted on a quarterly basis with Resident 38 and/or her representative from 6/6/2024 through 12/5/2024. During an interview on 12/05/24 at 2:45 P.M., the Social Service Director (SSD) indicated that she had not held any formal care plan meetings with Resident 38 and should have had them after quarterly assessments were completed on 8/14/2024 and on 11/6/2024. On 12/5/2024 at 3:00 P.M. a current policy, dated 8/2023, and titled, IDT Comprehensive Care Plan Policy was provided by the SSD. The policy indicated, .During the meeting all IDT members promptly meet with resident and/or representative at the bedside, or resident's desired location, at the time mutually agreed upon by SS, IDT, resident and/or representative 3.1-(d)(2)(B)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44111 Based on observation, interview and record review, the facility failed to 1 of 1 staff (LPN 2) met professional standards regarding signing off dressing changes for 1 of 3 residents reviewed for wounds. (Resident 42) Finding includes: During an observation and interview on 12/3/2024 at 9:41 A.M., Resident 42 indicated that she was supposed to get her dressing changed daily, and it had not been completed for two days. She had asked the evening shift to do it, but no one had completed her dressing change. The dressing covering the resident's left above the knee amputation revision wound was dated 11/30/2024. When Resident 42 pulled back the dressing, there was a large amount of reddish- brown thick drainage, an opening in the center of wound and erythema around the whole surgical site. During an observation and interview on 12/3/2024 at 10:12 A.M., LPN 2 indicated the dressing to the left leg was ordered to be changed daily, but the current dressing was dated 11/30, 4 days prior. LPN 2 indicated Resident 42 had went out of the building with a friend on 12/1/2024 and 12/2/2024 and had requested the dressing change to be completed later in the day, when she returned from her outings. A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. A Physician Order, dated 11/27/2024 indicated the following: - left surgical above the knee wound to cleanse with wound wash, dry, apply skin prep then xeroform to wound bed and cover with an abdominal dressing and wrap with kerlix dressing. A Current Care Plan, dated 10/30/2024, indicated impaired skin integrity related to a surgical wound, with the following intervention of treatment as ordered. A Treatment Administration Record, for December, dated 12/1/2024 - 12/4/2024, indicated the dressing was documented as changed on 12/1/2024 and 12/2/2024. During an interview on 12/4/2024 at 3:18 P.M., LPN 2 indicated she had not changed Resident 42's dressing and the dressing changes should not have been signed off as completed on the TAR for 12/1/2024 and 12/2/2024. On 12/4/2024 at 3:40 P.M., a policy was requested but one was not provided. 3.1-50(a)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44111 Based on observation, interview, and record review, facility failed to ensure a resident received a treatment per the physician order for 1 of 3 resident's reviewed for skin condition. (Resident 42) Finding includes: During an observation and interview, on 12/3/2024 at 9:41 A.M., Resident 42 indiated she was supposed to have gotten her dressing changed daily, but it had not been done for the past two days. She indicated she had requested the evening shift staff to complete it, but no one had came to change the dressing. The dressing on her left above the knee amputation site was dated 11/30/2024. The dressing was loose and a large amount of reddish-brown thick drainage was noted when the resident pulled back the edge of the dressing, the center of the wound had an opened area and the tissue around the wound and incision was red. A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. A Current Care Plan, dated 10/30/2024, indicated impaired skin integrity related to a surgical wound, with the following intervention of treatment as ordered. A Physician Order, dated 11/27/2024 indicated the following: -left surgical above the knee wound to cleanse with wound wash, dry, apply skin prep then xeroform to wound bed and cover with an abdominal dressing and wrap with kerlix dressing. During an observation and interview on 12/3/2024 at 10:12 A.M., LPN 2 indicated the dressing to the left leg was ordered daily but the current dressing was dated 11/30., four day prior LPN 2 indiated Resident 42 went out with a friend during the day, on 12/1/2024 and 12/2/2024, and requested the dressing changes be completed when she had returned from her outings. During an interview on 12/4/2024 at 3:18 P.M., LPN 2 indicated she had not passed on in report to the evening shift that Resident 42 needed her dressing change completed when she returned from her leave of absence on 12/1/2024 and 12/2/2024. The dressing was not changed, even though the TAR (Treatment Record) had been inaccurately signed as completed on 12/1/2024 and 12/2/2024. A Nursing Progress note, dated 12/1/2024 at 1:15 P.M., indicated Resident 42 had requested her dressing to remain in place as she was going out of the building with a friend On 12/5/2024 at 8:53 A.M., the DON indicated that they did not have a policy on following physician orders was just the standard of practice. 3.1-37(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 47419 Based on interview and record review, the facility failed to ensure residents were free from antibiotic medication used for an excessive duration for 1 of 6 residents reviewed for unnecessary medications. (Resident 41) Finding includes: A record review was completed on 12/5/2024 at 10:00 A.M. for Resident 41. Diagnoses included but were not limited to: acute osteomyelitis of left ankle and foot and stage 2 pressure ulcer on left heel. An Admission Minimum Data Set (MDS) assessment, dated 10/7/2024, indicated Resident 41's cognition was intact and he received antibiotic medication. Current Physician Orders included, but were not limited to, cephalexin (an antibiotic) ordered on 11/28/2024, 500 milligrams by mouth every 8 hours for a urinary tract infection. The antibotic was to have been completed and discontinued on 12/4/2024. A lab report, dated 11/30/2024, indicated a urine specimen showed no bacterial growth as the final result. The facility did not notify the Nurse Practioner, on 11/30/2024 of the need to discontinue the antibiotic treatment. An Event note, dated 12/5/2024, indicated the antibiotic was discontinued by the Nurse Practitioner due to no growth in the resident's urine, 5 days after the lab result was received. During an interview on 12/6/2024 at 1:14 P.M., the Infection Preventionist indicated it was normal to stop antibiotics due to the lab results from 11/30/2024. On 12/3/2024 at 1:00 P.M. a current policy, dated January 2023 and titled, Antibiotic Stewardship Program was provided by the Executive Director. The policy indicated, .The facility shall establish key elements for antibiotic prescribing and a system to monitor and manage antibiotic use 3.1-48(a)(2)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 44111 Based on observation, interview and record review, the facility failed to ensure a resident received fresh ice water per his preference for 1 of 3 residents reviewed for hydration. (Resident 21) Finding includes: During an observation and interview, on 12/4/2024 at 12:05 P.M., Resident 21 indicated he had did not have fresh ice water delivered daily to his room. He indicated he desired to have fresh ice water in his room. He indicated the last date he had water delivered was on 11/13 and 11/29. During an observation and interview, on 12/4/2025 at 1:16 P.M., Resident 21 indicated staff did not pass water and he had to go to the nurse's station and to ask for it in order to have a drink of water. During an observation on 12/5/2025 at 9:42 A.M., there was no cup of water in Resident 21's room. A record review was completed on 12/4/2024 at 2:11 P.M., for Resident 21. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following nontraumatic intracerebral hemmorrhage affecting left dominant side, type 2 diabetes mellitus with hyperglycemia, hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right non-dominant side and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 9/26/2024, indicated resident required set up assistance for eating and had upper and lower body range of motion impairment to one side of his body. A Quarterly Hydration Review assessment, dated 11/11/2024, indicated Resident 21 required assistance with food and fluids. A current Care Plan, dated 6/26/2024, indicated Resident 21 required assistance or monitoring of nutrition, hydration and elimination. The plan did not address the resident's desire to have fresh ice water in his room. During an interview on 12/5/2024 at 9:43 A.M., CNA 11 indicated she only provided water to residents' that wanted it and she did not just leave water in resident's rooms for them. She indicated that Resident 21 could do things for himself. On 12/9/2024 at 10:00 A.M., the Administrator provided a policy titled, Hydration Management, revised on 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of American Senior Communities to ensure that each resident is offered sufficient fluid intake to maintain proper hydration. 4. Hydration plans will be reviewed at a minimum of quarterly to determine if plan is still needed or requires revision. 9. Fresh water or other preferred beverages will be passed to all residents, unless medically contraindicated, on each shift . (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-46(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48145 Based on observation, interview and record review, the facility failed to store and serve food in a sanitary manner in the pantries, dining rooms, kitchen and kitchenettes. This had the potential to affect 57 of 57 residents who consumed food from the kitchen, pantries, dining rooms and kitchenettes. Findings include: 1. During the initial kitchen tour with the Culinary and Nutrition Manager (CNM) on [DATE] at 9:45 A.M., [DATE] at 8:30 A.M., [DATE] at 11:20 A.M. and [DATE] at 8:40 A.M. the following was observed: - the 6 burner gas range had a thick buildup of a black substance on all burner grates and below the grates. -there was a build up of grease on the stainless backsplash surrounding the gas range. -there was a build up of grease on the wall next to the gas burners. -A ceiling vent had a black substance that looked like mold above the stainless steel prep table behind the ovens. -The handwashing sink was dirty with a red colored dried substance on the wall by the soap dispenser. -Two ovens had a build up of a black substance on the inside, and both ovens had a buildup of grease and food debris on the outside. -The floor was dirty in the cooking area, dishwashing room and the dry storage room. During an interview on [DATE] at 8:45 A.M., the CDM indicated the cooking equipment, walls, floors, and ceiling vents were dirty and needed to be cleaned. He indicated the staff utilized a check list to clean the kitchen. 2. During an observation of meal service in the 2nd Floor Dining Room on [DATE] at 11:58 A.M., the following was observed: - The black four burner range had food debris on all four burners. - The inside of the oven had a build up of grease and food debris. During an interview on [DATE] at 12:00 P.M., Qualified Medication Aide 10 indicated the top of the range and inside of the oven were dirty and should be cleaned. She indicated it was the kitchen's job to clean the range and oven. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Housekeeping Supervisor (HS) on [DATE] at 9:44 A.M.,she indicated it was the kitchen's responsibility to clean out the oven in the 2nd floor Dinning Room. 3. During an observation of meal service in the Main Dining Room on [DATE] at 12:10 P.M., the following was observed: -A Puddle of water was under the ice machine. -The ice machine had a buildup of lime on the inside. -The wall behind the ice machine was dirty and had a brown substance splattered down the wall. -4 out of 14 chairs had a buildup food debris on the arms of the chairs. During an interview on [DATE] at 8:45 A.M., the CDM indicated the ice machine needed to be delimed and it was the kitchen's responsibility to delime the inside of the ice machine. During an interview with the Housekeeping Supervisor (HS) on [DATE] at 9:44 A.M., the HS indicated it was Housekeeping's responsibility to clean the dining room table, chairs and floors. During an interview with the Maintenance Director (MD) on [DATE] at 9:05 A.M., the MD indicated the ice machine had been leaking. 4. During an observation of the Cottage's kitchenette on [DATE] at 1:44 P.M., the following was observed: -A Clear container with 24 packs of single serve hot chocolate with no expiration dates. -A Clear container with packaged condiments that had no use by date. The container had 14 packets of tartar sauce, 12 packets of mild hot sauce, 2 packets of syrup and 2 packets of barbeque sauce. One packet of mild hot sauce was leaking an orange substance onto the other single serve condiment packages. During an interview on [DATE] at 1:45 P.M., LPN 6 indicated he was not able to identify when the hot chocolate or individual packets of condiments should be discarded. He indicated one of the hot sauce packets was leaking and all the packets should be thrown away. LPN 6 indicated it was the nursing staff's responsibility to throw away undated or expired food in the unit pantries and kitchenettes. 5. During an observation of the 100 Hall Unit Pantry on [DATE] at 10:50 A.M., the following was observed: -A cake, dated [DATE], with no resident identifying information. -A package of sliced turkey with no opened on or use by date. -5 single serve yogurt containers with an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two Zip Lock bags containing M & M candies with no resident identifying information and no opened on or use by date. -A half a stick of butter with no resident identifying information and no opened on or use by date. -There wasa large amount of a black substance that looked like mold on the bottom of the refrigerator. During an interview on [DATE] at 10:53 A.M., LPN 7 indicated the cake and yogurt were expired and should be thrown away. She indicated the sliced turkey, M & M candies and the half a stick of butter should have contained resident identifying information, the date the food was opened and the date the food should be discarded. She indicated the mold on the bottom of the refrigerator should not be there and the mold should be cleaned. She believed the nursing staff was responsible for cleaning out the pantry refrigerators. 6. During an observation of the kitchenette in the Activities Room on [DATE] at 1:45 P.M., the following was observed: -A one Gallon Ziploc bag of pizza sauce, dated [DATE]. -A one Gallon Ziploc bag of pizza sauce, dated [DATE]. -A Large block of butter with no opened on or use by dates. -A large Ziploc bag of shredded cheese, dated [DATE]. -The electric range had 4 burners and all 4 burners and their pans below the burners were dirty. -Inside of the oven had burnt on food debris. During an interview on [DATE] at 1:48 P.M., Activates Assistant (AA) 8 indicated the left overs should be thrown away 7 days after opening, but if there was no opened on date, the food should be thrown away immediately. AA 8 indicated it was Housekeeping's responsibility to clean the range, oven and refrigerator. During an interview on [DATE] at 10:00 A.M., the CDM indicated it was the kitchen's responsibility to clean all of the ranges, ovens and refrigerators in the building, including on the units and in the kitchenettes. On [DATE] at 9:22 A.M., the Executive Director indicated the facility did not have a policy for maintaining the kitchen and the kitchen equipment, but the facility followed the Food and Drug Administration's (FDA) Food Code as a guide. During an interview on [DATE] at 10:30 A.M., the Corporate Nurse indicated the facility used the FDA Code as a guide for maintaining the kitchen, dining rooms, unit pantries and kitchenettes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:15 A.M., the [NAME] President of Operations supplied a cleaning schedule for the kitchen and identified the cleaning schedule as the one currently used by the facility. The cleaning schedule indicated, .Ranges cleaned daily, Ovens cleaned on Saturday, ceiling vents cleaned monthly, sweep and mop floors daily . 3XXX,d+[DATE](3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44111 Based on observation, interview, and record review, the facility failed to ensure acceptable infection control standards were maintained during a surgical dressing change for 1 of 1 resident observed for a dressing change. (Resident 42) Finding includes: During an observation of a dressing change, on 12/3/2024 at 10:12 A.M., LPN 2 removed the soiled dressing from Resident 42's wound. LPN 2 then removed her gloves, pulled another pair of gloves out of her uniform pocket, donned them and proceeded to clean the resident's wound. Prior to starting the dressing change, LPN 2 had laid the supplies for the dressing change on the residents bed without placing a barrier between the resident's bed and the clean dressing supplies. A record review was completed for Resident 42 on 12/4/2024 at 2:00 P.M. Diagnoses included, but were not limited to: chronic hematogenous osteomyelitis, left femur-distal, infection following a procedure, chronic obstructive pulmonary disease, chronic diastolic heart failure, acquired absence of left leg above the knee and acquired absence of right leg above the knee, peripheral vascular disease, and atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs. During an interview on 12/3/2024 at 10:28 A.M., LPN 2 indicated she should have washed her hands after she had removed the soiled dressing and she should have cleaned off the bedside table and placed a barrier down for the dressing supplies. On 12/3/2024 at 2:48 P.M., the DON provided a policy titled, Dressing Change Clean Technique (Incision or Wound), revised 10/2024, and indicated the policy was the one currently used by the facility. The policy indicated .8. Set up clean field with dressing change supplies and other necessary equipment. 10. Removed old dressing from the resident and put directly in trash receptacle. 11. Remove gloves and discard. 12. Perform hand hygiene . 3.1-18(a)