Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove New Berlin	13755 W Fieldpointe Dr New Berlin, WI 53151

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on observation, interview and record review, the facility did not ensure 1 (R1) of 2 Residents reviewed received reasonable accommodation of needs, potentially affecting 24 of 87 residents. * Slings were not available to transfer R1 out of bed via a Hoyer mechanical lift. Residents using the same size sling that required [NAME] mechanial life transfers were also affected by slings not being availabe. Findings include: The Facility Policy and Procedure, with Subject Safe Individual Handling Program last reviewed 6/13/2023 documents (in part): Procedure: D. Maintenance 1. Mechanical lifts, slings, gait belts, and slide sheets are to be routinely inspected, used and maintained according to manufacturer's guidelines. 2. Any soft goods (slings, gait belts, and slide sheets) that have identified tears or frays will be pulled from service and replaced with new . The Arjo Huntleigh Maxi Move user manual with date of December 2011 documents (in part): Product Description/Functions Slings . Standard Range: Yellow - Medium - M Green - Large - L Purple - Large Large - LL (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Blue - Extra Large - XL Terracotta - Extra Extra Large - XXL Always refer to the label on the sling being used to make sure of its actual safe working load (SWL) . Sling Cleaning and Care The slings should be checked before and after each patient use and if necessary, washed in strict accordance to the instructions on the sling. This is especially important when using the same equipment for another patient, as it can minimize the risk of cross-infection . 1.) R1 was admitted to the facility on [DATE] and discharged on [DATE]. R1 has diagnoses which include, in part, fractures and other multiple trauma, Alzheimer's disease, dementia and seizure disorder or epilepsy. R1's 5 day Minimum Data Set (MDS) with an assessment reference date of 11/7/24 documents that R1 had a Brief Interview for Mental Status score of 99 (unable to assess). R1 has an activated power of attorney. R1's MDS was coded that cognitive skills for daily decision making are severely impaired-never/rarely made decisions. R1's MDS documented that no behaviors were noted. R1 is dependent for toileting and all transfers. On 11/13/2024 at 9:02 am, Surveyor observed a medium sling laying on a Hoyer (resident lift machine) in the rehablitation unit and no guide to determine correct sling to use was in view by the Hoyer lift. On 11/13/2024 at 9:02 am, Surveyor interviewed Certified Nursing Assistant (CNA)- J who stated that each resident should have their own sling, but they do not. CNA-J stated that there are some slings floating around but that CNA-J has to go to different units or to laundry to find the a different size if it is not on the unit. CNA-J stated that when staff ask for more slings, they are told they are ordered and that this has been going on a long time. On 11/13/2024, at 2:01pm, Surveyor interviewed R3 who stated that staff used a machine to lift him and weigh R3 at the beginning of stay. There was no issue with finding or fitting the sling. On 11/14/2024, at 9:30am, Surveyor followed up with CNA-J about the slings and was told there has been a shortage of slings for a long time and that management put up charts with sling sizes last night. CNA-J showed Surveyor that there were no slings on the laundry cart where they should be kept and stated what good is the chart then. CNA-J stated that the ambulance staff put residents into the bed when they are admitted , then staff use a sling and the mechanical lift to get the resident's weight. Staff 'eyeball' the person and choose a sling based on that and convenience to find the right sling, as the chart on the machine just tells the color and what size that is, no weight guide to follow for a person. Per CNA-J, part of the problem is that the in house laundry is for personals which includes the slings, staff put the slings into the linens bag that goes out to a service, then the slings are not returned. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/20204, at 9:32am, Surveyor interviewed CNA-E regarding slings and was told there are not enough, as staff need to search for them. CNA-E has mentioned the problem to laundry staff. CNA-E states that the size to use is based on weight of the resident. CNA-E picks a sling based on resident comfort and experience to pick the right one. On 11/14/2024 at 9:35 am, Surveyor interviewed CNA-K regarding slings. CNA-K stated there is no problem finding slings. When asked how to tell which size to use with each resident CNA-K responded that you tell by body weight and experience. CNA-K was going to find out where the sizing chart was and get back to Surveyor. On 11/14/2024 at 9:50 am, CNA-K let Surveyor know the chart is by the linen carts in the alcoves. Surveyor asked if it was there yesterday and CNA-K responded no, I'm not going to lie to you. On 11/14/2024, at 11:32 am, Surveyor observed both linen carts in rehab unit and noted that no slings were on the carts. On 11/14/2024, at 12:00 pm, Surveyor interviewed Occupational Therapist Registered (OTR)-M and was informed that while R1 was at the facility, physical therapy wanted occupational therapy to get R1 up after their session to be ready for the upcoming physical therapy session. The CNA that was on the unit that day normally does not work it and was unable to find a sling for the Hoyer to transfer R1. OTR-M had to get to another resident so OTR-M could not stay to help transfer R1. OTR-M told the unit manager (UM)-N that we were unable to find a sling and R1 was not able to get out of bed. OTR-M stated that OTR-M was not sure what happened after that or if a sling was found and R1 was transferred. The next day the regular aide was there and found a sling to transfer R1. On 11/14/2024, at 12:35 pm, Surveyor interviewed UM-N and was told that they do not recall concerns regarding Hoyer slings not being available. Staff are able to always get a sling. On 11/14/2024 at 2:20 pm, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding slings being available in rehabilitation unit. Surveyor asked where slings are in the unit and DON-B responded that there are some on the linen carts or in resident rooms. Surveyor asked how staff determine the correct size to use and was told there is a chart that was in the utility room and that yesterday after talking to Surveyors during the end of day meeting put the chart up in the alcoves by linen carts. Surveyor asked about not having any slings on the linen carts during observations and was told no one in rehabilitation unit needs one now. Surveyor asked if there was a shortage and was told it was never brought to DON-B's attention that slings were not available. Surveyor asked if the slings go to the linen laundry service and NHA-A replied that they have not had any go and come back yet. Surveyor noted that CNA-J and R3 stated Hoyer used to weigh residents on admission, hence need them available whether or not resident will need a Hoyer lift. On 11/14/2024, at 2:20pm, during the interview with NHA-A and DON-B, Surveyor shared the concern that slings were not available per staff when needed to accommodate the need of transfers of residents. No additional information was provided as to why the facility did not ensure R1 had received reasonable accommodation of needs by having the correct sling size available for R1 to be transfered.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 (R1) of 2 residents reviewed for surgical incision wounds. * R1 was admitted with surgical incision wounds, there were no comprehensive assessments or orders in place for care of the surgical incisions and R1's skin integrity comprehensive care plan did not indicate R1 had surgical wounds. Findings include: The facility policy entitled STANDARD SKIN PROTOCOL with no initiation date documents: PROBLEM: Potential/ Alteration in skin integrity, GOAL: Breaks in skin integrity will be minimized with current plan of care. RN (registered nurse): - Complete skin assessment on admission, weekly with bath and PRN (as needed). - Pressure reducing interventions (i.e. Therapeutic mattress/cushion, heel protectors, positioning devices, repositioning, etc.). - Weekly wound measurements. 1.) R1 was admitted to the facility on [DATE] and had diagnoses that includes fracture of superior rim of left pubis, fracture of sacrum, nondisplaced transverse fracture of right acetabulum, muscle weakness, cognitive communicative deficit, Alzheimer's disease- late onset, dementia, and urinary tract infection with urinary retention. R1's baseline care plan dated 11/1/2024 indicated R1 cognition was severely impaired with a brief interview of mental status (BIMS) score of 99 and the facility assessed R1 being totally dependent on 1-2 staff for (activities of daily living (ADL's) and required 2 person assist using a Hoyer lift for transfers. R1 was admitted with a foley catheter. R1 discharged from the facility on 11/7/2024. R1's referral paperwork dated 10/31/2024 documents on 10/28/2024 R1 underwent pinning joint sacroiliac and pelvis percutaneous procedure for diagnoses of closed fracture of hip, closed displaced and transverse fracture of the right acetabulum. R1 had a total of three incisions located: - Pelvis proximal, right lateral - Right ischium. - Groin R1's after visit summary from the hospital dated 10/25/2024 - 11/1/2024 documents: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orthopedic Trauma Surgery D/C (discharge) Instructions: . Incision: - Leave dressing in place for 2 (two) weeks then remove. - Closed with Dermabond skin glue. May leave open to air, glue will fall off on its own. May cover with gauze and tape if needed. Sponge bath only. Surveyor noted that the discharge instructions do not indicate which surgical incision has the non-removable dressing and which incisions are to be left open to air. The discharge instructions and referral paperwork also do not indicate how long the incisions are or give an assessment on how the area of the 3 incisions looked or measured. On 11/1/2024 nursing staff filled out the admission screener tool for R1 admission to the facility. In the skin integrity section nursing documented the following assessment for R1: - Color: Normal - Temperature: warm, equal, moist - Turgor: normal - Integrity: (nothing marked) - Comments: Skin intact Surveyor noted that the three surgical incisions R1 was admitted with were not documented and nursing documented R1's skin was intact and does not mention a non- removable dressing. Surveyor reviewed R1's baseline care plan dated 11/1/2024 and noted the following: Section 4. Skin risk: 4a. Current skin integrity 4b. History of skin integrity issues Surveyor noted that neither 4a or 4b were marked and section 4 Skin integrity was left blank. Surveyor reviewed R1's medication/ treatment administration record (MAR/TAR) and noted the following orders for nursing staff: - Complete skin assessment on admission or readmission every shift for 3 days. If any new skin abnormalities upon skin assessment, complete skin only evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor R (right) hip- leave dressing in place for 2 weeks and then remove. Closed with dermabond/ skin glue. May cover with gauze and tape as needed every day shift for 1 day remove dressing -r hip (start date 11/11/24, D/C date- 11/7/2024 - Monitor right hip- leave dressing in place for 2 weeks and then remove. Closed with dermabond/ skin glue. May cover with gauze and tape as needed. every shift until 11/11/2024, remove dressing 11/11/2024. (start date 11/7/2024, D/C date 11/7/2024) Surveyor noted that all shifts from 11/1/2024 night shift through 11/4/2024 evening shift are initialed as completed the skin assessments. Surveyor noted that there are no progress notes or skin only evaluations that document that R1 had 3 incisions. Surveyor also noted that the two orders for monitoring of the right hip dressing was not started until 11/7/2024 when R1 discharged from the facility and does not indicate what surgical incision R1 had the dressing and what incisions were to be left open to air, as there was no documentation by nursing staff that monitoring was completed. Surveyor reviewed progress notes for R1 and noted that progress notes do not indicate if R1 had surgical incisions or a non-removable dressings. The progress notes do document R1's skin condition until 11/4/2024. On 11/4/2024, at 2:55 AM, in the progress notes nursing documents a skin only note: Skin warm and dry, skin color WNL (within normal limits), mucous membranes moist. Turgor normal, no current skin issues noted at this time. Surveyor noted that there is no documentation or assessments of R1's 3 surgical incisions in R1's skin only note dated 11/4/2024. R1's potential for impairment to skin integrity care plan was initiated on 11/4/2024 for weakness, right hip fracture, catheter, neuropathy, and incontinence. Surveyor noted the interventions documented do not indicate that R1 had 3 surgical incisions or what care is needed for the 3 surgical incisions. On 11/13/2024, at 9:09 AM, Surveyor interviewed certified nursing assistant (CNA)-J who stated when R1 was admitted to the facility CNA-J recalled R1 having some areas that were covered and could recall an area on R1's right thigh and pubis. CNA-J stated that if there were concerns with wounds during cares the CNAs would notify nursing. CNA-J recalled that R1's dressing was to stay in place but could not recall much more regarding R1's wound care or skin monitoring. On 11/13/2024, at 2:08 PM, Surveyor interviewed licensed practical nurse (LPN)-H who stated skin assessments for new admissions are documented on the new admit screener with measurements and description and should be done within 24 hours of the resident being admitted . LPN-H stated wound rounds are done every Monday with the nurse practitioner and Wound Nurse-G. LPN-H stated if the wound is surgical, the resident will be put on wound rounds if the surgical wound is open otherwise would be as needed if there is a concern. LPN-H stated that if a resident was admitted with a surgical wound and glued or with a non-removable bandage the incision would still be measured and described if the bandage was clean, dry, and intact and explain what the incision looks like if it was not covered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/2024, at 8:14 AM, Surveyor interviewed Wound Nurse-G who stated Wound Nurse-G gets notified of wounds by the Director of Nursing (DON)-B in morning meetings or staff that submit a note. Wound nurse-G did not recall getting notified of R1's surgical incisions and did not have R1 on her list to visit with the wound nurse practitioner. Wound nurse-G stated a surgical incision would be followed if it was open or if there was a concern with it. Wound-nurse-G stated that nursing should still complete a comprehensive assessment of the area on admission and with weekly skin checks and do measurements and description of area and if it was a non-removable dressing, the dressing should still be assessed weather it was clean, dry, or intact. Wound nurse-G mentioned any orders for the surgical incisions should be transferred over to the residents MAR/TAR for staff to sign off when completed and a care plan should be in place with interventions for monitoring and care for the areas. On 11/14/2024, at 12:35 AM, Surveyor interviewed unit manager (UM)-N who stated the admitting nurse should input any orders into the MAR/TAR for the resident and if there are none or something needs clarification, the nurse is to call and get the orders if applicable. UM-N stated that nursing staff should be documenting any skin concerns and if a surgical incision, the area should be measured, and comprehensive assessment completed. UM-N stated if the are is covered with an order to not remove the bandage, then the bandage should be assessed at least daily unless ordered another way. UM-N was not aware of any concern wit R1 surgical incisions and did not observe R1's incisions. UM-N stated that there should have been orders for R1's surgical incisions in place and monitoring of the areas and dressings. UM-N stated that the care plan should have indicated the surgical areas for R1 and interventions for the care and management of R1's surgical incisions. On 11/14/2024, at 2:22 PM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B that R1's surgical incisions were never assessed while at the facility from 11/1/2024 - 11/7/2024 and there were no orders put in place for staff to care for R1's surgical incisions until 11/7/2024 when R1 discharged from the facility. Surveyor also shared concern that R1's skin integrity care plan did not document R1's 3 surgical incisions and that there were no interventions implemented for the care and monitoring of the 3 incision areas. NHA-A and DON-B acknowledged that there was not indication R1's surgical incisions were ever assessed, monitored, or cared for based on findings in the medical record. No additional information was provided as to why the facility did not ensure R1 received treatment and care in accordance with professional standards of practice for R1's surgical wounds.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on interview and record review, the facility did not ensure residents received adequate supervision and assistance devices were in place to prevent accidents for 1 (R2) of 4 residents reviewed for falls. R2 fell on [DATE] at approximately 7:30 AM and a root cause analysis was not completed to implement an appropriate intervention to prevent future falls. R2 fell on [DATE] at approximately 5:30 PM sustaining lacerations to the face requiring R2 to go to the hospital to be evaluated and treated. A fall mat was not in place at the time of the fall, per R2's care plan to reduce the possibility of injury at the time of the second fall on 7/2/2024. Findings include: The facility policy and procedure titled Falls dated 6/13/2023 documents: I. Policy: Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls. II. Procedure: . 2. Procedure of Fall Event and Implementation of Intervention: a. Licensed nurse completes electronic documentation of the Fall Incident Report. b. The care plan will be updated with an identified intervention. c. Registered Nurse reviews and completes the fall assessment and interventions. d. Fall follow-up assessments completed as indicated. 3. Administrative Review: a. The Interdisciplinary Team (IDT) will review Fall Incident report and utilize root cause analysis to make further recommendations. b. Director of Nursing (or designee) and Executive Director to review and sign Fall Incident Report. 1.) R2 was admitted to the facility on [DATE] with diagnoses of encephalopathy, giant cell arteritis, diabetes, chronic kidney disease, polymyalgia rheumatica, rheumatoid arthritis, and visual loss. R2 was admitted with hospice services and was not a resident of the facility long enough to have a Minimum Data Set (MDS) assessment completed. R2 had an activated Power of Attorney (POA). R2 was discharged from the facility on 7/3/2024. R2's Activities of Daily Living (ADL) Care Plan initiated on 6/28/2024 documented that R2 needed assistance with all cares and a description of the environment due to poor vision, wore a hearing aid in the left ear, and R2 was able to assist with upper body care, upper body dressing, and bed mobility. R2 transferred with the assistance of 1-2 people depending on strength, needing more assistance at night. R2's At Risk for Falls Care Plan initiated on 6/28/2024 had the following interventions: -Anticipate and meet R2's needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Be sure R2's call light is within reach and encourage R2 to use it for assistance as needed; R2 needs prompt response to all requests for assistance. -Follow facility fall protocol. -Physical and Occupational Therapy evaluate and treat as ordered or as needed. On 6/29/2024 at 12:41 AM, in the progress notes, nursing documented R2 was up in the wheelchair at the nurse's station due to confusion, hallucinations, and frequent self-transfer attempts. R2 was alert to self only and talked nonstop from one topic to another. R2 was toileted with one assist and was incontinent of bladder before toileting. R2 was assisted to bed at 12:40 AM. R2 was legally blind so does not see where R2 is going. A soft touch call light was placed on the side of the mattress to trigger if R2 attempts to get up. Bed was in the lowest position and R2 will be checked on frequently. On 7/2/2024 at 7:15 AM, in the progress notes, Licensed Practical Nurse (LPN)-L documented R2 had an unwitnessed fall. R2 was confused per baseline and was found sitting upright on the bathroom floor. R2 was assessed for injury, and none was found. R2 had gripper socks on, and the call light was not activated at the time of the fall. R2 was assisted into the wheelchair and brought out to the nurses' station. R2's blood pressure was 201/101 and hydralazine was administered per order for elevated blood pressure. R2 was administered Ativan for agitation which was not effective. R2's POA and the hospice nurse were made aware of the fall and medication administration. The hospice nurse would be in for a visit that day. On 7/2/2024 at 8:57 AM in the progress notes, LPN-L documented LPN-L was notified by a Certified Nursing Assistant (CNA) when the CNA walked into R2's room, R2 was found sitting upright against the wall. R2 was blind and R2 stated R2 was at home washing dishes when everything fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Investigation Report dated 7/2/2024 for the fall that occurred at 7:30 AM documented the summary of the fall. (Surveyor noted the progress note for the fall was documented at 7:15 AM so the fall occurred prior to that time.) Staff entered R2's room and observed R2 sitting on the floor in the bathroom against the wall in an upright position. When R2 was questioned as to what happened, R2 stated R2 was at home washing dishes when everything fell . No visible injury was noted. R2 had gripper socks on and the call light was not on. No incontinence was noted in R2's brief prior to falling. R2 was assisted per staff to the toilet and then back to the wheelchair. R2's blood pressure of 201/101 was the only vital not within normal limits. R2 received scheduled metoprolol along with as needed hydralazine and Ativan were given. R2 was assisted to the dining room for breakfast. After breakfast, R2's blood pressure was 163/86 and R2 was placed by the nurses' station to be in staff's vision. R2 had a history of encephalopathy, diabetes, chronic kidney disease, hallucinations, visual loss, and hard of hearing. Hospice was notified and a hospice nurse was present after the fall to do a post fall assessment. R2 appeared somewhat more restless than normal and has an as needed Ativan for this. Blood sugar checked before and after eating was within normal limits. The hospice nurse ordered daily nursing visit and a thick mattress to be placed next to the bed with the bed in the lowest position. The Care Plan was updated as well as the POA. The fall investigation packet included a statement by LPN-L. Surveyor noted the statement was a copy of the progress note LPN-L had documented in R2's medical record. A statement was obtained from a CNA that was on the unit at the time of the fall that had no knowledge of the fall and a statement from CNA-I that documented when CNA-I was going to do cares on R2's roommate, CNA-I noticed when CNA-I was closing the door, the brief bin had been knocked over and saw R2 on the floor. CNA-I documented CNA-I was unaware of how the incident happened. Surveyor noted the statement by CNA-I did not state where R2 was found, when R2 last seen by CNA-I, and where R2's wheelchair was in relation to R2. Surveyor noted the fall investigation did not include any statements from staff that had worked the night shift to see if R2 had been brought to the bathroom. On 7/2/2024 on the Hospice Visit Note, the hospice nurse documented safety instructions were provided to the facility for falls: floor mats requested. The hospice nurse documented R2 had a fall on 7/2/2024 where R2 fell out of bed onto the floor and tried to crawl to the bathroom. Surveyor noted the facility had not documented R2 had fallen out of bed or crawled to the bathroom. The hospice nurse documented additional equipment was needed: a geri-chair, a scoop mattress, and floor mats. Surveyor attempted to interview the hospice nurse on 11/14/2024 at 1:52 PM and was informed the nurse no longer was employed by the hospice agency and was not able to be interviewed. R2's Actual Fall Care Plan initiated on 7/2/2024 had the following interventions: -Bed in lowest position while in it. -Continue interventions on the at-risk plan. -For no apparent acute injury, determine and address causative factors of the fall. -Mat on the floor next to the bed while in it. On 7/2/2024 at 11:16 AM in the progress notes, LPN-H documented R2 appeared more calm sitting quietly in the dining room, less restless with R2's family member and the hospice nurse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lindengrove New Berlin		STREET ADDRESS, CITY, STATE, ZIP CODE 13755 W Fieldpointe Dr New Berlin, WI 53151	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 12:16 PM in the progress notes, LPN-H documented the hospice nurse stated that hospice will be ordering a Broda chair for comfort for R2 and will have nursing visits on a daily basis until further notice. R2 had an order for as needed morphine and lorazepam which were to be given if restlessness continues. R2 was administered morphine on 7/2/2024 at 12:23 PM, 2:23 PM, and 5:15 PM. The pain ratings at those times were 0 on a scale of 10. No documentation was found documenting R2 was agitated or restless at the times morphine was administered. On 7/2/2024 at 7:38 PM in the progress notes, LPN-D documented R2 had a fall attempting to self-transfer out of bed with a recommendation to send R2 to the hospital for evaluation and treatment. At 9:36 PM in the progress notes, LPN-D documented R2 was found on the floor by a CNA. When LPN-D entered the room, R2 was lying on R2's side on the floor next to the bed. R2's face was completely covered in blood with blood coming from the nose. Vital signs were stable. R2 was not able to state if R2 was in pain; R2 was lethargic. LPN-D documented LPN-D could not determine the origin of the facial injury due to R2's face being covered in blood. R2's neurological checks were positive. Hospice was notified and ordered R2 to be sent out to the emergency room STAT (immediately). R2's POA was notified. On 7/3/2024 at 12:53 AM in the progress notes, nursing documented the nurse called the hospital to get an update on R2. The nurse was told R2 was discharged from the hospital and transferred to a hospice facility for closer observation. The nurse was told R2 did not have any fractures but did have many lacerations on the face. R2 was not a resident at the time of survey. The Fall Investigation Report dated 7/3/2024 for the fall that occurred on 7/2/2024 at 7:57 PM documented the summary of the fall. (Surveyor noted the progress note for the fall was documented at 7:38 PM so the fall occurred prior to that time.) R2 was found on the floor in R2's room next to the bed. Blood was noted to R2's face. R2 was unable to answer assessment questions and was lethargic. Vital signs were stable. The neurological check was positive. Pain of 2 via the PAINAD scale. Hospice was updated and ordered to send R2 to the ER for evaluation. R2's POA was notified. R2's diagnoses include encephalopathy, diabetes, polymyalgia, rheumatoid arthritis, hallucinations, and visual loss. The IDT discussed the fall with plan to update the care plan upon R2's return from the hospital. R2 was discharged from the hospital to another facility. The fall investigation packet included a statement from the CNA that was caring for R2 at the time of the fall. The CNA statement documented R2 was last seen by the CNA at 4:00 PM with the hospice nurse. The CNA statement documented R2 was a little restless and needed to be repositioned frequently. The CNA statement documented the CNA was in with R2 around 4:00 PM and helped the hospice nurse reposition R2. When the CNA came into the room to give R2 the dinner tray, the CNA found R2 on the floor with blood on the face and immediately went to get the nurse. (The CNA that made the statement was no longer employed at the facility and unavailable for interview.) No documentation was found indicating the fall mat was in place or what position the bed was in at the time of the fall as per care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/13/2024 at 2:08 PM, LPN-H stated LPN-H was the Unit Manager at the time R2 was a resident at the facility. LPN-H recalled R2 was in hospice but could not recall the events surrounding R2's falls on 7/2/2024. LPN-H could not recall if R2 was agitated or restless after the first fall on 7/2/2024. Surveyor shared with LPN-H R2's Falls Care Plan was revised to include a fall mat after R2 fell on [DATE]. LPN-H stated if LPN-H adds a fall mat to a care plan, then the fall mat is put down right away. LPN-H could not recall specifically if that was done after R2's fall on 7/2/2024. In an interview on 11/14/2024 at 9:10 AM, CNA-I recalled R2 and R2's fall on 7/2/2024 in the morning. CNA-I stated CNA-I was going into R2's room to provide cares to R2's roommate when CNA-I saw R2 on the floor in the bathroom. Surveyor asked CNA-I if CNA-I had been in R2's room earlier that day to assist R2 with anything. CNA-I stated CNA-I had not been in R2's room before that time. CNA-I stated CNA-I starts work at 6:00 AM and had not done rounds or checked on R2 prior to going into the room and finding R2 on the floor. Surveyor asked CNA-I if a fall mat was put down on R2's floor after the fall or if R2 had been restless during the rest of the day. CNA-I could not remember if a fall mat was put down. CNA-I stated the hospice nurse was there during the day but could not remember any specifics. Surveyor attempted to call LPN-L on 11/14/2024 at 9:34 AM and 12:25 PM for an interview but LPN-L did not answer or return the calls. In an interview on 11/14/2024 at 1:46 PM, Surveyor asked Nurse Supervisor-G what staff comprises the IDT for fall reviews. Nurse Supervisor-G stated the three unit managers are part of the IDT. Nurse Supervisor-G stated the nurse on the floor does the risk management form after a fall and the nurse should put in an intervention into the care plan following the fall to address the cause of the fall. Nurse Supervisor-G stated the floor nurse also does all the assessments associated with the fall. Nurse Supervisor-G stated the fall packet has a cover letter that summarizes the fall. Surveyor asked Nurse Supervisor-G if staff statements are obtained for fall investigations. Nurse Supervisor-G stated they get staff statements from anyone working at the time of the fall. Nurse Supervisor-G stated the IDT then determines if the intervention the floor nurse put in was appropriate or if there is any other interventions that should be implemented to address the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/2024 at 2:21 PM, Surveyor asked LPN-D if LPN-D recalled R2 and 7/2/2024 when R2 had two falls. LPN-D stated LPN-D got report when coming on shift on 7/2/2024 and the day shift nurse told LPN-D that R2 had fallen that morning. LPN-D stated LPN-D told the CNA that was working with R2 on the second shift to keep an eye on R2 since R2 would try to self-transfer. LPN-D stated in the middle of the shift, LPN-D could not recall the exact time, two CNAs were having an altercation and LPN-D tried to calm them down. LPN-D stated it was in the middle of the two CNAs fighting that the CNA assigned to R2 came and told LPN-D that R2 was on the floor. LPN-D stated R2 was on the right side of the bed on the floor and there was blood all over R2's face. LPN-D stated LPN-D started the fall protocol by putting R2 on R2's back and going to get a Registered Nurse. LPN-D stated LPN-D called 911 at that time. LPN-D stated LPN-D got paperwork ready for the paramedics and since there was so much chaos with the two CNAs that were still fighting, the paramedics called R2's POA to inform the POA of what was going on. LPN-D stated the paramedics took R2 to the hospital at that time. Surveyor asked LPN-D if LPN-D saw the hospice nurse at all. LPN-D stated the hospice nurse had been at the facility earlier in the day, but LPN-D had not seen the hospice nurse personally. Surveyor asked LPN-D if R2 had been restless prior to the fall. LPN-D stated the CNA would have told LPN-D if R2 was trying to self-transfer and the CNA did not do that. LPN-D stated R2 was very relaxed when LPN-D administered morphine to R2 (at 5:15 PM on 7/2/2024). Surveyor asked LPN-D what R2's room looked like when LPN-D responded to the call, such as bed positioning and fall mat. LPN-D stated the bed was in a low position with the head of the bed slightly elevated. LPN-D stated there was a trash can on the side of the bed that R2 may have hit when falling. LPN-D stated there was no fall mat in place; that might have helped when R2 fell to not have gotten so injured. LPN-D did not know if there was an order for the fall mat or not. On 11/14/2024 at 3:20 PM, Surveyor asked Nursing Home Administrator (NHA)-A if hospice provides fall mats that they deem necessary or if the facility has the requested fall mat. NHA-A stated the facility mostly has their own equipment, but sometimes it needs to be ordered. Surveyor shared with NHA-A and DON-B the concerns regarding R2's fall on 7/2/2024 and that the actual time of the fall was hard to decipher due to lack of investigation by the facility with no interviews by staff on the previous night shift to determine who saw R2 last and when R2 was last toileted. Surveyor informed NHA-A that R2 was found in the bathroom, but it was unknown how R2 got to the bathroom, where the wheelchair was in relation to R2, and no statements indicating R2's activities prior to the fall. Hospice documented R2 fell out of bed and crawled to the bathroom, but no facility documentation supported that statement. Hospice ordered a thick fall mattress to be placed on the floor next to the bed and the bed to be in low position. Those interventions were added to the care plan, but through Surveyor interview, a fall mat was not placed. Surveyor informed NHA-A that through documentation and staff interviews, R2 was repositioned by a CNA and the hospice nurse at 4:00 PM and was given morphine by LPN-D at 5:15 PM with no restlessness at that time. R2 was found on the floor between 5:30 PM and 7:30 PM with blood all over R2's face. Conflicting documentation and statements made it difficult to decipher when the fall occurred. No fall mat was in place per LPN-D's interview. Surveyor shared the concern R2's first fall on 7/2/2024 did not have a thorough investigation to determine a root cause for the fall and that R2's second fall did not have the fall mat in place as per care plan to prevent injury. No additional information was provided as to why the facility did not ensure residents received adequate supervision and assistance devices were in place to prevent accidents for R2.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure 1 (R1) of 2 residents reviewed received appropriate treatment and services related to catheter care. * R1 was admitted to the facility on [DATE] with a foley catheter and did not have orders in place until 11/4/2024 for catheter care and monitoring. Findings include: The facility policy entitled Bowel and Bladder- Catheter Care with a reviewed date of 6/24/2022 documents: Policy: Nursing staff will assess catheter use to promote proper care. Procedure: A. Upon admission . 2. Obtain physicians order including appropriate diagnoses/ medical justification. B. Care Plan 1. Staff will care plan and implement interventions/ approaches for catheter use. C. Monitoring 1. Ongoing catheter use will be monitored for appropriate use and effectiveness. Additional interventions will be put in place as appropriate. 1.) R1 was admitted to the facility on [DATE] with a diagnoses that includes fracture of superior rim of left pubis, fracture of sacrum, nondisplaced transverse fracture of right acetabulum, muscle weakness, cognitive communicative deficit, Alzheimer's disease- late onset, dementia, and urinary tract infection with urinary retention. R1's baseline care plan dated 11/1/2024 documented that R1 cognition was unable to be obtained with a brief interview of mental status (BIMS) score of 99 and the facility assessed R1 being totally dependent on 1-2 staff for (activities of daily living (ADL's) and required 2 persons assist using a Hoyer lift for transfers. R1 was admitted with a foley catheter. R1 discharged from the facility on 11/7/2024. R1's orders did not include orders for R1 foley catheter care or monitoring until 11/4/2024 as indicated on R1's medication/treatment administration records (MAR/TAR) that documents the following orders: - Catheter- care every shift. Provide catheter care (start date: 11/4/2024, D/C (discontinue) date: 11/7/2024. - Monitor catheter output every shift. (start 11/5/2024, D/C 11/7/2024) (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Secure Catheter tubing to leg using a leg strap or securement device. Keep drainage bag below level of bladder every shift. (start 11/4/2024, D/C 11/7/2024) - Foley catheter- change as needed for occlusion or infection. (Start 11/4/2024. D/C 11/7/2024) - Change drainage bag every night shifts every two weeks on Friday. Date bag when changed (start date: 11/8/2024, D/C date: 11/7/2024) On 11/14/2024, at 12:35 PM, Surveyor interviewed unit manager (UM)-N who stated residents would be assessed on admission and if had a foley catheter orders would be put in for care and maintenance of the catheter. UM-N stated that orders should be input on admission and if there were no orders then nursing staff should obtain from the physician. On 11/14/2024, at 2:22 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R1 did not have orders for catheter care and monitoring until 11/4/2024. DON-B stated that there are standing orders for catheter care and monitoring that should have been implemented when R1 was admitted on [DATE]. No additional information was provided as to why the facility did not ensure R1 received appropriate treatment and services related to catheter care.