STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	8615 W Beloit Rd West Allis, WI 53227

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	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** 20483 Based on interview and record review the Facility did not ensure 1 (R3) of 3 Resident's representative was notified when there was change in condition and a need to alter treatment. On 11/11/24 R3 vomited in the morning and a KUB (kidney, ureter, bladder) was ordered. R3's resident representative was not notified. Findings include: The facility's policy titled, Nursing Policy & Procedure, Subject: Notification of Changes and last revised/reviewed 11/24 under Policy documents It is the policy of this facility that changes in resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. R3 is a [AGE] year old male with diagnoses which includes acute & chronic respiratory failure with hypoxia, ataxia following cerebral infarction, quadriplegia, legal blindness, anoxic brain injury, obesity, and epileptic seizures. R3 has a tracheostomy, gastrostomy & jejunostomy tube, and is non verbal. R3's power of attorney for healthcare is activated. The nurses note dated 11/11/24, at 7:41 a.m., documents CNA (Certified Nursing Assistant) reported pt (patient) having emesis during repositioning. Writer assessed ot (sic) emesis is brown color and has an odor. Rt (respiratory therapist) completed suction and oral care on patient. Sup (Supervisor) notified for further assessment. Sup updated NP (Nurse Practitioner); orders for KUB (kidney, ureter, bladder) requested by NP. This nurses note was written by LPN (Licensed Practical Nurse)-E. On 11/11/24, at 10:39 a.m., Surveyor observed R3 on an air mattress on the right side in bed with the head of the bed elevated. R3 is wearing glasses and did not respond when Surveyor spoke with R3. Surveyor observed there is a bag of Fibersource HN which is hung on the tube feeding pole but not running. (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	On 11/11/24, at 11:58 a.m., Surveyor spoke with R3's resident representative in R3's room. During this conversation, R3's resident representative stated to Surveyor no one called me that he threw up this morning. I called my husband no one called him. They are suppose to call me when something happens. R3's resident representative again stated why didn't they call me this morning when he threw up. At 12:38 p.m. LPN (Licensed Practical Nurse)-E entered R3's room stating she is going to check him, referring to R3. R3's resident representative stated no one told me he threw up. On 11/12/24, at 10:17 a.m., Surveyor asked RN (Registered Nurse) Supervisor-Q if there is a change in a resident and a new treatment is ordered do they notify the resident's representative. RN Supervisor-Q replied yes, absolutely. Surveyor informed RN Supervisor-Q yesterday (11/11/24) R3 vomited and the NP ordered a KUB. Surveyor informed RN Supervisor-Q Surveyor was unable to locate evidence R3's resident representatives were informed and R3's mother informed Surveyor no one told her son had vomited. Surveyor asked RN Supervisor-Q to look into this and get back to Surveyor. On 11/12/24, at 10:46 a.m., RN Supervisor-Q informed Surveyor he spoke with the staff and it was on their list of things to do and they wanted to make sure R3 was taken care of. RN Supervisor-Q informed Surveyor the family came in and noticed the vomit. RN Supervisor-Q stated we have to own it, it was our mistake, we dropped the ball on this one. On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on interview and record review the facility did not ensure 2 (R1 and R5) of 5 Residents who filed grievances with the facility had investigations into their grievances which included details on the steps taken to resolve the grievance, a summary of pertinent findings regarding the concern, a statement as to whether the grievance was confirmed or not, corrective action to be taken as a result of the grievance, and prompt attempts to resolve the grievance. Findings include: On 11/12/24 the facility's policy and procedure titled Grievance Procedure was reviewed and documented: The grievance official will initiate the appropriate notification and investigation processes per individual circumstance and facilities policies. The investigation will consist of at least the following: An interview with the person or persons reporting the incident, if applicable. Interviews with any witnesses to the incident or concern. An interview with staff members having any contact with the resident during the relevant periods or shifts of the alleged incidents. A root cause analysis of all circumstances surrounding the incident. The grievance official will complete a written response to the resident or resident representative which includes date of grievance/concerns, summary of grievance, investigation steps, findings, and resolution of outcome and action taken and date decision was issued. 1.) R5 was admitted to the facility on [DATE] and discharged from the facility on 8/27/24. R5's admission Minimum Data Set (MDS) dated [DATE] was reviewed and documented that R5 was assessed to have a Brief interview for Mental Status score of 15 which indicates R5 is cognitively intact. On 11/11/24, a grievance form dated 5/13/24 regarding R5 was reviewed. The form documented: (Former Administrator-FF) was contacted on 5/13/24 at 2:00 PM regarding concerns (R5) relayed regarding her air mattress not being comfortable, On 5/12/24 a male Certified Nursing Assistant (CNA) bent her leg while transferring her with the Hoyer lift, and CNA's are not setting up her meals for her. What was done to protect further violation of right while manner is under investigation? Care concerns given to nursing supervisor, bed fixed. Outcome of investigation: (R5) not harmed during cares. (R5) resistant to participate in cares. Corrective action taken by facility: Staff will verbalize all care interactions with (R5). Care in an unhurried way and document all refusal to do activities of daily living or transfer with assist. Investigation review with resident and/or responsible party: nothing is documented. Notification of/ Reviewed by Administrator: signed by Former Administrator-FF on 5/13/24. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No statement from R5, or any staff were completed. No follow up was documented as to if the grievances were corrected or continued to be a concern. No evidence could be found that R5 was given a written response to the grievance per their policy. R5's medical record was reviewed and included no assessment of her knee after the allegation was made of it being bent. On 11/12/24 at 11:30 AM, Director of Nurses (DON)-B was interviewed and indicated she was not aware that anything happened with R5's knee on 5/12/24 and that knees bend during the Hoyer transfer. DON-B was unable to locate any interviews or education provided after the grievance was filed and a written response to R5's grievance was not found. The above findings were shared with Administrator-A on 11/12/24 at 1:00 PM. Additional information was requested if available. None was provided as to why R5's grievance was not thoroughly investigated or followed up on with R5. 38829 2.) R1 was admitted to the facility on [DATE] with diagnoses of Hypertensive Chronic Kidney Disease, Paroxysmal Atrial Fibrillation, Stage 3 Kidney Disease, Fibromyalgia, and Anxiety Disorder. R1 is her own person. R1's Quarterly Minimum Data Set (MDS) completed 11/5/24 documents R1's Brief Interview for Mental Status (BIMS) score is 15, indicating R1 is cognitively intact for daily decision making. At the time of the assessment, R1 has minimal depression and no behaviors. R1's MDS documents R1 is set-up for eating. R1 has no range of motion impairment. R1 is dependent for toileting hygiene, showers, lower body dressing, and transfers. R1 requires partial/moderate assistance for upper body dressing and for rolling left to right. R1 requires substantial/maximum assistance for sit to lying. R1's MDS also documents R1 is always incontinent of bowel and bladder. R1 is at risk for pressure injury but currently does not have any. R1 filed 2 grievances with the facility. On 8/9/24, R1 filed a grievance with Nursing Home Administrator (NHA)-A that on 8/8/24, R1 waited over 45 minutes for someone to answer R1's call light. R1 stated that R1 soiled herself. It is documented that this occurred on day shift of 8/8/24. Question #7-Grievance assigned to and date is Blank. Question #8-What was done to prevent further violation of rights while matter is under investigation: Blank Question#10-Investigation of grievance:-Audit call light-pull report Question #11-Outcome of investigation:-Upon pulling call light report-R1's average wait time is less than 5 minutes Question #13-Corrective action taken by facility: Blank and not signed or dated (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The grievance states it was reviewed with R1 on 8/16/24, 8 days later. There is no documentation that R1 received in writing the results of the grievance. On 11/12/24, Surveyor reviewed the 8/8/24 call light report which documents no data found. On 11/12/24, at 10:21 AM, Surveyor spoke to NHA-A about the call light report from 8/8/24, with no data found. NHA-A informed Surveyor that the call light response system which provides the data of call light times was not working. NHA-A provided documentation from corporate Information Technology that the call light system for logging call light times was not working from 6/20-8/12/24. Surveyor notes that the facility was not able to pull a call light response report for 8/8/24 so the facility is not able to confirm that for 8/8/24, R1 did not wait 45 minutes for assistance. Surveyor notes the facility did not complete any other investigation into the grievance. The facility did not provide additional documentation that the facility interviewed the assigned caregiver to R1 on 8/8/24 during day shift, or other caregivers that worked on the unit on 8/8/24 during day shift. The facility also did not interview other Residents on the unit to determine if Residents had concerns with long call light response times. On 8/11/24, R1 filed a grievance that a Certified Nursing Assistant (CNA)-Y left R1's room without putting a shirt on R1 and went out to get assistance from another CNA. R1 had concerns of CNA-Y breaching protected healthcare information (HIPPA). The grievance form also documents that R1 had a concern of a long call light response time. On 8/13/24, it is documented on the grievance form that R1 had called and stated staff was talking about moving R1's room and would be getting a roommate and that CNAs were not rounding. Question #8-What was done to prevent further violation of rights while manner is under investigation: Blank Question#10-Investigation of grievance:-Audited call light report. R1 average wait time is less than 15 minutes. The grievance form provided to Surveyor by NHA-A has a portion of question 10 documentation that has been deleted off the form. Question #11-Outcome of investigation:-Staff are responding to R1's call light at very reasonable timeframe. Question #13-Corrective action taken by facility: Director of Nursing (DON)-B) and (NHA-A) will continue to monitor call light response time and address long wait times. The grievance form provided to Surveyor by NHA-A has a portion of question 13 documentation that has been deleted off the form. Question 13 is not signed or dated. Question #14-Investigation review to Resident and/or responsible party:-Blank and not dated There is no documentation that R1 received in writing the results of the grievance. Surveyor notes that the facility was not able to pull a call light response report for 8/11/24 so the facility is not able to confirm that for 8/11/24, R1 did not wait a long time for assistance. The grievance form documents that the grievance was received 8/11/24, but does not document the date or shift that R1 had concerns with. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor notes the facility did not complete any other investigation into the grievance. The facility did not provide additional documentation that the facility interviewed CNA-Y or other caregivers that worked on the unit during that time period. The facility also did not interview other Residents on the unit to determine if Residents had concerns with long call light response times or care issues. Surveyor also notes the facility only responded to the concern of a long call light response and not concerns about privacy concerns, CNAs not rounding, or the concern R1 may need to transfer to another room. On 11/12/24, at 11:48 AM, Surveyor shared the concern with NHA-A that R1's grievances were not investigated thoroughly. Surveyor also shared the actual grievance forms were incomplete and provided little documentation that the facility attempted to resolve R1's concerns. NHA-A acknowledged the concern and provided no further information at this time.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and interviews, the facility did not ensure that 3 allegations of abuse involving 3 Residents (R8, R2, and R3) were reported immediately to the State Survey Agency. * R1 reported to the night nursing supervisor (RN)- C that on the night shift of 11/3-11/4/24, R1 overheard Certified Nursing Assistant (CNA)-Z be verbally abusive to R8. The allegation of verbal abuse was not reported immediately to Nursing Home Administrator (NHA)-A and to the State Survey Agency. * On 11/11/24, Nursing Home Administrator (NHA)-A received a letter from R3's representative alleging abuse which was not reported to the State Survey Agency. * Administration was aware of an allegation of verbal abuse from R2's son to R2 on 9/22/24 and did not report to the State Survey Agency. Findings Include: The facility's policy Abuse, Mistreatment, Neglect and Misappropriation of Resident/Client Property/Funds, Injury of Unknown Origin revised 9/23 documents: .Policy: In keeping with our mission of caring for Residents with respect and dignity, Residents have the right to be free from abuse, neglect, misappropriation of Resident property, and exploitation. Residents are vulnerable and therefore at risk for abuse. 1. Residents will not be subjected to abuse by anyone, but not limited to, facility staff; other Residents; consultants or volunteers; staff or other agencies; family members; legal guardians; friends; or other individuals. 3. All employees must report any incident of alleged abuse, neglect, or misappropriation to their Administrator or designee as soon as the alleged abuse occurs, is discovered, or known to the employee. 4. After the incident of alleged abuse has been reported to the Administrator or designee, the Administrator or designee will direct the investigative process per facility policy and procedure. 5. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property will be reported by Administration to the Division of Quality Assurance (DQA) as soon as required by law. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The initial report will be sent to DQA no later than 2 hours after the allegation is made if the event(s) that caused the allegation involves abuse or results in serious bodily harm; or no later than 24 hours if the event(s) that caused the allegation does not involve abuse and does not result in serious bodily harm. Investigation The completed investigation report will be submitted within 5 days of the occurrence. 1.) R1 was admitted to the facility on [DATE] with diagnoses of Hypertensive Chronic Kidney Disease, Paroxysmal Atrial Fibrillation, Stage 3 Kidney Disease, Fibromyalgia, and Anxiety Disorder. R1 is her own person. R1's Quarterly Minimum Data Set (MDS) completed 11/5/24 documents R1's Brief Interview for Mental Status (BIMS) score is 15, indicating R1 is cognitively intact for daily decision making. At time of assessment, R1 has minimal depression and no behaviors. R1's MDS documents R1 is set-up for eating. R1 has no range of motion impairment. R1 is dependent for toileting hygiene, showers, lower body dressing, and transfers. R1 requires partial/moderate assistance for upper body dressing and for rolling left to right. R1 requires substantial/maximum assistance for sit to lying. R1's MDS also documents R1 is always incontinent of bowel and bladder. R1 is at risk for pressure injury but currently does not have any. R8 was admitted to the facility on [DATE] with diagnoses of Paroxysmal Atrial Fibrillation, Heart Disease, Pulmonary Hypertension, Nonrheumatic Tricuspid Valve Insufficiency, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Anemia, Obesity, and Major Depressive Disorder. R8 discharged from the facility on 11/11/24. R8 was R8's own person while at the facility. R8's Admission MDS documents R8's BIMS score to be 14, indicating R8 was cognitively intact. No mood or behaviors are documented. R8's MDS documents that R8 did not wear a hearing aide and had adequate hearing. R8 was able to understand others. R8 had no range of motion impairment. R8's MDS documents that R8 required supervision for mobility and transfers, partial/moderate assistance for dressing and was set-up for eating. Surveyor reviewed R8's comprehensive care plan and notes that there is no documented problem that R8 was hard of hearing while at the facility. On 11/11/24, at 10:07 AM, Surveyor interviewed R1 regarding the allegation of verbal abuse involving R8. R1 stated R1 remembered letting the supervisor know what R1 overheard. R1 stated that R1 heard CNA-Z yell at R8 to shut the F--- up. R1 informed the supervisor right away. R1 stated that no one came to talk to R1 about it. R1 remembers being told by the supervisor to mind your own business. On 11/12/24, at 8:31 AM, Surveyor spoke with Registered Nurse (RN) Supervisor (RN)-C about the allegation RN-C confirmed that RN-C was the supervisor on the shift of 11/3/24 PM to 6 AM on 11/4/24. R1 had informed RN-C that CNA-Z was yelling at R8 and slamming doors. RN-C followed up with CNA-Z and the nurse on the floor who both stated it did not happen. RN-C confirmed that RN-C did not inform Administration. RN-C did tell R1 that it did not happen. RN-C informed Surveyor that it was no big deal and was not substantiated. RN-C stated RN-C did not speak with R8 at the time of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 10:35 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated DON-B received a phone call from RN-C about the allegation that R1 overheard CNA-Z being verbally abusive to R8. DON-B informed Surveyor that R8 was hard of hearing and that CNA-Z normally speaks loud. DON-B recalls RN-C speaking with R8 and R8 stated it never happened. DON-B informed Surveyor that it was (R1's) perception of verbal abuse from (R1's) room. DON-B stated staff have had to talk to R1 about saying things that R1 thinks R1 has heard. DON-B recalls CNA-Z apologized to R8. On 11/12/24, at 11:48 AM, Surveyor interviewed NHA-A regarding the allegation of verbal abuse involving R8. NHA-A stated that if the allegation is corrected on the spot, there would be no investigation. If the allegation is abuse, neglect, or misappropriation, the expectation would be to complete an investigation. NHA-A confirmed that NHA-A was unaware of the allegation of verbal abuse from R1 involving CNA-Z and R8. NHA-A stated, depending on what (R1) said, I should have been notified and NHA-A stated the expectation that the allegation then would be submitted to The Division of Quality Assurance (DQA) and an investigation would be completed. Surveyor communicated to NHA-A that RN-C informed Surveyor that RN-C did not speak with R8 to confirm what was said or occurred. DON-B informed Surveyor that RN-C did speak with R8. DON-B informed Surveyor that R8 was hard of hearing, however, R8's MDS and care plan does not document this. Surveyor shared there is conflicting information and no documentation that this allegation of verbal abuse was reported immediately to NHA-A and the State Survey Agency. NHA-A understands the concern. No further information was provided by the facility at this time. 20483 2.) R3 is a [AGE] year old male with diagnoses which includes acute & chronic respiratory failure with hypoxia, ataxia following cerebral infarction, quadriplegia, legal blindness, anoxic brain injury, obesity, and epileptic seizures. R3 has a tracheostomy, gastrostomy & jejunostomy tube, and is non verbal. The significant change MDS (minimum data set) with an assessment reference date of 10/22/24 assesses R3 as having short & long term memory problems and is severely impaired for cognitive skills for daily decision making. R3 is dependent for toileting hygiene, roll left and right, chair/bed to chair transfer and is always incontinent of urine & bowel. On 11/11/24, at 9:53 a.m., Surveyor called R3's resident representative to discuss R3. R3's representative informed Surveyor she is coming to the facility. R3's representative explained she had problems last night and came to the facility at 2:30 a.m. R3's representative informed Surveyor her son was wet with bowel movement and staff didn't change R3. R3's representative informed Surveyor she wrote a statement and will speak with Surveyor when she comes in. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/24, at 11:58 a.m., Surveyor spoke with R3's resident representative. R3's representative was in R3's room at the time. Surveyor was informed R3 is suppose to be turned every two hours. R3's representative informed Surveyor about quarter to two she saw a CNA (Certified Nursing Assistant) walk in, didn't check R3, and then walk out. (There is a camera in R3's room.) R3's representative informed Surveyor she came in, her son was wet and had poop. R3's representative informed Surveyor this is neglect. R3's representative informed Surveyor she went downstairs, spoke with the Supervisor and told the Supervisor what happened. R3's representative informed Surveyor the supervisor told her to write a statement and stated she just gave it to the Administrator. Surveyor asked R3's representative when she gave her statement to the Administrator. R3's representative replied just a few minutes ago. R3's representative showed Surveyor a copy of what she gave to NHA (Nursing Home Administrator)-A and told Surveyor, Surveyor could have it. Surveyor noted the statement dated 11/11/24 and signed by R3's representative documents To Whom It May Concern, I, [Name] mother and power of attorney of [R3's name] am requesting that the CNA named [first name] will no longer be assigned to him going forward. This is due to too many issues of abuse and neglect for my son, who cannot speak for himself. The most recent incident was during the night of November 10th. I had to drive to VMP (Village Manor Park) around 2 AM, as [R3's first name] hadn't been turned for over 3 hours. When I arrived [Name] was walking out of [R3's first name] room. I went in, checked [R3's first name] and found that he had soiled himself with urine and a bowel movement. [Name] had gone into his room and left within a minute, without properly making sure that [R3's first name] was good. This is the most recent example of neglect and abuse for [R3's first name]. I cannot have someone in charge of taking care of [R3's first name] who does not respect and help him. If there are questions about more past issues, the supervisor who was there during the night of November 10th can be asked about them. On 11/12/24, at 12:29 p.m., Surveyor asked NHA (Nursing Home Administrator)-A if R3's mother voiced any concerns to her. NHA-A replied yes she gave me a letter. NHA-A explained she wants the CNA pulled from cares and there is an investigation. NHA-A informed Surveyor she followed up with the mother last night. Surveyor showed NHA-A the statement R3's representative had given Surveyor and asked NHA-A if this is what she received. NHA-A replied yes. Surveyor asked if she submitted a facility reported incident to the State. NHA-A replied no. Surveyor asked NHA-A why she didn't. NHA-A informed Surveyor she has to speak to the CNA and gather information. Surveyor informed NHA-A the statement she was given by R3's representative alleges abuse & neglect and this should have been reported within two hours. NHA-A replied you're right and explained she wanted to do her due diligence and gather as much information as possible before reporting. NHA-A informed Surveyor she could of read it right away. 49845 3.) R2 was admitted to the facility on [DATE] for after care of a femur fracture. R2 has an activated Health Care Power of Attorney. R2's admission Minimum Data Set (MDS), dated [DATE], documents R2 has a Brief Interview for Mental status (BIMS) of 00 indicating R2 could not be interviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	8615 W Beloit Rd West Allis, WI 53227

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/2024, at 11:59 AM, Surveyor interviewed Social Worker (SW)-P. SW-P indicated to Surveyor that SW-P left a message with Adult Protective Services (APS) regarding R2's family member being verbally aggressive with R2. SW-P informed Surveyor that SW-P did not write down in her call logbook the exact date/time APS was called, but stated it was about the time R2 was discharged home, and stated APS called SW-P back about a month later on 11/06/2024. SW-P informed Surveyor that SW-P did not think R2 was being abused but stated R2's family member was pushy and too firm with R2. SW-P informed Surveyor that SW-P informed R2's family member that they can not talk to R2 in that tone at the Facility. SW-P informed Surveyor that SW-P called APS to do a wellness check on R2. SW-P informed Surveyor that when APS returned SW-P's call, APS informed SW-P that APS does not conduct welfare checks and that SW-P would have to call law enforcement. On 11/11/2024, at 02:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M. LPN-M informed Surveyor that she recalls R2's family member yelling at R2 making comments like if you don't do this then we can't take you home. LPN-M indicated to Surveyor that no physical abuse was observed just verbal. On 11/11/2024, at 02:43 PM, Surveyor interviewed LPN- N. LPN-N informed Surveyor that LPN-N witnessed verbal abuse of R2 by R2's family member and reported it to SW-P and Nursing Supervisor- Q. LPN-N informed Surveyor that R2's family member was observed yelling at R2 and shook R2's wheelchair. LPN-N informed Surveyor that LPN-N believed what she observed was abuse. LPN-N indicated no interventions were put into place after LPN-N reported the incidents. On 11/11/2024, at 03:03 PM, Surveyor interviewed Nursing Supervisor-Q. Nursing Supervisor-Q informed Surveyor of an incident that occurred between R2's family member and Nursing Supervisor-Q, which resulted in Nursing Supervisor-Q calling the police to have R2's family member escorted out of the Facility. Nursing Supervisor-Q informed Surveyor that R2's family member was berating and yelling at Nursing Supervisor-Q. Nursing Supervisor-Q. informed Surveyor that staff has made Nursing Supervisor-Q aware of concerns regarding R2's family member yelling at R2 to get out of bed. Nursing Supervisor-Q informed Surveyor that Director of Nursing (DON) B and Nursing Home Administrator (NHA)-A were made aware of the situation and concerns. Nursing Supervisor-Q informed Surveyor that no grievance was completed. On 11/11/2024, at 03:20 PM, Surveyor interviewed DON-B and NHA-A. DON-B indicated to Surveyor that DON-B recalls concerns with R2's family member. DON-B informed Surveyor that on different occasions staff felt uncomfortable with the interactions between R2's family member and R2. DON-B informed Surveyor that DON-B has a statement from a staff member regarding inappropriate verbal concerns on 09/22/2024 and 10/10/2024 involving R2 and R2's family member. NHA-A indicated to Surveyor that SW-P made a referral to APS regarding the concerns. DON-B informed Surveyor that a copy of the nurse's statement will be given to Surveyor and indicated that the 09/22/2024 and 10/10/2024 statement are on the same paper. NHA-A indicated that NHA-A would locate the file regarding the investigation into the allegations and get back to Surveyor with more information. On 11/12/2024, at 08:06 AM, NHA-A informed Surveyor that on 09/25/2024, SW-O interviewed R2 without family present, and would have SW-O speak with Surveyor. NHA-A provided Surveyor with a copy of the staff member's statement, which excluded the statement on 09/22/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/2024, at 08:08 A M, Surveyor interviewed SW-O. SW-O informed Surveyor that SW-O did speak with R2 on 09/25/2024 but only discussed paperwork regarding Health Care Power of Attorney (HCPOA). SW-O informed Surveyor that R2 requested to change her HCPOA and SW-O and SW-P assisted R2 with the request. SW-O denies speaking to R2 regarding concerns of verbal abuse allegations with R2's family member. On 11/12/2024, DON-B provided Surveyor with a copy of the original, complete statement made by staff regarding the allegations of verbal abuse toward R2 that occurred on 09/22/2024 and 10/10/2024. R2 was discharged home from the Facility on 10/10/2024. No Further information was provided to Surveyor regarding why the Facility did not report verbal abuse allegations to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on record review and interviews, the facility did not ensure a thorough investigation was completed for allegations of abuse/neglect for 2 (R1 & R2) of 2 residents reviewed for alleged abuse investigations. *The Facility did not ensure a thorough investigation was completed for an allegation of verbal abuse of R2 on 09/22/2024 and 10/10/2024 by R2's family member. *R1 reported to the night nursing supervisor (RN)- C that on the night shift of 11/3-11/4/24, R1 overheard Certified Nursing Assistant (CNA)-Z be verbally abusive to R8. The allegation of verbal abuse was not investigated thoroughly including obtaining staff statements and conducting Resident interviews. Findings include: The Facility policy, titled, Abuse, Mistreatment, Neglect and Misappropriation of Resident/Client Property/Funds, Injury of Unknown Origin, with a last revised date of 09/2023, documents in part, POLICY: In keeping with our mission of caring for residents with respect and dignity, residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents are vulnerable and therefore at risk for abuse. 1. Residents will not be subjected to abuse by anyone including, but not limited to, facility staff; other residents; consultants or volunteers; staff or other agencies; family members; legal guardians; friends; or other individuals.4. After the incident of alleged abuse has been reported to the Administrator or designee the administrator or designee will direct the investigative process per facility policy and procedure. 5. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property will be reported by Administrator to the division of quality assurance (DQA) as soon as required by law. Investigation . 2. Upon receiving a complaint of alleged abuse, mistreatment, neglect, exploitation, injuries of unknown origin and misappropriation of property the Administrator or designee initiates a preliminary investigation (concern review form and occurrence report); to include time, date, place, parties involved and resulting behavior or outcomes. Any employee who is named in an allegation must be available to complete an investigative interview within 24 hours of being called by the investigator. 4. An allegation of Abuse occurs, the following protocol must be followed: a) Residents will be separated immediately if abuse is resident or resident. b) Investigation will be started immediately upon occurrence of incident observed. c) Administrator or designee will be notified of incident as soon as the incident occurs via phone call or pager regardless of the time of day. d) Resident/residents will be placed on 24 hr. board for ongoing monitoring for 72 hours. e) incident will be discussed at morning stand up to alert staff of the occurrence and interventions put in place for resident safety. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f) IDT Team will meet to discuss interventions that need to be implemented for resident/residents involved. POC will be updated to reflect interventions implemented. g) Referral to psychologist/psychiatrist/counselor as deemed appropriate. h) If incident is reported to be abuse to staff-counseling will be offered by Pastoral Care and/or staff member will be offered the Employee Assistance Program for additional resources. k) A complete investigation will ensue following the same protocols used for allegation of mistreatment, neglect, or abuse, including misappropriation of resident property. The completed allegation will be submitted to the DQA according to State and Federal regulations. Action . 4. A complete investigation will follow. This involves interviewing all employees, residents, and visitors with knowledge of the alleged incident or had contact with the resident at the time of the alleged incident. All notes taken during the interview must be objective, relate a complete story and be presented in complete sentences using accurate grammar and spelling. 5. Upon completion of the interviews, an investigation summary is completed. 1.) R2 was admitted to the facility on [DATE] for after care of a femur fracture. R2 has an activated Health Care Power of Attorney. R2's admission Minimum Data Set (MDS), dated [DATE], documents R2 has a Brief Interview for Mental status (BIMS) of 00. On 11/11/2024, at 11:59 AM, Surveyor interviewed Social Worker (SW)-P. SW-P indicated to Surveyor that SW-P left a message with Adult Protective Services (APS) regarding R2's family member being verbally aggressive with R2. SW-P informed Surveyor that SW-P did not write down in her call logbook the exact date/time APS was called, but stated it was about the time R2 was discharged home, and stated APS called SW-P back about a month later on 11/06/2024. SW-P informed Surveyor that SW-P did not think R2 was being abused but stated R2's family member was pushy and too firm with R2. SW-P informed Surveyor that SW-P informed R2's family member that they can not talk to R2 in that tone at the Facility. SW-P informed Surveyor that SW-P called APS to do a wellness check on R2. SW-P informed Surveyor that when APS returned SW-P's call, APS informed SW-P that APS does not conduct welfare checks and that SW-P would have to call law enforcement. On 11/11/2024, at 02:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M. LPN-M informed Surveyor that she recalls R2's family member yelling at R2 making comments like if you don't do this then we can't take you home. LPN-M indicated to Surveyor that no physical abuse was observed just verbal. On 11/11/2024, at 02:43 PM, Surveyor interviewed LPN- N. LPN-N informed Surveyor that LPN-N witnessed verbal abuse of R2 by R2's family member and reported it to SW-P and Nursing Supervisor- Q. LPN-N informed Surveyor that R2's family member was observed yelling at R2 and shook R2's wheelchair. LPN-N informed Surveyor that LPN-N believed what she observed was abuse. LPN-N indicated no interventions were put into place after LPN-N reported the incidents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/2024, at 03:03 PM, Surveyor interviewed Nursing Supervisor-Q. Nursing Supervisor-Q informed Surveyor of an incident that occurred between R2's family member and Nursing Supervisor-Q, which resulted in Nursing Supervisor-Q calling the police to have R2's family member escorted out of the Facility. Nursing Supervisor-Q informed Surveyor that R2's family member was berating and yelling at Nursing Supervisor-Q. Nursing Supervisor-Q. informed Surveyor that staff has made Nursing Supervisor-Q aware of concerns regarding R2's family member yelling at R2 to get out of bed. Nursing Supervisor-Q informed Surveyor that Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A were made aware of the situation and concerns. Nursing Supervisor-Q informed Surveyor that no grievance was completed. On 11/11/2024, at 03:20 PM, Surveyor interviewed DON-B and NHA-A. DON-B indicated to Surveyor that DON-B recalls concerns with R2's family member. CON-B informed Surveyor that on different occasions staff felt uncomfortable with the interactions between R2's family member and R2. DON-B informed Surveyor that DON-B has a statement from a staff member regarding inappropriate verbal concerns on 09/22/2024 and 10/10/2024 involving R2 and R2's family member. NHA-A indicated to Surveyor that SW-P made a referral to APS regarding the concerns. DON-B informed Surveyor that a copy of the nurse's statement will be given to Surveyor and indicated that the 09/22/2024 and 10/10/2024 statement are on the same paper. NHA-A indicated that NHA-A would locate the file regarding the investigation into the allegations and get back to Surveyor with more information. NHA-A and DON-B made aware of Surveyors concerns regarding the allegations of verbal abuse not being thoroughly investigated. On 11/12/2024, at 08:06 AM, NHA-A informed Surveyor that on 09/25/2024, SW-O interviewed R2 without family present, and would have SW-O speak with Surveyor. NHA-A provided Surveyor with a copy of the staff member's statement, which excluded the statement on 09/22/2024. On 11/12/2024, at 08:08 AM, Surveyor interviewed SW-O. SW-O informed Surveyor that SW-O did speak with R2 on 09/25/2024 but only discussed paperwork regarding Health Care Power of Attorney (HCPOA). SW-O informed Surveyor that R2 requested to change her HCPOA and SW-O and SW-P assisted R2 with the request. SW-O denies speaking to R2 regarding concerns of verbal abuse allegations with R2's family member. On 11/12/2024, DON-B provided Surveyor with a copy of the original, complete statement made by staff regarding the allegations of verbal abuse toward R2. R2 was discharged home from the Facility on 10/10/2024. No Further information was provided to Surveyor regarding what the Facility did to investigate the verbal abuse allegations toward R2. 38829 2.) R1 was admitted to the facility on [DATE] with diagnoses of Hypertensive Chronic Kidney Disease, Paroxysmal Atrial Fibrillation, Stage 3 Kidney Disease, Fibromyalgia, and Anxiety Disorder. R1 is her own person. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Quarterly Minimum Data Set (MDS) completed 11/5/24 documents R1's Brief Interview for Mental Status (BIMS) score is 15, indicating R1 is cognitively intact for daily decision making. At time of assessment, R1 has minimal depression and no behaviors. R1's MDS documents R1 is set-up for eating. R1 has no range of motion impairment. R1 is dependent for toileting hygiene, showers, lower body dressing, and transfers. R1 requires partial/moderate assistance for upper body dressing and for rolling left to right. R1 requires substantial/maximum assistance for sit to lying. R1's MDS also documents R1 is always incontinent of bowel and bladder. R1 is at risk for pressure injury but currently does not have any. R8 was admitted to the facility on [DATE] with diagnoses of Paroxysmal Atrial Fibrillation, Heart Disease, Pulmonary Hypertension, Nonrheumatic Tricuspid Valve Insufficiency, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Anemia, Obesity, and Major Depressive Disorder. R8 discharged from the facility on 11/11/24. R8 was R8's own person while at the facility. R8's Admission MDS documents R8's BIMS score to be 14, indicating R8 was cognitively intact. No mood or behaviors are documented. R8's MDS documents that R8 did not wear a hearing aide and had adequate hearing. R8 was able to understand others. R8 had no range of motion impairment. R8's MDS documents that R8 required supervision for mobility and transfers, partial/moderate assistance for dressing and was set-up for eating. Surveyor reviewed R8's comprehensive care plan and notes that there is no documented problem that R8 was hard of hearing while at the facility. On 11/11/24, at 10:07 AM, Surveyor interviewed R1 regarding the allegation of verbal abuse involving R8. R1 stated R1 remembered letting the supervisor know of what R1 overheard. R1 stated that R1 heard CNA-Z yell at R8 to shut the F--- up. R1 informed the supervisor right away. R1 stated that no one came to talk to R1 about it. R1 remembers being told by the supervisor to mind your own business. On 11/12/24, at 8:31 AM, Surveyor spoke with Registered Nurse (RN) Supervisor (RN)-C about the allegation RN-C confirmed that RN-C was the supervisor on the shift of 11/3/24 PM to 6 AM on 11/4/24. R1 had informed RN-C that CNA-Z was yelling at R8 and slamming doors. RN-C followed up with CNA-Z and the nurse on the floor who both stated it did not happen. RN-C confirmed that RN-C did not inform Administration. RN-C did tell R1 that it did not happen. RN-C informed Surveyor that it was no big deal and was not substantiated. RN-C stated RN-C did not speak with R8 at the time of the allegation. On 11/12/24, at 10:35 AM, Surveyor interviewed Director of Nursing (DON)-B. DON-B stated DON-B received a phone call from RN-C about the allegation that R1 overheard CNA-Z being verbally abusive to R8. DON-B informed Surveyor that R8 was hard of hearing and that CNA-Z normally speaks loud. DON-B recalls RN-C speaking with R8 and R8 stated it never happened. DON-B informed Surveyor that it was (R1's) perception of verbal abuse from (R1's) room. DON-B stated staff have had to talk to R1 about saying things that R1 thinks R1 has heard. DON-B recalls CNA-Z apologized to R8. DON-B would need to look for any written documentation of RN-C obtaining statements from CNA-Z, the nurse, R1 and R8. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 11:48 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A regarding the allegation of verbal abuse involving R8. NHA-A stated that if the allegation is corrected on the spot, there would be no investigation. If the allegation is abuse, neglect, or misappropriation, the expectation would be to complete an investigation. NHA-A confirmed that NHA-A was unaware of the allegation of verbal abuse from R1 involving CNA-Z and R8. NHA-A stated, depending on what (R1) said, I should have been notified and NHA-A stated the expectation that the allegation then would be submitted to DQA and an investigation would be completed. Surveyor communicated to NHA-A that RN-C informed Surveyor that RN-C did not speak with R8 to confirm what was said or occurred. DON-B informed Surveyor that RN-C did speak with R8. DON-B informed Surveyor that R8 was hard of hearing, however, R8's MDS and care plan does not document this. Surveyor shared there is conflicting information and no documentation that this allegation of verbal abuse was addressed and investigated. Surveyor shared the allegation of verbal abuse from R1 about R8 was not thoroughly investigated. Surveyor shared the facility does not have documentation that staff statements were obtained, R1 and R8's statement was obtained, and other Resident interviews were completed in order to determine if other Residents had concerns of verbal abuse or other forms of abuse involving CNA-Z. Surveyor also shared that a thorough investigation was not submitted to the State Survey Agency. NHA-A understands the concern. No further information was provided by the facility at this time.

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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** 20483 Based on comprehensive assessment the facility did not ensure 1 (R3) of 7 residents received treatment and care in accordance with professional standards of practice. On 11/11/24 R3 was observed with a foam dressing on R3's mid back which was dated 11/3/24. There is no physician order for the foam dressing. Findings include: R3 is a [AGE] year old male with diagnoses which includes acute & chronic respiratory failure with hypoxia, ataxia following cerebral infarction, quadriplegia, legal blindness, anoxic brain injury, obesity, and epileptic seizures. R3 has a tracheostomy, gastrostomy & jejunostomy tube, and is non verbal. The nurses note dated 10/26/24, at 14:06 (2:06 p.m.) documents 11:15 am - Pts (patients) Mother insisted she look at pts. back wound, Pt turned as far over as comfortably possible. She then opened the bandage and touched the wound w/ (with) her ungloved hands. Stated she still couldn't see it good enough to take a clear picture and tried to push him over more. Writer asked her to stop due to pts. arm being out of alignment. Pt then re-positioned back down onto his back. Writer noted wound had no new drainage and is still closed at this time. Re-assured pts Mother. Will continue to monitor. This nurses note was written by LPN (Licensed Practical Nurse)-W. On 11/11/24, from 1:04 p.m. to 1:27 p.m., Surveyor observed CNA (Certified Nursing Assistant)-CC and CNA-H provide incontinence cares for R3 and change the sheets on R3's bed. During this observation when R3 was positioned on the right side, Surveyor observed a foam dressing on R3's mid back dated 11/3. Surveyor reviewed R3's medical record and was unable to locate a physician order for the foam dressing. On 11/11/24, at 2:41 p.m., Surveyor observed LPN (Licensed Practical Nurse)-BB taking R3's vital signs. Surveyor informed LPN-BB Surveyor had observed a foam dressing on R3's mid back and asked if Surveyor could see how the skin looks under the foam dressing. On 11/11/24, at 2:46 p.m., LPN-BB, CNA-DD, and CNA-EE entered R3's room and placed gloves on. CNA-DD & CNA-EE positioned R3 on the right side. Surveyor asked if the foam dressing is dated 11/3. CNA-DD replied yes. LPN-BB removed the foam dressing and cleansed the mid back with wound cleanser on a four by four gauze. Surveyor observed the area is not open. After cleansing the area, LPN-BB applied a foam dressing over the mid back. LPN-BB informed Surveyor she is going to check R3's medical record to see if there is anything to apply. LPN-BB removed her gloves and cleansed her hands. On 11/11/24, at 3:18 p.m., LPN-BB informed Surveyor there is nothing to put on R3. Surveyor informed LPN-BB Surveyor was unable to find a physician order for the foam dressing. LPN-BB informed Surveyor she didn't see an order in the system. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/24, at 3:20 p.m., RN (Registered Nurse) Supervisor-Q informed Surveyor he looked at R3's record and didn't see an order and the dressing is on for protection. Surveyor asked RN Supervisor-Q if there should be an order including when the dressing should be changed. RN Supervisor-Q replied that I don't know. Surveyor informed RN Supervisor-Q the dressing was dated 11/3, eight days ago. On 11/11/24, at 3:36 p.m., Surveyor asked RN Supervisor-GG if a dressing is on a resident for protection do they get a physician order for the dressing. RN Supervisor-GG replied yes. Surveyor asked if the order would include when the dressing should be changed. RN Supervisor-GG replied yes. On 11/12/24, at 10:16 a.m., Surveyor asked RN Supervisor-Q if a dressing is placed on protection, do they need a physician order. RN Supervisor-Q replied I will have to look into that as well. On 11/12/24, at 10:46 a.m., RN Supervisor-Q informed Surveyor they need an order for a dressing that is on for protection. On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 11:43 a.m., DON-B informed Surveyor in regards to the foam dressing, R3 had a wound that resolved 8/1/24 and the family wanted something in place as they were anxious about the area reopening. DON-B informed Surveyor she believes there was an order for protection prior, R3 went to the hospital, and when R3 came back the order was not put in. DON-B informed Surveyor she was able to speak with the nurse responsible for putting the dressing on 11/3. DON-B informed Surveyor the nurse tried to get in and out as quickly as possible to avoid confrontation with the family as the nurse doesn't regularly have R3. DON-B explained the last time the nurse had R3 there was an order in place. DON-B informed Surveyor the nurse should of made sure there was an order in place. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	8615 W Beloit Rd West Allis, WI 53227

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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** 51016 Based on observation, interview and record review, the facility did not ensure 1 of 1 resident (R4)'s environment remains free of accident hazards. * R4 was admitted to the facility ventilator wing on 5/29/24 with a diagnosis of Chronic Respiratory Failure. The facility did not ensure R4's room remained free of accident hazards after a heating and air conditioning condensation valance, located on the wall near the ceiling, fell open on 07/10/24 splashing condensate on R4's bed. The condensation valance fell open again on 08/08/24 splashing condensate and debris on R4. Findings include: The facility's policy and procedure titled; Hazardous Surveillance Inspection last reviewed 07/24: documents the following Policy: The Buildings and Grounds Department recognizes that it has the responsibility to the associates, residents, and visitors of this facility to provide equipment that is in good working condition. Procedure: In order to ensure that equipment is maintained in a state of good repair, it is incumbent upon each individual in buildings and grounds to inspect the equipment they are using for any signs of deterioration or safety hazards b) Safety/Fire Inspection Check List ix. If conditions in any area are found to be below guidelines, specify the location of the deficiency in the column set aside for that purpose. x. An explanation of the exact deficiency should be listed on the bottom of the inspection sheet xii. the Director of Buildings and Grounds in cooperation with the Chairperson of the Safety Committee will evaluate and recommend a course of action to be taken to correct the deficiencies. A report will be sent to the parties responsible for the area so they may take appropriate action to correct unsafe conditions. R4 was admitted [DATE] to the ventilator unit with Chronic Respiratory Failure, and Guillain-Barre Syndrome. R4 was moved off the ventilator unit on 8/8/24 after the second time the valance fell . R4's Quarterly MDS (Minimum Data Set) dated 10/29/24 documents R4 has a BIMS (Brief Interview for Mental Status) score of 13. A score of 13-15 indicates intact mental status for daily decision making. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Quarterly MDS dated [DATE] documents R4 is assessed to require total maximum assistance with all self-care areas of: feeding, dressing, washing, brushing teeth. R4 requires total maximum assist in all areas of mobility: moving in bed, all transfers, use of the wheelchair. Total Maximum assist is defined as dependent-helper does all of the effort, Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. On 11/11/24, at 09:35 AM Surveyor interviewed R4 and Family Member -D. Surveyor asked R4 if everything was going okay with R4's stay. R4 informed the Surveyor, it was better here at least at first, than my previous unit. R4 informed the Surveyor a large cover fell down over me twice. Family Member-D informed the Surveyor, water fell on him but not the cover (of the heating and cooling valance). Family Member-D informed Surveyor, Family Member-D came in R4's room shortly after it happened, it was gross, moldy, water on him. R4 informed the Surveyor, that was after the second time the Valance fell . R4 informed Surveyor, it got me wet. On 11/11/24, at 10:41 AM, Surveyor observed the heating and cooling valance in R4's previous room where the 2 incidents of the valance falling occurred. The Surveyor observed the metal on the right side was separated approximately a quarter of an inch and white caulking was observed in the separation. Surveyor observed a display board partially under the valance on the right side. The board had ripples in the area under the valance indicating water damage. There was a brown steak on the wall from the valance to the display board. On 11/11/24, at 01:31 PM, Surveyor interviewed CNA (Certified Nursing Assistant)-H,. Surveyor asked CNA-H if she remembered the incidents from July and August of 2024 when water fell from the heating and cooling valance on to R4. CNA-H informed Surveyor they heard about the first incident and was at the second incident. CNA-H informed Surveyor CNA-H heard the RT (Respiratory Therapist)-G scream its hanging and dripping on the resident. Surveyor asked if the incident was reported to the supervisor. CNA-H replied the nurse came in; we were all working together so she had to know. Surveyor asked, CNA-H if she remembered the nurse's name. CNA-H replied, I don't remember. CNA-H informed the Surveyor the resident was removed right away and given a shower and Maintenance came in and fixed it that day. Surveyor asked if CNA-H remembered if a mechanical lift hit the valance. CNA-H informed Surveyor she had never seen that before, but I suppose it could happen. On 11/11/24, at 01:35 PM, Surveyor interviewed RT (Respiratory Therapist)-G., Surveyor asked if RT-G remembered the incidents in July and August of 2024 with water coming from the heating and cooling valance in R4's room. (RT-G was noted in the incident report for 8/8/24 as first on the scene) RT-G informed Surveyor, RT-G remembered it happened but not the time frame. RT-G told Surveyor she was in the room at the time., RT-G stated, I remember R4 was moved out right away and maintenance came in. Surveyor asked, RT-G if the incident was reported to a supervisor. RT-G stated right away. RT-G could not recall which nurse was on at the time. RT-G informed Surveyor, that's all I remember. On 11/11/24, at 01:36 PM, Surveyor interviewed CNA -I. Surveyor asked if CNA-I remembered the incident from July and August of 2024 with R4. CNA-I informed Surveyor she remembered both times, but I didn't go into R4's room. CNA-I informed Surveyor, that's all I know. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 11:19 AM, Surveyor conducted a phone interview with CNA -F, Surveyor inquired if CNA-F remembered the incident on 7/10/24. (CNA-F was noted as first on the scene on 7/10/24 incident report) CNA-F replied you mean with R4. CNA-F informed Surveyor, they caught the cover from the heating and cooling valance. We were moving him (R4) in bed. Water hit the side of the bed. The other nursing assistant with me made sure R4 didn't get hit with anything while I held the cover up. Surveyor asked CNA-F if she knew why it fell . Surveyor inquired if the valance was hit by the lift. CNA-F replied, we didn't hit it, I think it was wear (SIC). CNA-F informed Surveyor, I have never seen the Hoyer hit it before at least not that I'm aware of. Surveyor asked if the incident was reported to a supervisor. CNA-F replied, yes right away the nurse came in. I believe she filled out an incident report. On 11/13/24, at 11:32 AM, Surveyor received a phone call from LPN (Licensed Practical Nurse)-E. Surveyor asked LPN-E what she recalled about the incidents on 7/10/24 with R4. (LPN-E was the nurse who charted on the incident on 7-10-24) LPN-E informed the Surveyor, the aides just got done giving R4 a shower. R4 was not hit with anything. The other aide moved him on the bed. Surveyor asked LPN-E if this incident was reported to a supervisor. LPN-E replied yes right away, an incident form was filled out and Maintenance came in. LPN-E replied, that's all I remember. On 11/12/24, at 8:59 AM, Surveyor received an interdisciplinary note from NHA-A which documented, on 7/10/24, at 10:04 PM, LPN-E documented; after bath time pt (patient) was taken back into room w/ (with) CNAS. While being transferred back into bed via Hoyer lift. During the transfer on (sic). CNA noticed a metal casing falling from over ceiling wall pipes. CNA reached to hold it in place while second CNA laid pt in bed for safety. While holding the casing the pipes were also leaking water. CNAS stabilized pt in bed and covered him up. Pt was transferred to another room temperatorily [SIC]. SUP (Supervisor) aware. Awaiting further instructions. On 11/11/24, at 2:49 PM, Surveyor interviewed Director of Building and Grounds (Director)-J on equipment maintenance, safety, and prevention of hazards. Director-J informed Surveyor the facility does safety rounds and have a safety committee review problems and concerns. Director-J stated the Facility has a TELS system that alerts the department of checks and maintenance needed at certain times. Surveyor asked Director-J what was done for both the July and August incidents surrounding the valance coming down. Director-J informed Surveyor clamps were placed on the valance to secure it and the second time, against my better judgement, put screws in it. Surveyor asked Director-J about what was meant by better judgement. Director-J stated, they are designed to come off so I felt this would cause more damage if the valance was hit again. Surveyor asked Director-J what plan was put in place to prevent this from happening in all the rooms. Director-J informed Surveyor, they are cleaned and inspected every quarter. Surveyor requested whatever documentation, policy and logs available related to the quarterly inspections. On 11/11/24, at 3:05 PM Surveyor received from Director-J items labeled Logbook Documentation. Director-J informed writer this was 2 years of documentation. Surveyor asked Director-J about the quarterly documentation discussed. Director-J indicated he misspoke, and it was every 6 months, not every quarter. Surveyor inquired about the water build up and how the cleaning was done in the valance. Director-J informed Surveyor, sometimes the drain gets plugged but that drain wasn't plugged, we clean with bleach water and condensate tablets that are dropped into the drainage channel. There is always some water in the channel till it fills a certain amount then it triggers to drain. Surveyor asked if Director-J had any further documentation or logs related to the maintenance of the heating and cooling valances. Director-J replied, this is what we do the TELS system. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 8:45 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A if she was aware of the incident of the heating and cooling valance falling in R4's room in July and August of 2024. NHA-A informed Surveyor NHA-A started in August but heard about the July incident. NHA-A told Surveyor the August incident happened right after NHA-A started. NHA-A informed Surveyor NHA-A called an ad hoc quality assurance meeting. We added reinforcement clamps and the screws because this was the second time. NHA-A informed Surveyor, she got the Chief Operating Officers involved from corporate headquarters to help put a plan in place. Surveyor requested the incident reports and the plan for both July and August incidents. On 11/12/24, at 9:24 AM, Surveyor received both incident reports and one follow up action report from NHA-A. The first report dated 7/10/24, at 5:00 PM and a second report dated 8/8/24, at 9:30 AM. Investigation follow up dated 8/12/24, at 9:04 AM. Surveyor asked if there was an investigation and plan for the 7/10/24 incident. NHA-A informed Surveyor they were still looking for it. On 11/12/24, at 9:24 AM, Surveyor reviewed the investigation/follow-up documentation dated 8/12/24, 9:04 AM. Documented was Late entry from 8/8/24 [NAME] (collects condensation from the pipes) in room partially disconnected from the ceiling. Subsequently the contents (water and debris) from the [NAME] fell on to the resident. Upon assessment resident alert/oriented and remains at baseline. Resident was immediately moved out of room and relocated to another room. Resident received a shower, new bedding, new bed and clean clothes. DON and NHA went to speak with resident (sister) at bedside to offer assistance and to make them aware a plan will be put into place to address the [NAME] issue. An emergency meeting was called at 1030 to discuss the situation that took place and a resolution moving forward to safeguard all residents residing in facility to ensure [NAME] disconnecting would never happen again. The director of buildings and grounds, management partners: . COO (Chief Operating Officer), Regional Maintenance director and VP (Vice President) of Operations and . COO of Management company were all present for the call. Plan of action for all rooms as follows: 1 We vacuum the entire valance getting the water, sludge, or debris out. 2 we wash out the valance with bleach water and rags. 3 we spray mold resistant spray inside the valance. 4 We drop gel tabs to keep the sludge from forming. To clean out all rooms resident's will be moved temporarily out of the room. Valance reinforced with clips to assure adherence. On 11/12/24, at 10:08 AM Surveyor was informed by NHA-A she had no other information left from the previous Nursing Home Administrator related to the 7/10/24 incident. NHA-A informed Surveyor Director-J would come back in to explain what happened on the 7/10/24 incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 11:04 AM, Surveyor interviewed Director-J about the follow up plan given to this Surveyor for the 8/8/24 incident. Surveyor requested any addition information for the 7/10/24 follow up investigation and plan. Director-J gave surveyor a work order dated 8/8/24 for the valance service in R4's original room. Surveyor asked Director-J what was done directly after the 7/10/24 incident. Director-J informed the Surveyor the valance was put back on the hooks, they are all on the same hooks, they had never fallen before. Surveyor asked Director-J if anyone had told him the valance was hit by the mechanical left. Director-J told Surveyor the staff didn't tell Director-J that it was hit, Director-J felt the dent in the valance indicated it must have been. Surveyor asked Director-J when the clamps and cleaning started on the valances. Director-J informed Surveyor, after the 8/8/24 incident, the screws were placed 2 weeks after to be on the safe side because it was the second time it fell . Surveyor asked Director-J if during the 6-month inspection and cleaning were all the valances cleaned and inspected. Director-J informed the Surveyor, no they are not all cleaned, we get on a ladder and inspect them. If the valances have gunk or water in them, we clean them with the bleach and drop the tablets in them. If they look good and dry, we move on to the next one. Surveyor asked Director-J if the plan of action given to the Surveyor was implemented as written. Director-J yes, we check them, but only clean as needed, we do spray them. Surveyor requested any addition information Director-J may have. On 11/12/24, at 1:57 PM, a list of the work orders for the year 2024 were provided. Surveyor reviewed the list and noted it contained the same work order for room R4's former room dated 8/8/24. On 11/12/24, at 12:17 PM, Surveyor interviewed the NHA-A. Surveyor informed NHA-A of the concerns with no investigation or root cause analysis into the 7/10/24 incident of the valance falling open over R4's bed and the concern no intervention was put into place to prevent this from happening again. This resulted in a second time, on 8/8/24, R4 was splashed with condensate and debris from the valance. NHA-A informed writer she would continue to look for something from the previous administrator. On 11/13/24, at 11:36 AM, Surveyor received additional information provided by the Facility. Surveyor reviewed the information sent. A plan was discussed in the E-Mails the valances in all the rooms to be checked for 2 weeks to be placed in their maintenance TELS program. Surveyor informed NHA-A that Director-J gave Surveyor 2 years of TELS data related to the valance inspections and work orders. Surveyor requested the TELS information mentioned in the E-mail presented from NHA-A. On 11/15/24, at 12:38 PM, Surveyor was informed by NHA-A the data in the E-Mail from July 11,2024, valance checks placed in the TELS program addressing the July 10, 2024, incident plan of action are not available. NHA-A informed Surveyor the data did not transfer with their last management change. NHA-A informed Surveyor the facility had no other information.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview, and record review the facility did not provide pharmaceutical services to assure accurate dispensing and administering medications to meet the needs of each resident and did not ensure drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 2 (R2 & R3) of 2 residents reviewed. *The Facility did not have records to account for R2's controlled medication administration. *R3 did not receive Mexiletine 150 mg on 11/10/24 at 12:00 p.m., 6:00 p.m., 11/11/24 at 12:01 a.m., 6:00 a.m., 6:00 p.m., 11/12/24 12:01 a.m., & 6:00 a.m. as the medication was not available. Findings include: 1.) R2 was admitted to the facility on [DATE] for after care of a femur fracture. R2's admission Minimum Data Set (MDS), dated [DATE], documents R2 has a Brief Interview for Mental status (BIMS) of 00. R2's admissions MDS documents R2 was on a scheduled pain medication regimen, received as needed pain medication and did not receive nonpharmacological pain interventions for pain in the last 5 days. A pain interview was conducted and documents the following, presence of pain- Yes, pain frequency- Frequent, pain interference with therapy activities- Occasionally, pain interference with day-to-day activities- Occasionally, and pain intensity- 05. The Facility policy, titled, Nursing Policy & Procedure, with a last revised date of 11/2024, documents in part, SUBJECT: Controlled Substances. POLICY: Nursing Staff will ensure resident safety by following regulatory requirements and best practices for the storage and use of controlled substances. Medication technician, nurse, or RN Supervisor will hold the keys at all times. PROCEDURE: . 2. Nursing staff we'll maintain and document on an individual record for each controlled substance ordered for and administered to resident. The form will contain the following information: a) Name of Medication. b) Dose. c) Resident Name. d) Physician Name. e) Signature for every dose administered. f) Balance of medication after each dose administered. 10. T Director of Nursing (DON) of designee will retain completed individual records in the respective resident chart. The Facility provided document for R2, titled, MEDICATION RECORD FOR 09/2024, documents in part R2 having the following medication orders, Tramadol 50 mg tablet [generic] Type M-Meds (except psych, oxy, resp) -1 tab By Mouth Every 6 Hours as needed For pain; Diagnosis/Reason = pain; 1 tab PO Q6HPRN (every 6 hours as needed) with a start date of 09/12/2024 and end date 09/27/2024.Tramadol 25 mg tablet [generic] Type M-Meds (except psych, oxy, resp) -25 mg By Mouth Every 6 Hours hold if patient sleepy/lethargic For pain; Diagnosis/Reason = pain; 25 mg PO Q6H (every 6 hours), time 6:00 AM, 12:00 PM, 6:00 PM and 12:01 AM with a start date of 09/27/2024 and end date 10/09/2024. Surveyor noted Tramadol is a controlled pain medication. On 11/11/2024, Surveyor requested narcotic count sheets for R2 from the Facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/2024, at 2:22 PM, Quality Support Nurse-L provider Surveyor with a copy of document for R2 titled, Controlled Drug Record, dated 09/18/2024, and documents Tramadol 50mg, quantity 1, with zero remaining. Quality Support Nurse-L informed Surveyor there are no other count sheets for R2's controlled medication and indicated the other count sheets were sent home with R2 upon discharge. On 11/11/2024, at 02:51 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-M. LPN-M informed Surveyor that controlled medications that are left over once a resident is discharged , are sent with the resident. LPN-M informed Surveyor that the count sheets are signed by 2 nurses and the resident or residents' power of attorney upon discharge. LPN-M informed Surveyor that count sheets are not usually sent home with residents upon discharge, and that the count sheets are to be given to the manager to be filed in medical records. LPN-M informed Surveyor LPN-M may have sent the count sheets with R2 upon discharge. Nursing Home Administrator (NHA)-A provided Surveyor with a document titled, Coaching Notice, and documents in part, Date of Non-Compliance 10/19/2024 Date Discussed with employee 11/11/2024 and documents re-education provided to LPN-M regarding narcotic count sheets and the process. 20483 The facility's policy titled, Medication Ordering and Receiving from Pharmacy Provider and dated 1/23 under procedure documents c. If not utilizing cycle fill or anniversary fill system, all medications shall be reordered in advance by writing the medication name and prescription number, or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Under 2. Receiving medications from the pharmacy: documents a. Licensed nurse or appropriate personnel as required by law receives medications delivered to the nursing care center from the pharmacy and documents delivery on the medication delivery receipt/manifest . Returns a signed copy of the delivery receipt/manifest to the pharmacy via driver, fax or other method, as defined by the pharmacy provider. Retains a copy of the delivery receipt for an appropriate time to reconcile any ordering issues. 2.) R3's diagnosis includes cardiac arrhythmia. The physician order dated 10/21/24 documents Mexiletine 150 mg (milligrams) capsule [generic] 1 cap (capsule) tube four times a day for arrhythmia's. The nurses note dated 11/10/24, at 13:47 (1:47 p.m.), documents Pt. (patient) out of his Mexiletine, call placed to pharmacy to send today. Awaiting call back. This nurses note was written by LPN (Licensed Practical Nurse)-W. The nurses note dated 11/12/24, at 12:32 p.m., includes documentation of 9:34 am - Call placed to [Pharmacy Company Name] to find out why the L (Levo)-Thyroxine & Mexiletine weren't delivered. This nurses note was written by LPN-W and modified by MRD/RN (Medical Records Director/Registered Nurse)-HH. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R3's November 2024 MAR (medication administration record) and noted Mexiletine 150 mg has a code of V which means not available on 11/10/24 at 12:00 p.m. 11/11/24 at 12:01 a.m., 11/11/24 at 6:00 a.m., 11/12/24 at 12:01 a.m., & 11/12/24 at 6:00 a.m. The 12:00 p.m. dose on 11/10/24 has a note which documents Call placed to [Pharmacy Name] for delivery (did not come on yesterday's delivery). Surveyor noted the 6:00 p.m. dose is initialed as being administered on 11/10/24 & 11/11/24. On 11/12/24, at 9:24 a.m., Surveyor asked LPN (Licensed Practical Nurse)-V how medication is reordered so a resident doesn't run out of their medication. LPN-V explained normally they have two cards but it depends if the medication is scheduled or the doctor is trying out the medication. If the medication is a narcotic there is a reorder number. On 11/12/24, at 10:15 a.m., Surveyor asked RN (Registered Nurse) Supervisor-Q how scheduled medication is reordered so a resident doesn't run out of the medication. RN Supervisor-Q informed Surveyor they have a month supply and he'll have to follow up to give Surveyor an exact answer. On 11/12/24, at 10:44 a.m., RN Supervisor-Q informed Surveyor medication is ordered on demand and they don't use a cycle fill. RN Supervisor-Q explained it's up to the nurse that is taking care of the resident if their medication is low to call the pharmacy, fax, or do it through the computer. Surveyor asked RN Supervisor-Q if he knew why R3 Mexiletine 150 mg was not available. RN Supervisor-Q replied I'd have to look into it, I don't know. On 11/12/24, at 11:24 a.m., RN Supervisor-Q informed Surveyor they have been calling [Name of pharmacy] who said they were going to send the medication and didn't send it. RN Supervisor-Q informed Surveyor they re-faxed it this morning. RN Supervisor-Q informed Surveyor the pharmacy said they delivered the medication on the 8th (11/8/24) but they can't prove they have a manifest to show the medication was delivered. RN Supervisor-Q informed Surveyor he called the clinical client representative and left a message that they need the medication. On 11/12/24, at 11:49 p.m., Surveyor asked DON (Director of Nursing)-B if she was aware of R3's Mexiletine 150 mg not being available. DON-B informed Surveyor if they were having trouble she would get involved and speak with the representative [Name] herself and get the medication in here. DON-B stated no I wasn't made aware. On 11/12/24, at approximately 1:30 p.m., Surveyor asked DON-B if Mexiletine 150 mg is in contingency. DON-B informed Surveyor she didn't know and will check to see. On 11/12/24, at 2:02 p.m., DON-B informed Surveyor the medication is not in contingency. Surveyor showed DON-B R3's November MAR where the Mexiletine 150 is initialed as being administered when the other entries indicate the medication is not available. On 11/12/24, at 2:32 p.m., DON-B informed Surveyor the medication was not here, referring to Mexiletine 150 mg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525069	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	8615 W Beloit Rd West Allis, WI 53227

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 20483 Based on observation, interview, and record review the Facility did not ensure there was a medication error rate below 5 percent. There were 4 medication errors in 25 opportunities which resulted in a medication error rate of 16%. Medication errors were identified for R9, R10, & R11. * On 11/12/24 R9 was not administered Sennosides 8.6 mg (milligram)-docusate sodium 50 mg and only 20 cc (cubic centimeters) was added to Polyethylene Glycol 3350 17 grams. * On 11/12/24 Licensed Practical Nurse (LPN)-W added only 30 cc (one ounce) to R10's Polyethylene Glycol 3350 17 grams. * R11 did not receive Aspirin 81 mg tablet delayed release on 11/12/24. Findings include: According to https://dailymed.nlm.nih.gov under directions for Polyethylene Glycol 3350 documents 1. Note: This product cap is for dosing. A capful contains about 17 grams of powder. 2. Daily dose is 17 grams per day or as directed by a physician. 3. Pour 17 grams (about 1 heaping tablespoon) of powder into a cup. 4. Stir the powder in 4 to 8 oz of water, juice, soda, coffee or tea until completely dissolved. 5. Drink the solution. 1.) On 11/12/24, at 7:19 a.m., Surveyor observed LPN (Licensed Practical Nurse)-X prepare R9's medication which consisted of Oxycodone 5 mg (milligrams) one tablet, Pregabalin 75 mg one capsule, Furosemide 20 mg one tablet, Pantoprazole 40 mg one tablet, Polyethylene glycol 3350 17 grams, Prednisone 10 mg one tablet, Multivitamin one tablet, Senna 8.6 mg one tablet, Spironolactone 25 mg one half tablet, Tadalafil 20 mg one tablet, Thiamine B-1 100 mg one tablet, Vitamin D3 25 mcg (micrograms) one tablet, Sertraline 25 mg one tablet, Sertraline 100 mg one tablet and Eliquis 5 mg one tablet. At 7:34 a.m., LPN-X crushed R9's medication with the exception of Polyethylene Glycol 3350 17 grams which had been poured into a plastic up and Pregabalin 75 mg capsule. After crushing R9's medication, LPN-X placed gloves on and opened the capsule of Pregabalin 75 mg and poured the medication into R9's crushed medication. At 7:37 a.m., LPN-X placed R9's medication on an over bed table and placed gloves & gown on. LPN-X added 20 cc (cubic centimeters) of water to R9's crushed medication, flushed R9 tube, and administered R9's medication via the tube. LPN-X added 20 cc of water to R9's Polyethylene glycol and administered this medication to R9 via the tube. LPN-X checked R9's blood sugar, removed her gloves & gown and cleansed her hands. At 7:47 a.m., LPN-X was provided with a bottle of Vitamin B-6 50 mg. LPN-X poured Vitamin B-6 50 mg one tablet into a medication cup and crushed the Vitamin B-6. At 7:50 a.m., LPN-X placed gloves & gown on, added 10 cc of water to the crushed Vitamin B-6 and flushed R9's tube with 15 cc of water. LPN-X administered R9's Vitamin B-6 and then flushed the tube with 15 cc of water. LPN-X removed her gown & gloves and washed her hands. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R9's physician orders and noted an order dated 11/4/24 Sennosides 8.6 mg - docusate sodium 50 mg tablet [generic] - 1 tab (tablet) Tube Twice a day for constipation. R9 received Sennosides 8.6 mg. On 11/12/24, at 9:34 a.m., Surveyor informed LPN-X Surveyor wanted to check her medication cart and accompanied LPN-X to the medication cart. Surveyor observed in the cart there is a bottle of Senna (Sennosides 8.6 mg) and a bottle of Senna plus (Sennosides 8.6 mg-docusate sodium 50 mg). LPN-X asked Surveyor what Surveyor was looking for. Surveyor informed LPN-X Surveyor was checking to see if there was a bottle of Senna Plus in the medication cart. LPN-X informed Surveyor she did not give R9 Senna plus. Surveyor then informed LPN-X R9's physician order is for Senna Plus not Senna. This resulted in a medication error for R9. On 11/12/24, at 9:36 a.m., Surveyor informed LPN-X Surveyor would like to see the Polyethylene glycol bottle. Surveyor noted the label on the back of the bottle documents 4 to 6 ounces of liquid should be added. LPN-X added less than one ounce of water. This resulted in a medication error for R9. On 11/12/24, at 10:10 a.m., Surveyor asked RN (Registered Nurse) Supervisor-Q how much water should be added to Miralax (Polyethylene Glycol). RN Supervisor-Q informed Surveyor he'll have to get back to Surveyor and then explained he personally adds four ounces of water. Surveyor then informed RN Supervisor-Q R9 received Senna not Senna plus according to physician orders. On 11/12/24, at 10:44 a.m., RN Supervisor-Q informed Surveyor four to eight ounces of water should be added to Miralax (Polyethylene Glycol). This observation resulted in two medication errors for R9. On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above. 2.) On 11/12/24, at 8:00 a.m., Surveyor observed LPN (Licensed Practical Nurse)-W prepare R10's medications which included Polyethylene Glycol 3350 17 grams. At 8:07 a.m. after administering R10's other medication according to physician orders, LPN-W flushed R10's tube with 15 cc of water, added 30 cc of water to Polyethylene Glycol 3350 and administered this medication via tube. R10's physician orders dated 7/17/24 documents Polyethylene Glycol 3350 17 grams oral powder packet [generic] 17 gram Tube every day for constipation hold if having diarrhea. On 11/12/24, at 10:10 a.m., Surveyor asked RN (Registered Nurse) Supervisor-Q how much water should be added to Miralax (Polyethylene Glycol). RN Supervisor-Q informed Surveyor he'll have to get back to Surveyor and then explained he personally adds four ounces of water. On 11/12/24, at 10:44 a.m., RN Supervisor-Q informed Surveyor four to eight ounces of water should be added to Miralax (Polyethylene Glycol). Adding only one ounce (30 cc) of water to R10's Polyethylene Glycol 3350 17 grams resulted in a medication error for R10. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above. 3.) On 11/12/24, at 8:25 a.m., Surveyor observed LPN (Licensed Practical Nurse)-V prepare R11's medication which consisted of Chewable Aspirin 81 mg (milligrams) one tablet, Folic Acid 1000 mcg (micrograms) one tablet, Losartan Potassium 100 mg one tablet, Sertraline 50 mg one tablet, and Carvedilol 12.5 mg one tablet. At 8:28 a.m. LPN-V administered R11 his medication whole with water. Surveyor reviewed R11's physician orders and noted an order dated 11/7/24 Aspirin 81 mg tablet, delayed release [generic] 1 tab (tablet) by mouth every day for heart health. On 11/12/24, at 9:28 a.m., Surveyor asked LPN-V if she has Aspirin 81 mg delayed release as R11's physician order is for delayed release not chewable. LPN-V looked in her medication cart and stated I don't see it I'll have to ask central supply. Surveyor asked LPN-V if she noted R11's physician order is for Aspirin 81 mg delayed release. LPN-V replied yes after you said something. LPN-V administered R11 chewable aspirin 81 mg not aspirin 81 mg delayed release. This resulted in a medication error for R11. On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above.

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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. 20483 Based on observation, interview, and record review the facility did not maintain an infection prevention and control program designed to reduce the transmission of disease and infection for 2 (R3 & R10) of 4 Residents. * Staff did not wear appropriate PPE (personal protective equipment) when providing incontinence cares and changing a dressing for R3. R3 is on EBP (enhanced barrier precautions). * Staff did not wear appropriate PPE when administering R10's medication via the feeding tube. R10 is on EBP. Findings include: The facility's policy titled, Infection Control Policy & Procedure, Subject: Enhanced Barrier Precautions and last revised/reviewed 11/24 under Policy documents To prevent the spread of infection within the VMP facility through the use of Enhanced Barrier Precautions with residents, when appropriate. Under Procedure documents Enhanced Barrier Precautions (EBP) expand the use of PPE (personal protective equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi-Drug Resistant Organisms) may be indirectly transferred from resident-to resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. 1.) R3's diagnoses includes acute & chronic respiratory failure with hypoxia, ataxia following cerebral infarction, quadriplegia, legal blindness, anoxic brain injury, obesity, and epileptic seizures. R3 has a tracheostomy and gastrostomy & jejunostomy tube. The physician orders with an order date of 10/21/24 documents Enhanced Barrier Precautions - Every Shift. On 11/1/24, at 10:40 a.m., Surveyor observed an enhanced barrier precaution sign outside R3's room. On 11/11/24, from 1:04 p.m. to 1:27 p.m., Surveyor observed CNA (Certified Nursing Assistant)-CC and CNA-H provide incontinence cares for R3 and change the sheets on R3's bed. Surveyor observed during this observation CNA-CC and CNA-H were wearing gloves but neither CNA-CC or CNA-H wore a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/24, at 2:46 p.m., Surveyor observed LPN-BB, CNA-DD, and CNA-EE entered R3's room and placed gloves on. Surveyor observed LPN (Licensed Practical Nurse)-BB, CNA-DD, & CNA-EE were not wearing gowns CNA-DD & CNA-EE positioned R3 on the right side. LPN-BB removed the foam dressing and cleansed the mid back with wound cleanser on a four by four gauze. Surveyor observed the area is not open. After cleansing the area, LPN-BB applied a foam dressing over the mid back. CNA-DD & CNA-EE repositioned R3. LPN-BB, CNA-DD, & CNA-EE removed their gloves and cleansed their hands. On 11/12/24, at 10:02 a.m., Surveyor asked IP (Infection Preventionist)-U how staff know a resident is on enhanced barrier precautions. IP-U informed Surveyor there is signage posted and an order is in Matrix (facility's electronic medical record system). Surveyor asked when a resident is on enhanced barrier precautions what are staff required to do. IP-U informed Surveyor hand hygiene and wearing gown & gloves. IP-U explained staff would wear appropriate PPE (personal protective equipment) during anything considered high contact such as changing, bathing, anything of that nature. Surveyor informed IP-U of the observations with R3 of staff not wearing appropriate PPE as they only wore gloves and not a gown. On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above. 2.) On 11/12/24, at 8:00 a.m., Surveyor observed LPN (Licensed Practical Nurse)-W prepare R10's medications which included Polyethylene Glycol 3350 17 grams. Surveyor observed there is an enhanced barrier sign posted on the left side of the door frame. On this sign is a white label which documents enhanced barrier precautions both bed A & B. Change PPE (personal protective equipment) and wash hands between residents. At 8:05 a.m. LPN-W placed gloves on, entered R10's room and flushed R10's feeding tube. LPN-W did not place a gown on. At 8:07 a.m. after administering R10's other medication according to physician orders, LPN-W flushed R10's tube with 15 cc of water, added 30 cc of water to Polyethylene Glycol 3350 and administered this medication via tube. LPN-W flushed R10's feeding tube with 10 cc of water, stated she's going to rinse the syringe as the syringe gets stained from B complex, and rinsed out the syringe in the bathroom. LPN-W removed her gloves, told R10 she would see him later and cleansed her hands. On 11/12/24, at 8:12 a.m., Surveyor asked LPN-W who is on enhanced barrier precautions. LPN-W replied I don't know because we only put on for artificial airway, says A & B referring to the white label on the enhanced barrier precaution sign, but I don't know. I'll have to speak to [first name] IP (Infection Preventionist). On 11/12/24, at 8:15 a.m., LPN-W asked IP-U why there's a EBP sign on R10's door. IP-U asked LPN-W doesn't R10 have a peg tube. LPN-W replied yes, I wasn't thinking. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24, at 10:02 a.m., Surveyor asked IP (Infection Preventionist)-U how staff know a resident is on enhanced barrier precautions. IP-U informed Surveyor there is signage posted and an order is in Matrix (facility's electronic medical record system). Surveyor asked when a resident is on enhanced barrier precautions what are staff required to do. IP-U informed Surveyor hand hygiene and wearing gown & gloves. IP-U explained staff would wear appropriate PPE (personal protective equipment) during anything considered high contact such as changing, bathing, anything of that nature. Surveyor informed IP-U LPN-W did not wear a gown when administering R10's medication via the feeding tube. On 11/12/24, at 11:34 a.m., DON (Director of Nursing)-B and Quality and Clinical Support Nurse-L were informed of the above. On 11/12/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A was informed of the above.