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	02/13/2025

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not provide written notice to residents and offer them a choice in a change of room for 4 (R7, R8, R9, and R10) of 4 residents reviewed for room change. R7, R8, R9, and R10 were moved from one unit to another without having taken resident preference into account or offering to show the possible rooms to the resident/resident representative prior to the move. Findings include: In a letter to residents and families of the facility dated 2/3/2025, the letter documents: In our ongoing commitment to enhancing the quality of care for our residents, we have implemented a reorganization plan aimed at better meeting their needs. This plan will be rolled out in two phases. Phase one is anticipated to be completed during the week of February 24th. During this phase, all ventilator residents currently on Sunnyview 2 will be relocated to Parkview 2. Phase two will involve transitioning all tracheostomy patients from Sunnyview 2 to the general population between the 1st and 2nd floor, depending on the resident's needs and bed availability. Our building and grounds team will be working diligently to refurbish the rooms, ensuring that they are equipped with all the essentials for our residents. Then, Sunnyview 2 will primarily serve our short-term rehabilitation residents moving forward. We believe these changes will significantly enhance the overall experience and care we provide. Please note that the time frames mentioned for the two phases are subject to change. Thank you for your understanding and support as we strive to better serve our residents. If you have any questions or concerns, please do not hesitate to reach out. Surveyor noted the letter provided to residents and families did not provide personalized information to the resident or family member as to what rooms were available to take resident or family member preference into account. 20 residents were involved in changing rooms for the benefit of the facility; 9 residents with tracheostomies were moved with three residents moving from a private room to a room with a roommate and 11 residents that were ventilator dependent were moved with one ventilator dependent resident currently in the hospital but would return to the new room. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Maplewood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 W Beloit Rd West Allis, WI 53227	

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/13/2025 at 8:37 AM, Surveyor asked Registered Nurse Supervisor (RN Sup)-M about the moving of residents to different rooms and units. RN Sup-M stated everyone was moved on 2/11/2025 and it was organized chaos. RN Sup-M stated the residents from the two units swapped room with staff moving all their personal items. RN Sup-M stated no families were present for the move. In an interview over the phone on 2/13/2025 at 11:48 AM, Pulmonologist-DD stated the facility moved residents on a ventilator to one unit so they are easier to handle with the staff. Pulmonologist-DD did not know if the residents had been moved to the different rooms at that time. Pulmonologist-DD stated the facility was going to have a 12-bed ventilator unit for the one Respiratory Therapist. In an interview on 2/13/2025 at 1:35 PM, Social Worker (SW)-GG stated residents on vents were moved to Parkview 2 and that was a total of 12 residents so the Respiratory Therapist could be on the vent unit. SW-GG stated SW-GG was updated last week about the move and to send out the letter to residents and resident families. SW-GG stated she called and got consents from residents and families regarding the move. SW-GG stated all residents were moved on 2/11/2025. SW-GG stated if the resident was on a ventilator, they were expected to move to the vent unit. SW-GG stated none of the families she talked to disagreed to the move; all the rooms on the new vent unit are private rooms and have been remodeled. Surveyor asked SW-GG why the residents were moved on 2/11/2025 and not the week of 2/24/2025 as said in the letter. SW-GG did not know why everyone moved on 2/11/2025 but thought that was pretty sudden. 1.) R7 was admitted to the facility on [DATE]. R7 was ventilator dependent. R7 was resident responsible. R7 was moved to a different room and unit on 2/11/2025. On 2/12/2025 at 5:42 AM in the progress notes, nursing documented R7 was adjusting well to the new unit and did not have any issues or concerns that shift. Surveyor noted no documentation was found indicating R7 had been aware of the upcoming room change or given a preference as to which room R7 would like. On 2/13/2025 at 1:20 PM, Surveyor observed R7 sitting in a wheelchair in R7's room doing a puzzle at a table. R7 was unable to communicate verbally due to R7's ventilator status but was able to respond with head movements yes and no. Surveyor asked R7 if there had been any communication with R7 prior to R7 changing rooms. R7 shook the head side to side indicating no. Surveyor asked R7 if R7 was told why R7 was changing rooms. R7 shook the head side to side indicating no. Surveyor asked R7 if R7 had received a letter explaining the move and the reason for the move. R7 shook the head side to side indicating no. Surveyor asked R7 if anyone had talked to R7 and told R7 why there was a room change since the move. R7 shook the head side to side indicating no. In an interview on 2/13/2025 at 1:35 PM, Surveyor shared with SW-GG R7's response to questions regarding the room change; R7 had not received the letter provided by the facility and was not aware of why the room had been changed. SW-GG stated R7 may not have been in R7's room when the letters were provided to residents that were their own person and may not have been verbally told the reason for the move. 2.) R8 was admitted to the facility on [DATE]. R8 was ventilator dependent. R8 was resident responsible. R8 was moved to a different room and unit on 2/11/2025. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/2025 at 2:08 PM in the progress notes, Social Worker (SW)-GG documented SW-GG met with R8 and discussed a room change from the current room [ROOM NUMBER]A to 2114 as was outlined in the letter R8 received. R8 was aware of the move and would let R8's family know. R8 was aware the move may occur as early as 2/11/2025. Surveyor noted R8 was not offered a choice in rooms or given a preference. Surveyor noted R8 was moved to a different room than the room that SW-GG discussed with R8. On 2/11/2025 at 9:15 PM in the progress notes, Licensed Practical Nurse (LPN)-O documented R8 was adjusting well to the new room during the shift. R8 assisted staff with arranging the room to a comfortable position. R8 did not have any concerns and was able to make needs known. On 2/13/2025 at 1:04 PM, Surveyor observed R8 sitting up in bed. R8 used a phone for communication as well as mouthing words with no vocalization due to the ventilator. R8 stated R8 was aware of the room change prior to moving rooms. R8 stated R8 was given a letter from the facility describing the change in rooms. Surveyor shared with R8 that R8 was not moved to the room R8 had been told R8 was moving to and asked R8 when was R8 aware that R8 was moving to a different room than had been discussed. R8 stated R8 found out the day R8 moved that it would be to a different room. In an interview on 2/13/2025 at 1:35 PM, Surveyor asked SW-GG why R8 was not moved to 2114 as had been discussed prior to the move. SW-GG stated another resident's family came to the facility and did not want staff to move any of the resident's belongings. SW-GG stated the only empty room at that time was 2114 so the other resident moved into 2114 and R8 was moved into a different room. Surveyor asked SW-GG if R8 was in agreement to that room. SW-GG stated the rooms are all private and the same and did not hear any disagreement from R8. 3.) R9 was admitted to the facility on [DATE]. R9 was ventilator dependent. R9 had an activated Power of Attorney (POA). R9 was moved to a different room and unit on 2/11/2025. On 2/3/2025 at 12:41 PM in the progress notes, Social Worker (SW)-GG documented SW-GG spoke to R9's family on 1/30/2025 regarding a room change from 2313A to 2312A. R9's family was in agreement. Surveyor noted R9's family was not offered a choice in rooms or given a preference. On 2/4/2025 at 3:11 AM in the progress notes, nursing documented R9 was sent to the hospital with a change in condition. On 2/11/2025 at 5:29 PM in the progress notes, Registered Nurse Supervisor (RN Sup)-M documented R9 was readmitted to the facility to room [ROOM NUMBER]. Surveyor noted this was not the room R9's family had been in agreement to moving to on 2/3/2025. On 2/13/2025 at 9:47 AM in the progress notes, SW-GG documented SW-GG spoke with R9's POA and let the POA know that R9 was readmitted the day before and is adjusting to the new room [ROOM NUMBER]. In an interview on the phone on 2/13/2025 at 11:11 AM, Surveyor asked R9's POA if R9's POA had been notified of R9's room change. R9's POA stated R9's POA had received a call that morning to say R9 was in room [ROOM NUMBER]. R9's POA had received a letter from the facility about the room changes but had not been given any choices as to what room R9 could move to. R9's POA stated R9's POA was fine with the move. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/13/2025 at 1:35 PM, Surveyor asked SW-GG why R9 was not moved to 2312A as had been discussed prior to the move. SW-GG stated R9 was in the hospital at the time everyone moved so when R9 readmitted , they moved R9 to the room on the vent unit. SW-GG stated SW-GG contacted R9's POA that morning to inform them of the new room number. Surveyor noted R9's POA was not aware of the new room change until two days after R9 was moved into the new room. 4.) R10 was admitted to the facility on [DATE]. R10 was ventilator dependent. R10 had an activated Power of Attorney (POA). R10 was moved to a different room and unit on 2/11/2025. On 2/10/2025 at 4:25 PM in the progress notes, Social Worker (SW)-GG documented SW-GG updated R10's POA of R10's room change to 2113 tomorrow, 2/11/2025. On 2/11/2025 at 10:10 PM in the progress notes, Licensed Practical Nurse (LPN)-O documented R10 was adjusting well to the new room change. Surveyor noted R10 moved to room [ROOM NUMBER], not the room R10's POA had been in agreement to. In a phone interview on 2/13/2025 at 11:16 AM, Surveyor asked R10's POA if R10's POA had been notified of R10 changing rooms. R10's POA stated SW-GG emailed R10's POA on 2/10/2025 about R10 moving to room [ROOM NUMBER] and had not received any letter from the facility about the plan to change rooms for ventilator residents. R10's POA stated R10's POA asked SW-GG the reason for moving R10 and SW-GG told R10's POA the facility was moving all ventilator residents from Sunnyview 2 to Parkview 2 because it works better for a smaller unit to have the ventilator residents for staffing the unit. Surveyor asked R10's POA to verify what room R10 was currently in. R10's POA stated R10 was in room [ROOM NUMBER]. Surveyor shared with R10's POA that R10 had been moved to room [ROOM NUMBER]. R10's POA stated they were not aware R10 was not in the room that had been told to them. In an interview on 2/13/2025 at 1:35 PM, Surveyor shared with SW-GG the conversation with R10's POA and the concern R10 had not been moved to the room R10's POA had been told and agreed to. SW-GG reviewed the progress note and R10's census information and agreed R10 was not in the room that had been provided to R10's POA and was not sure what happened in changing the room. Surveyor shared with SW-GG that Surveyor provided R10's correct room number to R10's POA. On 2/13/2025 at 3:10 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concerns residents were moved to different rooms for staff convenience and residents and resident representatives were not notified of specific rooms with options to choose what room they would prefer. NHA-A stated a letter was sent out to all residents with the information of how the facility was reconfiguring their units and residents. Surveyor shared the concerns R7 was not aware of the move until R7 was moved, R8 was moved to a room that was not the room R8 agreed to, R9 was moved to a different room when readmitting to the facility after a hospitalization and R9's POA was not made aware of the room change until two days after readmission, and R10 was moved to a room R10's POA was not aware of until today when Surveyor talked to R10's POA. Surveyor shared none of the residents were given options of which room they would prefer, and the letter did not provide the specific written room information specific to each resident.

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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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not provide the right to refuse transfer to another room in the facility when the purpose of the move is solely for the convenience of staff for 4 (R7, R8, R9, and R10) of 4 residents reviewed for room change. R7, R8, R9, and R10 were moved from one unit to another without having the opportunity to refuse the transfer. Findings include: In a letter to residents and families of the facility dated 2/3/2025, the letter documents: In our ongoing commitment to enhancing the quality of care for our residents, we have implemented a reorganization plan aimed at better meeting their needs. This plan will be rolled out in two phases. Phase one is anticipated to be completed during the week of February 24th. During this phase, all ventilator residents currently on Sunnyview 2 will be relocated to Parkview 2. Phase two will involve transitioning all tracheostomy patients from Sunnyview 2 to the general population between the 1st and 2nd floor, depending on the resident's needs and bed availability. Our building and grounds team will be working diligently to refurbish the rooms, ensuring that they are equipped with all the essentials for our residents. Then, Sunnyview 2 will primarily serve our short-term rehabilitation residents moving forward. We believe these changes will significantly enhance the overall experience and care we provide. Please note that the time frames mentioned for the two phases are subject to change. Thank you for your understanding and support as we strive to better serve our residents. If you have any questions or concerns, please do not hesitate to reach out. The letter was signed by Nursing Home Administrator (NHA)-A and included NHA-A's phone number and email address. Surveyor noted the letter provided to residents and families did not provide the information that they had the right to refuse to transfer rooms. 20 residents were involved in changing rooms for the benefit of the facility; 9 residents with tracheostomies were moved with three residents moving from a private room to a room with a roommate and 11 residents that were ventilator dependent were moved with one ventilator dependent resident currently in the hospital but would return to the new room. In an interview on 2/13/2025 at 8:37 AM, Surveyor asked Registered Nurse Supervisor (RN Sup)-M about the moving of residents to different rooms and units. RN Sup-M stated everyone was moved on 2/11/2025 and it was organized chaos. RN Sup-M stated the residents from the two units swapped room with staff moving all their personal items. RN Sup-M stated no families were present for the move. In an interview over the phone on 2/13/2025 at 11:48 AM, Pulmonologist-DD stated the facility moved residents on a ventilator to one unit so they are easier to handle with the staff. Pulmonologist-DD did not know if the residents had been moved to the different rooms at that time. Pulmonologist-DD stated the facility was going to have a 12-bed ventilator unit for the one Respiratory Therapist. (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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/13/2025 at 1:35 PM, Social Worker (SW)-GG stated residents on vents were moved to Parkview 2 and that was a total of 12 residents so the Respiratory Therapist could be on the vent unit. SW-GG stated SW-GG was updated last week about the move and to send out the letter to residents and resident families. SW-GG stated she called and got consents from residents and families regarding the move. SW-GG stated all residents were moved on 2/11/2025. SW-GG stated if the resident was on a ventilator, they were expected to move to the vent unit. SW-GG stated none of the families she talked to disagreed to the move; all the rooms on the new vent unit are private rooms and have been remodeled. SW-GG stated SW-GG told the residents with tracheostomies they did not have to move rooms. Surveyor asked SW-GG why the residents were moved on 2/11/2025 and not the week of 2/24/2025 as said in the letter. SW-GG did not know why everyone moved on 2/11/2025 but thought that was pretty sudden. 1.) R7 was admitted to the facility on [DATE]. R7 was ventilator dependent. R7 was resident responsible. R7 was moved to a different room and unit on 2/11/2025. On 2/12/2025 at 5:42 AM in the progress notes, nursing documented R7 was adjusting well to the new unit and did not have any issues or concerns that shift. Surveyor noted no documentation was found indicating R7 had been aware of the upcoming room change or given the option to refuse the move. On 2/13/2025 at 1:20 PM, Surveyor observed R7 sitting in a wheelchair in R7's room doing a puzzle at a table. R7 was unable to communicate verbally due to R7's ventilator status but was able to respond with head movements yes and no. Surveyor asked R7 if there had been any communication with R7 prior to R7 changing rooms. R7 shook the head side to side indicating no. Surveyor asked R7 if R7 had received a letter explaining the move and the reason for the move. R7 shook the head side to side indicating no. Surveyor asked R7 if anyone had talked to R7 and told R7 why there was a room change since the move. R7 shook the head side to side indicating no. Surveyor asked R7 if R7 was happy with the new room. R7 nodded the head up and down indicating yes. In an interview on 2/13/2025 at 1:35 PM, Surveyor shared with SW-GG R7's response to questions regarding the room change; R7 had not received the letter provided by the facility and was not aware of why the room had been changed. Surveyor shared with SW-GG the letter sent out did not indicate residents had the right to refuse the room change. SW-GG stated R7 may not have been in R7's room when the letters were provided to residents that were their own person and may not have been verbally told the reason for the move. 2.) R8 was admitted to the facility on [DATE]. R8 was ventilator dependent. R8 was resident responsible. R8 was moved to a different room and unit on 2/11/2025. On 2/7/2025 at 2:08 PM in the progress notes, Social Worker (SW)-GG documented SW-GG met with R8 and discussed a room change from the current room [ROOM NUMBER]A to 2114 as was outlined in the letter R8 received. R8 was aware of the move and would let R8's family know. R8 was aware the move may occur as early as 2/11/2025. Surveyor noted R8 was moved to a different room than the room that SW-GG discussed with R8. (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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/2025 at 9:15 PM in the progress notes, Licensed Practical Nurse (LPN)-O documented R8 was adjusting well to the new room during the shift. R8 assisted staff with arranging the room to a comfortable position. R8 did not have any concerns and was able to make needs known. On 2/13/2025 at 1:04 PM, Surveyor observed R8 sitting up in bed. R8 used a phone for communication as well as mouthing words with no vocalization due to the ventilator. R8 stated R8 was aware of the room change prior to moving rooms. R8 stated R8 was given a letter from the facility describing the change in rooms. Surveyor asked R8 if R8 was given the option of not moving rooms. R8 stated no. R8 stated R8's roommate had recently passed away so the room change was a good move for R8. In an interview on 2/13/2025 at 1:35 PM, Surveyor asked SW-GG why R8 was not moved to 2114 as had been discussed prior to the move. SW-GG stated another resident's family came to the facility and did not want staff to move any of the resident's belongings. SW-GG stated the only empty room at that time was 2114 so the other resident moved into 2114 and R8 was moved into a different room. Surveyor asked SW-GG if R8 was in agreement to that room. SW-GG stated the rooms are all private and the same and did not hear any disagreement from R8. Surveyor noted R8 was not offered the option to refuse the move. 3.) R9 was admitted to the facility on [DATE]. R9 was ventilator dependent. R9 had an activated Power of Attorney (POA). R9 was moved to a different room and unit on 2/11/2025. On 2/3/2025 at 12:41 PM in the progress notes, Social Worker (SW)-GG documented SW-GG spoke to R9's family on 1/30/2025 regarding a room change from 2313A to 2312A. R9's family was in agreement. Surveyor noted R9's family was not offered the option to refuse the move. On 2/4/2025 at 3:11 AM in the progress notes, nursing documented R9 was sent to the hospital with a change in condition. On 2/11/2025 at 5:29 PM in the progress notes, Registered Nurse Supervisor (RN Sup)-M documented R9 was readmitted to the facility to room [ROOM NUMBER]. Surveyor noted this was not the room R9's family had been in agreement to moving to on 2/3/2025. On 2/13/2025 at 9:47 AM in the progress notes, SW-GG documented SW-GG spoke with R9's POA and let the POA know that R9 was readmitted the day before and is adjusting to the new room [ROOM NUMBER]. In an interview on the phone on 2/13/2025 at 11:11 AM, Surveyor asked R9's POA if R9's POA had been notified of R9's room change. R9's POA stated R9's POA had received a call that morning to say R9 was in room [ROOM NUMBER]. R9's POA had received a letter from the facility about the room changes. Surveyor asked R9's POA if R9's POA was informed R9's POA could refuse the move. R9's POA stated no, but R9's POA was fine with the move. In an interview on 2/13/2025 at 1:35 PM, Surveyor asked SW-GG why R9 was not moved to 2312A as had been discussed prior to the move. SW-GG stated R9 was in the hospital at the time everyone moved so when R9 readmitted , they moved R9 to the room on the new vent unit. SW-GG stated SW-GG contacted R9's POA that morning to inform them of the new room number. Surveyor noted R9's POA was not aware of the new room change until two days after R9 was moved into the new room. Surveyor shared with SW-GG the letter sent out did not indicate residents had the right to refuse the room change. (continued on next page)

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) R10 was admitted to the facility on [DATE]. R10 was ventilator dependent. R10 had an activated Power of Attorney (POA). R10 was moved to a different room and unit on 2/11/2025. On 2/10/2025 at 4:25 PM in the progress notes, Social Worker (SW)-GG documented SW-GG updated R10's POA of R10's room change to 2113 tomorrow, 2/11/2025. On 2/11/2025 at 10:10 PM in the progress notes, Licensed Practical Nurse (LPN)-O documented R10 was adjusting well to the new room change. Surveyor noted R10 moved to room [ROOM NUMBER], not the room R10's POA had been in agreement to. In a phone interview on 2/13/2025 at 11:16 AM, Surveyor asked R10's POA if R10's POA had been notified of R10 changing rooms. R10's POA stated SW-GG emailed R10's POA on 2/10/2025 about R10 moving to room [ROOM NUMBER] and had not received any letter from the facility about the plan to change rooms for ventilator residents. R10's POA stated R10's POA asked SW-GG the reason for moving R10 and SW-GG told R10's POA the facility was moving all ventilator residents from Sunnyview 2 to Parkview 2 because it works better for a smaller unit to have the ventilator residents for staffing the unit. Surveyor asked R10's POA to verify what room R10 was currently in. R10's POA stated R10 was in room [ROOM NUMBER]. Surveyor shared with R10's POA that R10 had been moved to room [ROOM NUMBER]. R10's POA stated they were not aware R10 was not in the room that had been told to them. Surveyor asked R10's POA if R10's POA had been given the option to not change rooms. R10's POA stated they had not been given the option to change or not change rooms. R10's POA stated R10's POA felt it would have been better if R10 would not have changed rooms because R10 had been in that room for a couple of years and the staff knew R10. In an interview on 2/13/2025 at 1:35 PM, Surveyor shared with SW-GG the conversation with R10's POA and the choice R10's POA to move rooms would be to have R10 stay in the room R10 had previously been in. SW-GG stated SW-GG knows they have a right to refuse a room change and that the facility can not make any of the residents move, but the ventilator residents were not given that option. On 2/13/2025 at 3:10 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concerns residents were moved to different rooms for staff convenience and residents and resident representatives were not given the option to refuse the transfer. NHA-A stated a letter was sent out to all residents with the information of how the facility was reconfiguring their units and residents and there was contact information if anyone wanted to reach NHA-A. Surveyor shared with NHA-A and DON-B the letter sent out did not indicate residents had the right to refuse the room change. Surveyor shared the concerns R7 was not aware of the move until R7 was moved, R8 was moved to a room that was not the room R8 agreed to, R9 was moved to a different room when readmitting to the facility after a hospitalization and R9's POA was not made aware of the room change until two days after readmission, and R10 was moved to a room R10's POA was not aware of until today when Surveyor talked to R10's POA and would have opted not to have R10 change rooms. Surveyor shared none of the residents were given a choice to move or not move.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Maplewood Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 W Beloit Rd West Allis, WI 53227	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, interview, and record review, the facility did not allow 4 (R7, R8, R9, and R10) of 4 residents reviewed for room change the right to make a choice regarding moving within the facility. R7, R8, R9, and R10 were moved from one unit to another without taking resident preference into account or offering to show the possible rooms to the resident/resident representative prior to the move. Findings include: In a letter to residents and families of the facility dated 2/3/2025, the letter documents: In our ongoing commitment to enhancing the quality of care for our residents, we have implemented a reorganization plan aimed at better meeting their needs. This plan will be rolled out in two phases. Phase one is anticipated to be completed during the week of February 24th. During this phase, all ventilator residents currently on Sunnyview 2 will be relocated to Parkview 2. Phase two will involve transitioning all tracheostomy patients from Sunnyview 2 to the general population between the 1st and 2nd floor, depending on the resident's needs and bed availability. Our building and grounds team will be working diligently to refurbish the rooms, ensuring that they are equipped with all the essentials for our residents. Then, Sunnyview 2 will primarily serve our short-term rehabilitation residents moving forward. We believe these changes will significantly enhance the overall experience and care we provide. Please note that the time frames mentioned for the two phases are subject to change. Thank you for your understanding and support as we strive to better serve our residents. If you have any questions or concerns, please do not hesitate to reach out. Surveyor noted the letter provided to residents and families did not provide personalized information to the resident or family member as to what rooms were available to take resident or family member preference into account. 20 residents were involved in changing rooms for the benefit of the facility; 9 residents with tracheostomies were moved with three residents moving from a private room to a room with a roommate and 11 residents that were ventilator dependent were moved with one ventilator dependent resident currently in the hospital but would return to the new room. In an interview on 2/13/2025 at 8:37 AM, Surveyor asked Registered Nurse Supervisor (RN Sup)-M about the moving of residents to different rooms and units. RN Sup-M stated everyone was moved on 2/11/2025 and it was organized chaos. RN Sup-M stated the residents from the two units swapped room with staff moving all their personal items. RN Sup-M stated no families were present for the move. In an interview over the phone on 2/13/2025 at 11:48 AM, Pulmonologist-DD stated the facility moved residents on a ventilator to one unit so they are easier to handle with the staff. Pulmonologist-DD did not know if the residents had been moved to the different rooms at that time. Pulmonologist-DD stated the facility was going to have a 12-bed ventilator unit for the one Respiratory Therapist. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 2/13/2025 at 1:35 PM, Social Worker (SW)-GG stated residents on vents were moved to Parkview 2 and that was a total of 12 residents so the Respiratory Therapist could be on the vent unit. SW-GG stated SW-GG was updated last week about the move and to send out the letter to residents and resident families. SW-GG stated she called and got consents from residents and families regarding the move. SW-GG stated all residents were moved on 2/11/2025. SW-GG stated if the resident was on a ventilator, they were expected to move to the vent unit. SW-GG stated none of the families she talked to disagreed to the move; all the rooms on the new vent unit are private rooms and have been remodeled. Surveyor asked SW-GG why the residents were moved on 2/11/2025 and not the week of 2/24/2025 as said in the letter. SW-GG did not know why everyone moved on 2/11/2025 but thought that was pretty sudden. 1.) R7 was admitted to the facility on [DATE]. R7 was ventilator dependent. R7 was resident responsible. R7 was moved to a different room and unit on 2/11/2025. On 2/12/2025 at 5:42 AM in the progress notes, nursing documented R7 was adjusting well to the new unit and did not have any issues or concerns that shift. Surveyor noted no documentation was found indicating R7 had been aware of the upcoming room change or given a preference as to which room R7 would like. On 2/13/2025 at 1:20 PM, Surveyor observed R7 sitting in a wheelchair in R7's room doing a puzzle at a table. R7 was unable to communicate verbally due to R7's ventilator status but was able to respond with head movements yes and no. Surveyor asked R7 if there had been any communication with R7 prior to R7 changing rooms. R7 shook the head side to side indicating no. Surveyor asked R7 if R7 was told why R7 was changing rooms. R7 shook the head side to side indicating no. Surveyor asked R7 if R7 had received a letter explaining the move and the reason for the move. R7 shook the head side to side indicating no. Surveyor asked R7 if anyone had talked to R7 and told R7 why there was a room change since the move. R7 shook the head side to side indicating no. In an interview on 2/13/2025 at 1:35 PM, Surveyor shared with SW-GG R7's response to questions regarding the room change; R7 had not received the letter provided by the facility and was not aware of why the room had been changed. SW-GG stated R7 may not have been in R7's room when the letters were provided to residents that were their own person and may not have been verbally told the reason for the move. 2.) R8 was admitted to the facility on [DATE]. R8 was ventilator dependent. R8 was resident responsible. R8 was moved to a different room and unit on 2/11/2025. On 2/7/2025 at 2:08 PM in the progress notes, Social Worker (SW)-GG documented SW-GG met with R8 and discussed a room change from the current room (room number) to (different room number) as was outlined in the letter R8 received. R8 was aware of the move and would let R8's family know. R8 was aware the move may occur as early as 2/11/2025. Surveyor noted R8 was not offered a choice in rooms or given a preference. Surveyor noted R8 was moved to a different room than the room that SW-GG discussed with R8. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/2025 at 9:15 PM in the progress notes, Licensed Practical Nurse (LPN)-O documented R8 was adjusting well to the new room during the shift. R8 assisted staff with arranging the room to a comfortable position. R8 did not have any concerns and was able to make needs known. On 2/13/2025 at 1:04 PM, Surveyor observed R8 sitting up in bed. R8 used a phone for communication as well as mouthing words with no vocalization due to the ventilator. R8 stated R8 was aware of the room change prior to moving rooms. R8 stated R8 was given a letter from the facility describing the change in rooms. Surveyor shared with R8 that R8 was not moved to the room R8 had been told R8 was moving to and asked R8 when was R8 aware that R8 was moving to a different room than had been discussed. R8 stated R8 found out the day R8 moved that it would be to a different room. In an interview on 2/13/2025 at 1:35 PM, Surveyor asked SW-GG why R8 was not moved to (different room number) as had been discussed prior to the move. SW-GG stated another resident's family came to the facility and did not want staff to move any of the resident's belongings. SW-GG stated the only empty room at that time was (the different room number) so the other resident moved into (different room number) and R8 was moved into a different room. Surveyor asked SW-GG if R8 was in agreement to that room. SW-GG stated the rooms are all private and the same and did not hear any disagreement from R8. 3.) R9 was admitted to the facility on [DATE]. R9 was ventilator dependent. R9 had an activated Power of Attorney (POA). R9 was moved to a different room and unit on 2/11/2025. On 2/3/2025 at 12:41 PM in the progress notes, Social Worker (SW)-GG documented SW-GG spoke to R9's family on 1/30/2025 regarding a room change from (room number) to (different room number). R9's family was in agreement. Surveyor noted R9's family was not offered a choice in rooms or given a preference. On 2/4/2025 at 3:11 AM in the progress notes, nursing documented R9 was sent to the hospital with a change in condition. On 2/11/2025 at 5:29 PM in the progress notes, Registered Nurse Supervisor (RN Sup)-M documented R9 was readmitted to the facility to room (room number). Surveyor noted this was not the room R9's family had been in agreement to moving to on 2/3/2025. On 2/13/2025 at 9:47 AM in the progress notes, SW-GG documented SW-GG spoke with R9's POA and let the POA know that R9 was readmitted the day before and is adjusting to the new room (room number). In an interview on the phone on 2/13/2025 at 11:11 AM, Surveyor asked R9's POA if R9's POA had been notified of R9's room change. R9's POA stated R9's POA had received a call that morning to say R9 was in room (room number). R9's POA had received a letter from the facility about the room changes but had not been given any choices as to what room R9 could move to. R9's POA stated R9's POA was fine with the move. In an interview on 2/13/2025 at 1:35 PM, Surveyor asked SW-GG why R9 was not moved to (different room number) as had been discussed prior to the move. SW-GG stated R9 was in the hospital at the time everyone moved so when R9 readmitted , they moved R9 to the room on the vent unit. SW-GG stated SW-GG contacted R9's POA that morning to inform them of the new room number. Surveyor noted R9's POA was not aware of the new room change until two days after R9 was moved into the new room. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) R10 was admitted to the facility on [DATE]. R10 was ventilator dependent. R10 had an activated Power of Attorney (POA). R10 was moved to a different room and unit on 2/11/2025. On 2/10/2025 at 4:25 PM in the progress notes, Social Worker (SW)-GG documented SW-GG updated R10's POA of R10's room change to 2113 tomorrow, 2/11/2025. On 2/11/2025 at 10:10 PM in the progress notes, Licensed Practical Nurse (LPN)-O documented R10 was adjusting well to the new room change. Surveyor noted R10 moved to room (room number), not the room R10's POA had been in agreement to. In a phone interview on 2/13/2025 at 11:16 AM, Surveyor asked R10's POA if R10's POA had been notified of R10 changing rooms. R10's POA stated SW-GG emailed R10's POA on 2/10/2025 about R10 moving to room (room number) and had not received any letter from the facility about the plan to change rooms for ventilator residents. R10's POA stated R10's POA asked SW-GG the reason for moving R10 and SW-GG told R10's POA the facility was moving all ventilator residents from Sunnyview 2 to Parkview 2 because it works better for a smaller unit to have the ventilator residents for staffing the unit. Surveyor asked R10's POA to verify what room R10 was currently in. R10's POA stated R10 was in room (room number). Surveyor shared with R10's POA that R10 had been moved to room (different room number). R10's POA stated they were not aware R10 was not in the room that had been told to them. In an interview on 2/13/2025 at 1:35 PM, Surveyor shared with SW-GG the conversation with R10's POA and the concern R10 had not been moved to the room R10's POA had been told and agreed to. SW-GG reviewed the progress note and R10's census information and agreed R10 was not in the room that had been provided to R10's POA and was not sure what happened in changing the room. Surveyor shared with SW-GG that Surveyor provided R10's correct room number to R10's POA. On 2/13/2025 at 3:10 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concerns residents were moved to different rooms for staff convenience and residents and resident representatives were not notified of specific rooms with options to choose what room they would prefer. NHA-A stated a letter was sent out to all residents with the information of how the facility was reconfiguring their units and residents. Surveyor shared the concerns R7 was not aware of the move until R7 was moved, R8 was moved to a room that was not the room R8 agreed to, R9 was moved to a different room when readmitting to the facility after a hospitalization and R9's POA was not made aware of the room change until two days after readmission, and R10 was moved to a room R10's POA was not aware of until today when Surveyor talked to R10's POA. Surveyor shared none of the residents were given options of which room they would prefer, and the letter did not provide the individual written room information specific to each resident.

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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** 47094 Based on record review and interviews, the facility did not ensure a through investigation was completed for 1(R1) of 3 facility self-reports reviewed. * The facility did not thoroughly investigate an allegation of neglect reported for R1 on 2/4/2025. Findings include: * R1 was admitted to the facility on [DATE] and has diagnoses that include acute on chronic respiratory failure with hypoxia, ataxia following cerebral infarction, quadriplegia, legal blindness, anoxic brain injury, and epileptic seizures. R1 has a tracheostomy (non-ventilator dependent/requires trach mask hooked up to oxygen), gastrostomy and jejunostomy tube, R2 is non-verbal and not able to make needs known. Surveyor reviewed the facility self-report the facility submitted on 2/4/2025 at 2:23 PM which documents: - R1's family member-J reported to social worker (SW)-GG that when R1 was sent to the hospital and when R1 arrived R1 was wet, and the hospital staff had to clean R1 up and put a new hospital gown on and R2 was sent to the hospital without hearing aids or glasses. SW-GG reported the allegation to nursing home administrator (NHA)-A and an investigation was initiated. - The investigation included staff statements from staff that were scheduled for first shift (6:00 AM- 2:30 PM), and resident interviews. - The concluding investigation statement documents: At this time the facility could not substantiate neglect on the caregivers involved regarding this incident. The staff responded to am emergency where the resident was in respiratory distress and was in the middle of sending the resident out via ambulance, while making sure the resident is dry, we can understand why the aides did [sic] prioritize getting resident changed during the time of emergency. All staff were reminded to make sure to send residents out with necessities when sending residents out to an appointment. At 2/4/2025, at 2:24 PM, in the progress notes nursing documented R1 had been dropping in oxygen levels during shift. Respiratory therapy (RT) notified nursing of change in condition and writer went to go assess R1. R1 oxygen turned up to 10 liters and pulse oxygenation (PO2) at 90%. R1 sent out for further evaluation around 9:15 AM. Surveyor noted that night shift (10:00pm - 6:30 AM) staff were not interviewed and the investigation did not indicate when R1 was last checked on or changed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/2025, at 11:11 AM, Surveyor interviewed certified nursing assistant (CNA)-HH who stated that CNA-HH offered to check and change R1 but was told not to because R1 was being sent out. Surveyor asked when CNA-HH last checked on R1 prior to going to the hospital. CNA-HH stated that R1 was not checked on yet during the shift, but CNA-HH was making her way to R1's room when she was notified R1 was going to the hospital. Surveyor asked if report was given from the previous shift of when R1 was last checked and changed. CNA-HH stated that report was given but could not remember when or if t was reported when R1 was last checked on. On 2/13/2025, at 12:26 PM, Surveyor called and left a message for the CNA-II who worked the night of 2/3/2025 into the morning of 2/4/2025 to inquire when the last time R1 was checked and changed. CNA-II did not return phone call to Surveyor. On 2/13/2025, at 2:00 PM, Surveyor interviewed quality and clinical support registered nurse (RN)-G who stated RN-G was in charge of collecting staff statements for the investigation. RN-G stated that night shift staff were not interviewed because first shift staff stated not checking on R1 prior to R1 going to the facility, so did not feel it was needed. Surveyor asked RN-G if it was known when R1 was last checked and changed. RN-G stated it was not known and should have interviewed the night shift to determine when R1 was last checked and changed. RN-G also stated that staff were directed not to manipulate R1 because R1 was already experiencing some respiratory distress, and staff did not want to make it worse with moving R1 around. On 2/13/2025, at 3:10 PM, surveyor shared concerns with NHA-A and director of nursing (DON)-B that the investigation for R1 allegation of neglect was not thoroughly investigated. Surveyor shared that night shift staff were not interviewed to determine when R1 was last checked and changed to determine how long R1 was possibly wet for. NHA-A and DON-B expressed understanding, no further information was provided at the time of this write up. On 2/17/2025, at 9:26 AM, Surveyor received an email from NHA-A that documented NHA-A was able to get a statement from CNA-II confirming that CNA-II checked and repositioned R1 on the morning of 2/4/2025 during CNA-II's last rounds. On 2/18/2025, at 8:57 AM, Surveyor sent email back to NHA-A requesting to send the written statement from CNA-II. On 2/18/2025, at 2:26 PM, surveyor received an email from NHA-A. The email was a forwarded email that was sent to NHA-A from CNA-II on 2/18/2025 at 1:56 PM documenting that CNA-II last turned (repositioned R1 on 2/4/2025 at 5:00 AM. Surveyor noted that the statement from CNA-II was not obtained by NHA prior to Surveyors investigation into the concern or during the time the facility was investigating the allegation of neglect. Surveyor still has concern that there was not a thorough investigation conducted for the allegation of neglect on the morning of 2/5/2025 and that facility staff that worked the night of 2/4/2025 into the morning of 2/5/2025 were not interviewed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review the facility did not revise care plans for 1 (R1) of 7 residents care plans that were reviewed. * R1's family was observed by facility staff suctioning R1. R1's care plan was not revised, or interventions implemented to indicate to staff what to do if family is observed suctioning R1 again unassisted. * R1 was care planned to have an [NAME] device/camera in room to communicate with family. Facility policy was changed, and video cameras not allowed- R1's care plan was not revised to indicate this change. Findings include: 1.) R1 was admitted to the facility on [DATE] and has diagnoses that include ataxia following cerebral infarction (brain damage after stroke), quadriplegia, and acute and chronic respiratory failure requiring tracheostomy (Trach mask on oxygen/ non-ventilator dependent). R1's quarterly minimum data set (MDS) dated 1/10/2025 indicated R1 had severely impaired cognition, R1 was non-verbal and could not make needs known. The facility assessed R1 needing extensive assistance with 1-2 staff for all activities of daily living (ADL) cares. R1 has a gastrostomy tube that delivered medication and nutrition to R1. R1 had a care plan initiated on 11/13/2024- R1's family wishes for R1 to return home when ready and able. R1 will continue skilled nursing placement until community resources are in place. Goal: R1 will have a safe return to the community with appropriate assistance, services, and equipment when appropriate. The following intervention was initiated on 12/6/2024: . -Provide care giver training. Describe: catheter care, tube feeding needs, suctioning techniques, and wound care treatment. On 1/27/2025, 1:46 PM, in the progress notes licensed practical nurse (LPN)-N documented . R1's family at bedside with concern that R1 has increased secretions and reports R1 had vomited. Per assessment R1 did not vomit and had normal amount of yellow tinged sputum and trach site. LPN-N provided oral care. R1's family member reports suctioning R1 themself without staff assistance or oversight. On 1/30/2025, at 10:25 AM, Surveyor observed R1's family at R1's bedside. Family member-J stated that the facility taught them how to suction R1 because R1 is getting ready to go home. Surveyor asked if family was allowed to suction R1 without staff present. R1's family member-J stated that there is never staff around or staff that know how to do it, so family member-J does it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/2025, at 11:30 AM, director of nursing (DON)-B came into R1's room for a scheduled education session with R1's family to provide caregiver training techniques with family that R1 will need when discharged home. On 2/3/2025, at 10:39 AM, Surveyor interviewed LPN-N who stated family member-J told LPN-N that family member-J was suctioning R1. LPN-N told family member-J that staff should be doing suctioning for R1. Surveyor asked LPN-N what education is provided for R1's family in regard to suctioning. LPN-N was not sure what education to provide to R1's family or if R1's family is able to do it. LPN-N stated LPN-N usually does not work that unit and was not aware of family being able to do that for residents. LPN-N stated LPN-N wrote a progress note stating that family was suctioning R1 and not sure what happened after that. On 2/5/2025, at 10:35 AM, Surveyor shared concern with nursing home administrator (NHA)-A and DON-B Surveyors concerns that R1's care plan was not revised after family was noted to have suctioned R1 on several occasions without staff supervision and direction for staff on what direction to educate R1's family. DON-B stated that there are scheduled times R1's family comes in and goes over education with DON-B regarding the care R1 will need when discharged . DON-B stated that R1's family has been educated to not suction R1 without staff present. Surveyor shared concern that the care plan does not give direction to staff for what education has been provided or what to do in event family continues to suction R1 without staff supervision. No further information provided at time of write up. 16584 2.) R1's quarterly minimum data set (MDS) dated [DATE] indicated R1 had severely impaired cognition, R1 was non-verbal and could not make needs known. Surveyor reviewed R1's communication care plan initiated on 11/13/2024 with the following intervention: [NAME] device/ camera in room per family wishes to facilitate off hour family communication with resident. (created 12/6/2024) Surveyor conducted a review of R1's CNA (certified nursing assistant) Care Card with a print date of 2/3/25. The care card documents that R1 has an [NAME] device/camera in room per family wishes to facilitate off hour family communication with R1. Make sure nothing covers device. May pull curtain when providing cares. On 1/30/2025, at 10:25 AM, Surveyor spoke with R1's family/representative who stated that they had a camera in R1's room for about 1 1/2 years and there was never a concern with it. Representative/ family stated the facility has a new policy recently that tells them they cannot have a camera. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 11:30 a.m., Surveyor interviewed Administrator- A regarding the use of cameras in resident rooms. Administrator -A stated that there became a concern with the use of cameras/ recording devices in resident rooms related to resident rights. Administrator- A stated that there was also a concern that the use of cameras would impact the roommate's right to privacy. Administrator- A stated that previously, the facility did not have a clear policy on the use of cameras and has since developed a policy that was placed into action in January 2025 (exact date not provided). Administrator- A stated that all residents, family, and legal representatives were made aware of the new policy and if they wanted to use a camera in a resident room, they would have to submit a request, and it would be reviewed by Administration. Administrator- A stated that R1's family/ representative was made aware that the use of the camera/ recording device was no longer allowed, and the camera needed to be removed from R1's room immediately. Administrator- A confirmed that R1's family, at the time of this interview, had not submitted a request for the use of the camera, per the new policy guidelines, so the camera is no longer allowed to be used in R1's room. Observations were made of R1's room during the survey and there was no camera observed in the room. On 2/5/25 at 11:45 a.m., Surveyor interviewed Administrator- A regarding R1's plan of care and CNA care card that documents an [NAME] device/ camera is in use in R1's room to facilitate off hour family communication. Administrator- A confirmed that the camera is no longer allowed in R1's room and that the care plan should have been updated. As of the time of exit, no additional information had been provided as to why R1's plan of care was not updated regarding no longer using the [NAME]/ camera device in R1's room.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 49011 Based on interview and record review, the Facility did not ensure a resident received treatment and care in accordance with professional standards of practice to include individual assessment and reporting when experiencing a medical change of condition, per standards of practice for respiratory therapists. This was discovered with 1 (R2) of 1 resident reviewed that had a medical change of condition while on a ventilator. On [DATE], at 11:12 PM, there was a progress note written by the Respiratory Therapist (RT)-T that indicated shortness of breath was present for R2 and that this was new, not chronic. RT-T raised R2's oxygen flow rate from 5 lpm (liters per minute) to 8 lpm. There is no evidence that any further assessment was completed indicating why to increase the flow rate or to help determine why R2 was newly short of breath. There is no evidence of further assessment to determine if increasing the oxygen flow rate improved the shortness of breath symptoms. There is no evidence this change of condition was communicated to the Registered Nurse working the same shift or to staff working the next shift. There is no evidence the change of condition was reported to R2's physician for consultation and treatment. R2 passed away in the Facility and was found deceased for several hours on [DATE] and pronounced dead at 8:40 AM by the Pulmonary Doctor. The Facility's failure to provide assessment and follow up created a finding of immediate jeopardy that began on [DATE]. Surveyor notified the Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A of the immediate jeopardy on [DATE], at 10:53 AM. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of an E (potential for harm/pattern) as the facility continues to implement its action plan. Findings include: The Facility Policy titled Notification of Changes last reviewed ,d+[DATE], documents (in part) . Policy: It is the policy of this facility that changes in a 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. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident . Procedure: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The nurse will immediately notify the resident, resident's physician, and the resident representative(s) for the following (list not all inclusive): An SBAR (situation, background, assessment, recommendation) will be completed in the EMR (electronic medical record) to reflect pertinent info to notify the physician of . B. A significant change in the resident's physical, mental, or psychosocial status. C. A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. D. A need to alter treatment significantly . 2. The nurse will notify the resident, resident's physician, and the resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician . The Facility Policy titled Respiratory Assessment last reviewed ,d+[DATE], documents (in part) . Policy: A Respiratory Assessment will be performed on the following residents to ensure proper respiratory treatments, equipment, and modalities are ordered to meet the resident's needs . 3. Any resident with a change of condition requiring respiratory treatments or oxygen therapy . General Information: The Respiratory assessment is performed one time for each of the above and charted in the EMR (Electronic Health Record). Procedure: 1. List Cardiopulmonary history. 2. Document heart rate; respiratory rate; O2 (oxygen) Saturation; FiO2/LPM (fraction of inspired oxygen/liters per minute); breath sounds, sputum color, consistency, and volume; expiratory time, breathing pattern; and ability to cough effectively. 3. If a trach resident, document the trach size and type; insertion or change date; and stoma site integrity. 4. If a vent resident, document the ventilator settings including the mode, tidal volume, respiratory rate, peep, FiO2; the amount of pressure support; and any weaning plans. 5. Check the planned modalities of treatment for the resident. 6. List any pertinent comments vital to their treatment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the American Association for Respiratory Care, The practice of a respiratory therapist is directed by a licensed independent practitioner and is determined by state licensure laws where applicable. The practice typically focuses on: . o Direct and indirect patient observation and monitoring of signs, symptoms, reactions, general behavior and general physical response to respiratory care and diagnostic interventions. o Implementation of respiratory therapy procedures, medical technology, and diagnostic procedures necessary for disease prevention, treatment management, and pulmonary rehabilitation . The responsibilities of a respiratory therapist include, but are not limited to: 1. Performance and collection of diagnostic information . https://www.nbrc.org/wp-content/uploads/,d+[DATE]/AARC-Scope-of-Practice.pdf R2 was readmitted to the facility on [DATE]. R2's pertinent diagnoses include chronic respiratory failure with hypoxia, chronic kidney disease-stage 4, dependence respirator (ventilator) status, major depressive disorder, generalized anxiety disorder, insomnia, hypertensive chronic kidney disease, acute on chronic systolic (congestive) heart failure. R2's Quarterly Minimum Data Set (MDS) with an assessment reference date of [DATE] indicated R2 had a Brief Interview for Mental Status score of 14 (cognitively intact). R2 is responsible for self. R2 is listed as full code for resuscitation. R2's MDS showed that oxygen therapy, suctioning, tracheostomy care and invasive mechanical ventilator were used for respiratory treatment. R2 is assessed as having no impairment to upper or lower extremities and R2 uses a wheelchair for mobility. R2 is assessed as occasionally incontinent of bladder and frequently incontinent of bowel. R2 has a pulmonary care plan which documents R2 has potential for complications from COPD (chronic obstructive pulmonary disease), respiratory failure, CHF (chronic heart failure). Pertinent interventions include: Monitor for complications such as dyspnea, shortness of air, cyanosis or tachypnea. Start Date [DATE] Monitor Oxygen saturation and administer Oxygen per physician orders. Start Date [DATE] Provide treatment per physician's orders and monitor for response. Observe for side effects and inform physician. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date [DATE] Administer medications per orders and monitor for response. Observe for side effects and inform physician prn. Start Date [DATE] R2 has an alteration in respiratory status vent/trach care plan which reads R2 has alteration in respiratory status related to ventilator/trach use. Pertinent interventions include: Monitor and report signs of hypoxia (cyanosis, tachypnea, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse) Start date [DATE] Monitor O2 (oxygen) sats (saturation). Q (every) shift & PRN Start Date [DATE] Monitor for signs and symptoms of respiratory infection, shortness of breath. Start Date [DATE] RT (respiratory therapist) consult as needed Start Date [DATE] Monitor oxygen saturation via pulse oximetry Q shift and PRN when on continuous oxygen therapy. Start Date [DATE] Check O2 settings Q shift and PRN Start Date [DATE] Maintain patent airway Start Date [DATE] Suction PRN per MD (medical doctor) orders Start Date [DATE] Airway checks, q shift and PRN Start Date [DATE] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	FiO2 (fraction of inspired oxygen) to keep SpO2 (oxygen saturation) at/above 90% Start Date [DATE] Surveyor reviewed the electronic medical record (EMR) and found physician orders related to R2's ventilator (vent) and tracheostomy (trach) care which included: Vent Settings: PC (pressure control) ,d+[DATE] / RR (respiratory rate) 18 / FIO2 TO KEEP SPO2 AT / ABOVE 90%, Every Shift, effective [DATE] RT change trach Q12 weeks, Once A Day on Monday, effective [DATE] Surveyor notes a review of charting showed resident oxygen was kept at 5 liters leading up to the night of the incident. On [DATE], a respiratory progress note written by RT-T with time of 11:12 PM was entered with the notation of Recorded as Late Entry on [DATE] 03:15 AM. The progress note reads: Lung Sounds: diminished Respirations Rhythm/Pattern: Regular/Unlabored Cough present?: No Shortness of Breath present?: Yes (New or Chronic) New Fever present?: No Oxygen in use?: Yes (Liter Flow) 8 lpm Oxygen delivered by: Not Applicable Isolation Precautions in place?: Not Applicable Restlessness present?: No Anxiety present?: No Fatigue present?: No Comments: Vent settings: PC mode 25 PIP, 5 of PEEP, 18 RR, 5 lpm Actual PT: 25 PIP, 7.2 MVE, 386TV, 18 RR, Breath sounds: diminished Trach care: Gauze changed, and site cleaned (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Oral Care: mouth and gums brushed Secretions: PT (patient) didn't need suctioning Vital Signs: 84 HR (heart rate), RR (respiratory rate) 18, SPO2 97% Surveyor notes the progress note written by RT-T indicates R2 was having shortness of breath, which was new. The oxygen in use was recorded as 8 lpm. The vital signs were 84 for heart rate, 18 for respiratory rate, spo2 97%. There is no indication if these vitals were before or after the oxygen was increased. There is no subsequent follow up by RT-T. Based on interviews of staff working that shift (as shown below), there is no evidence RT-T communicated this change to other staff. No SBAR was completed and there was no communication with the physician. The next progress note was written by Registered Nurse (RN)-U on [DATE], at 05:10 AM. It documents writer went into room at 0500 to give resident her prn APAP (Tylenol) that she requests each morning. Resident was sleeping comfortably. Color was baseline and lips were pink. No complaints from either residents (sic) in that room all shift. Surveyor notes the last PRN dose of Tylenol recorded as administered on the MAR (Medication Administration Record) was at 12:27 AM, on [DATE], by RN-U. The next respiratory progress note was written on [DATE], by RT-S with time of 8:20 AM, which documents: Lung Sounds: N/A Respirations Rhythm/Pattern: Regular/Unlabored Comments: Vent Settings: Received on ACPC ,d+[DATE]+ R 18 on 10L (liters) Vent Actuals: VT 80 MVE 1.9 PIP 24.3 PMAP 5.3 I/E 1:1.1 Vital Signs: HR POX RR unable to obtain Breath Sounds: Unable to obtain Secretions: N/A Trach Care: N/A Oral Care: N/A Tx: N/A Misco: N/A (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident unresponsive between approx. ,d+[DATE]. RT bagged PT on 15L, nurse present, supervisor arrived. RT unable to obtain POX (pulse oximetry) and HR (heart rate) with POX device. BS (breath sounds) unable to be heard. Bilateral chest rise present from ventilation assistance. NP (nurse practitioner) present, nurse and nursing supervisor. Surveyor notes there is no documentation as to when oxygen was increased from 8 to 10 liters per minute. On [DATE], at 8:45 AM, a progress note was written by Nurse Practitioner (NP)-V that documents . evaluated at bedside this AM 0825, mottled/cyanotic/pupils fixed. No pulse/audible HR/ no BP/no respirations. Extremities stiff c/w (consistent with) rigor mortis. By estimation, pt likely expired at least several hours prior .reviewed with (Pulmonary Doctor) via phone, concurs, pronounced dead @ (at) 0840am. On [DATE], at 8:46 AM, Surveyor interviewed R8, the roommate of R2, and was told that R2 put the call light on that night and said something about breathing, roommate heard RT-T tell R2 that they turned up the oxygen. The Facility did an investigation after the incident and the statement Nursing Home Administrator (NHA)-A wrote as a statement from R8 indicates R8 reported that around 9pm she heard (R2) on the phone with her grandsons, playing a virtual game. Later, during the 3rd shift around 11pm, (R2) called the CNAs (Certified Nursing Assistants) to warm up her usual snack, hot pockets. (R8) stated that both she and (R2) received their breathing treatments close to midnight from the night (RT-T) and (R2) was fine at that time. (R8) also mentioned that she heard staff in the room about 3 times throughout the night . On [DATE], at 11:51 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-W who stated they were not her (R2's) nurse that day but NP-V went into R2's room and came out and said R2 was not breathing. During walk around between 6:,d+[DATE]:00 AM, R2 and roommate were sleeping which was not unusual. Later when LPN-W went into the room with NP-V, R2 was ashen in color and looked like she was sleeping. On [DATE] at 1:50 PM, Surveyor interviewed CNA-Z who stated they rounded at around 7am and thought R2 was sleeping at that time. On [DATE], at 2:11 PM, Surveyor interviewed RT-AA who worked the next shift after the incident. RT-AA stated that the incident could be attributed to poor communication, there was a change in condition that was not reported or passed on. Surveyor asked what that change was and was told by RT-AA it was that the oxygen had been increased on the night shift. On [DATE], at 2:52 PM, Surveyor interviewed LPN-X via phone and was told at around 7am LPN-X went into the room as the roommate's vent lights were going off, LPN-X turned off the vent lights and looked over both patients and they were both in their sleeping positions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 10:44 AM, Surveyor interviewed RT-T via telephone who was on the night shift and increased the oxygen level for R2. When asked if R2 was experiencing a change of condition RT-T stated the oxygen was at 5 liters and that they did raise it to 8 liters. RT-T stated this is common to do. R2's pulse ox was at 91% but R2 was not having trouble breathing. RT-T saw resident in no distress and R2 did not tell RT-T there was a problem. Surveyor notes this shows discrepancy from the progress note written the night of the incident that indicates R2 was experiencing a new change in condition of shortness of breath and does not follow physician order to raise SPO2 to keep saturation above 90%, R2 was above 90% according to RT-T's statement. The Facility investigation after the incident included a statement NHA-A wrote from their interview with RT-T. (RT-T) stated that (R2's) vital signs were normal throughout the night and that he was able to administer treatments as scheduled. He stated he performed (R2's) breathing treatment around 11 pm, closer to midnight. (RT-T) last checked on her around ,d+[DATE]am, describing her as seemingly fine and possibly asleep. He stated that (R2) had not complained of any shortness of breath or distress during their interactions that night. (RT-T) noted that (R2) appeared stable and routine, with no indications of distress observed during their rounds. He expressed surprise at the news of her passing, stating that nothing seemed abnormal during the shift. Surveyor notes documentation of respiratory therapist administered treatments were requested starting with the night of [DATE] and Surveyor was provided the Medication Administration Record (MAR) for a nebulizer treatment done by nursing twice a day that was last done on the [DATE] second shift by Licensed Practical Nurse (LPN)-BB. Surveyor noted there was no documentation of a breathing treatment done by RT-T. Surveyor notes the discrepancy of RT-T's interview with Surveyor and statement of interview with RT-T from NHA-A. On [DATE], at 11:21 AM, Surveyor interviewed RN-U, via telephone, who was working on the night shift before R2 passed. RN-U stated that R2 was alert and oriented times 4, so would alert staff if there was an issue. RN-U stated she saw R2 at midnight, R2 was on her tablet and there were no complaints. When asked about the oxygen being increased RN-U stated that if there had been an issue RT-T would have let RN-U know and RN-U was not alerted of any change. On [DATE], at 1:43 PM, Surveyor interviewed LPN-BB, via telephone, who worked the PM shift before the oxygen level was increased. Surveyor asked if there was any indication of a change of condition for R2 to which LPN-BB responded no, R2 was vocal and would have been taken care of as needed, R2 was alert and oriented times 4 and would let RT, Nurse or aide know if there was any discomfort. On [DATE], at 8:23 AM Surveyor interviewed Pulmonary NP-V via telephone. NP-V could not remember the exact numbers but thought R2 was normally on ,d+[DATE] liters of oxygen and that the oxygen was increased to ,d+[DATE] liters. NP-V let Surveyor know that only the RT can increase the oxygen level, the resident cannot. NP-V stated that if the oxygen is increased that would suggest something is happening. NP-V remembers R2 looked like they were sleeping, NP-V checked on R2's roommate first, the room was dark. It was 8:,d+[DATE]:30ish in the morning and the curtain was closed between the two residents. When NP-V went to R2 their eyes were closed and they did not respond to verbal stimuli. R2 had no pulse or blood pressure, pupils were fixed and dilated, R2's body was cold and stiff when found so best estimate was R2 had been gone a few hours. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 10:23 AM, Surveyor interviewed RT-S, via telephone, who was on the shift that R2 was found deceased . RT-S did not check on R2 between the start of shift and time R2 was found deceased , they started the shift and had multiple issues to deal with before this occurred. RT-S was told the nurse and Certified Nursing Assistant on the shift thought R2 was sleeping when they rounded. R2 did not have any medications due from RT-S until 9 am. RT-S stated that NP-V found R2 deceased and determined this had been for hours due to the condition of R2's body. RT-S stated there was wrongdoing on the part of the night shift (NOC) RT-T, R2 was not tended to properly when they complained they could not breathe, and RT-T increased the oxygen flow rate. The NOC RT (T) reported no changes even though the RT (T) had raised the oxygen flow rate. RT-S told Surveyor that the NOC RT (T) raised the oxygen flow per the roommate because R2 told RT-T that R2 could not breathe. When RT-S responded to the call for help R2's oxygen was at 10 liters and 5 liters is the norm for R2. RT-S stated the raising of the oxygen liters was a change of condition that should have been reported. RT-S stated that it is in the scope of practice for an RT to increase oxygen flow level but need to assess what is going on. If the pulse ox is low need to determine if resident needs to be suctioned, if the inner cannula has a mucus plug or if resident needs a PRN breathing treatment. The RT needs to figure out why a resident cannot breathe, not just turn up the oxygen. On [DATE], at 1:27 PM, Surveyor spoke to RN-U, via telephone, to clarify when Tylenol was brought to R2's room around 5am how RN-U could tell R2 was sleeping, per RN-U R2 was upright in bed, breathing and when RN-U touched R2's arm, R2 moved a bit and was warm. Surveyor asked RN-U if a pain assessment or any assessment had been done at this time as RN-U was bringing in a PRN medication. RN-U shared there was no assessment of R2 at this time. Surveyor noted there is no indication of a nursing assessment throughout the shift. On [DATE], at 1:49 PM, Surveyor interviewed RT-Y who works PRN for the Facility. When asked about increasing a resident's oxygen level Surveyor was told an assessment would be needed in addition to checking the pulse ox. RT-Y stated you need to look and touch resident. An increase in oxygen would be considered a change in condition because it is not the normal for the resident. Communication of the change would be expected and did not happen in this case. RT-Y felt this was a failure on RT-T's part. On [DATE], at 2:38 PM, Surveyor followed up with NP-V and asked what should be done before increasing oxygen on a resident and was told the RT should assess for suctioning and assess the situation. Surveyor then asked what should be done after the oxygen is increased and was told if the resident remains hypoxic it means they could need suction, do not have good profusion, and need to check for a fever. If the problem persists RT would need to again contact the provider and get an order for a chest x-ray. Overall, the RT needs to do an assessment to figure out why the resident needs more oxygen, need to troubleshoot. NP-V agreed with Surveyor that not reporting an increase in the oxygen needs of a resident is a problem as this is a change of condition all team members should be aware of. Surveyor notes 3 interviews with RT's that work with R2 (RT-S, RT-Y, RT-AA) stated a need to increase oxygen would be a change of condition that should be assessed and reported to the physician for consultation. RT-S stated that it is within the scope of practice for an RT to increase oxygen flow level but need to assess what is going on. (continued on next page)

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

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 3:21 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B regarding the NOC shift of [DATE] and R2's oxygen being increased from 5 to 8 liters. They stated that this would be part of the RT's job. Their assessment would include taking a pulse oximetry which would indicate the need for more oxygen. They also stated that there was a lack of checks on R2 because R2 was not a resident that needed to be checked for incontinence or needed to be changed on a schedule. They stated R2 was a highly functioning resident. Surveyor notes R2's care plan states R2 should be monitored for incontinence every ,d+[DATE] hours prn, staff should offer to assist with toileting with each encounter and whenever observed to be awake at night and supervision is required with transfer with a walker and gait belt. On [DATE], at 10:34 AM, Surveyor followed up with NHA-A and DON-B to find out what the rounding schedule should be on the unit, to which it was stated, for Certified Nursing Assistants and Nurses should be every 2 hours, there is not a set rounding requirement for RT's. NHA-A and DON-B went on to discuss RT-T's assessment the night of the oxygen increase showed R2's respiratory rate and rhythm were fine, and no treatment was needed, they stated that the documentation showed no physiological signs the patient was in distress. Surveyor asked DON-B if an assessment should be completed after a resident's oxygen is increased to which DON-B stated yes, that would be advised as best practice. They stated that because the charting says R2 was at 97% oxygen, R2 was not in distress. They stated that it must be factored in that R2 was a highly functioning resident, that R2 could suction themselves. When asked how oxygen got from 8 liters to 10 liters, NHA-A and DON-B did not have an answer. Surveyor again noted the vitals RT-T documented do not indicate if they were before or after R2's oxygen was increased and whether R2's shortness of breath had been resolved throughout the shift as no additional assessments or monitoring had been completed. Surveyor notes the physician orders state to increase the oxygen if below 90%. Surveyor has an interview with RT-T where RT-T stated R2 was at 91%, which was not within the parameter to increase the oxygen and that the 91% was never charted. Surveyor notes nowhere in the care plan is it stated R2 had been assessed and could suction themselves as indicated by NHA-A and DON-B. Surveyor notes there is no documentation on how the oxygen lpm got to 10. The conclusion to the Facility investigation includes Throughout the prior shift, staff were consistently attentive and frequently checked on (R2), as confirmed by interviews. (R2) was independent in most of her functional abilities and would call staff for any assistance. (R2) had a routine for most of her cares and typically requested assistance around 9am. During all staff visits to (R2's) room throughout the shift, nothing out of the ordinary was observed. (R2) had a recent hospitalization in November due to chronic heart failure (CHF) and it is likely that she experienced sudden cardiac arrest, a possibility supported by her medical history. It is important to note that the ventilator was set to assist control pressure support (ACPC) which means that while the machine was providing respiratory support, it would not have alarmed in the event of a sudden cardiac arrest . During this investigation, we identified areas for improvement and have since implemented walking rounds to exchange reports. Staff were educated on this new process to enhance communication and patient monitoring. The facility exercised due diligence in providing care for (R2) and responded appropriately to all her needs. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Surveyor notes the care plan and assessments including the MDS do not support the statement that R2 was independent in functional abilities. Surveyor notes a new diagnosis of CHF would make R2 frailer and needing more assessment with a change of condition. It was also noted by Surveyor R2 had only been using a vent since late 2024.

Surveyor notes that R2 had a change of condition that was not assessed appropriately or reported to other staff. R2's physician was not consulted with regarding the change in condition of shortness of breath leading to increasing R2's oxygen setting. R2 was not assessed/monitored during the shift by RT or nursing staff. R2 was found with their oxygen level raised to 10 lpm and deceased by the respiratory nurse practitioner-V. who indicated R2 had been deceased for a length of time based upon R2's physical condition at the time of finding R2 deceased . The Facility failed to take immediate action by not having follow up on the care provided to R2 following a change in condition the night before R2 passed. These actions created a reasonable likelihood for serious harm, thus leading to the finding of immediate jeopardy starting [DATE]. The facility removed the immediate jeopardy on [DATE] when the facility implemented the following:

The Director of Nurses along with a consulting respiratory therapist will provide education to all nurses and RT's who will be delegated to the respiratory unit related to recognition of all respiratory changes of condition to include policies and procedures related to same and or other physiological changes of condition.

Education included the following:

Staffing expectations for all shifts related to the respiratory unit

Change of condition policy and procedures titled: Physician Notification

Respiratory policy and procedures which include:

Mechanical Ventilation: Set up and Monitoring

Oxygen Administration

Pulse Oximetry

Tracheostomy Care

Notification and documentation expectations with change of condition

Where to look for a comprehensive list of orders and treatment within the EHR

Shift to shift report expectations and use of 24 hour report board

Competency exercises - competency will include a return demonstration on care for a resident with a ventilator and or other open airway that includes verbal affirmation of what, when and whom to report any changes in condition.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing and respiratory staff will collaborate and communicate any change in condition as a team, implementing appropriate interventions as ordered by provider. Signs were posted at the clinical hub on the vent unit to inform clinical staff that if they have not received the competency, they are not permitted to work on the unit until they've received the training. All nurses and RT's will be required to view the in-service prior to their next working shift. Once present for their scheduled shift a competency will be provided by a DON or a verified competent facility designee. Education was started on [DATE] with PM shift. Education will continue on [DATE]. All nurses and RT's will be trained prior to their next working shift. Oxygen Administration Pulse Oximetry Tracheostomy Care Notification and documentation expectations with change of condition Where to look for a comprehensive list of orders and treatment within the EHR Shift to shift report expectations and use of 24 hour report board Competency exercises - competency will include a return demonstration on care for a resident with a ventilator and or other open airway that includes verbal affirmation of what, when and whom to report any changes in condition. Nursing and respiratory staff will collaborate and communicate any change in condition as a team, implementing appropriate interventions as ordered by provider. A competent RN will be designated to respond to all emergency situations for ventilator and tracheostomy residents at all times. The RN will be delegated and present and available to ensure timely and comprehensive assessments to any resident demonstrating a potential change in condition. This scheduling pattern will begin on [DATE] pm shift. The unit will be staffed with an RN who has demonstrated competency in caring for ventilator residents. CNAs will be scheduled to meet residents, and RT's scheduled as necessary. The Change of Condition policy, Physician Notification has been reviewed and modified to include; Examples of Change of Condition Notification expectations with change of condition Documentation of a change of condition Vital sign expectations All changes in condition will be listed on the 24-hour report board (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility standard of practice policies from [NAME] have all been reviewed, and implemented to include: Mechanical Ventilation: Set up and Monitoring, Oxygen Administration, Pulse Oximetry,Tracheostomy Care Shift to shift report expectations protocol has been developed to use with 24 hour report board Medical Director-EE consulted during the development of this corrective action plan. The DON and or designee will review progress notes and 24-hour report board daily for 1 month for any changes of condition to ensure all condition changes have been recognized and appropriate for the residents status. An audit tool has been developed to support identification of any condition change. Audits will continue daily for 1 month with ad hoc training provided as necessary for any missed opportunities. Audits will continue 3x per week for 2 months. The DON and or designee will observe the delivery of respiratory care assigned by nurse or RT 3x per week for two weeks and weekly observations for two months. All audits will be brought to the Quality Improvement Committee for review and recommendations.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on observation, interview, and record review the facility did not ensure the necessary Respiratory Therapy services to provide respiratory care consistent with professional standards of practice to 2 (R7 and R1) of 3 residents reviewed for respiratory cares/ services. The facility did not ensure staff were trained, knowledgeable and competent to provide respiratory care to 9 residents who are ventilator dependent and 7 residents who are not ventilator dependent but have tracheostomies (trach). *On 01/25/2025, R7 was not put on R7's ventilator at night due to the Facility not having a Respiratory Therapist at the Facility. R7 did not have Respiratory orders relating to R7's ventilator. R7 did not have a documented Respiratory Assessment for every shift, between 01/06/2025 through 02/04/2025. *On 2/1/2025 R1's family member had to hook up R1's trach mask to oxygen due to scheduled facility staff not having the knowledge/competencies to hook R1's trach mask up to oxygen. R1's family provided suctioning to R1 due to staff not having the competency to provide suctioning for R1. *The facility does not ensure nursing staff have competencies to care for vulnerable residents requiring Respiratory Therapy Services when Respiratory therapists are not in the building or that licensed practical nurses (LPN's) scheduled to care for the residents with respiratory needs are not working outside their scope of practice and if delegated to, they are competent to carry out delegated tasks with supervision from competent registered nurses (RN). Facility failure to provide nursing staff with Respiratory Therapy Services competencies to vulnerable residents on the ventilator unit created a finding of immediate jeopardy that began on 1/25/2025. Surveyors notified the nursing home administrator (NHA)-A, Director of nursing (DON)-B of the immediate jeopardy on 2/6/2025 at 10:53 AM. On 2/13/25 Surveyors retuned to the facility to verify removal of the immediate jeopardy and complete the partial extended survey tasks. Based upon observation, interview and record review on 2/13/15 it was determined the immediate jeopardy was not removed upon exit from the facility. Findings include: The facility policy titled Respiratory Therapy Policy and Procedure: Respiratory Assessment reviewed on 7/2024 and applies to Nursing Services and Respiratory Therapy documents: POLICY: A respiratory assessment will be performed on the following residents to ensure proper respiratory treatments, equipment, and modalities are ordered to meet the resident's needs. 1. New admissions and re-admission to Respiratory Unit. 2. New admissions and re-admissions of resident's underlying pulmonary diagnosis, respiratory treatments, oxygen therapy, or a tracheostomy (Trach), by physician order. 3. Any resident with a change in condition requiring respiratory treatments or oxygen therapy, or with signs and symptoms of respiratory infection, by physician order. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Procedure: 1. List cardiopulmonary history. 2. Document heart rate, respiratory rate, oxygen saturation, fraction of inspired oxygen/ liters per minute (FiO2/LPM, amount of oxygen in the air that a person inhales), breath sounds, sputum (saliva/mucus coughed up from the respiratory tract) color/ consistency/volume, expiratory time, breathing pattern, and ability to cough effectively. 3. If a trach resident, document the trach size and type, insertion or change date, and stoma site integrity. 4. If a ventilator (vent) resident, document the ventilator setting including the mode, tidal volume, respiratory rate, peep, FiO2, the amount of pressure support and any weaning plans. 5. Check the planned modalities of treatment for the resident. 6. List any pertinent comments vital to their (resident's) treatment. The facility policy entitled Respiratory Therapy Policy and Procedure: Ventilator Alarms and Call Lights Response reviewed on 7/2024 and applies to Nursing and Respiratory Therapy documents: Policy: Ventilator alarms will be responded to immediately by all staff. Alarms notify staff of life-threatening situations. Call lights will be responded to by all staff and care will be provided within the scope of the caregiver or reported to the caregiver needed to provide the care needed. The care provided will be documented appropriately. Procedure: 1. Determine if alarm is respiratory related. a) Respiratory related alarms include but not limited to: i. Patient needs suctioning. ii. Continual high pressure without cares. iii. Alarming after cares. iv. Patient disconnect. v. Unwitnessed alarms of unknow origin. vi. Call light from tracheostomy needing respiratory care. b) If the alarm is respiratory related provide emergency care as needed. c) Assess residents and provide needed care. (continued on next page)

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d) Reassess residents and provide any care indicated.

e) Document assessment and cares provided using respiratory assessment form in MatrixCare or on paper respiratory assessment form.

f) Completed paper forms are to be placed in respiratory basked located near the Director's office.

The facility policy entitled Respiratory Therapy Policy and Procedure: Suctioning (oral cavity) reviewed on 7/2024 and applies to Nursing Services and Respiratory Therapy documents: Policy: Oral suction will be performed according to proper practice standards.

General Information:

1. Oral suctioning removes secretions from the oral cavity by means on a Yankauer inserted in the mouth. The procedure is used to:

1.1 Prevent aspiration

1.2 Decrease the potential for infection that may result from accumulated oral secretions.

2. Procedure to be performed by the respiratory therapist (RT), registered nurse (RN), licensed practical nurse (LPN), or certified nursing assistant (CNA).

3. Emergency suction machines are kept at kept on all nursing units.

4. For frequent suctioning, assign a machine to the resident and keep at bedside.

The facility policy entitled Respiratory Therapy Policy and Procedure: Suctioning (oral/nasopharyngeal) reviewed on 7/2024 and applies to nursing services and respiratory therapy documents: Policy: Oral-Nasopharyngeal suction will be performed according to best practice.

General information:

1. Oral-nasopharyngeal suction removes secretions from the pharynx by means of a suction catheter inserted through the mouth or nose. This procedure is used to:

a) Maintain airway patency-prevent aspiration.

b) Decrease the potential for infection that may result in accumulated secretions.

c) Stimulate an effective cough and expectoration.

2. Procedure to be performed by RTs, RN, or LPN.

The facility policy entitled Respiratory Therapy Policy and Procedure: Tracheostomy- Care and Maintenance reviewed on 6/2024 and applies to nursing and respiratory services documents: Policy: Tracheostomy care will be provided according to proper practice standards.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	General Information: . Safety: . 2. Keep an ambu bag visible in room. Take ambu bag with resident when off unit. The facility policy entitled Respiratory Therapy Policy and Procedure: Treatments- Administration/ Documentation reviewed 7/2024 and applies to nursing services and respiratory services documents: Policy: To administer and the document all treatments on the Treatment Administration Request (TAR) or Respiratory Medication Administration Record (MAR) in the Electronic Medical Record (EMR). General Information: 1. Treatments and medications administration records are to be kept in the EMR. 2. All treatments including directions, sites, etc. will be transcribed in the EMR according to physician orders by . nurse, or RT and verification will be done by RN/LPN/RT. 3. All treatments performed by RN's, LPN's, RT's, and CNA's will be documented in the EMR. Surveyor notes that all the policies and procedures noted above are based on Lippincott Nursing procedures. Surveyor also notes that the above policies and procedures do not differentiate who does what. (Nursing services versus therapy services). There is no delegation of responsibilities for the specialized care on the ventilator/ tracheostomy unit. R1 RESPIRATORY SERVICES CONCERNS: * R1 was admitted to the facility on [DATE] and has diagnoses that include acute on chronic respiratory failure with hypoxia, ataxia following cerebral infarction, quadriplegia, legal blindness, anoxic brain injury, and epileptic seizures. R1 has a tracheostomy (non-ventilator dependent/requires trach mask hooked up to oxygen), gastrostomy and jejunostomy tube, R2 is non-verbal and not able to make needs known. On 1/27/2025, 1:46 PM, in the progress notes licensed practical nurse (LPN)-N documented . R1's family at bedside with concern that R1 has increased secretions and reports R1 had vomited. Per assessment R1 did not vomit and had normal amount of yellow tinged sputum and (sic) trach site. LPN-N provided oral care. R1's family member reports suctioning R1 themself without staff assistance or oversight. On 1/30/2025, at 10:25 AM, Surveyor observed R1's family at R1's bedside. Family member-J stated that the facility taught them how to suction R1 because R1 is getting ready to go home. Surveyor asked if family was allowed to suction R1 without staff present. R1's family member-J stated that there is never staff around or staff that know how to do it, so family member-J does it. Family member- J stated that on 1/27/2025 family member-J suctioned R1 because R1 had some emesis and there was not a respiratory therapist (RT) in the facility and R1's nurse did not know how to suction R1. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/3/2025, at 10:39 AM, Surveyor interviewed LPN-N who stated family member-J told LPN-N that family member-J was suctioning R1. LPN-N stated that R1's family member-J stated R1 has emesis and was suctioning R1's mouth out. LPN-N stated that R1 was not having emesis, and it was normal drainage. LPN-N stated that LPN-N normally does not work on the vent unit so got another nurse to help suction R1 because there was not a RT in the facility at that time. LPN-N stated LPN-N does not suction or do any trach cares for the residents on the vent unit, so LPN-N will call the nursing supervisor or get another staff member to do those tasks if they were needed. Surveyor asked LPN-N what LPN-N would do if there was an emergency with a resident that had a Trach. LPN-N stated LPN-N would call the supervisor, call the doctor/nurse practitioner (NP), or send the resident out to the hospital. On 2/3/2025, at 2:45 PM, Surveyor was called into R1's bedroom by R1's family member-J. Family member-J stated that R1 went to the hospital on 1/31/2025 and came back to the facility on [DATE] early in the morning. When R1 and Family member-J arrived back at the facility around 5:00 AM on 2/1/2025 there was no RT in the building and the nurse on the unit did not know how to hook R1's trach mask up to the oxygen and asked family member-J to do it. Surveyor reviewed R1's progress notes and noted that there was no progress notes documented of R1 returning to the facility on [DATE]. Surveyor reviewed the schedule for 1/31/2025 night shift (10:00 PM- 6:30 AM 2/1/2025). Surveyor notes that there was not a RT assigned during the night shift and 1 registered nurse (RN) and 1 LPN nurse, both from an agency, were assigned to work the ventilator unit. On 2/3/2025, at 3:15 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B that R1's family member was suctioning R1 and hooked R1's trach up to oxygen because staff were not available that had competencies in completing those tasks/cares. DON-B stated it would get looked into. VENT UNIT NURSING COMPETENCY/ STAFFING CONCERNS: * The facility has a total of 59 beds available for residents requiring a ventilator. Currently the facility has 9 ventilator dependent and 7 non-ventilator dependent residents with tracheostomies with schedules of receiving oxygen via a trach mask requiring respiratory cares/ services. The Facility advertises on the facility website at https://www.vmpcares.com/healthcare/ventilator-care/ and through brochures that it has 24/7 respiratory therapists and ventilator certified nurses. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 1/30/2025, at 1:13 PM, Surveyor interviewed Scheduler-P who stated depending on facility census scheduler-P tries to schedule 2 respiratory therapists (RT's) on the ventilator unit for day (6:00 AM- 2:30 PM) and Evening (2:00 PM- 10:30 PM) shift; for night shift (10:00 PM- 6:30AM) 1 RT is to be scheduled. Surveyor asked what happens to the schedule if a RT is not available. Scheduler-P replied that requests to work go out to other facility RT's or ask for RTs to stay on shift for incentive. Scheduler-P stated that if an RT is not available then an agency RT is called in. Surveyor asked how it is determined when an RT is not available to work that nursing staff have the competencies to care for residents on the ventilator unit. Scheduler-P stated that all nursing is able to perform suctioning for residents. Surveyor asked about nursing competencies for the ventilator and tracheostomy cares. Scheduler-P stated that Director of Nursing (DON)-B has a list of nurses that have training with the ventilator and DON-B will communicate with Scheduler-P who to schedule if RT is not available. Scheduler-P stated that DON-B has that list. On 2/3/2025, at 3:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and DON-B who stated that the facility has experienced some changes recently with staffing RT's. DON-B stated RT staff have been leaving for other opportunities and administration noted that they had to do something. DON-B stated that on 1/9/2025 several nursing staff attended a ventilator certification course. DON-B stated that if an RT is not scheduled then they make sure to have one of the nursing staff that attended the course on the unit. DON-B stated that RT's used to make up their own schedules and primarily report to the pulmonologist but with the RT's leaving, the scheduling and reporting has changed to Scheduler-P and RT's now report to DON-B. NHA-A stated that there has been discussion on transferring all the residents with ventilators to the same unit and all the residents with tracheostomies will be on another unit. NHA-A stated that way they could have all the ventilators together and plan on having 1 RT, 1 nurse and 2 CNAs scheduled to that unit. NHA-A also stated that there is a plan to get all nurses to the ventilator certification course. On 1/30/2025, at 1:37 PM, Surveyor interviewed licensed practical nurse (LPN)-O who stated LPN-O received training on how to suction, perform trach cares, and trach ties when hired. LPN-O stated there was no ventilator training on hire and that LPN-O was not authorized to touch the ventilator or change settings. Surveyor asked LPN-O if a ventilator alarm went off and an RT was not available what would nursing do. LPN-O stated that if an alarm on the ventilator went off it could mean that the resident was in distress, so LPN-O would assess the situation and call the supervisor, on call doctor/ nurse practitioner (NP), or pulmonary on call. Surveyor asked what would happen in event of emergency and no one was available right away when called. LPN-O stated 911 would be called and send the resident out for further evaluation. On 2/3/2025, at 8:04 AM, Surveyor interviewed Anonymous staff-D who stated education was provided on how to suction, give treatments, and trach cares. Anonymous staff-D stated that if there was no RT on the unit and there was a concern that nursing would call the pulmonologist, and if there was concern or a resident was noted to be in distress, then nursing would send out to get further evaluation. Anonymous staff-D stated that nursing can touch the vent to a point, but does not touch settings or change anything, usually it is just to silence an alarm that may be going off. (continued on next page)

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

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F 0695

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

On 2/3/2025, at 10:45 AM, Surveyor interviewed RT-Q who stated RTs provide suctioning, trach cares, and oral cares to residents on the ventilator unit. RT-Q stated that not all of the residents have the pulmonary oversight like all the ventilator dependent residents do and technically nursing staff can do the suctioning and trach cares, but RT will do the cares if nursing staff ask them to because not all the nursing staff is sure on how to do suction or trach cares or has not done it for a long time.

On 2/3/2025, at 11:02 AM, Surveyor interviewed RN supervisor-M. Surveyor asked RN-Supervisor-M how it is assured that the nurses scheduled on the vent unit have the competencies to care for the residents if RT is not in the building. RN supervisor-M stated he would need to get back to surveyor with that information since RN supervisor-M does not make up the schedule. Surveyor asked what the expectation of nursing staff is if a resident on a ventilator needed assistance, and no RT was available. RN supervisor-M stated that the doctor/NP, and pulmonary NP are on call 24/7 to get direction. RN supervisor-M stated that currently the facility is working on getting the nursing staff ventilator certified, but only a handful has been through the certification so far.

On 2/4/2025, at 8:37 AM, Surveyor interviewed anonymous staff-C who stated that the RN supervisor is not directly assigned a unit but oversees the whole building. Anonymous staff-C stated that the RN supervisor is not always available for supervision of staff because they get pulled everywhere, whether it involves taking on a unit due to a call in, working with an admission, working on a discharge, or other tasks. The RN manager does not always have time to directly supervise someone. Surveyor asked what kind of cares nursing provides to the residents that are ventilator and non-ventilator dependent on the vent unit. Anonymous staff-C stated that the RT does most of the trach suctioning, trach cares, and vents. Anonymous staff-C stated they would be hesitant to hook up a resident to oxygen if they had a trach mask because they have never done it before and anonymous staff-C stated they do not touch or do anything with the ventilators and has never had any training on what to do. Surveyor asked anonymous staff-C what nursing staff would do in the event of an emergency or someone on a ventilator needed assistance. Anonymous staff- C stated that they would call the on-call doctor or send the resident out but would not be comfortable doing anything with the ventilators.

Surveyor requested to look at what competencies nursing (LPN and RN) are expected to be able to perform at the facility. The following competencies were documented that pertain to the ventilator/trach unit:

- Oral Hygiene

- Oxygen

- Trach care/ inline suctioning.

Surveyor notes that there are no ventilator competencies.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/4/2024, at 3:23 PM, Surveyor interviewed NHA-A and DON-B. Surveyor asked how it is determined that the ventilator unit has staff that are competent and how do they ensure agency staff have the competencies to a care for the vulnerable residents that require ventilator/trach cares. DON-B stated that when an RT is not scheduled, they always make sure a nurse that went to the vent certification course is scheduled to the unit. Surveyor asked how are the LPN's that were certified supervised and delegated on the unit with such vulnerable residents. DON-B stated that there is a nursing supervisor on the schedule, 24/7 on call doctor/NP, and pulmonary doctor/NP are always available by phone 24/7. DON-B stated that DON-B is always available by phone as well. Surveyor asked what if there was a situation that required emergent care for the resident, and no one was available. DON-B stated that staff would call 911 and send the resident out to be further evaluated. Surveyor requested to review the education provided in the ventilator certification class and what staff attended the class and the check off competencies for trach care/ in line suctioning provided to nursing staff upon hire. DON-B stated that there is not a check off competency and the DON-B will go over it with staff. Surveyor requested to see what DON-B goes over with nursing staff. DON-B stated she will write something up. On 2/5/2025, at 9:18 AM, Surveyor was provided the Ventilator Certification course material and DON-B stated that the facility staff that attended the course on 1/9/2025 included: DON-B, Staff development Coordinator, and 5 LPN's. DON-B stated the next class offered will be in March 2025. Surveyor asked if any of the RN supervisors were educated on the ventilator. DON-B stated that no RN supervisors attended the course, but RT gave some education to nursing staff. Surveyor requested to see what the RT went over with staff, and who RT went over it with. Please note, Surveyor has not received a list of staff or education RT went over with facility staff on the ventilator unit or what DON-B goes over with staff regarding suctioning, and trach cares at time of write up. Surveyor reviewed the course material for the ventilator certification course. The Adult Ventilator Care Certification course was provided through [Hospital] and the instructors were Respiratory care practitioners employed at [Hospital]. The class was eight hours and included handouts, lecture, return demonstrations and a 50 question exam. The class objectives included: 1. Verbalize the components of routine pulmonary assessment including: a. Ventilatory pattern. b. Breath sounds. c. Sputum characteristics. d. Oxygenation. 2. Ability to discuss the components of oxygenation systems and auxiliary oxygen delivery devices. 3. Demonstrate tracheostomy tube change, site care, and suctioning. 4. Ability to recognize and react to tracheostomy emergency situations. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Ability to adjust ventilator settings according to physician orders. 6. Ability to troubleshoot ventilator settings and alarms. Surveyor notes that 2 staff members that attended the ventilator certification course (LPN-O and Anonymous staff-D) stated that the nursing staff do not touch the ventilator and just verify settings and would call the on-call supervisor, doctor/ NP, pulmonary doctor, and call 911 in event of an emergency. That does not match up with what was taught in the ventilator certification course on 1/9/2025 for staff to complete. During interviews, there were staff, (despite possibly attending the 1/9/25 training) that still do not feel comfortable providing respiratory cares. Surveyor reviewed the staff schedules for January 2025, the following dates/ shifts had the following staff scheduled without a RT scheduled: (note shift hours - Day shift: 6:00 AM - 2:30PM, Evening shift: 2:00 PM-10:30 PM, Night shift 10:00 PM - 6:30 AM). 1/5/2025: Day shift- no RT scheduled; 2 LPNs scheduled both vent certified Evening shift- RT scheduled for 6:30 PM - 10:30 PM, 2 LPNs scheduled both vent certified Night shift- no RT scheduled, 1 agency LPN, 1 LPN vent certified. 1/6/2025: Evening shift- RT scheduled for 6:30 PM- 10:30 PM, 1 agency LPN, 1 LPN vent certified. 1/7/2025: Evening shift- no RT scheduled, 1 LPN scheduled 2:00PM - 6:30PM, 1 LPN scheduled 6:30PM- 10:30PM, 1 LPN vent certified. Night shift- no RT scheduled, 1 agency RN, 1 LPN vent certified. 1/8/2025: Evening shift- RT scheduled from 6:30PM- 10:30PM, 1 LPN schedule for 2:30PM - 6:30PM, 1 LPN, 1 LPN vent certified. 1/10/2025: Evening shift- RT scheduled until 7:00PM, 1 LPN, 1 agency LPN Night shift- no RT scheduled, 1 agency LPN, 1 LPN vent certified. 1/13/2025: Evening shift- No RT scheduled until 6:30PM, 2 LPN both vent certified (continued on next page)

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Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

(b) Perform delegated acts beyond basic nursing care under the direct supervision of an R.N. or provider. An L.P.N. shall, upon request of the board, provide documentation of his or her nursing education, training or experience which prepares the L.P.N. to competently perform these assignments.

On 2/5/2025, at 10:35 AM, Surveyors shared concerns with NHA-A and DON-B of the oversight of the vulnerable residents residing on the ventilator unit and staff having the ability to assess and treat residents when necessary. Surveyor shared concern with NHA-A and DON-B that the ventilator unit is specialized, and the RT's have their tasks and expertise, however RT's do not have the ability to delegate tasks to LPN's. Surveyor shared concerns that there is no direct oversight of an RN over the LPNs on the unit and that no RN's are vent certified that would oversee the LPN's. Surveyor asked how the tasks are delegated to the LPN if there is no RN supervision over the LPN staff that is scheduled especially if the RN did not have ventilator training. DON-B stated that there is always an RN supervisor on each shift and they can contact DON-B if not in the building, doctor/NP on call, or the pulmonary on call. Surveyor asked to clarify the RN supervisor role. DON-B stated that the RN Supervisor oversees the whole facility. On day and evening shift there is 1 RN supervisor for 2nd floor, 1 RN supervisor for 1st floor, and night shift there is 1 RN supervisor for the whole building. Surveyor asked if a RN supervisor is directly assigned only for the ventilator unit. DON-B stated there is not an RN supervisor assigned only to the ventilator unit. Surveyor shared concern that facility staff do not have all the competencies or direct oversight to care for residents that are ventilator and non-ventilator dependent residing on the ventilator unit when a RT is not in the building. Surveyor shared concerns with DON-B that not all RN supervisor staff have the competencies or feel confident about caring for residents on the ventilator unit.

49845

* R7 was admitted to the facility on [DATE] with diagnoses that include Acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia (too much carbon dioxide in the blood stream), dependence on respirator (ventilator, Pneumonitis due to inhalation of food and vomit, and Chronic obstructive pulmonary disease with exacerbation.

R7's Admission Minimum Data Set (MDS), dated [DATE], documents in part that R7 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R7 is cognitively intact. R7's MDS documents R7 has Respiratory treatments documented as: continuous oxygen therapy, suctioning as needed, tracheostomy care, invasive mechanical ventilator, and had 7 days of respiratory therapy for at least 15 minutes a day in the last 7 days.

On 02/04/2025, at 10:18 AM, Surveyor interviewed R7, who indicated having no concerns.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed R7's Facility provided document, titled Care Plan for R7. Surveyor noted, R7's care plan documents the following problem category, Pulmonary and documents R7 has alteration in respiratory status related to ventilator/trach use. Surveyor noted R7's care plan documents in part the following: . Change trach Q (every) 6 weeks & as needed (PRN) . Change tubing, masks, cannula & other equipment, per protocol . Check O2 (oxygen) settings Q4H (every 4 hours) & PRN . Elevate HOB (head of bed) to 30 degrees . Encourage pursed lip breathing . Humidifier, per MD order . Lab/Diagnostic work, per MD orders . Maintain patent airway . Maxorb 2 Ag+ Alginate wound Dressing with silver placed under Tracheostomy dressing TID (three times daily) for wound . Mechanical Vent Support, per MD orders . Monitor and report signs of hypoxia (cyanosis (blue skin), tachypnea (fast breathing), dyspnea (shortness of breath), confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse) . Monitor for S/Sx (signs/symptoms) of respiratory infection, shortness of breath . Monitor O2 sats, Q4H & PRN . Monitor oxygen saturation via pulse oximetry Q4 hours & PRN when on continuous oxygen therapy . Monitor Respiratory status, per MD orders or PRN . Oral Hygiene Q Shift & PRN . Provide calm environment free of stimuli to reduce /prevent anxiety . Resident will require a minimum of 7 hours each night of ventilator support chronic respiratory failure with hypercarbia. This will be continuous. Resident to be on ventilatory support each night and PRN during the day. Sip/puff call light . Stonghold device to be placed to prevent accidental ventilator disconnection. Suction PRN per MD orders . Trach care Q Day & PRN . Vent Settings: ACVC 450/18/5+ FiO2 to keep SpO2 at or above 92% . R7's respiratory care plan with a problem start date of 11/23/2024 includes an intervention with an approach Start Date of 12/19/2024. Respiratory therapy: ___ (specify plan -nebulizers, inhalers, etc.). Surveyor noted this was not individualized or complete for R7. On 02/04/2025, Surveyor reviewed R7's document titled, Physician Order dated 02/04/2025, and noted orders related to R7's medications, treatments, and enhanced barrier precautions and no orders related to ventilator care and/or management is documented. Surveyor reviewed the Facility provided document titled, Physician Order Report, dated 01/01/2025-01/31/2025, which documents R7 had documented Respiratory orders with a start date of 11/21/2024 and discontinued on 01/06/2025. Surveyor reviewed the Facility provided document titled, Physician Order Report, dated 12/18/2024-12/31/2024, which documents R7 had Respiratory orders documented with a start date of 11/21/2024 and discontinued on 01/06/2025. ORDER INTERVIEWS (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/04/2025, at 10:25 AM, Surveyor asked Respiratory Therapist (RT)-R to show Surveyor what R7 has for Respiratory Therapy while in R7's room. RT-R indicated R7 is on a ventilator at night and switched to an aerosol, T-piece valve (a specialized adaptor used to safely deliver aerosolized medications to an individual who is on a ventilator) during the day, which R7 currently had on. RT-R indicated that nurses are responsible for ensuring R7 is on the ventilator at night and taken off the ventilator in the morning when RT is not at the Facility. Surveyor asked RT-R how nursing staff or agency staff would know of R7's ventilator orders, RT-R indicated that RT orders are separate from the nursing orders and was not sure if nursing staff could see the RT orders for R7. RT-R indicated that report would be given to the next shift from RT or RN supervisor. RT-R indicated that RT-R was the lead RT until recently when he was demoted after a meeting with NHA-A and DON-B regarding RT to resident ratios. On 02/04/2025, at 10:30 AM, Surveyor [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on observation, interview, and record review, the Facility did not ensure staff followed infection control procedures for 1 (R4) of 2 Residents. * Appropriate hand hygiene was not observed during incontinence cares for R4. Findings include: The Facility's policy titled, Hand hygiene, dated 08/18/2024, documents in part, . Hand hygiene is a general term used by the Center for Disease Control and Prevention (CDC) and World Health Organization (WHO) to refer to handwashing, antiseptic handwashing, antiseptic hand rubbing, and surgical hand asepsis. The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to a patient, and from a staff member to a patient. Because of this, hand hygiene is the single most important procedure to prevent infection. To protect patients from healthcare-associated infection, hand hygiene must be performed routinely and thoroughly. Washing with soap and water is appropriate when the hands are visibly soiled or contaminated with blood or other body fluids, when exposure to potential spore-forming pathogens (such as Clostridioides difficile or Bacillus anthracis) is strongly suspected or proven, and after using the restroom. R4 was admitted to the facility on [DATE] and has diagnoses which include Chronic diastolic (congestive) heart failure, tachypnea, chronic kidney disease, fibromyalgia, morbid obesity, Resistance to multiple antimicrobial drugs, urinary tract infections (UTI), and history of other disease or urinary system. R4's Annual Minimum Data Set (MDS), dated [DATE], documents R4 has a Brief Interview for Mental Status (BIMS) of 15, does not exhibit behaviors related to rejection of care, no impairment in upper or lower extremities, uses a wheelchair for mobility, is dependent on helper for toileting hygiene, and always incontinent of bowel and bladder R4's most recent Quarterly MDS, dated [DATE], documents in part, R4 has a BIMS of 14, does not exhibit behaviors related to rejection of care, no impairment of upper or lower extremities, is dependent on helper for toileting hygiene, and always incontinent of bowel and bladder. Surveyor reviewed the Facility provided document, titled Care Plan History for R4. R4's care plan documents in part, R4 has recurrent UTI related to history of Multidrug-Resistant Organism (MDRO) with interventions including Enhanced Barrier Precautions (EBP). R4 has urinary incontinence or is at risk related to immobility and weakness and documents, Resident has history of frequent UTIs, frequent urination (small amounts), discomfort when voiding, and retention. (sometimes requests assistance about every 30 minutes and often at change of shift). On 02/03/2025, at 01:42 PM, Surveyor observed from the hall, R4's call light to alarming. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/2025, at 01:43 PM, Surveyor observed LPN-I and CNA-H respond to R4's call light. Surveyor then observed LPN-I and CNA-H don EBP PPE and provide incontinence cares for R4. Surveyor noted R4 to have a small bowel movement in R4's brief. Surveyor observed CNA-H clean R4's bowel movement using wash cloths. Surveyor then observed CNA-H discard the contaminated washcloths. CNA-H then obtained new washcloths and proceed to clean R4's vaginal region. Surveyor noted CNA-H did not discard contaminated gloves and perform hand hygiene before starting a new task and providing pericare for R4. On 02/03/2025, at 03:15 PM, Surveyor informed NHA-A and DON-B of above findings. On 02/04/2025, at 12:57 PM, DON-B indicated CNAs have pericare competencies on orientation. DON-B indicated infection control practices are discussed monthly during meetings. DON-B indicated re-education was given to staff after Surveyor informed the Facility of the concerns. No further information provided as of time of write up.