STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review the facility did not ensure 1 of 19 residents (R4) were treated with respect and dignity. The facility did not provide laundry services timely for R4. R4's personal laundry was in the laundry department for three weeks before being returned to R4. Evidenced by: The Resident Rights in the facility's admission packet, states, in part: . Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility . 4. Respect and dignity. The resident has a right to be treated with respect and dignity, including: . b. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents . R4 was admitted to the facility on [DATE] and has diagnoses that include: metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood, which can impair brain function), acute and chronic respiratory failure (develops when the lungs can't get enough oxygen into the blood making it difficult to breathe), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). R4's Admission Minimum Data Set (MDS) Assessment, dated 3/31/24 shows that R4 has a Brief Interview of Mental Status (BIMS) score of 7 indicating R4 has severe cognitive impairment. (continued on next page)

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

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 2:54 PM, Surveyor interviewed FM C (Family Member) who indicated while R4 was in the facility her mother went 8 days without clothing due to laundry services. FM C indicated R4 was admitted to the facility with 10 pairs of pants, 8-10 t-shirts and 8-10 pairs of socks. On 5/13/24 or 5/14/24, FM C could not be sure which day, FM C spoke with SW D (Social Worker), the receptionist and a nurse and asked where her mother's clothes were. FM C indicated she was told they were in laundry, then told there was no laundry services on the weekends and told there was a new person in laundry. FM C indicated she was irritated with the facility. FM C indicated on 5/13/24 and 5/14/24 R4 had the same clothes on and there were no clothes in her dresser. On 6/19/24 at 9:50 AM, Surveyor interviewed HH F (Head Housekeeper). HH F indicated she had spoken with FM C regarding concerns about R4's laundry. HH F indicated she informed FM C that she was working hard on replenishing R4's laundry. HH F indicated the whole month of May the clothing labeling machine was not working, and clothes piled up that needed to be labeled. HH F indicated after speaking with FM C laundry was working on going through the clothes pile and started bringing up a few items at a time up to R4 and asking if they were hers. HH F indicated the process took 3 weeks before R4's clothing was replenished back to R4. On 6/19/24 at 12:35 PM, Surveyor spoke with DON B (Director of Nursing) and asked what a reasonable time frame would be for a resident to get laundry back after taken to laundry services. DON B indicated the next day. Surveyor asked if 3 weeks would be acceptable for a resident to go before laundry was returned. DON B indicated no, that would be a concern.

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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 0564 Level of Harm - Actual harm Residents Affected - Few	Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interviews, and record review, the facility did not ensure that residents had the right to receive visitors of their choosing at the time of their choosing for 1 of 19 residents (R5) reviewed for visitation rights. This resulted in R5 experiencing depression, financial hardship, and disinterest in participating in activities of daily living (ADLs). R5's husband is limited by the facility to visiting between the hours of 8:00 AM to 4:30 PM, regardless of the resident's wishes. Findings include: The facility policy, entitled Resident Right to Access and Visitation, undated, states: Policy: It is the policy of this facility to support and facilitate the resident's right to receive visitors of their choosing, at the time of their choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of other residents . The policy also states, 1. The facility will provide immediate access to a resident by immediate family and other relatives of the resident . Resident's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions, placed by the facility according to CDC (Centers for Disease Control) guidelines, and/or local health department recommendations. R5 was admitted to the facility on [DATE], and has diagnoses that include: multiple sclerosis (degenerative disorder causing nerve damage which leads to paralysis, vision loss, fatigue, and mood disturbance) , sickle cell disorder with acute chest syndrome (red blood cells become crescent-shaped causing severe pain with occlusion of arteries and veins around the lungs), idiopathic aseptic necrosis of right femur (death of bone tissue related to loss of blood supply), idiopathic aseptic necrosis of left femur, and other chronic pain. R5 has a Brief Interview of Mental Status (BIMS) of 15, indicating that she is cognitively intact. R5's Care Plan indicates activity interventions of R5 activity preferences: visits from husband, TV, shopping, resting, smoking, snacking, socializing with other residents, smartphone games, bingo . Allow private time for her and husband. These interventions were initiated on 12/11/23 and maintained following a revision on 3/15/24. R5 has an additional care plan focus of The resident is at risk for mood impairment r/t (related to) decline in capabilities r/t dx (diagnosis) of MS (multiple sclerosis). Goal: The resident will verbalize improved well-being by next review date. Intervention: Monitor/document/report PRN (as needed) any risk for harm to self: . This focus was initiated on 12/2/23 and maintained through a revision on 5/15/24, with a target date of 8/15/24. (continued on next page)

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F 0564 Level of Harm - Actual harm Residents Affected - Few	The Facility also created a typed document that is untitled to restrict R5's visitation hours. The document is dated 1/3/24. This document states, Witnesses have reported seeing the resident's significant other utilizing resources that are meant for the resident, and resident alone. It has been determined that R5's progress to health and wellness is being compromised by the presence of the significant other. This document specifies that starting 1/4/24, the husband's visitation was restricted to business hours of 8:00 AM to 4:30 PM. The document also states, If the significant other is seen on the premises, he will be asked to leave. If this is unsuccessful, we will be required to contact[sic] law enforcement. Emergency shelter address and contact information also included. This document was signed by SW D (Social Worker). R5 and her husband did not sign the document. Of note: No evidence provided as to how the facility made the determination that R5's progress to health and wellness was being compromised by the presence of her husband. On 6/18/24 at 10:07 AM, Surveyor interviewed R5. Surveyor asked R5 if her visitors have ever been restricted. R5 indicates that the facility is currently restricting her husband's visitation hours and has been since January of this year. Facility staff have told R5 and her husband that the husband can only visit between the hours of 8:00 AM and 4:30 PM. R5 denies ever receiving a valid reason to why this restriction was put in place. R5 also states that the facility tried to get her to sign a contract agreeing to this visitation restriction which both the resident and her husband refused to sign because they did not agree to the conditions imposed by the facility. The contract itself was initiated by a prior administrator, and when R5 approached NHA A (Nursing Home Administrator) to remove these restrictions, as it was R5's wish to visit with her husband outside of these hours and that the contract was never signed, NHA A advised the resident that it didn't matter that R5 and her husband didn't sign the contract, the restriction would remain in place. Surveyor asked R5 why the restriction was initially implemented. R5 states that staff observed her husband lying in her bed several months ago and claimed that her husband was trying to live here. R5 explains that her husband worked the night shift at the time, and the resident did not use her bed as she remained in her electric wheelchair by choice. They were watching a movie together when her husband fell asleep after working all night. Surveyor asked if her husband currently has a residence of his own. R5 reports that her husband has his own residence and has since before she was admitted to the facility, as they had separated several months prior to her admission to the facility and were living separately before her admission. R5 also indicates that her husband is currently caring for their 8-year-old child at the husband's personal residence. R5 states that recently, the facility has started calling the police when they see her husband on facility grounds after 4:30 PM, without a prior verbal warning as the contract she did not sign states. Surveyor asked if police ever charged her husband with any crime. R5 indicated that police took no other action then to just ask her husband to leave, which he complied. On 6/19/24 at 8:43 AM, Surveyor interviewed CNA I (Certified Nursing Assistant). Surveyor asked CNA I if she is familiar with R5's husband. CNA I indicated that she is familiar with him. Surveyor asked CNA I if she has ever had any issues or negative interactions with R5's husband. CNA I indicates that she has never had any issues or seen R5's husband act in an aggressive manner towards other residents or staff. (continued on next page)

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F 0564 Level of Harm - Actual harm Residents Affected - Few	On 6/19/24 at 8:55 AM, Surveyor interviewed LPN G (Licensed Practical Nurse). Surveyor asked LPN G if she is familiar with R5's husband. LPN G indicated that she is familiar with him. Surveyor asked LPN G if she has ever had any issues or negative interactions with R5's husband. LPN G indicates that she has never experienced any negative interaction towards herself. However, several months ago, she witnessed an incident between R5, R5's husband, and SWA J (Social Worker Assistant), in which the husband was yelling at SWA J which included vulgar language. LPN G does not know what the argument was about. LPN G did not witness any physical aggression at that time and has not witnessed or experienced any incidents since that time. Of note: This is the only clinical staff member who witnessed aggression from R5's husband that Surveyor was able to interview. On 6/19/24 at 9:29 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked about R5's husband when DON B indicated that the husband was another problem. Surveyor asked DON B if the facility was restricting the husband's visiting hours. DON B indicates that they are restricting his visiting hours. Surveyor asked why the husband's visiting hours are restricted. DON B indicates that he is scary, intimidating, swears, raises his voice to herself, staff, and other residents. DON B indicates that it doesn't matter what the facility rules are, he will just pull his car into the driveway and basically tailgate in the driveway. Surveyor asked if DON B was aware of how these restrictions started as DON B was not employed by this facility when the restrictions were initiated. DON B indicates that through discussions with the previous administration, R5's husband was eating R5's meals and sleeping in her bed. DON B indicates that at that time, the facility believed the husband to be homeless. DON B reiterates that she is intimidated by R5's husband. On 6/19/24 at 10:43 AM, Surveyor interviewed R18. R18 has a BIMS of 15, indicating she is cognitively intact, and was admitted to the facility three years ago. R18 resides in a room across the hall from R5's room. Surveyor asked R18 if she ever has had any issues with a visitor in the building. R18 indicates that she has never had any problem with a visitor. Surveyor asked R18 if she has ever heard any loud arguments, disturbances, or been intimidated by a visitor from the facility. R18 reports that she has never been intimidated or disturbed by a visitor within the facility. R18 indicates that she would report the incident if she had been bothered by a visitor. Of note: No residents that Surveyor was able to interview reported any issues with a visitor in the facility. (continued on next page)

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F 0564 Level of Harm - Actual harm Residents Affected - Few	On 6/19/24 at 1:57 PM, Surveyor interviewed R5. Surveyor asked R5 if she could remain in the building to visit with her husband. R5 states that she can visit with her husband anywhere on the property from 8:30 AM to 4:30 PM, but after that she must visit with him off the property. R5 indicates that they usually visit on the bridge which Surveyor notes to be a public pedestrian bridge adjacent to the property. Surveyor asked R5 if she has ever been completely denied access to her husband, which R5 indicates that she has not. Surveyor asked R5 if the visitor hour restriction on her husband limits her ability to visit with her child. R5 indicates that it does, since her daughter is only in Wisconsin for the summer, and since it is not safe for her child to be outside in the extreme heat, she has not been able to visit with her daughter as much as she wants. Surveyor asked R5 how not being able to visit with her husband and daughter at the times of her choosing has affected her. R5 reports to Surveyor that she fights hard every day and that she is in a constant state of depression. Surveyor asked R5 if she could describe what she means by fights hard every day. R5 paused for a moment, shook her head, looked away, and was visibly tearful. Surveyor asked R5 if there was anything else she was willing to share about what she was experiencing. R5 describes not being able to focus on anything going on outside of the facility because she is constantly worried about and missing her family. R5 also describes financial hardship as her husband lost his job because he was taking so much time off work trying to visit with her before 4:30 PM when his visiting hours ended. R5's husband is also spending more money on gas trying to facilitate visits with R5's daughter while she is residing locally over the summer. On 6/19/24 at 2:15 PM, Surveyor interviewed CNA H. Surveyor asked CNA H if she was familiar with R5's husband. CNA H states that she is familiar with R5's husband. Surveyor asked CNA H if she has ever experienced R5's husband acting aggressively or had any problems with him. CNA H reports that she has never had any problems with him. CNA H also states, I think it is just wrong what they are doing to her and her husband. They don't restrict any other visitors here. CNA H also believes they are hurting R5 by not letting her husband visit. (continued on next page)

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F 0564 Level of Harm - Actual harm Residents Affected - Few	On 6/19/24 at 2:30 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if the facility has a visitation policy. NHA A indicates that the facility does have a visitation policy and Surveyor was provided the policy upon request. Surveyor asked NHA A if the facility restricts any visitors. NHA A indicates the facility only restricts visitation hours for R5's husband. Surveyor asked NHA A if there was anything restricting R5's husband's visitation besides the imposed hour restriction. NHA A reports that there are no additional restrictions and that R5's husband is allowed to utilize the entire property when visiting R5. NHA A indicates that the visitation hour restriction was in place prior to his employment with the facility but he has not seen any indication that the restriction should be lifted. Surveyor asked NHA A to describe the reason for the continuation of the visitor restriction. NHA A indicates that R5's husband has cursed at staff, used derogatory language against staff, flipped me off from his car window, and used derogatory language towards DON B. Surveyor asked NHA A if other residents were around during these incidents. NHA A indicates that he does not recall if residents were around or not. Surveyor asked NHA A if he believes that R5's husband is a threat to staff safety. NHA A states absolutely. NHA A states that R5's husband is scary, and that facility staff are worried about going to their car at night. NHA A reports that the week R5 was in the hospital was a relief to him because he didn't have to worry about his safety walking to his car at night. NHA A also indicates that, in his perspective, R5's husband is physically intimidating and reports the tailgating incident that DON B reported in her interview. Surveyor asked NHA A if he believes there is a threat to resident safety, since his staff feel threatened. NHA A states yes, there is a threat to resident safety and that if NHA A's mother resided at the facility, he would be concerned for her safety with R5's husband around. Surveyor asked NHA A, since he believed there is a threat to resident safety, if any self-reports were made regarding incidents occurring with R5's husband. NHA A indicates that the facility has not made any self-reports because no reportable incidents have occurred yet, but that the facility has contacted the police several times for R5's husband being on the property after 4:30 PM. Surveyor asked NHA A if any residents had approached him personally regarding R5's husband or his behavior. NHA A indicated that no residents had reported anything to him personally but was unsure if anything had been reported to other staff members. Surveyor asked NHA A if the facility had received any police reports from the facility calling the police on R5's husband. NHA A indicates they have not received any police reports. NHA A also made a statement to Surveyor that NHA A believes that if the facility were to lift the visitor restriction, the facility would turn into a 24-hour bed and breakfast for R5's family members. Of note: No grievances or self-reports were provided to Surveyor that accused R5's husband of resident mistreatment. The facility's unreasonable visitation restriction of R5's husband has caused R5 pyschosocial harm as evidenced by R5 has voicing constant depression, feeling hopeless, and can not focus on other things as she is worried and misses her family.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not immediately consult with a resident's physician or update resident's guardian when there was a change in resident's condition and need to alter treatment for 1 resident (R4) out of 3 reviewed for notification of changes. R4 was sent to the emergency department on 5/4/24 and R4's guardian was not immediately notified. R4 had three falls on 5/11/24 and R4's guardian was not notified of one of those falls. Evidenced by: The facility policy entitled Notification of Changes, dated 10/22/23, states, in part: . Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification . Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents . 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status . 4. A transfer or discharge of the resident from the facility . R4's progress note dated 5/4/24 indicates R4 was sent to the emergency room for low oxygen saturation of 83%, shortness of breath, cold and clammy. Of note there is no mention of guardian being notified. R4's progress note dated 5/6/24 indicates R4 readmitted to facility from hospital. Of note: Surveyor asked DON B (Director of Nursing) for information regarding R4 being sent to emergency room and guardian notification. DON B indicated they would look. Surveyor did not receive additional documentation showing guardian was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's progress note dated 5/11/24, at 2:11 PM, states, in part: .while turning the corner to proceed down center hall resident turned fast to yell at writer that I was dumb, while turning back around she jumped out of her wheelchair and landed on the floor while continuing to yell, this time about needing her cell phone. This action was witness by Birch nurse and social worker. B/P (blood pressure) 147/72 Resident continued to sit on floor and yelled about credit card and her missing phone. Assisted back into wheelchair with CNA (Certified Nursing Assistant), escorted to dining room. Two Tylenol were given a few minutes prior to this for general discomfort. Appetite good. Resident sitting in wheelchair at this time by dining room. Of note: there is no mention of R4's guardian being notified. Of note: Surveyor requested fall report /investigation for this fall and was not provided with it. On 6/18/24 at 9:55 AM, Surveyor interviewed LPN G (Licensed Practical Nurse) and asked when a resident's POA (Power of Attorney)/ guardian be notified. LPN G indicated with any change in condition, changes in medical treatments, if sent out to the hospital, with falls and with new skin wounds or skin tears. On 6/19/24 at 12:35 PM, Surveyor interviewed DON B (Director of Nursing) who indicated POAs/guardians should be notified if a resident gets sent to emergency room , has a fall or with a change in condition. Surveyor asked DON B if R4's guardian should have been notified of the transfer to the emergency roiagnom on [DATE] and all R4's falls on 5/11/24. DON B indicated yes. Surveyor indicated to DON B that Surveyor was unable to observe notification in progress notes or fall documentation. Surveyor asked DON B if this should be documented, and DON B indicated yes. DON B indicated she would look to see if there was documentation that the guardian had been notified. Additional information was provided to Surveyor but did not include notification for R4's hospitalization or the notification for the fall on 5/11/24 at 2:11 PM.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 41788 Based on photographic evidence and interview, the facility failed to keep residents' personal health information confidential for 1 of 3 residents reviewed for health information (R18). R18's private health care information was found in R4's room. Evidenced by: The facility policy entitled Confidential of Personal and Medical Records, dated 5/15/24, states, in part: . Policy: This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. Policy Explanation and Compliance Guidelines: . 2. Keep confidential is defined as safeguarding the content of information including written documentation, video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative . 8. Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons . R4 was a short-term rehab resident at the facility. On 5/13/24 R4's family member found R18's personal health information including R18's name, activities of daily living, care plan interventions, and information indicating R18 was on hospice in R4's room. On 6/18/24 at 2:54 PM, Surveyor interviewed FM C (Family Member) who indicated on 5/13/24 R18's Certified Nursing Assistant (CNA) Kardex with R18's personal information on it was in R4's room. FM C indicated R4 did not have a roommate. FM C provided Surveyor photographic evidence of R18's Kardex. On 6/19/24 at 9:30 AM, Surveyor interviewed DON B (Director of Nursing) and asked should a CNA Kardex for a resident who does not reside in a room, be found in that room. DON B indicated that is confidential information and would be a HIPPA (Health Insurance Portability and Accountability) violation. Surveyor asked what if a family member of another resident got a hold of it and DON B shook head no and indicated that should not happen and it is confidential information.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not ensure that each resident had a baseline care plan developed and implemented, within 48 hours, with needed instructions to provide effective and person-centered care for 1 of 18 residents (R3) reviewed. R3 did not have a baseline care plan completed. This is evidenced by: The facility policy, entitled Baseline Care Plan, dated 11/2023, states in part: the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of the residence admission, will include the minimum health care information necessary to properly care for a resident including, but not limited to: initial goals based on admission orders, physician orders, dietary orders, therapy orders, social services, and PASRR (Preadmission Screening and Resident Review) recommendations . the admitting nurse shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and the resident representative . once gathered, initial goals shall be established that reflect the resident's stated goals and objectives, interventions [NAME] initiated that address the resident's current needs, including: any health and safety concerns to prevent decline or injury . any identified needs for supervision, behavioral interventions and assistance with activities of daily living, or any special needs . once established, the goals and interventions shall be documented in the designated format . a supervising nurse shall verify within 48 hours that a baseline care plan has been developed . a written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand . R3 was admitted to the facility on [DATE] and has diagnoses including displaced fracture of coronoid process of left ulna, anterior dislocation of right humerus, unspecified dementia with psychotic disturbance, depression, osteoarthritis, and unspecified convulsions. R3's native language is Hmong, not English. On 6/18/24 at 10:52 AM, during an interview Resident Representative N indicated staff were unsure how to care for R3 when she arrived. They were unsure of her most recent fracture in her elbow, unsure what her physician orders were, unsure what her diet was, and they did not know how much assistance she required. (It is important to note R3's Medical Record does not contain a Baseline Care Plan.) R3's Comprehensive Care Plan, initiated 5/3/24, includes: Bathing/Showering: The resident requires (blank) . Bed mobility: the resident requires (blank) . Dressing: The resident requires: (blank) . Eating: The resident requires (blank) . Personal Hygiene: the resident is able to: (blank) . Toilet use: The resident requires: (blank) . Transfer: The resident requires (blank) . (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(It is important to note R3's Comprehensive Care Plan did not include goals or interventions related to ADL/activities of daily living care.) On 6/19/24 at 8:53 AM, during an interview CNA I (Certified Nursing Assistant) indicated she gets the information she needs to care for residents on a Kardex. CNA I indicated the information on the Kardex auto populates from the resident's Comprehensive Care Plan. CNA I indicated the Comprehensive Care Plan is an extension of the Baseline Care Plan. On 6/19/24 at 8:55 AM, RN O (Registered Nurse) indicated residents are to have Baseline Care Plans within 48 hours of admission. RN O indicated the information on the resident Kardex auto-populates from the Comprehensive Care Plan stating, If it is not on the care plan it is not on the Kardex. RN O indicated R3's Baseline Care Plan is incomplete, and staff were to fill in the blanks with information from the hospital discharge and admission assessments. On 6/19/24 at 8:57 AM, LPN G (Licensed Practicing Nurse) indicated residents are supposed to have Baseline Care Plans within 48 hours of admission. LPN G indicated R3's Baseline Care Plan is included in her Comprehensive Care Plan and is incomplete. LPN G indicated staff were to fill in the blanks. On 6/19/24 at 9:29 AM, DON B (Director of Nursing) indicated R3's Baseline Care Plan is not completed and should have been. DON B indicated it is the admission nurse's responsibility to fill in the blanks and complete the Baseline Care Plan within the first 48 hours of the resident's stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not ensure that 2 residents (R4 & R15) reviewed for Activities of Daily Living (ADL) out of a total sample of 19 received the necessary services to maintain good nutrition, grooming, personal and oral hygiene. R4 did not receive weekly scheduled showers in April, May, and June 2024. R15 did not receive weekly showers as scheduled in April, May, and June 2024. Evidenced by: The facility policy entitled Activities of Daily Living, undated, states, in part: Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs (activities of daily living) do not deteriorate unless deterioration is unavoidable. Cares and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . Example 1 R4 was admitted to the facility on [DATE] and has diagnoses that include: metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood, which can impair brain function), acute and chronic respiratory failure (develops when the lungs can't get enough oxygen into the blood making it difficult to breathe), and chronic obstructive pulmonary disease (COPD; a group of lung diseases that block airflow and make it difficult to breathe). R4's Admission Minimum Data Set (MDS) Assessment, dated 3/31/24 shows that R4 has a Brief Interview of Mental Status (BIMS) score of 7 indicating R4 has severe cognitive impairment. R4's Care Plan dated, 3/28/24, states, in part: . Focus: The resident has an ADL self-care performance deficit r/t (related to) neurological and pulmonary comorbidities. Date Initiated: 3/28/24 Revision on: 5/13/24. Goal: Resolved: The resident will improve current level of function in assisting with ADLs through the review date. Resident will be able to: assist with cares as tolerable. Date Initiated: 3/28/24 . Interventions: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Bathing/Showering: The resident requires assistance by (1) staff with (bathing/showering) Monday PM and as necessary. Date Initiated: 3/28/24 . R4's CNA shower documentation for April, May and June shows the following: - R4 received a shower on 4/1/24 - R4 received a shower on 5/14/24 - R4 received a bed bath on 5/19/24 - R4 received a bed bath on 5/20/24 Of note: R4 admitted to facility on 3/26/24 and should have received weekly showers. There is no shower documentation for: 4/1/24, 4/8/24, 4/15/24, 4/22/24, 4/29/24, 5/6/24, 5/27/24, and 6/3/24. Example 2 R15 admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and is not using it for energy) and heart failure (a chronic condition in which the heart does not pump blood as well as it should). R15's Certified Nursing Assistant (CNA) Kardex with a print date of 6/19/24, states, in part: . - Bathing: ADL/GG- Bathing Thursdays AMs -Bathing/Showering: The resident requires assist by (1) staff with (bathing/showering) and as necessary . R15's Care Plan dated 4/23/24 states, in part: . Focus: The resident has an ADL self-care performance deficit r/t (related to) Date Initiated: 4/2/3/24. Goal: The resident will improve current level of function in (SPECIFY ADLS) through the review date .Date Initiated: 4/23/24 Target Date: 5/11/24 Interventions: Bathing/Showering: The resident requires assist by (1) staff with (bathing/showering) and as necessary. Date Initiated: 4/23/24 Revision on 6/18/24 . R15's CNA shower documentation for April, May and June shows the following: -R15 received a shower on 5/14/24 Of note: R15 admitted to facility on 4/22/24 and should have received weekly showers. There is no shower documentation for: 4/25/24, 5/2/24, 5/9/24, 5/23/24, 5/30/24, 6/6/24, and 6/13/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15's grievance dated 6/13/24, states, in part: . Reference # 1892 Category: Care Concern Incident Date: 6/13/24 Reported Date: 6/13/24. Reported by: [[NAME]] R15 . Grievance Details: Resident requested a shower from a CNA who said she was too busy to give him a shower. Resident stated he had not had a shower for some time. Summary of Investigation: Resident requested a shower and was told that the next shift would be able to help. Summary of Findings: The CNA was placed on this wing later in the morning. This made the CNA feel as though they were behind in providing cares for everyone. When the resident asked for a shower, the CNA was aware of there being other call lights and residents that needed assistance. Summary of Actions Taken: Follow up with CNA to discuss the situation. Ensured that resident received a shower as soon as possible. Facility's documentation entitled [NAME] Nursing and Rehab Shower/Tasks 4/5/24 shows: Item: What actionable interventions will be accomplished for the identified resident? . Action: Showers not scheduled correctly on the tasks in order to come up on POC (point of care) for charting. -Audit completed of all tasks for bathing. -Education to Unit Managers for proper scheduling of showers in tasks. Person: DON (Director of Nursing) Completion Date: 4/5/24 Item: How the facility will identify all residents that have the potential to be affected and interventions that will be accomplished? Action: All residents have the potential to be affected. -Residents schedule provided in tasks. Person: DON UM (Unit Managers) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Completion Date: 4/5/24 Item: What measures will be put in place or systemic changes made and for what departments and people? Action: Education to UM on entering schedule for show on tasks . Completion Date: 4/5/24 . On 6/18/24 at 10:25 AM, Surveyor interviewed CNA K and asked what the process for shower documentation was. CNA K indicated shower documentation gets documented in PCC (Point Click Care) whether residents receive a shower, bath, bed bath, or refuse. On 6/19/24 at 12:35 PM, Surveyor interviewed DON B and asked if resident showers are expected to be documented and DON B indicated yes in PCC. Surveyor asked if residents should receive their scheduled weekly showers and DON B indicated yes and it is the residents' right to receive or refuse showers. Surveyor informed DON B that R4 and R15 had not received their weekly showers per facility documentation. DON B indicated they should have, and she identified shower schedules were not being put into PCC correctly, so they were not popping up for CNAs to see and document. DON B indicated she is working on this. Surveyor showed DON B the documentation DON B provided to Surveyor indicating the facility is working on this concern. Surveyor pointed out the completion date was 4/5/24 and showers were still not being documented. DON B indicated she still has work to do regarding this matter.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation and interview, the facility failed to ensure the resident environment remains as free of accident hazards as is possible. This affected 2 of 19 sampled residents (R5 and R14) R5's electric wheelchair charges in her room with her roommate, R14, also present. This is evidenced by: Facility policy, entitled Power Mobility Device, reviewed 1/1/24, includes, in part: Battery charging installations shall be located in areas designated for that purpose . Example 1 R5 admitted to the facility on [DATE]. R5's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 6/7/24, indicates R5 is impaired on both sides of her upper and lower extremities and utilizes an electric wheelchair for mobility. On 6/18/24 at 3:21 PM, Surveyor observed R5's wheelchair power charging cable plugged in next to her nightstand. R5 demonstrated to Surveyor that she was able to charge it without assistance of staff. R5 confirmed that she always charges her wheelchair in her room using the cord currently plugged into the wall. R14 is also in the room at this time. Example 2 R14 admitted to the facility on [DATE]. R14's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 3/12/24, indicates R14 is has no impairment of her upper extremities and is impaired on both sides of her lower extremities. R14 utilizes a manual wheelchair and is dependent on staff for all mobility. On 6/18/24 at 3:26 PM, Surveyor interviewed AD Q (Activities Director). Surveyor asked AD Q if he was aware of where electric wheelchairs are supposed to be charged. AD Q states electric wheelchairs are charged on the Aspen unit behind the showers. AD Q explains in the shower room, there is a separate room behind a second door and that is where electric wheelchairs are charged. AD Q indicates that he has been employed by the facility for several years and that location is always where electric wheelchairs have been charged. Surveyor asked AD Q if he assisted with moving wheelchairs or if he knew who moved wheelchairs. AD Q states he does not move any wheelchairs for charging, and he does not know who has that responsibility. Surveyor explained that R5 is charging her electric wheelchair in her room. AD Q states, Oh, that's not OK. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 3:31 PM, AD Q notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) that R5 is charging her electric wheelchair in her room. SW D (Social Worker) also notified and reports that she was unaware of the issue. SW D removed the cord immediately following notification. On 6/18/24 at 4:41 PM, Surveyor interviewed DON B. Surveyor asked DON B where she would expect electric wheelchairs to be charged. DON B states electric wheelchairs should not be charging in residents' room and should be charged according to facility policy.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interviews, and record review, facility staff did not ensure that each resident who required pain management received such services according to the comprehensive person-centered care plan and the resident's goals and preferences for 2 of 19 residents (R6 and R5) reviewed for pain management. R6 asked for her as needed pain medication and did not receive it for almost 22 hours resulting in emotional distress, agitation, becoming physically hostile, and throwing objects. R5 was experiencing breakthrough pain at an 8 out of 10. R5 consistently takes her as needed (PRN) Hydromorphone every 4 hours for breakthrough pain. The facility ran out of R5's hydromorphone and R5 went several hours without her PRN medication which resulted in increased verbalizations of pain and uncontrolled pain. R5's progress notes indicate that this facility ran out of R5's medications twice in the span of four days. R5's care plan does not include any non-pharmacological interventions. Evidenced by: The facility policy, entitled Pain Management, dated 10/1/23, states: Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, the policy states: In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will . c. manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the residents' goals and preferences. In the section titled, Pain Management and Treatment facility policy states, non-pharmacological interventions will include but are not limited to . a. environmental comfort measures . cognitive/behavioral interventions (e.g., Music, relaxation techniques, activities, diversions, spiritual and comfort support .) .Opioids will be prescribed and dosed in accordance with current professional standards of practice and manufactures' guidelines . Of note: This policy does not indicate the procedure for ordering additional pain medication from the pharmacy when a resident's supply runs low or how to obtain or access additional stores of pain medication if a medication runs out. Example 1 R6 admitted to the facility on [DATE] with the following diagnoses: bipolar disorder, generalized anxiety disorder, fibromyalgia, non-displaced fracture of olecranon process without intraarticular extension of unspecified ulna (fracture within the elbow), and an abscessed tooth with inflammatory conditions of the jaws. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R6's Hospital Discharge, dated 4/29/24, include: . Date of admission: 4/21/24 . Date of discharge: 4/29/24 . history of myoepithelial carcinoma of parotid gland, status post parotidectomy in 2020, Hypertension, chronic back pain and jaw, bipolar, Attention Deficit Hyper Activity disorder, generalized anxiety disorder . who is being admitted with weakness, falls gait instability, hyponatremia, and anemia . Patient complained of dry mouth related to prior cancer . Patient takes 6 oxycodone per day, lorazepam up to 3 per day . Patient complained of elbow pain since one of her falls . Chronic pain- fibromyalgia . generalized debility: She did fall and have an olecranon fracture which is going to be followed up the week after discharge with orthopedic clinic . Myoepithelial carcinoma of parotid gland status post parotidectomy 2020: Osteoradionecrosis of temporal bone . CT (CAT Scan/Medical Imaging) of facial bones with contrast: 4/24/24 result date: impression Periapical lucency again identified adjacent to the left first mandibular molar tooth. A periapical abscess is suspected . XR Panorex (x-ray): 4/23/24 result date: impression: large cavity in the left first mandibular molar, probably associated with root abscess . XR elbow right . : 4/21/24 result date: . Nonoperative olecranon fracture: splint provided by orthopedics along with sling . Discharge Medications: . lorazepam 0.5MG (milligrams) Take one tablet by mouth every 8 hours as needed for Anxiety or Agitation . Oxycodone Immediate Release 5MG Take one tablet by mouth every 6 hours as needed . Lorazepam 0. 5MG Take one tablet three times a day as needed for Anxiety . Oxycodone Immediate Release 5MG Take one tablet by mouth every 4 hours as needed for Pain: do not exceed 6 tablets per day, must last 28 days . R6's Physician Orders, 4/29/24-5/31/24, include: start date 4/29/24 Lorazepam Oral Tablet 0.5MG Give 1 tablet by mouth every 8 hours as needed for agitation/anxiety . start date 4/30/24 Lorazepam Oral Tablet 0. 5MG Give 1 tablet by mouth every 8 hours as needed for agitation/anxiety for 13 days .start date 4/29/24 Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for pain . start date 4/30/24 Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for pain for 13 days . R6's Pain Evaluation, dated 4/29/24, includes: Have you had pain or hurting any time in the last 5 days? Yes . Pain frequency: Frequently . Numerical Rating Scale: 6 . Pain Goal: 3 . Verbal depicter scale: Moderate . where is pain located: back . How long have you had it? Chronic . Describe pain: aching . What alleviates pain: medications and rest . Pain effect sleep? Occasionally. Pain interferes with therapy activities. Occasionally . Pain interferes with day-to-day activities? Occasionally . R6's Nurse Notes, include: 4/29/2024 9:29 PM Clinical Summary: resident arrived via emergency medical services . resident alert and oriented x3 able to make needs known resident is one assist . states she is able to use a cane . resident able to transfer with standby assist . gait mildly unsteady when standing/pivot, has a splint to right upper extremity with limited range of motion . has 0 skin issues. 4/29/2024 9:30 PM Resident complains regarding medication and anxiety appears heightened because of this. Resident given emotional support, encouragement; continues with complaint. Pharmacy has been called with voice mail entered . wide, noticeable change in mood with resident going from calm, pleasant and cooperative to angry with outbursts and insults. Soft cast is intact to right upper extremity . Unsteady gait is noted. Resident is here to participate in an individualized program of physical rehabilitation . She plans to return home. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	4/29/2024 11:15 PM Encountered resident at bedside during initial room rounds. She is alert, awake and oriented with noted anxiety. Resident asking about her medications. All medication orders have been sent to pharmacy to be dispensed. This is a new admission arriving from hospital earlier this evening. Resident has soft cast to right upper extremity, secondary to hospitalization , fall, and fracture. Review of available records indicate hospital course started in emergency room with patient complaining of weakness, confusion, and falls. 4/30/2024 12:50 AM Resident scheduled to resume course of oral antibiotic therapy secondary to infected abscesses within oral cavity. She denies pain to mouth, neck, or jaw. She is afebrile at 98.2 oral measurement. Will be further observed for s/s (signs/symptoms) uncontrolled infection with interventions as indicated. 4/30/2024 2:15 AM An individual, unknown to writer, presents in doorway of nurses station yells out I want to know who the hell is taking care of my sister. This individual appears to be a thin, female of approximately 5'9 (tall) with long blonde hair who comes to be known as the sister of this resident. Expresses concern regarding medications and other care issues for this resident. General information provided and she is asked multiple times to cease / control angry presentation, she was instructed to leave nursing office. Writer continued with efforts to secure access to (facility's contingency box) system. This person exited workstation and was in resident's room approximately 15 mins. After which time she returned to nursing station, again with an agitated angry presentation, stated I did not want to have my sister in this ghetto place and what you're doing just prove me (explicit language) right. Again, instruction is given to refrain from yelling and swearing at which time she turned and traveled down hallway, turned, and began shouting . This person exited the unit and proceeded to exit the building. Observed resident at bedside, reassured resident of continued efforts to secure ordered (medication) but not prescribed narcotics. Resident appears anxious, there is no observable, nonverbal signs, and symptoms of severe pain. Assisted to position of comfort. 4/30/2024 4:45 AM Resident's family member identified herself as resident's sister, returned to facility asking for an update on resident's pain and anxiety .controlled narcotic medications. Writer informed her that facility medical director has been called . Provided education on the process and immediate options available to include Emergency Services assessment and transport to emergency room for immediate intervention . Writer responded to loud commotion in hall, came to know this family member was yelling and swearing at staff . who was clearly providing stand by physical assist and personal care as needed. Family dismissive, continuing to swear while assuming aggressive posturing. Sister . expresses regret about losing it, she is instructed on policy prohibiting aggressive behavior. 4/30/2024 8:11 AM Personal Care Provider and Physician Assistant's numbers incorrect in the electronic health record system. Correct number listed on resident profile. Voicemail left .Voicemail says not normal business hours . Will attempt call-back after 9:00 AM. (It is important to note at least 11 hours after admission the facility just realized they are not using the correct phone number for R6's Personal Care Provider/MD or R6's Physician Assistant.) 4/30/2024 8:38 AM Resident in emotional distress, becomes more agitated with any discussion or answer to questions in general, resident becomes physically hostile throwing items in room-unable to obtain consents or review admission paperwork. Immunizations in hospital records. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	(It is important to note the documented state of R6 and that there is no numeric pain rating with this note.) 4/30/2024 9:52 AM Physician's office called back-they are calling pharmacy directly to give narcotic prescriptions and okay' d psych consult. 4/30/2024 6:48 PM Yesterday, 4/29/24 after resident being discharged from hospital and admitting to facility, narcotic (written) prescriptions were not sent to facility's pharmacy. The Physician's office returned the call today and sent prescriptions to the pharmacy for as needed medications Lorazepam and Oxycodone. However, upon follow-up, the medications have not arrived at the facility at this time due to the prescriptions now being sent to the wrong pharmacy. (It is important to note R6's Nurse Notes do not include any pain monitoring using the numeric scale the facility used for R6's pain risk evaluation, dated 4/29/24. It is unknown if R6's pain was at, under, or above her pain goal of 3 throughout this review period.) R6's Medication Administration Record (MAR), 4/29-5/31, includes: 4/30/2024 7:13 AM Oxycodone HCl Oral Tablet 5 MG . Given . 5/7/24 3:00 PM Lorazepam 0.5MG . Given (It is important to note R6's MAR does not include any pain monitoring using the numeric scale the facility used during R6's pain risk evaluation, on 4/29/24. It is also important to note R6 went without prescribed as needed Oxycodone and as needed Lorazepam for over 22 hours when she has a history of taking 6 Oxycodone a day and 3 lorazepam a day.) R6 Grievance Form, dated 4/30/24, includes, in part: . Resident did not receive controlled substance medication . R6 was concerned that they did not receive their controlled substance medications . Resident's physician sent medications to the wrong pharmacy . On 6/18/24 at 3:58 PM, NP L (Nurse Practitioner) stated, Getting medications on admission has been an issue in this facility. On 6/19/24 at 12:31 PM, LPN G (Licensed Practical Nurse) indicated the facility pharmacy is hard to work with and cause issues with acquiring medications. LPN G indicated it is the responsibility of the facility's floor nurse to fax orders to the facility's pharmacy when there is a new admission. LPN G indicated the facility's Medical Director has the ability to write emergency orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/19/24 at 12:40 PM, LPN M (Licensed Practical Nurse) indicated there has been delays getting medications from the pharmacy with new admissions. LPN M indicated the hospital will fax the medication orders and hand-written prescriptions to the pharmacy and then the floor nurse will also fax the orders when the resident arrives in the facility. LPN M indicated the hospital sent R6's medication orders and handwritten prescriptions to the wrong pharmacy. Then when the facility staff sent R6's orders to the facility's pharmacy they did not have the handwritten prescriptions for her narcotics and would not give facility staff a code to obtain them from the contingency box. LPN M indicated the facility staff tried to call R6's MD throughout the first day to get the handwritten prescriptions to the correct pharmacy, but they were using an incorrect phone number until 8:00 AM the following day. LPN M indicated R6 was showing signs of being in distress and agitated by raising her voice, throwing objects, using foul language, and verbalizing pain/discomfort. Surveyor asked if the facility offered to send R6 to the emergency department, LPN M indicated she thinks they did. Surveyor asked if the facility's Medical Doctor was notified to see if he would give an emergency written prescription for the controlled narcotics. LPN M indicated she was unsure. LPN M indicated R6 was asking for her as needed oxycodone and did not receive it for over 22 hours. LPN M indicated the facility received access to R6's oxycodone and lorazepam at the same time, but R6 did not request to have her as needed lorazepam until 5/7/24. LPN M indicated she was unsure if non-pharmaceutical interventions were attempted with R6 during this time. (It is important to note there is one time where emergency services were brought up to R6's sister, but there is no evidence of R6 being offered to go to the emergency room . The facility did not provide evidence of the facility's Medical Director being notified and asked to write an emergency order for the controlled narcotics.) On 6/19/24 at 12:56 PM, DON B (Director of Nursing) indicated the facility pharmacy would not give the facility a code to access oxycodone or lorazepam from the facility's contingency stock box, because they did not have the handwritten prescriptions. DON B indicated the facility's Medical Director does have the ability to write emergency prescriptions and she is unaware if the Medical Director was asked to do this or not. DON B indicated the delay in obtaining R6's medications was caused by the hospital sending the order and handwritten prescriptions to the wrong pharmacy, the facility staff not using the correct contact information for R6's Medical Doctor, and the staff not consulting with the facility's Medical Director. DON B indicated the pharmacy is not always timely with filling orders and keeping medications stocked in the contingency box. DON B indicated R6's distress was caused by waiting for so long for her pain medication. DON B indicated staff should have recorded if they offered R6 to go to the emergency room . 49434 Example 2 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R5 was admitted to the facility on [DATE], and has diagnoses that include: multiple sclerosis (degenerative disorder causing nerve damage which leads to paralysis, vision loss, fatigue, and mood disturbance) , sickle cell disorder with acute chest syndrome (red blood cells become crescent-shaped causing severe pain with occlusion of arteries and veins around the lungs), idiopathic aseptic necrosis of right femur (death of bone tissue related to loss of blood supply), idiopathic aseptic necrosis of left femur, and other chronic pain. R7's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/7/24 includes a Brief Interview of Mental Status (BIMS) of 15, indicating that she is cognitively intact. The MDS also indicates R5 is not receiving non-medication pain interventions and that her pain frequently interferes with her day-to-day activities and sleep. R5's Pain Assessment, dated 5/28/24 at 17:13 indicates the resident had a pain level of 8 out of 10 and verbally described the pain as very severe, horrible at the time of assessment. The assessment indicates that R5 has a pain goal of 2 out of 10. R5 indicates that her pain is constant, generalized all over her body, and occurs due to several chronic medical conditions. This assessment indicates that her pain occasionally affects her sleep and almost constantly interferes with her day-to-day activities. Medications ordered for the resident to treat her pain are listed as morphine and hydromorphone. R5's Care Plan, dated 5/29/24, with a target date of 8/15/24, states, The resident has an alteration in musculoskeletal status r/t (related to) dx (diagnosis) of MS (multiple sclerosis). Goal: The resident will remain free of injuries or complications related to MS by review date. Interventions: Give analgesics as ordered by the physician. Monitor and document for side effects and effectiveness. Monitor for fatigue. Plan activities during optimal times when pain and stiffness abated . An additional care plan focus initiated 4/17/24 and revised on 5/15/24 with a target date of 6/26/24, states, The resident is on pain medication r/t (related to) disease process sickle cell/(crisis). Goal: The resident will be free of any discomfort or adverse side effects from pain medication through the review date. Interventions: Administer ANALGESIC (pain relief) mediations as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (every shift) . R5's care plan also has a focus initiated 12/2/23 and revised on 5/15/24 with a target date of 5/31/24, states, The resident has chronic pain r/t MS. Goal: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function . Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Provide the resident with reassurance that pain is time limited. Encourage (SPECIFY: resident, NAME, me) to try different pain-relieving methods i.e., positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultra-sound. The resident is able to: (SPECIFY: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain). The resident prefers to have pain controlled by: Dilaudid prn (administer as needed). R5's Physician Orders, active as of 6/18/24, include: Acetaminophen (Tylenol) Oral Tablet 500 MG (milligram), Give 2 tablet by mouth every 5 hours as needed for Pain. Take 2 tablets by mouth every 6 hours as needed. Start date: 5/28/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Baclofen (muscle relaxer) Oral Tablet 10 MG, Give 1 tablet by mouth four times a day for Muscle Spasticity. Start date: 5/28/24. Baclofen (muscle relaxer) Oral Tablet 5 MG. Give 1 tablet by mouth every 8 hours as needed for Muscle Spasticity 1 tab PO every 8 hours as needed. Start date: 5/28/24. Gabapentin (relieves nerve pain) Oral Capsule 300 MG. Give 2 capsule by mouth every 4 hours as needed for Pain. Start date: 5/28/24. Hydromorphone (Dilaudid, Opioid pain medication) HCl Oral Tablet 4 MG. Give 2 tablet by mouth every 4 hours as needed for Pain. Take 2-3 tabs by mouth every 4 hours as needed. Start date: 5/28/24. Morphine (Opioid) Sulfate ER Oral Tablet Extended Release 15 MG (Morphine Sulfate). Give 1 tablet by mouth one time a day for Chronic Pain. Start date: 5/30/24. Morphine (Opioid) Sulfate ER Oral Tablet Extended Release 30 MG (Morphine Sulfate). Give 1 tablet by mouth two times a day for Chronic Pain. Start date: 5/30/24. Zanaflex Oral Tablet 4 MG (Tizanidine HCl, muscle relaxer). Give 1 tablet by mouth six times a day for MUSCLE SPASM. Start date: 6/1/24. Order to hold medication for sedation. Four times a day. Start date: 6/6/24. On 6/14/24 at 11:50 PM, a Progress Note indicates, in part, Resident presents to nursing station seat[sic] in electric wheelchair, requesting PRN narcotic for c/o(complaint) pain. Upon attempt to administer discovered floor supply to be depleted. Resident observed with s/s (signs and symptoms) of anxiety re: (regarding) when new supply can be obtained. Reassured resident contact will be pursued to establish refill delivery or subsequent orders. Resident with continued questioning. Inquiry as to present pain, resident states It's eight . Resident declines emergency room intervention. Call placed to pharmacy, message left .Nsng (nursing) observation is inconsistent with mod-high pain level . Of note: Individuals with chronic pain often do not display typical pain responses to high levels of pain. They may not exhibit outward displays of emotion similar to those with acute pain. Several articles have been written on this topic including, Over-Rating Pain is Overrated: A Fundamental Self-Other Bias in Pain Reporting Behavior from the Journal of Pain, DOI: https://doi.org/10.1016/j.jpain.2022.06.002 R5's Medication Administration Record (MAR), from June 2024, includes, in part: 6/14/24: 7:29 AM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 7/10 1:43 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 6/10 7:30 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 5/10 Of note, 6/14/24 shows R5 consistently takes PRN Hydromorphone every 6 hours. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	6/15/24: 1:27 AM- Baclofen 5 MG x1 tablet administered for Muscle Spasticity 2:28 AM- Gabapentin 300 MG x2 capsule administered for Pain .Pain Rating: Not documented. 4:01 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 10/10 On 6/15/24 at 3:31 AM, a Progress Note indicates, Spoke with [Pharmacy] pharmacy technician regarding depletion of Hydromorphone. States additional supply is available on existing order; RPh (pharmacist) contacted for authorization, #30 tablets to be sent on STAT (Immediate) delivery basis. Resident is presently outside facility; Will advise when she returns; Will report to oncoming RN in AM. On 6/15/24 at 6:30 AM, a Progress Note indicates, Resident remains off unit. Reported and discussed with oncoming, RN (Registered Nurse), reported to unit manager, PRN narcotic delivery remains pending. R5's MAR from June 2024, includes, in part: 6/16/24: 8:33 AM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 9/10 12:56 PM- Hydromorphone 4 MG x2 tablets administered for Pain .Pain Rating: 8/10 8:09 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 8/10 11:30 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 8/10 6/17/24: 8:55 AM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 3/10 1:18 PM- Hydromorphone 4 MG x2 tablets administered for Pain .Pain Rating: 8/10 6:42 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 6/10 Note R5's consistent use of the PRN Hydromorphone. 6/18/24: 2:00 AM- Baclofen 5 MG administered for Muscle Spasticity 2:45 AM- Hydromorphone 4 MG x2 tablets administered for Pain .Pain Rating: 6/10 12:36 PM- Gabapentin 300 MG x2 capsule administered for Pain .Pain Rating: Not documented. 12:38 PM- Baclofen 5 MG administered for Muscle Spasticity (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Of note: R5 receives a dose of hydromorphone on 6/18 at 2:45 AM and the facility again runs out of her PRN pain medication. Of note: No Tylenol or tizanidine administered or marked refused and no medications were held for sedation. Gabapentin and Baclofen were only administered when R5 was out of her Hydromorphone. From 6/14/24 through 6/15/24 for a period of 16 hours and on 6/18/24 for a period of 10 hours, patient went without her pain relief ordered by her physician and indicated on her care plan and pain assessment. It is also important to note muscle relaxers are not prescribed to treat sickle cell pain. On 6/18/24 at 10:07 AM, Surveyor interviewed R5. R5 stated, This is the second time they let me run out of pain meds. R5 states that she takes PRN (as needed) pain medicine every 4 hours and that in the past when the facility has run out of her medication, she has needed to be admitted to the hospital for pain control. R5 reports that the last time she ran out of her medicine was on Friday (6/14/24) and that she is out of her medication again today (6/18/24). During Surveyor interview with R5, LPN P (Licensed Practical Nurse) entered the room to administer the resident's morning medications. Without prompting, LPN P stated that the facility was out of R5's pain medication and that a call has been placed to pharmacy for a STAT (immediate) order. R5 was visibly upset at this information but took the rest of the medications handed to her at this time. On 6/18/24 at 3:01 PM, Surveyor interviewed LPN P. Surveyor asked LPN P if she asked R5 if she would like to receive her hydromorphone. LPN P indicates that R5 told her that she wanted her pain medication and LPN P told her that she would let her know when it comes in from the pharmacy. LPN P indicates that she did give R5 prn Baclofen and Gabapentin. Surveyor asked if R5 came up any additional times to request pain medication. LPN P states that she did not. Surveyor asked what the process is for refilling prescriptions. LPN P states that the pill packs indicate when the supply is running low, and she calls pharmacy to reorder when she sees that indicator on the pill pack. LPN P indicated she called the pharmacy last night about the same prescription, but it was after hours, and she had to leave a message. LPN P indicates she has called again today regarding the prescription, as well as the Nurse Practitioner. Surveyor asked LPN P if there was any of the hydromorphone in the facility's contingency supply. LPN P states she was told that there was no hydromorphone in contingency, and if there was, she would not have access as agency staff do not have access to the contingency supply. Surveyor asked if LPN P would expect non-pharmacological interventions to be on the care plan. LPN P states she would expect non-pharmacological interventions to be on the care plan. Surveyor asked LPN P if she is aware of R5's acceptable pain level according to her most recent pain assessment. LPN P states she is not aware of R5's acceptable pain level. On 6/18/24 at 3:14 PM, Surveyor interviewed R5. R5 reports that she has still not received her PRN pain medication. Over the course of the interview, Surveyor observed several non-verbal indicators of pain including grimacing, wincing, staccato speech (speaking in 2-3-word sentences), holding her breath, intermittent repositioning, and audible cracking of joints as the resident attempted to reposition. Surveyor asked the resident to describe how her uncontrolled pain has been affecting her, and R5 reported that because of her history of sickle cell and multiple sclerosis, breakthrough pain often causes exacerbations of these disorders. R5 reports that she believes she is starting to experience an exacerbation of her multiple sclerosis as her legs were starting to go numb which has happened in the past. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/18/24 at 3:54 PM, Surveyor interviewed NP L (Nurse Practitioner). Surveyor asked if she was contacted over the weekend regarding R5's hydromorphone prescription. NP L indicates that she does not work nights or weekends but when she checked her phone today (6/18/24) she had received a voice message at some point regarding the prescription. Surveyor asked NP L what her expectation was of nursing staff if a resident was to run out of a prescription. NP L indicates that during the weekday she can be contacted, otherwise they can use contingency medications, and if that is empty, she would expect them to call the on-call physician. Surveyor asked NP L if R5 requires complex pain management. NP L indicates that R5 does have a complex pain management strategy due to her multiple chronic pain diagnoses that all play into each other. NP L indicates that she has recommended R5 see pain specialists as further support for her pain management. On 6/18/24 at 4:41 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she was aware that R5 ran out of her hydromorphone on 6/14/24 and 6/18/24. DON B indicates she was not aware. Surveyor asked DON B what her expectation would be for nursing staff if a resident's medication ran out. DON B states nursing staff need to call the pharmacy, and if they are unable to obtain additional medication, they need to call the physician. DON B would also expect these steps to be taken before the medication runs out. DON B reports to Surveyor that R5 has severe, chronic pain with associated behaviors that is not manageable. Surveyor asks DON B if she would expect the care plan to reflect the non-pharmacological interventions identified in the pain assessment. DON B states that non-pharmacological interventions should be in the care plan. On 6/18/24 at 5:01 PM, a Progress Note indicates, NP sent prescription of Dilaudid 6 tablets to [Pharmacy] for STAT, prescription picked up and delivered to Facility at this time. R5 was admitted with diagnoses including multiple sclerosis and sickle cell with acute chest syndrome. R5 had severe, breakthrough pain and the facility did not provide R5 with her prescribed and care planned pain medication or provide non-pharmacological pain management causing exacerbation in symptoms of her chronic conditions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's to meet the needs of each resident for 2 residents out of 18 reviewed (R6 and R5). R6 was asking for her as needed (PRN) medications/controlled substance medications and the facility did not acquire R6's medications timely upon her admission. R6 went for at least 22 hours without her PRN medications. R5 consistently takes her PRN Hydromorphone every 4 hours for breakthrough pain. The facility ran out of R5's hydromorphone. Evidenced by: Facility policy, entitled Pharmacy Services, undated, includes pharmaceutical services refers to the process of receiving and interpreting prescriber's orders, acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, using/and or disposing of all medications, biologicals, chemicals . The process of identifying, evaluating, and addressing medication-related issues . The provision, monitoring, and/or use of medication related devices . The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. The facility will employ or obtain the services of a licensed pharmacist in accordance with state requirements . The facility in accordance with the licensed pharmacist will provide for: a system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications . the facility will maintain a limited supply of medications for emergency or after-hours situations in accordance with facility policy and applicable state laws. The pharmacist, in collaboration with the facility and medical director, should include within its services to: determine the contents of the emergency supply of medications and monitor the use, replacement, and disposition of the supply . Develop mechanisms or communicating, addressing, resolving issues related to pharmaceutical services . strive to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescriber . identification of facility educational and informational needs about medications and provision of the information from sources such as nationally recognized organizations to the facility staff, practitioners, residents, and families. Example 1 R6 admitted to the facility on [DATE] with the following diagnoses: bipolar disorder, generalized anxiety disorder, fibromyalgia, non-displaced fracture of olecranon process without intraarticular extension of unspecified ulna (fracture within the elbow), and an abscessed tooth with inflammatory conditions of the jaws. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Hospital Discharge, dated 4/29/24, include: . Date of admission: 4/21/24 . Date of discharge: 4/29/24 . history of myoepithelial carcinoma of parotid gland, status post parotidectomy in 2020, Hypertension, chronic back pain and jaw, bipolar, Attention Deficit Hyper Activity disorder, generalized anxiety disorder . who is being admitted with weakness, falls gait instability, hyponatremia, and anemia . Patient complained of dry mouth related to prior cancer . Patient takes 6 oxycodone per day, lorazepam up to 3 per day . Patient complained of elbow pain since one of her falls . Chronic pain- fibromyalgia . generalized debility: She did fall and have an olecranon fracture which is going to be followed up the week after discharge with orthopedic clinic . Myoepithelial carcinoma of parotid gland status post parotidectomy 2020: Osteoradionecrosis of temporal bone . CT of facial bones with contrast: 4/24/24 result date: impression Periapical lucency again identified adjacent to the left first mandibular molar tooth. A periapical abscess is suspected . XR Panorex: 4/23/24 result date: impression: large cavity in the left first mandibular molar, probably associated with root abscess . XR elbow right . : 4/21/24 result date: . Nonoperative olecranon fracture: splint provided by orthopedics along with sling . Discharge Medications: . lorazepam 0.5MG (milligrams) Take one tablet by mouth every 8 hours as needed for Anxiety or Agitation . Oxycodone Immediate Release 5MG Take one tablet by mouth every 6 hours as needed . Lorazepam 0.5MG Take one tablet three times a day as needed for Anxiety . Oxycodone Immediate Release 5MG Take one tablet by mouth every 4 hours as needed for Pain: do not exceed 6 tablets per day, must last 28 days . R6's Physician Orders, 4/29/24-5/31/24, include: start date 4/29/24 Lorazepam Oral Tablet 0.5MG Give 1 tablet by mouth every 8 hours as needed for agitation/anxiety . start date 4/30/24 Lorazepam Oral Tablet 0. 5MG Give 1 tablet by mouth every 8 hours as needed for agitation/anxiety for 13 days .start date 4/29/24 Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for pain . start date 4/30/24 Oxycodone HCl Oral Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for pain for 13 days . R6's Nurse Notes, include: 4/29/2024 9:29 PM Clinical Summary: resident arrived via emergency medical services . resident alert and oriented x3 able to make needs known. 4/29/2024 9:30 PM Resident complains regarding medication and anxiety appears heightened because of this. Resident given emotional support, encouragement; continues with complaint. Pharmacy has been called with voice mail entered . 4/29/2024 11:15 PM .Resident asking about her medications. All medication orders have been sent to pharmacy to be dispensed. This is a new admission arriving from hospital earlier this evening. 4/30/2024 02:15 AM . Writer continued with efforts to secure access to (facility's contingency box) system. Observed resident at bedside, reassured resident of continued efforts to secure ordered (medication) but not prescribed narcotics. 4/30/2024 8:11 AM Personal Care Provider and Physician Assistant's numbers incorrect in the electronic health record system. Correct number listed on resident profile. Voicemail left .Voicemail says not normal business hours . Will attempt call-back after 9:00 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(It is important to note the facility that at least 11 hours after admission the facility just realized they are not using the correct phone number for R6's Personal Care Provider/MD or R6's Physician Assistant.) 4/30/2024 9:52 AM Physician's office called back-they are calling pharmacy directly to give narcotic prescriptions. 4/30/2024 6:48 PM Yesterday, 4/29/24 after resident being discharged from hospital and admitting to facility, narcotic (written) prescriptions were not sent to facility's pharmacy. The Physician's office returned the call today and sent prescriptions to the pharmacy for as needed medications Lorazepam and Oxycodone. However, upon follow-up, the medications have not arrived at the facility at this time due to the prescriptions now being sent to the wrong pharmacy. R6's Medication Administration Record (MAR), 4/29-5/31, includes: 4/30/2024 7:13 AM Oxycodone HCl Oral Tablet 5 MG . Given . 5/7/24 3:00 PM Lorazepam 0.5 MG . Given . On 6/18/24 at 3:58 PM, NP L (Nurse Practitioner) stated, Getting medications on admission has been an issue in this facility. On 6/19/24 at 12:31 PM, LPN G (Licensed Practical Nurse) indicated the facility pharmacy is hard to work with and causes issues with acquiring medications. LPN G indicated it is the responsibility of the facility's floor nurse to fax orders to the facility's pharmacy when there is a new admission. LPN G indicated the facility's Medical Director has the ability to write emergency orders. On 6/19/24 at 12:40 PM, LPN M indicated there has been delays getting medications from the pharmacy with new admissions. LPN M indicated the hospital will fax the medication orders and hand-written prescriptions to the pharmacy and then the floor nurse will also fax the orders when the resident arrives in the facility. LPN M indicated the hospital sent R6's medication orders and handwritten prescriptions to the wrong pharmacy. Then when the facility staff sent R6's orders to the facility's pharmacy they did not have the handwritten prescriptions for her narcotics and would not give facility staff a code to obtain them from the contingency box. LPN M indicated the facility staff tried to call R6's MD throughout the first day to get the handwritten prescriptions to the correct pharmacy, but they were using an incorrect phone number until 8:00 AM the following day. LPN M indicated R6 was asking for her as needed oxycodone and did not receive it for over 22 hours. LPN M indicated the facility received access to R6's oxycodone and lorazepam at the same time, but R6 did not request to have her as needed lorazepam until 5/7/24. On 6/19/24 at 12:56 PM, DON B (Director of Nursing) indicated the facility pharmacy would not give the facility a code to access oxycodone or lorazepam from the facility's contingency stock box, because they did not have the handwritten prescriptions. DON B indicated the facility's Medical Director does have the ability to write emergency prescriptions and she is unaware if the Medical Director was asked to do this or not. DON B indicated the delay in obtaining R6's medications was caused by the hospital sending the order and handwritten prescriptions to the wrong pharmacy, the facility staff not using the correct contact information for R6's Medical Doctor, and the staff not consulting with the facility's Medical Director. DON B indicated the pharmacy is not always timely with filling orders and keeping medications stocked in the contingency box. 49434 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525074	A. Building B. Wing	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R5 consistently takes her as needed (PRN) Hydromorphone every 4 hours for breakthrough pain. The facility ran out of R5's hydromorphone. R5's progress notes indicate that this facility ran out of R5's medications twice in the span of four days. R5 was admitted to the facility on [DATE], and has diagnoses that include: multiple sclerosis (degenerative disorder causing nerve damage which leads to paralysis, vision loss, fatigue, and mood disturbance) , sickle cell disorder with acute chest syndrome (red blood cells become crescent-shaped causing severe pain with occlusion of arteries and veins around the lungs), idiopathic aseptic necrosis of right femur (death of bone tissue related to loss of blood supply), idiopathic aseptic necrosis of left femur, and other chronic pain. R7's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/7/24 includes a Brief Interview of Mental Status (BIMS) of 15, indicating that she is cognitively intact. R5's Physician Orders, active as of 6/18/24, include: Hydromorphone (Dilaudid, Opioid pain medication) HCl Oral Tablet 4 MG. Give 2 tablet by mouth every 4 hours as needed for Pain. Take 2-3 tabs by mouth every 4 hours as needed. Start date: 5/28/24. On 6/14/24 at 11:50 PM, a Progress Note indicates, in part, Resident presents to nursing station seat[sic] in electric wheelchair, requesting PRN narcotic for c/o(complaint) pain. Upon attempt to administer discovered floor supply to be depleted. Resident observed with s/s (signs and symptoms) of anxiety re: (regarding) when new supply can be obtained. Reassured resident contact will be pursued to establish refill delivery or subsequent orders. Resident with continued questioning. Inquiry as to present pain, resident states It's eight . Resident declines emergency room intervention. Call placed to pharmacy, message left .Nsng (nursing) observation is inconsistent with mod-high pain level . R5's Medication Administration Record (MAR), from June 2024, includes, in part: 6/14/24: 7:29 AM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 7/10 1:43 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 6/10 7:30 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 5/10 Of note, 6/14/24 shows R5 consistently takes PRN Hydromorphone every 6 hours. 6/15/24: 4:01 PM- Hydromorphone 4 MG x3 tablets administered for Pain .Pain Rating: 10/10 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/15/24 at 3:31 AM, a Progress Note indicates, Spoke with [Pharmacy] pharmacy technician regarding depletion of Hydromorphone. States additional supply is available on existing order; RPh (pharmacist) contacted for authorization, #30 tablets to be sent on STAT (Immediate) delivery basis. Resident is presently outside facility; Will advise when she returns; Will report to oncoming RN in AM. On 6/15/24 at 6:30 AM, a Progress Note indicates, Resident remains off unit. Reported and discussed with oncoming, RN (Registered Nurse), reported to unit manager, PRN narcotic delivery remains pending. 6/18/24: 2:45 AM- Hydromorphone 4 MG x2 tablets administered for Pain .Pain Rating: 6/10 Of note: R5 receives a dose of hydromorphone on 6/18 at 2:45 AM and the facility again runs out of her PRN pain medication. From 6/14/24 through 6/15/24 for a period of 16 plus hours and on 6/18/24 for a period of 10 hours, patient went without her pain relief ordered by her physician and indicated on her care plan and pain assessment. On 6/18/24 at 10:07 AM, Surveyor interviewed R5. R5 stated, This is the second time they let me run out of pain meds. R5 states that she takes PRN (as needed) pain medicine every 4 hours and that in the past when the facility has run out of her medication, she has needed to be admitted to the hospital for pain control. R5 reports that the last time she ran out of her medicine was on Friday (6/14/24) and that she is out of her medication again today (6/18/24). During Surveyor interview with R5, LPN P (Licensed Practical Nurse) entered the room to administer the resident's morning medications. Without prompting, LPN P stated that the facility was out of R5's pain medication and that a call has been placed to pharmacy for a STAT (immediate) order. R5 was visibly upset at this information but took the rest of the medications handed to her at this time. On 6/18/24 at 3:01 PM, Surveyor interviewed LPN P. Surveyor asked LPN P if she asked R5 if she would like to receive her hydromorphone. LPN P indicates that R5 told her that she wanted her pain medication and LPN P told her that she would let her know when it comes in from the pharmacy. Surveyor asked what the process is for refilling prescriptions. LPN P states that the pill packs indicate when the supply is running low, and she calls pharmacy to reorder when she sees that indicator on the pill pack. LPN P indicated she called the pharmacy last night about the same prescription, but it was after hours, and she had to leave a message. LPN P indicates she has called again today regarding the prescription, as well as the Nurse Practitioner. Surveyor asked LPN P if there was any of the hydromorphone in the facility's contingency supply. LPN P states she was told that there was no hydromorphone in contingency, and if there was, she would not have access as agency staff do not have access to the contingency supply. On 6/18/24 at 3:14 PM, Surveyor interviewed R5. R5 reports that she has still not received her PRN pain medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 3:54 PM, Surveyor interviewed NP L (Nurse Practitioner). Surveyor asked if she was contacted over the weekend regarding R5's hydromorphone prescription. NP L indicates that she does not work nights or weekends but when she checked her phone today (6/18/24) she had received a voice message at some point regarding the prescription. Surveyor asked NP L what her expectation was of nursing staff if a resident was to run out of a prescription. NP L indicates that during the weekday she can be contacted, otherwise they can use contingency medications, and if that is empty, she would expect them to call the on-call physician. On 6/18/24 at 4:41 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she was aware that R5 ran out of her hydromorphone on 6/14/24 and 6/18/24. DON B indicates she was not aware. Surveyor asked DON B what her expectation would be for nursing staff if a resident's medication ran out. DON B states nursing staff need to call the pharmacy, and if they are unable to obtain additional medication, they need to call the physician. DON B would also expect these steps to be taken before the medication runs out. On 6/18/24 at 5:01 PM, a Progress Note indicates, NP sent prescription of Dilaudid 6 tablets to [Pharmacy] for STAT, prescription picked up and delivered to Facility at this time.