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	10/10/2024

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 20 residents (R220) was treated with respect and dignity. R220 is on Cares with Pairs per facility. Non-licensed staff member was in room with CNA (Certified Nursing Assistant) while the CNA was performing cares with R220, thus violating R220's right to privacy and dignity. Evidenced by: The facility Admission Packet document entitled [NAME] of Resident Rights, undated, states, in part: . Bill of Resident Rights: Each person residing in a Wisconsin nursing center is accorded extensive rights guaranteed under federal and state law . 3. Privacy and Confidentiality: *You have the right to privacy in accommodations, medical treatment, . personal care . 4 Dignity and Respect: . We will promote your right to receive care and treatment in a manner and in an environment that maintains or enhances your dignity and respect . R220 was 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 using it for energy), abnormalities of gait and mobility and lack of coordination. R220's Quarterly Minimum Data Set Assessment, dated 10/5/24, shows that R220 has a Brief Interview of Mental Status (BIMS) score of 15, indicating R220 is cognitively intact. Section GG shows R220 requires supervision or touch assistance with toileting and toileting transfer. It shows R220 requires partial to moderate assist with lower body dressing. R220's Care Plan, dated 7/14/21, states, in part: . (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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(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	Focus: ADL (activities of daily living): Potential risk for Complications with Deficit's with ADL's R/T (related to) weakness, impaired balance, noncompliance with therapy recommendations for increased independence. Date Initiated: 7/14/21 Revision on: 6/27/24 . Interventions: . *Dressing- set up minimum assist with upper body dressing. Maximum assist with lower body dressing. Date initiated: 7/14/21 Revision on: 6/27/24. *Toilet Use- Resident uses bedside commode and urinal, Resident able to be modified independent with toileting needs. May need assistance with cleansing following a BM (bowel movement) .Resident may need assistance with placement/holding of urinal from bed and w/c (wheelchair) level r/t spillage . On 10/8/24 at 1:34 PM, R220 voiced concern to Surveyor that the scheduler, that is not a CNA, has been in 3-4 times with the CNA to watch the CNA assist me on the commode or get the urinal placed. R220 indicated he is on care with pairs since the last weekend in June. R220 indicated the facility told him he is on care with pairs because he complains too much and writes things down and calls State. R220 indicated the scheduler is not certified and should not be in room during cares. On 10/8/24 at 3:41 PM, Surveyor interviewed SCH C (Scheduler). SCH C indicated her CNA license lapsed in 2020 so she does not hold a current CNA license. Surveyor asked SCH C if it is acceptable for a staff that is not certified to be in a resident room while cares are being provided. SCH C indicated if she asks the resident, and they give permission it is acceptable. Surveyor asked if SCH C has been in R220's room while cares have been provided and SCH C indicated she has been a witness to watch CNAs do cares for the care in pairs program. SCH C indicated she has witnessed CNA placing R220's urinal. On 10/9/24 at 1:15 PM, Surveyor interviewed DON B (Director of Nursing) and asked if it is acceptable for a staff member who is not certified be in a resident's room for care with pairs and DON B indicated no. Surveyor informed DON B that R220 and SCH C indicated SCH C was in R220's room to witness cares with R220, such as placing urinal. DON B indicated she should not have been.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49436 Based on observation and interview, the facility did not ensure each resident has a safe, clean, comfortable, and homelike environment for 12 of 20 sampled residents (R). Surveyor observed one bag of soiled linen and one bag of trash, including soiled briefs, sitting in the middle of the hallway on 10/7/24 affecting the 12 residents who reside on the hallway. Surveyor observed a dried sticky substance on R26's floor which had been covered with two towels on 10/8/24. Surveyor observed a wet bag of linen on R3's floor on 10/8/24. This is evidenced by: Example 1 On 10/7/24 at 1:54 PM, Surveyor observed one bag of soiled linen and one bag of trash, including soiled briefs, sitting in the middle of the hallway of a unit on which 12 residents lived. No staff were present. On 10/7/24 at 1:55 PM a staff member walked past the bags. On 10/7/24 at 1:57 PM a staff member walked past the bags. On 10/7/24 at 1:57 PM, Surveyor observed CNA CC (Certified Nursing Assistant) walk down the hall, pick up both trash bags, and remove them. On 10/7/24 at 2:08 PM, Surveyor interviewed CNA CC. CNA CC indicated she should have put them in the soiled utility room instead of putting them on the floor. Example 2 On 10/8/24 at 10:37 AM, Surveyor observed R26 in bed. Surveyor observed a dried sticky substance on the floor which had been covered with 2 towels. On 10/8/24 at 10:37 AM, Surveyor interviewed R26. R26 indicated when breakfast had been served earlier that morning, staff knocked over her can of soda which spilled on the floor. R26 stated, They just threw a towel over it and that's as far as it got. R26 indicated she would have expected the staff to wipe it. Surveyor observed the hospice CNA (Certified Nursing Assistant), who had just finished working with R26's roommate, wipe up the spill. On 10/9/24 at 1:21 PM, Surveyor interviewed CNA K. CNA K indicated CNAs are expected to wipe up the spill, then ask housekeeping to mop up the area so it will not be sticky. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 On 10/8/24 at 12:15 PM, Surveyor observed R3 in bed. Surveyor observed a bag of soiled, wet linen on the floor near the foot of the bed. On 10/8/24 at 12:34 PM, Surveyor stopped CNA FF (Certified Nursing Assistant) in the hallway. Surveyor asked CNA FF about the bag of soiled, wet linen at the foot of R3's bed. CNA FF walked into R3's room, picked up the bag, stated the bag was damp linen, and dropped the bag on the floor. As CNA FF walked out of the room, she stated. I will pick it up when I change her. On 10/8/24 at 1:36 PM, Surveyor observed the bag of soiled, wet linen had been removed. On 10/9/24 at 3:48 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated staff should clean up spills and should not leave bags of soiled linen or trash on the floor.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not follow their grievance process for 2 of 20 Residents (R19 & R11). R19 voiced concern with Surveyor that staff are rough with him and manhandle him. Facility did not do a grievance on this concern. R11 reported to laundry staff she was missing clothes. A grievance was not filed for missing items when clothes were not all located. Evidenced by: The facility policy, entitled Grievance Guideline, dated 5/31/23, states, in part: . Purpose: To provide a process to voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) and respond with prompt efforts to resolve while keeping the resident and/or resident representative appropriately apprised of progress toward resolution . The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have . Response: Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official . Upon receipt of a grievance or concerns, the Grievance Official will review the grievance, determine immediately if the grievance meets a reportable complaint consistent with the facility Abuse Prevention Policy. The Grievance Official will immediately report all alleged violations involving neglect, abuse. Including injuries of unknown sources and/or misappropriation of resident property by anyone to the Administrator as required by State Law . As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential continuations of any additional and like resident concerns while the grievance is being investigated. Resolution: The Grievance Official and/or designee will complete a response within 5 days of receipt to the resident and/or resident representative . The facility policy, entitled Resident and Family Grievances, dated October 2022, states, in part: . Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Definitions: Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance . Policy Explanation and Compliance Guidelines: . 7. Information on how to file a grievance . c. The time frame that a resident may reasonably expect completion of the review of the grievance and a written decision regarding his or her grievance. 8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official . 10. Procedure: . b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right. ii. Report any allegations involving neglect, abuse, injuries of unknown source . immediately to the administrator and follow procedures for those allegations. c. Forward the grievance form to the Grievance Official as soon as practicable. d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form . e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. Example 1 R19 was admitted to the facility on [DATE] and has diagnoses that include degenerative disease of the nervous system (condition where the cells of the central nervous system gradually deteriorate and die, leading to progressive loss of function), major depressive disorder, and anxiety disorder. R19's Quarterly Minimum Data Set (MDS) assessment dated [DATE] shows R19 has a Brief Interview of Mental Status (BIMS) score of 8 indicating R19 has moderate cognitive impairment. Section GG shows R19 is dependent on staff for toileting, dressing, transferring, and personal hygiene. R19's Care Plan, dated 11/29/23, states, in part: . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) weakness and pain. Date Initiated: 11/29/23 Revision on: 4/8/24 . Interventions: *Bathing/Showering: The resident requires total assist by 1 staff with (bathing/showering) as necessary. Date Initiated: 11/29/23 Revision on: 6/18/24. *Bed Mobility: The resident requires total assist by 2 staff to turn and reposition in bed every 2 hours and as necessary . Date Initiated: 11/29/23 Revision on: 6/18/24. *Dressing: The resident requires total assist by 1 staff to dress. Date Initiated: 11/29/23. Revision on: 6/18/24 . * Transfer: The resident requires total assist by 1 staff to move between surfaces . Date Initiated: 11/29/23. Revision on: 6/18/24 . On 10/7/24 at 11:15 AM, R19 voiced concern to this Surveyor that staff are rough with him. Surveyor asked R19 if he knows what staff are rough with him and R19 indicated the black ones. Surveyor asked R19 how staff are rough with him and R19 indicated the staff manhandle him with turning/repositioning. Surveyor asked if staff are abusive, hit him or hurt him with cares and R19 stated with loudness in his voice, They are rough! They manhandle me! Surveyor asked if R19 could tell Surveyor what staff are rough with him, certain shift or time of day, and R19 indicated again with loudness in his voice, The black ones! Surveyor asked R19 if he had reported this to anyone and R19 indicated no. Surveyor asked how long this has been happening and R19 indicated he has been here for three years. Surveyor informed R19 the NHA (Nursing Home Administrator) will be notified and will come talk to him. R19 asked Surveyor what the NHA's name was, and Surveyor told R19. On 10/7/24, at 11:30 AM, Surveyor informed NHA A that R19 reported to Surveyor the black ones are rough with R19 and manhandle R19 with turning/repositioning. NHA A indicated to Surveyor that being rough does not sound reportable. Surveyor informed NHA A to do with the information what he feels and what the facility policy indicates. NHA A stated, The black ones, what does that sound like to you? Surveyor indicated to NHA A to do with the information what his policy says. NHA A indicated he will go down and talk with R19. On 10/9/24, at 9:22 AM, Surveyor spoke with SW D (Social Worker) and asked for all the grievances filed in the past month by or on behalf of R19. SW D indicated there are no grievances and the last grievance was 8/21/24, which was a care concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24, at 3:14 PM, Surveyors interviewed NHA A and DOO P (Director of Operations). Surveyor asked if the investigation was complete and NHA A indicated no. NHA A indicated he has 5 days to complete it. Surveyor asked NHA A to walk through what he has completed so far and NHA A indicated he first thought it was a Customer Service issue towards black staff in the building. NHA A indicated he sent unit manager LPN E (Licensed Practical Nurse) to talk with R19. Surveyor asked NHA A to help Surveyor to understand how NHA A determined to send LPN E when R19 voiced a concern about staff that LPN E fits the description of. NHA A indicated because she is good with residents and is management. NHA A then indicated he interviewed other residents and two staff. Surveyor asked DOO P if a grievance should have been completed for R19 and DOO P indicated yes. Surveyor asked NHA A if a grievance was completed for R19 and NHA A indicated he does not know if it got started because it switched to self-report, so it changed for me. Example 2 R11 admitted to the facility on [DATE], and has diagnoses that include Metabolic Encephalopathy (a brain disorder that occurs when a chemical imbalance in the blood affects the brain), Type 2 Diabetes Mellitus (a long term condition in which the body has trouble controlling blood sugar and using it for energy), and megaloureter (a disorder in which the passage carrying urine from the kidney to bladder is enlarged, sometimes to the size of the small intestine). R11's Admission Minimum Data Set (MDS) Assessment, dated 9/12/24, shows R11 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R11 is cognitively intact. On 10/7/24, at 10:04 AM, Surveyor interviewed R11. R11 indicated her son brought her in a bag of clothes 5 weeks ago and the bag went downstairs to get labeled with R11's name and never came back. R11 indicated she is missing 4 pairs of pajamas, 4 jeans, and a red pair of pants and shirts. R11 indicated she spoke with a lady in laundry three weeks ago and the lady is looking for them. On 10/9/24, at 12:03PM, Surveyor interviewed HSKG I (Housekeeping Supervisor) who indicated she did not know about any missing clothes for R11. HSKG I indicated the process if clothes are reported missing is to check laundry and if not labeled, we check in lost and found. If we do not find it, we report to management. HSKG I indicated if laundry is not found in a week, a grievance would get filled out by HSKG I and it would be given to SW D. On 10/9/24 at 12:10 PM, Surveyor and HSKG I spoke with HSKG J who indicated she was aware of R11's missing clothes. HSKG J indicated R11's son came to her the weekend of September 18th and reported missing clothes. That Monday following, HSKG J indicated she found some of the missing clothes, all except a missing pair of blue jeans. Surveyor asked HSKG J if she filled out a grievance or reported to HSKG I and HSKG J indicated no. HSKG I indicated HSKG J should have reported it, and a grievance should have been completed. HSKG I indicated she would have expected a grievance to be completed after a week and all the clothes were not found. On 10/9/24 at 1:00 PM, Surveyor asked if SW D has a grievance for R11 and missing clothes. SW D indicated no. On 10/10/24 at 5:34 PM, Surveyor interviewed DON B (Director of Nursing) and informed her of R11's missing clothes, all found but missing blue jeans. DON B indicated she would have expected a grievance to be completed for the missing jeans that were not found.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately to the administrator of the facility and to other officials, including the State Survey Agency, in accordance with State law though established procedures for 1 of 4 abuse investigations (R19) reviewed for not reporting all allegations of abuse. Facility became aware of an abuse allegation on 10/7/24 and did not report to the State Agency until 10/8/24 at 9:53AM. This is evidenced by: The facility policy. Entitled Abuse, Neglect and Exploitation, dated 9/18/23, states, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19 was admitted to the facility on [DATE] and has diagnoses that include degenerative disease of the nervous system (condition where the cells of the central nervous system gradually deteriorate and die, leading to progressive loss of function), major depressive disorder, and anxiety disorder. R19's Quarterly Minimum Data Set (MDS) assessment dated [DATE] shows R19 has a Brief Interview of Mental Status (BIMS) score of 8 indicating R19 has moderate cognitive impairment. Section GG shows R19 is dependent on staff for toileting, dressing, transferring, and personal hygiene. On 10/7/24 at 11:15 AM, R19 voiced concern to this Surveyor that staff are rough with him. Surveyor asked R19 if he knows what staff are rough with him and R19 indicated the black ones. Surveyor asked R19 how staff are rough with him and R19 indicated the staff man handle him with turning/repositioning. Surveyor asked if staff are abusive, hit him or hurt him with cares and R19 stated with loudness in his voice, They are rough! They man handle me! Surveyor asked if R19 could tell Surveyor what staff are rough with him, certain shift or time of day and R19 indicated again with loudness in his voice, The black ones! Surveyor asked R19 if he had reported this to anyone and R19 indicated no. Surveyor asked how long this has been happening and R19 indicated he has been here for three years. Surveyor informed R19 the NHA (Nursing Home Administrator) will be notified and will come talk to him. R19 asked Surveyor what the NHA's name was, and Surveyor told R19. On 10/7/24 at 11:30 AM, Surveyor informed NHA A (Nursing Home Administrator) that R19 reported to Surveyor the black ones are rough with R19 and man handle R19 with turning/repositioning. NHA A indicated to Surveyor that being rough does not sound reportable. Surveyor informed NHA A to do with the information what he feels and what the facility policy indicates. NHA A stated, The black ones, what does that sound like to you? Surveyor indicated to NHA A to do with the information what his policy says. NHA A indicated he will go down and talk with R19. On 10/7/24 at 3:50 PM, Surveyor was observing a medication administration on R19. R19 stated to this Surveyor in a loud voice, You sent in a black woman! Surveyor explained to R19 that Surveyor had talked to the administrator and asked R19 if the administrator had come in to talk with R19. R19 kept staring at Surveyor and repeated loudly and slowly, You sent in a black woman! Surveyor apologized that had happened. R19 was obviously very angry and upset with who was sent in to talk with R19. On 10/8/24 at 8:29AM, Surveyor interviewed R19 who indicated he did not know who LPN E (Licensed Practical Nurse) was when she came in his room. R19 indicated he did not know if LPN E was one of the ones he was talking about being rough with R19 or not. R19 indicated LPN E was obviously mad and was very hostile when she came in his room. R19 indicated LPN E was accompanied by RN F (Registered Nurse). R19 indicated that he does not feel safe in this nursing home. LPN E came in R19's room and slapped her hands down on bedside table and stated, I hear you say that the black CNAs (Certified Nursing Assistants) rough you up. Her face was full of anger. R19 indicated to LPN E two times he wanted to see the administrator because the Surveyor said that she would send the administrator in to see him. R19 indicated then in comes a black woman. R19 indicated he told the NHA A when he came down that one of the black CNAs came in his room and ignores R19 and talks above R19, they talk about money and their husbands and other people. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 9:05 AM, Surveyor interviewed RN F and asked if she could tell Surveyor about the conversation that occurred between LPN E and R19. RN F indicated LPN E approached R19 and indicated to R19 that he has complained black CNAs are rough with him. R19 responded by saying he wanted to talk to the administrator. RN F indicated LPN E was bent over R19 while talking to him. RN F indicated both she and LPN E left R19's room. On 10/8/24 at 9:50 AM, Surveyor informed DON B (Director of Nursing) and DOO P (Director of Operations) of abuse allegation regarding LPN E slapping hands on the bedside table, R19 not feeling safe in facility, and intimidation expressed by R19. On 10/8/24 at 12:20 PM, Surveyor interviewed LPN E. LPN E indicated she went to R19's room to talk with him regarding his concern with staff being rough with him. LPN E indicated she asked R19 what happened and who was rough with him. R19 indicated he wanted to talk with someone in administration, not LPN E or my kind. LPN E indicated she told NHA A and DON B (Director of Nursing). LPN E indicated she was standing upright behind bedside table and not bent over. Surveyor asked LPN E if standing over a resident could be intimidating and LPN E indicated no, anything you do in R19's room is offensive, even if you sit. LPN E indicated we go in, do what we have to, and leave. LPN E indicated NHA A indicated to her that the complaint was that staff was handling R19 roughly and how they were turning him. LPN E indicated if she would have known the complaint was regarding black people she would not have gone in and tried to talk with R19. LPN E indicated she felt she was blindsided. LPN E indicated RN F and she had to do a statement and LPN E indicated she was suspended, then brought back in. LPN E indicated she had to sign education on customer service and abuse by intimidation. The facility did not report the abuse allegation to the State Agency until 10/8/24 at 9:53 AM. On 10/8/24, at 4:15 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and DON B (Director of Nursing) and asked what had been done with the concern from R19 that was brought to NHA A. NHA A indicated he sent in unit manager LPN E to talk with R19 and R19 had refused to talk with LPN E. NHA A indicated DON B had to go in and talk with R19. Surveyor asked NHA A to help Surveyor understand how NHA A determined to send in a staff member that fit the description of the staff R19 had described he had a concern with would be helpful. NHA A indicated he did not send LPN E in to talk with R19 because she was black, NHA A sent LPN E in because she is the Unit Manager and is good at communicating with cantankerous men. Another Surveyor asked NHA A what the allegation from R19 was. This Surveyor indicated the black ones are rough with R19 and manhandle R19 with positioning. NHA A indicated he did not send LPN E intentionally because she was black. DON B indicated she spoke with R19 and asked if R19 felt safe here at facility and R19 indicated yes. DON B indicated she asked if this occurred at a specific time of day and R19 indicated no. DON B indicated she asked R19 what rough meant but did not R19 did not give his response. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24, at 3:14 PM, Surveyors interviewed NHA A and DOO P (Director of Operations). Surveyor asked if the investigation was complete and NHA A indicated no. NHA A indicated he has 5 days to complete it. Surveyor asked NHA A to walk through what he has completed so far and NHA A indicated he first thought it was a Customer Service issue towards black staff in the building. NHA A indicated he sent Unit Manager LPN E (Licensed Practical Nurse) to talk with R19. Surveyor asked NHA A to help Surveyor to understand how NHA A determined to send LPN E when R19 voiced a concern about staff that LPN E fits the description of. NHA A indicated because she is good with residents and is management. NHA A then indicated he interviewed other residents and two staff. Surveyor asked DOO P if a grievance should have been completed for R19 and DOO P indicated yes. Surveyor asked NHA A if a grievance was completed for R19 and NHA A indicated he does not know if it got started because it switched to self-report. NHA A indicated he has other resident interviews, and 2 staff interviews: RN F and LPN E. NHA A indicated he ruled out abuse from talking with LPN E and RN F, resident interviews, and was starting education. NHA stated the Police were contacted. LPN E had RN F in with her while she spoke with R19. NHA A indicated he interviewed R19 and LPN E; he did not have the interviews wrote down anywhere, he indicated he was working on putting them in the computer. Surveyor asked what was put into place to protect R19 and other residents and NHA A responded LPN E was suspended, education was started, residents were interviewed, and R19 was interviewed. Surveyor asked NHA A what staff was interviewed and NHA A indicated the interdisciplinary team. Surveyor asked for names and NHA A indicated DON B and IP G (Infection Preventionist). NHA A could not provide the interviews, NHA A indicated he was in the process of documenting them in the computer and did not have a hard copy yet. Surveyor asked DOO P if RN F could have covered for LPN E and DOO P indicated yes.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not ensure that in response to allegations of abuse, neglect, exploitation, or mistreatment, that all alleged violations are thoroughly investigated, and that steps were taken to prevent further abuse for 1 resident (R19) of 4 reviewed. On 10/7/24, the facility became aware of an abuse allegation regarding R19. The facility failed to provide evidence to prevent further abuse to R19 and other residents. The facility suspended a staff member and then brought staff member back to work before investigation was completed. This is evidenced by: The facility policy. Entitled Abuse, Neglect and Exploitation, dated 9/18/23, states, in part: . Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . Policy Explanation and Compliance Guidelines: V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; . C. Increased supervision of the alleged victim and residents; . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19 was admitted to the facility on [DATE] and has diagnoses that include degenerative disease of the nervous system (condition where the cells of the central nervous system gradually deteriorate and die, leading to progressive loss of function), major depressive disorder and anxiety disorder. R19's Quarterly Minimum Data Set (MDS) assessment dated [DATE] shows R19 has a BIMS (Brief Interview of Mental Status) score of 8 indicating R19 has moderate cognitive impairment. Section GG shows R19 is dependent on staff for toileting, dressing, transferring and personal hygiene. R19's Care Plan, dated 11/29/23, states, in part: . Focus: The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) weakness and pain. Date Initiated: 11/29/23 Revision on: 4/8/24 . Interventions: *Bathing/Showering: The resident requires total assist by 1 staff with (bathing/showering) as necessary. Date Initiated: 11/29/23 Revision on: 6/18/24. *Bed Mobility: The resident requires total assist by 2 staff to turn and reposition in bed every 2 hours and as necessary . Date Initiated: 11/29/23 Revision on: 6/18/24. *Dressing: The resident requires total assist by 1 staff to dress. Date Initiated: 11/29/23. Revision on: 6/18/24 . *Toilet Use: The resident requires total assist by (1) staff for toileting. Date Initiated: 11/29/23. Revision on 6/18/24. * Transfer: The resident requires total assist by 1 staff to move between surfaces . Date Initiated: 11/29/23. Revision on: 6/18/24 . Of note: Surveyor asked the facility for a copy of initial report and investigation under way. Surveyor never received. On 10/7/24, at 11:15 AM, R19 voiced concern to this Surveyor that staff are rough with him. Surveyor asked R19 if he knows what staff are rough with him and R19 indicated the black ones. Surveyor asked R19 how staff are rough with him and R19 indicated the staff man handle him with turning/repositioning. Surveyor asked if staff are abusive, hit him or hurt him with cares and R19 stated with loudness in his voice, They are rough! They man handle me! Surveyor asked if R19 could tell Surveyor what staff are rough with him, certain shift or time of day and R19 indicated again with loudness in his voice, The black ones! Surveyor asked R19 if he had reported this to anyone and R19 indicated no. Surveyor asked how long this has been happening and R19 indicated he has been here for three years. Surveyor informed R19 the NHA (Nursing Home Administrator) will be notified and will come talk to him. R19 asked Surveyor what the NHA's name was, and Surveyor told R19. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 11:30 AM, Surveyor informed NHA A (Nursing Home Administrator) that R19 reported to Surveyor the black ones are rough with R19 and man handle R19 with turning/repositioning. NHA A indicated to Surveyor that being rough does not sound reportable. Surveyor informed NHA A to do with the information what he feels and what the facility policy indicates. NHA A stated, the black ones, what does that sound like to you? Surveyor indicated to NHA A to do with the information what his policy says. NHA A indicated he will go down and talk with R19. On 10/7/24 at 3:50 PM, Surveyor was observing a medication administration on R19. R19 stated to this Surveyor in a loud voice You sent in a black woman! Surveyor explained to R19 that Surveyor had talked to the administrator and asked R19 if the administrator had come in to talk with R19. R19 kept staring at Surveyor and repeated loudly and slowly, You sent in a black woman! Surveyor apologized that had happened. R19 obviously very angry and upset with who was sent in to talk with R19. On 10/8/24 at 8:29 AM, Surveyor interviewed R19 who indicated he did not know who LPN E (Licensed Practical Nurse) was when she came in his room. R19 indicated he did not know if LPN E was one of the ones he was talking about being rough with R19 or not. R19 indicated LPN E was obviously mad and was very hostile when she came in his room. R19 indicated LPN E was accompanied by RN F (Registered Nurse). R19 indicated that he does not feel safe in this nursing home. LPN E came in R19's room and slapped her hands down on bedside table and stated, I hear you say that the black CNAs (Certified Nursing Assistants) rough you up. Her face was full of anger. R19 indicated to LPN E two times he wanted to see the administrator because the Surveyor said that she would send the administrator in to see him. R19 indicated then in comes a black woman. R19 indicated he told NHA A when he came down that one of the black cnas come in his room and ignores R19 and talks above R19, they talk about money and their husbands and other people. On 10/8/24 at 9:05 AM, Surveyor interviewed RN F and asked if she could tell Surveyor about the conversation that occurred between LPN E and R19. RN F indicated LPN E approached R19 and indicated to R19 that he has complained black cnas are rough with him. R19 responded by saying he wanted to talk to the administrator. RN F indicated LPN E was bent over R19 while talking to him. RN F indicated both she and LPN E left R19's room. On 10/8/24 at 9:50 AM, Surveyor informed DON B (Director of Nursing) and DOO P (Director of Operations) of abuse allegation regarding LPN E slapping hands on the bedside table, R19 not feeling safe in facility, and intimidation expressed by R19. On 10/8/24 at 10:51 AM, DON B indicated to Surveyor LPN E had been suspended. On 10/8/24 at 12:00 PM, Surveyor was informed LPN E was back in work status by DON B. LPN E (Licensed Practical Nurse) schedule for 10/8/24-10/15/24: -Unit Manager 10/8/24 8:00AM-4:30PM -Unit Manager 10/9/24 8:00AM-4:30PM -10/10/24 8:00AM-4:30PM- Spent 45 minutes on the floor on Birch to assist with medication pass. -10/11/24 8:00AM-4:30PM (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/14/24 8:00AM-4:30PM -10/15/24 8:00AM-4:30PM LPN E Punch Card shows: -10/7/24- 7:32am (in) - 8:17pm (out) -10/8/24- 5:45am (in) -9:32am (out), 11:07am (in) - 5:18pm (out) -10/9/24 - 6:32 am (in) - 8:06 pm (out) - 10/10/24- 6:15am (in) On 10/9/24, at 3:14 PM, Surveyors interviewed NHA A (Nursing Home Administrator) and DOO P (Director of Operations). Surveyor asked if the investigation was complete and NHA A indicated no. NHA A indicated he has 5 days to complete it. Surveyor asked NHA A to walk through what he has completed so far and NHA A indicated he first thought it was a Customer Service issue towards black staff in the building. NHA A indicated he sent unit manager LPN E (Licensed Practical Nurse) to talk with R19. Surveyor asked NHA A to help Surveyor to understand how NHA A determined to send LPN E when R19 voiced a concern about staff that LPN E fits the description of. NHA A indicated because she is good with residents and is management. NHA A then indicated he interviewed other residents and two staff. Surveyor asked DOO P if a grievance should have been completed for R19 and DOO P indicated yes. Surveyor asked NHA A if a grievance was completed for R19 and NHA A indicated he does not know if it got started because it switched to self-report. NHA A indicated he has other resident interviews, and 2 staff interviews: RN F and LPN E. NHA A indicated he ruled out abuse from talking with LPN E and RN F, resident interviews, and starting education. Police were contacted. LPN E had RN F in with her while she spoke with R19. NHA A indicated he interviewed R19 and LPN E; he did not have the interviews written down anywhere, he indicated he was working on putting them in the computer in his notes. Surveyor asked what was put into place to protect R19 and other residents and NHA A responded LPN E was suspended, education was started, residents were interviewed and R19 was interviewed. Surveyor asked NHA A what staff was interviewed and NHA A indicated ID team. Surveyor asked for names and NHA A indicated DON B and IP G (Infection preventionist). NHA A could not provide the interviews, NHA A indicated he was in the process of documenting them in the computer and did not have a hard copy yet. Surveyor asked DOO P if RN F could have covered for LPN E and DOO P indicated yes. Surveyor asked DOO P if two staff could abuse a resident behind closed doors and DOO P indicated yes. The facility, by allowing LPN E to come back to work even though an investigation had not yet been completed, failed to protect other residents from further potential abuse.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman of transfers/discharges for 7 of 7 residents (R64, R29, R49, R63, R26, R31, and R13) reviewed for transfers/discharges. This is evidenced by: The facility policy titled Transfer and Discharge (including AMA (Against Medical Advice)) dated [DATE] includes: The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand .The facility will maintain evidence that the notice was sent to the Ombudsman. Example 1 R64 admitted to the facility on [DATE] and discharged on [DATE]. R64 readmitted to the facility on [DATE] and discharged on [DATE]. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R64. Example 2 R29 admitted to the facility on [DATE] and transferred to a hospital on [DATE]. R29 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R29 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R29 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R29 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R29 readmitted to the facility on [DATE]. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R29. Example 3 R49 admitted to the facility on [DATE] and transferred to a hospital on [DATE]. R49 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R49 readmitted to the facility on [DATE] and remains in the facility. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R49. Example 4 R63 admitted to the facility on [DATE] and transferred to a hospital on [DATE]. R63 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R63 readmitted to the facility on [DATE] and expired on [DATE]. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R63. Example 5 R26 admitted to the facility on [DATE] and transferred to a hospital on [DATE]. R26 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R26 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R26 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R26 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R26 readmitted to the facility on [DATE] and remains in the facility. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R26. Example 6 R31 admitted to the facility on [DATE] and transferred to a hospital on [DATE]. R31 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R31 readmitted to the facility on [DATE] and transferred to a hospital on [DATE]. R31 readmitted to the facility on [DATE] and remains in the facility. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R31. Example 7 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13 admitted to the facility on [DATE] and transferred to a hospital on [DATE]. R13 readmitted to the facility on [DATE] and remains in the facility. The facility did not provide evidence that a transfer/discharge notice was provided to the Ombudsman for R13. On [DATE] at 3:32 PM, Surveyor asked SW D (Social Worker) for documentation of notification of transfers/discharged to the State Long-Term Care Ombudsman. SW D was unable to provide the documentation of notification. SW D indicated notification to the State Long-Term Care Ombudsman should be done but the notifications had not been done.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49436 Based on interview and record review, the facility did not ensure the required written bed-hold notice was provided to residents (R) when being transferred to the hospital for 6 of 6 residents (R13, R26, R29, R31, R36, and R49) reviewed for bed-holds. R13 was transferred to the hospital on 10/7/24 and was not provided a bed-hold notice. R26 was transferred to the hospital on 5/18/24, 6/12/24, 7/18/24, 9/16/24, and 9/29/24 and was not provided a bed-hold notice. R29 was transferred to the hospital on 6/18/24, 6/28/24, 7/21/24, 8/10/24, and 8/25/24 and was not provided a bed-hold notice. R31 was transferred to the hospital on 6/3/24, 7/10/24, and 8/18/24 and was not provided a bed-hold notice. R36 was transferred to the hospital on 5/26/24 and 8/16/24 and was not provided a bed-hold notice. R49 was transferred to the hospital on 4/27/24 and 8/3/24 and was not provided a bed-hold notice. This is evidenced by: The facility policy titled, Bed Hold Notice Upon Transfer dated 7/10/24, states in part: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. Bed-Hold means the holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information . In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies . the facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file. Example 1 R13 was transferred to the hospital on 10/7/24 and was not provided a bed-hold notice for this transfer. Example 2 R26 was transferred to the hospital on 5/18/24, 6/12/24, 7/18/24, 9/16/24, and 9/29/24 and was not provided a bed-hold notice for these transfers. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 3 R29 was transferred to the hospital on 6/18/24, 6/28/24, 7/21/24, 8/10/24, and 8/25/24 and was not provided a bed-hold notice for these transfers. Example 4 R31 was transferred to the hospital on 6/3/24, 7/10/24, and 8/18/24 and was not provided a bed-hold notice for these transfers. Example 5 R36 was transferred to the hospital on 5/26/24 and 8/16/24 and was not provided a bed-hold notice for these transfers. Example 6 R49 was transferred to the hospital on 4/27/24 and 8/3/24 and was not provided a bed-hold notice for these transfers. On 10/10/24 at 3:32 PM, Surveyor asked SW D (Social Worker) for the required bed-hold notices. SW D was unable to provide the bed-hold documentation. SW D indicated the bed-hold notices should have been given to the residents, but the notices were not completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 1 of 20 residents (R36) reviewed for MDS accuracy. R36's MDS assessment indicated that R36 had a Foley catheter when R36 did not have one. Evidenced by: Facility policy entitled, MDS 3.0 Completion, dated 9-18-24, states, in part: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the RAI (resident assessment index) specified by the State. R36's care plan indicates Goal: The resident will remain free from skin breakdown due to incontinence and brief use . Date initiated: 2/26/24. R36's MDS, dated [DATE], indicates Catheter Indwelling-yes. On 10/8/24 at 9:19 AM, Surveyor interviewed MDS T and asked if R36 has a catheter. MDS T stated no. Surveyor asked if the MDS should indicate that R36 has a catheter. MDS T stated maybe she does have one. MDS T reviewed the chart and stated that the MDS was marked inaccurately. Surveyor asked if the MDS should reflect the resident's status. MDS T stated yes, she would need to amend the MDS. On 10/10/24 at 10:38 AM, Surveyor interviewed DON B and asked if staff was expected to complete the MDS accurately. DON B stated yes. On 10/10/24 at 1:41 PM, Surveyor interviewed NHA A and asked if staff was expected to complete the MDS accurately. NHA A stated yes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on record review and interview, the facility did not complete the Preadmission Screening and Resident Review (PASARR) Level II when it was realized that a resident would reside in the facility for more than 30 days. This affected 3 of 3 residents (R24, R11, and R17) reviewed for PASARR and 1 supplemental resident (R45). R45, R24, R11, and R17 resided in the facility longer than 30 days and required a PASARR Level II screen, but the facility failed to complete the screening. This is evidenced by: The facility policy titled Resident Assessment - Coordination with PASARR Program dated 9/18/24 states in part: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission . A record of the pre-screening shall be maintained in the resident's medical record . Exceptions to the preadmission screening program, dependent upon State requirements, include those individuals who: .Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services . If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: .The social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Example 1 R45 admitted to the facility on [DATE] with diagnoses including delusional disorders, dementia, and recurrent major depressive disorder with psychotic symptoms. R45's Physician Orders, dated 10/10/24, indicate R45 takes Olanzapine (an antipsychotic medication). R45's PASARR Level I screen, dated 2/15/23, includes: The resident is suspected of having a serious mental illness. Hospital Discharge Exemption - 30 Day Maximum. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after R45 exceeded the 30-day exemption. Example 2 R24 admitted to the facility on [DATE] with diagnoses including anxiety disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R24's Physician Orders, dated 10/10/24, indicate R24 takes Trazodone (a psychotropic medication) for anxiety. R24's PASARR Level I screen, dated 3/30/23, includes: Within the past six months, has this person received psychotropic medication(s) to treat symptoms or behaviors of a major mental disorder under the Diagnostic and Statistical Manual for Mental Disorders. Hospital Discharge Exemption - 30 Day Maximum. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after R24 exceeded the 30-day exemption. Example 3 R11 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, schizophrenia, and major depressive disorder. R11's Physician Orders, dated 10/10/24, indicate R11 takes fluvoxamine maleate (a psychotropic medication) and risperidone (an antipsychotic medication). R11's PASARR Level I screen summary, dated 9/6/24, includes: Does this person have a major mental disorder? Yes. Has this person received psychotropic medication(s) to treat symptoms or behaviors of a major mental disorder? Yes. Hospital Discharge Exemption - 30 Day Maximum Yes. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after R11 exceeded the 30-day exemption. Example 4 R17 admitted to the facility on [DATE] with diagnoses including depression, post-traumatic stress disorder, dissociative identity disorder, panic disorder, psychotic disorder with delusions due to known physiological condition, auditory hallucinations, and severe major depressive disorder. R17's Physician Orders, dated 10/10/24, indicate R17 takes quetiapine (an antipsychotic medication), venlafaxine and mirtazapine (antidepressant medications). R17's PASARR Level I screen, dated 6/27/23, includes: The resident is suspected of having a serious mental illness. Hospital Discharge Exemption - 30 Day Maximum. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after R17 exceeded the 30-day exemption. On 10/10/24 at 9:36 AM, Surveyor asked SW D (Social Worker) for the PASARRs. SW D was unable to provide the PASARR documentation. SW D indicated the PASARRs should have been completed, but they were not. On 10/10/24 at 2:49 PM, Surveyor interview DON B (Director of Nursing). DON B indicated only the PASARR Level I screens were completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on interview and record review the facility did not develop a comprehensive, person-centered care plan for 2 of 21 sampled (R266 and R36) reviewed for person-centered care plans. R266 does not have a comprehensive care plan that includes discharge planning. R36's care plan contained inaccurate information such as stating that R36 was ventilator dependent, had a tracheostomy, and had a catheter, none of which R36 has. Evidenced by: Facility policy entitled Comprehensive Care Plans, dated 9/18/24, states, in part; It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care.3. The comprehensive care plan will describe, at a minimum, the following: .d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (minimum data set) assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.8. Qualified staff responsible for carrying out interventions specified in the car plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Example 1 R266 was admitted to the facility on [DATE] with diagnoses that include cutaneous abscess of neck (a pus-filled mass that forms in the neck due to a bacterial or viral infection), pyothorax without fistula (accumulation of pus in the pleural space (area between the lungs and the chest wall) without an abnormal connection (fistula) to the airway or other body cavity), and osteoarthritis. R266's most recent Minimum Data Set (MDS) dated [DATE] states that R266 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R266 is cognitively intact. On 10/7/24 at 11:04 AM, Surveyor interviewed R266. R266 reported to Surveyor that her IV (Intravenous) was removed today and that she would be going home soon. Surveyor asked R266 if any of the facility staff has talked with her about her discharge plan, R266 stated no. Surveyor reviewed R266's Electronic Health Record (EHR) and found no documentation of any discharge planning. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is important to note that R266's care plan did not include a discharge care plan. On 10/9/24 at 11:47 AM, Surveyor interviewed SW D (Social Worker). Surveyor asked SW D when does discharge planning start, SW D stated that it starts upon admission to the facility. Surveyor asked SW D if she had discussed discharge planning with R266, SW D stated yes. Surveyor asked SW D if her discussion was documented in R266's EHR, SW D stated no. Surveyor asked SW D if discharge planning should be included in R266's care plan, SW D stated yes. 50228 Example 2 R36 admitted to the facility on [DATE] with diagnoses that include, in part: metabolic encephalopathy (a brain disorder that occurs when a chemical imbalance in the blood affects the brain) and acute and chronic respiratory failure with hypercapnia (difficulty breathing on one's own due to too much carbon dioxide in the blood). R36's Minimum Data Set (MDS), dated [DATE], indicates R36's Brief Interview of Mental Status (BIMS) is a 15, indicating that R36 is cognitively intact. Surveyor reviewed R36's care plan which states, in part: *Focus-The resident has a tracheostomy r/t (related to). Goal-The resident will have no abnormal drainage around trach site through the review date. Interventions-monitor/document for restlessness, agitation, confusion, increased heart rate (tachycardia), and bradycardia (slow heart rate). Date initiated: 8/21/24 *Focus-The resident is ventilator dependent r/t . Goal-The resident will be on the most appropriate ventilator and ventilator settings to maintain adequate ventilation: Mode: Respiratory Rate: Positive Pressure: Type of Ventilator: Interventions-Allow resident to express their emotions/feelings about being on a ventilator. Date initiated: 8/21/24 *Focus-The resident has (SPECIFY: Condom/Intermittent/Indwelling Suprapubic) Catheter:. Goal-The resident will be/remain free from catheter-related trauma through review date. Date initiated: 8/21/24 Important to note: the resident has not had a tracheostomy, has not been ventilator dependent, and has not had a catheter between 8/21/24 and present. On 10/10/24 at 10:28 AM, Surveyor interviewed RN G (Registered Nurse) and asked how the care plan is developed. RN G stated that nurses on the unit complete assessments and the care plan generates from that. Suveyor asked how often the care plan is reviewed. RN G stated I'm not sure, that is done by management. RN G indicated that management was the unit manager or the DON (Director of Nursing). On 10/10/24 at 10:31 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) and asked how often the care plan is reviewed. LPN E stated I don't know, I'd need to review the policy. Surveyor asked who is responsible to develop and modify the care plan. LPN E stated, I don't know how that works here; there are some changes made at our morning meeting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 10:38 AM, Surveyor interviewed DON B (Director of Nursing) and asked how often the care plan is reviewed. DON B stated with any resident change in condition, with MDS completion, and monthly. Surveyor reviewed R36's care plan with DON B and asked if DON B would expect the care plan to be accurate. DON B stated yes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on record review and interview, the facility did not ensure each resident (R), or their representative had the right to participate in the care planning process for 2 of 5 residents (R36 and R21) reviewed for care conferences. R36 indicated she does not have care plan meetings to discuss her care. R21's medical record shows a care plan meeting on 10/13/23 with no subsequent meetings. Evidenced by: Facility policy, entitled Comprehensive Care Plans, dated 9/18/24, states in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care.2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment.3. The comprehensive care plan will describe, at a minimum, the following: .f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated.4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limed to: a. The attending physician or non-physician practitioner designee involved in the resident's care . b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable . 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Example 1 R36 admitted to the facility on [DATE] with diagnoses that include, in part: metabolic encephalopathy and acute and chronic respiratory failure with hypercapnia. R36's Minimum Data Set (MDS), dated [DATE], indicates R36's Brief Interview of Mental Status (BIMS) is a 15, indicating that R36 is cognitively intact. On 10/7/24 at 3:00 PM, Surveyor interviewed R36 who indicated that she had only been at one care planning meeting a couple months ago and would like to be involved in the planning of care. Surveyor reviewed R36's medical record and was only able to locate a care conference note for 6/13/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Important to note that this conference's listed staff attendees only includes SW D; there is not input documented from nursing, therapy, or dietary staff members. Example 2 R21 admitted to the facility on [DATE] with diagnoses that include, in part: Multiple sclerosis, type 2 diabetes mellitus with diabetic neuropathy, and anxiety disorder. On 10/7/24 at 9:47 AM, Surveyor interviewed R21 during initial screening. R21 indicated plan to transfer to another facility. Surveyor reviewed R21's medical record for care planning and was only able to locate a care conference note for 10/13/23. On 10/10/24 at 9:16 AM, Surveyor interviewed SW D (Social Worker) and asked how often care conference meetings are held for residents. SW D stated within the first couple days of admission, then quarterly. SW D indicated that this is an interdisciplinary meeting, including therapy, nursing, social services, activities, the resident and resident representative, if applicable. Surveyor asked if the meeting for R36 on 6/13/24 was interdisciplinary. SW D stated, no, nursing and therapy were not involved in that meeting. Surveyor asked if there were any further documented meetings. SW D stated no. Surveyor asked if there had been a recent care conference meeting for R21. SW D stated not this quarter. SW D indicated that a meeting had been held in April of 2024 and there should have been another meeting by 7/25/24, but no meeting had been scheduled as of this date. Important to note: documentation of a 4/2024 meeting for R21 was requested. No documentation was provided. On 10/10/24 at 9:50 AM, Surveyor interviewed DON B (Director of Nursing) and asked how often a resident should have a care conference meeting. DON B stated on admission and quarterly. Surveyor asked if the care conference should involve the interdisciplinary team. DON B stated yes. Surveyor asked if nursing and therapy are not involved in a care plan meeting, is this considered a comprehensive care planning meeting. DON B stated no. On 10/10/24 at 1:41 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if residents should have care conference meetings on admission and quarterly. NHA A stated yes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and record review, the facility did not provide services as required in the person-centered care plan staff did not follow physician orders for a sleep assessment or for ketoconazole 2% shampoo application. This affects 2 of the 21 sampled residents (R48 and R36). Findings include: Facility policy, titled Unnecessary Drugs, includes: it is the facilities policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being . Example 1 R48 admitted to the facility on [DATE] and has the following diagnoses: schizophrenia, weakness, tremors, traumatic ischemia of muscle, and a personal history of malignant neoplasm of breast. R48's Physician Orders, February 2024, include: Trazadone HCl Oral Tablet 50MG: Give 1 tablet by mouth one time a day related to Depression. Start date 6/22/23 . R48's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/12/24 indicates R48's cognition is severely impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. R48's physician telephone order, dated 2/7/24, includes: complete a sleep log for 7 days. Update the Nurse Practitioner when complete. R48's Medical Record does not contain a sleep assessment or sleep log. On 10/09/24 at 8:24 AM, LPN U (Licensed Practical Nurse) indicated telephone orders should be followed up on. LPN U indicated a sleep log should have been completed following a telephone order for a 7-day sleep log to be completed and the Nurse Practitioner should have been updated pending the results. On 10/10/24 at 10:05 AM, DON B (Director of Nursing) indicated there is no sleep study from that order in February and there should be. 50228 Example 2 R36's physician orders state, in part: Ketoconazole External Shampoo 2% Apply to scalp topically one time a day every Wed, Sat for seborrheic dermatitis. Leave on for five minutes then rinse. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ketoconazole Shampoo label (https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/019927s032lbl.pdf) states: Dosage and administration: Apply the shampoo to the damp skin of the affected area and a wide margin surrounding this area. Lather, leave in place for 5 minutes, and then rinse off with water. On 10/7/24 at 2:58 PM, Surveyor interviewed R36 during initial screening and R36 stated, I only get a shower once a week and they have only used the ketoconazole a couple of times. On 10/10/24 at 11:24 AM, Surveyor interviewed LPN S (Licensed Practical Nurse) and asked the process for use of ketoconazole shampoo. LPN S stated it is rubbed into the scalp. Surveyor asked how it is rinsed. LPN S stated it doesn't need to be. Surveyor read the order to the LPN S. LPN S stated, oh yes, I wipe it with towels. Surveyor asked if a water rinse is completed. LPN S stated R36 doesn't want to get wet, so I take damp towels and wipe it off. On 10/10/24 at 11:37 AM, Surveyor interviewed DON B (Director of Nursing) and asked if Ketoconazole Shampoo needs to be rinsed with water. DON B stated yes. Surveyor asked DON B is damp towels wiped through the hair would be considered a rinse. DON B stated no.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38882 Based on interview and record review, the facility did not provide showers to 2 of 4 residents reviewed for Activities of Daily Living (ADLs) assistance (R266, R37) and 2 supplemental residents (R25, R9). R25 indicated she does not always get her scheduled showers. R37 indicated she does not always get scheduled showers. R9's medical record indicates she was not offered showers weekly. R266 had a shower on 9/15/24. There is no other documentation showing that R266 had any other weekly showers. Evidenced by: Facility policy, titled Activities of Daily Living (ADLs), dated 11/28/23, includes: care and services will be provided for the following activities of daily living: . bathing . 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 R25 admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/21/24 indicates R25's cognition is intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 10/10/24 at 1:56 PM, R25 indicated she has missed showers due to staff not offering or not having time. R25's Care Plan, initiated on 8/15/24, includes: The resident has an ADL self-care deficit related to limited mobility . The resident requires assistance by 1 staff with bathing/showering Tuesday evening and as necessary. R25's documentation of showers given, includes: 8/17 bed bath 8/22 N/A 9/3 refused 9/10 refused 9/17 no documentation regarding shower on this date (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/24 no documentation regarding shower on this date 10/1 refused 10/8 no documentation regarding shower on this date On 10/9/24 at 2:02 PM, DON B (Director of Nursing) and NHA A (Nursing Home Administrator) indicated staff should be giving showers when scheduled and if the resident refuses they are to mark refused, if the resident is unavailable staff are to reapproach and try again. Example 2 R37 admitted to the facility on [DATE] and has the following diagnoses: schizophrenia, weakness, tremors, traumatic ischemia of muscle, and a personal history of malignant neoplasm of breast. R37's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/12/24 indicates R37's cognition is severely impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. On 10/7/24 at 10:21 AM, R37 indicated she does not always get her showers as scheduled. R37 indicated they don't even offer some times and it just gets skipped. R37's Medical Record includes the following: Comprehensive Care Plan, initiated 10/20/23, includes: The resident has an ADL self- care performance deficit related to weakness . The resident requires assistance by 1 staff for bathing and showering every Wednesday morning and as needed. R37's documentation of showers given: 6/26 shower 7/03 (no documentation on this date related to showers) 7/10 shower 7/17 shower 7/24 shower 7/31 shower 8/07 shower 8/14 (no documentation on this date related to showers) (continued on next page)

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Madison Health and Rehabilitation Center	110 Belmont Rd Madison, WI 53714

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/21 (no documentation on this date related to showers) 8/28 shower 9/1 shower 9/4 not available 9/8 shower 9/11 shower 9/18 refused 9/25 N/A 10/2 N/A On 10/9/24 at 2:02 PM, DON B (Director of Nursing) and NHA A (Nursing Home Administrator) indicated staff should be giving showers when scheduled and if the resident refuses they are to mark refused, if the resident is unavailable staff are to reapproach and try again. Example 3 R9 admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/30/24 indicates R9 rarely speaks and is never understood. R9's care plan, initiated on 5/6/22, includes: The resident has an ADL self-care performance deficit related to confusion and disease process . Bathing/Showering: 1 assist . Transfer: hoyer lift . R9's showers given documentation, includes: 8/26 shower 9/2 shower 9/9 no documentation on this date related to bathing/showers 9/16 shower 9/23 no documentation on this date related to bathing/showers 9/30 no documentation on this date related to bathing/showers 10/7 resident refused (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 2:02 PM, DON B (Director of Nursing) and NHA A (Nursing Home Administrator) indicated staff should be giving showers when scheduled and if the resident refuses they are to mark refused, if the resident is unavailable staff are to reapproach and try again. 42038 Example 4 R266 was admitted to the facility on [DATE] with diagnoses that include cutaneous abscess of neck (a pus-filled mass that forms in the neck due to a bacterial or viral infection), pyothorax without fistula (accumulation of pus in the pleural space (area between the lungs and the chest wall) without an abnormal connection (fistula) to the airway or other body cavity), and osteoarthritis. R266's most recent Minimum Data Set (MDS) dated [DATE] states that R266 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R266 is cognitively intact. R266's MDS also indicates that she requires partial/ moderate assistance for showering/ bathing. R266's care plan dated 9/17/24 states in part . Focus: The resident has an ADL (Activities of Daily Living) self- care performance deficit r/t (related to) generalized weakness. Goal: The resident will maintain current level if function in ambulation through the review date. Interventions/ Tasks: Bathing/ Showering: The resident requires assistance by x1 staff with bathing/ showering every Sunday morning and as necessary . R266's shower documentation states Task: ADL/GG- Bathing SUNDAY AM shift indicates that R266 had a shower on 9/15/24. There is no other documentation showing that R266 had any other weekly showers. On 10/7/24 at 11:05 AM, Surveyor interviewed R266. R266 reported to Surveyor that she had not been receiving her showers. R266 did report that she received a shower from the OT (Occupational Therapist) on 9/26/24, after reporting that she was not receiving showers. R266 also reported to Surveyor that on the Sunday after 9/26/24 facility staff refused to shower her because she already had a shower. Surveyor asked R266 if she wanted a shower on 9/29/24, R266 stated yes. On 10/9/24 at 12:41 PM, Surveyor interviewed CNA K (Certified Nursing Assistant). Surveyor asked CNA K how she knows which residents get a shower each day, CNA K reported that there is a schedule hanging in the nurse's station. Surveyor asked CNA K if she gave R266 a shower on 9/22/24 and 9/29/24, CNA K reported that R266 had refused her shower on 9/29/24 because she had received a shower from therapy. Surveyor asked CNA K if she documented the refusal, CNA K stated no. Surveyor asked if she had reported the refusal to the nurse, CNA K stated no. Surveyor asked CNA K about R266's shower on 9/22/24, CNA K reported to Surveyor that she was new and did not know when R266's shower day was. Surveyor asked CNA K if she was aware that R266 had not been receiving her showers, CNA K reported that she knew that R266 was complaining that she hadn't had a shower in 14 days. It is important to note that CNA K was the CNA scheduled to work on R266's hall on 9/22/24 and 9/29/24. On 10/9/24 at 1:41 PM, Surveyor interviewed OTA L (Occupational Therapy Assistant). Surveyor asked OTA L if R266 had reported that she was not receiving her showers, OTA L reported that R266 did mention that she hadn't had a shower in about 15 days. Surveyor asked OTA L if she had given R266 a shower, OTA L stated yes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice (N9, Wisconsin Nurse Practice Act) when experiencing a change in condition for 1 of 21 residents (R36) reviewed for quality of care. R36 experienced a change in condition with subsequent hospitalization s on 2/27/24, 3/8/24, and 3/20/24. Respiratory and cardiac assessments were not completed prior to transfers. Evidenced by: The facility policy entitled Notification of Changes, dated 8/27/24, states, in part: .Changes of condition require an evaluation, using the SBAR Communication Form and Progress Note Evaluation ensures proper documentation and notification has been made. N9 Wisconsin Nurse Practice Act states, (1) GENERAL NURSING PROCEDURES. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process: (a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis. R36 admitted to the facility on [DATE] with diagnoses that include, in part: metabolic encephalopathy and acute and chronic respiratory failure with hypercapnia. R36's Minimum Data Set (MDS), dated [DATE], indicates R36's Brief Interview of Mental Status (BIMS) is a 15, indicating that R36 is cognitively intact. R36's progress notes include the following: *2/27/24 11:12 AM Nurses Note-- .updated NP on resident's unstable oxygenation status. Resident seems to drop sporadically to 85-86% . Important to note-this note does not include vital signs of temperature, pulse, and respirations; nor does it include lung assessment. *3/8/24 11:28 AM SBAR-Change of Condition-- .VS (vital signs) were BP (blood pressure) 121/75 P (pulse):87 RR (respiratory rate) 20 O2 (oxygen): 90% .I think she feels like having SOB (shortness of breath) but physically I didn't see any SS (signs/symptoms) of SOB. I checked her BS (blood sugar): 174 I don't know what is happening but I am worried. Important to note-this note does not include lung assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*3/20/24 6:20 AM-Nurses Note -Resident c/o (complained of) crushing chest pain. No orders for Nitrostat in place. BP and HR elevated. Oxygen on 5L 92%. Resident wanted to be sent to(Hospital Name) emergency department . Important to note-this note does not include values of vital signs of temperature, pulse, and respirations; nor does it include cardiac or respiratory assessment. On 10/10/24 at 2:09 PM, Surveyor interviewed RN R (Registered Nurse) and asked what is done when a resident has a respiratory/cardiac change in condition. RN R stated investigate the reason, obtain vital signs, apply oxygen as needed, try a nebulizer treatment if ordered, complete a lung/heart assessment. Surveyor asked if this is documented. RN R stated, yes on an SBAR (Situation Background Assessment Response) or a progress note. On 10/10/24 at 2:16 PM, Surveyor interviewed DON B (Director of Nursing) and asked if staff is expected to perform a thorough assessment, including heart and lung sounds, when a resident has a change in condition. DON B stated yes. Surveyor asked if staff is expected to document this assessment on the SBAR or progress note. DON B stated yes.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility did not ensure residents (R) received treatment and care in accordance with professional standards of practice for diabetic foot care for 2 of 2 residents (R26 and R48) and 1 supplemental resident (R53) reviewed for diabetic foot care. The facility did not provide diabetic foot checks to R26, R48, and R53 daily in accordance with the current standards of practice. This is evidenced by: The facility policy, titled Skin Integrity - Foot Care, dated 2/14/23, states, in part: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot . Licensed nurses will conduct diabetic foot check, daily. The current standard of practice per the American Diabetes Association copyright 1995-2024, https://diabetes.org, includes, in part: .1. Check your feet daily for sores, cuts, cracks, blisters, or redness . Example 1 R26 admitted to the facility on [DATE] with diagnoses including type 2 diabetes. R26's Physician Orders, dated 10/10/24, include an order for foot check (diabetic) with a start date of 10/9/24. Contrary to professional standards of practice, R26's Treatment Administration Record for October 2024 indicates diabetic foot check were not being completed prior to 10/9/24. Example 2 R48 admitted to the facility on [DATE] with diagnoses including type 2 diabetes. R48's Physician Orders, dated 10/10/24, include an order for foot assessment every M, W, F (Monday, Wednesday, Friday) (if patient allows) at bedtime. It is important to note, R48's order is not daily. The facility was not completing daily diabetic foot checks per standards of practice. Example 3 R53 admitted to the facility on [DATE] with diagnoses including type 2 diabetes. R53's Physician Orders, dated 10/10/24, does not include an order for daily diabetic foot checks. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53's Treatment Administration Record for October 2024 does not indicate a daily diabetic foot check. On 10/9/24 at 2:54 PM, Surveyor interviewed RN R (Registered Nurse). RN R indicated every diabetic should have a diabetic foot check in their physician orders so it will appear on the Treatment Administration Record. RN R indicated the nurses complete diabetic foot checks on residents when it appears on the Treatment Administration Record. It is important to note, if there is not an order in the resident's physician orders, the treatment will not show up on the Treatment Administration Record. On 10/9/24 at 3:48 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated all diabetics should have diabetic foot checks completed daily.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49436 Based on observation, interview, and record review, the facility did not ensure each resident (R) received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (R219) reviewed for smoking, 2 of 2 residents (R17 and R13) reviewed for wandering and elopement potential, 1 of 1 medication carts left unattended with the potential to affect all residents on this hall. R17 is at risk for elopement and did not have a code alert bracelet on, contrary to physician's order and R17's care plan. LPN DD (Licensed Practical Nurse) was checking for a code alert bracelet on R17. LPN DD thought the code alert bracelet was the plastic bracelet that stated if a resident was a DNR (Do Not Resuscitate) or Full code. LPN DD did not know the code alert bracelet was for elopement risk residents. R13 is at risk for elopement and did not have a code alert bracelet on, contrary to physician's order and R13s care plan R219 is a smoker and is care planned for both supervision with smoking and unsupervised with smoking. A medication cart was left unlocked and unattended. This is evidenced by: The facility policy titled Elopements and Wandering Residents dated 2/8/23 includes: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . The facility is equipped with door locks/alarms to help avoid elopements .The facility shall establish and utilize a systematic approach to monitoring and managing resident at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary .Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team .Interventions to increase staff awareness of the resident's risk, modify the resident's behavior or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff .Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. The effectiveness of interventions will be evaluated, and changes will be made as needed. Definitions: A code alert bracelet is a transmitter that will trigger an alarmed door to signal when a resident wearing the transmitter gets close to the door or goes through the door. Example 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17 admitted to the facility on [DATE] with diagnoses that include post-traumatic stress disorder, dissociative identity disorder, dementia, panic disorder, psychotic disorder with delusions and auditory hallucinations. R17's Minimum Data Set (MDS) annual assessment dated [DATE] has a Brief Interview of Mental Status (BIMS) score of 9 indicating R17 has moderate cognitive impairment. R17's Elopement Risk Review, dated 7/9/24, states in part: The resident is an elopement risk. R17's Physician Orders dated 10/10/24 include Check placement of code alert each shift and check function every night shift start date 1/1/24. R17's comprehensive care plan states, in part: The resident is an elopement risk/wanderer r/t (Related To) Resident wanders aimlessly, makes comments about wanting to leave with husband-looks for him by doors . Resident is able to remove wanderguard (code alert bracelet), to be placed on wc (Wheelchair) and attempt to keep out of sight. Frequent checks to ensure placement (date initiated 10/1/24). On 10/7/24 at 9:36 AM Surveyor observed R17 in her room, lying in bed. R17 did not have a code alert bracelet on her body nor in her wheelchair. Surveyor notified LPN HH (Licensed Practical Nurse). LPN HH looked for the code alert on R17 and in R17's wheelchair. LPN HH did not find the code alert bracelet. On 10/7/24 at 3:54 PM, Surveyor went to R17's room to ensure a code alert was in place for R17. R17 was not in her room. Surveyor went to the lobby to check the resident sign out book to see if R17 left the facility with her husband. CS EE (Central Supply staff) was sitting behind the receptionist desk. Surveyor spoke to CS EE. CS EE stated R17 left with her husband and was signed out in the resident sign out book. Surveyor observed the front door and reception area. Surveyor observed a binder at the receptionist desk for elopement risk residents. The binder contains two residents' information for being at risk for elopement, R17 and R13. The code alert access box is on the right side of the door frame. The receptionist desk is on the left side of the door. Behind the receptionist desk, there is a button which unlocks the front door. CS EE indicated he had pushed the button behind the receptionist desk to open the door to allow R17 to leave with her husband. Surveyor asked CS EE if the code alert had alarmed. CS EE indicated the code alert did not alarm. CS EE indicated he was not sure but since the alarm did not sound, he thought when the button is pushed from the receptionist side, it prevents the door from alarming when a resident with a code alert leaves. On 10/8/24 at 7:54 AM, Surveyor observed AC GG (Admissions Coordinator) at the receptionist desk. Surveyor interviewed AC GG. AC GG indicated when the button behind the receptionist desk is pushed for the door, the code alert will still alarm. She stated a staff member must enter the access code into the code alert box to allow a resident with a code alert bracelet to go through the door. On 10/8/24 at 8:00 AM, Surveyor observed R17 in bed. A code alert was not on R17 nor in the wheelchair. Surveyor approached RN W (Registered Nurse) about R17's code alert. RN W was unable to locate R17's code alert. On 10/8/24 at 9:33 AM, Surveyor spoke to LPN HH who had worked the previous day shift. LPN HH indicated she left early and did not replace R17's code alert bracelet on 10/7/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/24 at 2:40 PM Surveyor interviewed LPN II. LPN II worked PM shift on 10/7/24. She indicated R17 returned from the outing with her husband around 8:30 PM. LPN II indicated when R17 came back to the facility, LPN II checked her vitals and gave R17 her medications. LPN II stated she did sign out on the Treatment Administration Record that she checked the placement of the code alert bracelet and admits she did not assess fully as to weather R17 had the code alert bracelet on. LPN II indicated the code alert bracelet should be on if a resident has an order for it. On 10/8/24 at 2:58 PM, Surveyor observed LPN E bring a code alert bracelet to R17's room to place in R17's wheelchair. Surveyor interviewed LPN E. LPN E stated on 10/7/24, LPN HH should have placed a new code alert on R17 when LPN HH was aware of the missing code alert. On 10/8/24 at 3:05 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated R17 frequently removes her code alert bracelet. DON B indicated she expected staff to replace a resident's code alert bracelet if there is an order and they do not have a code alert bracelet on. She indicated if a staff member does not know where to locate one, she would expect the staff to ask for help. DON B indicated she would have expected LPN II to look for the code alert bracelet and if LPN II could not find it on R17 or in R17's wheelchair to place a new code alert bracelet. It is important to note, 3 nurses were aware R17's code alert was missing and did not place a new code alert bracelet on R17. On 10/8/24 at 2:54 PM, Surveyor interviewed LPN DD about the code alert bracelet for R17. LPN DD opened R17's Physician Orders on his computer. LPN DD scrolled through the Physician Orders down to the bottom of the page and then started to go back through the Physician Orders. LPN DD was unable to locate the order. Surveyor pointed out the physician order Check placement of code alert each shift. LPN DD indicated he thought the check placement of code alert each shift was in regard to the resident's advanced directive status of being a DNR or full code. He stated he did not know it was for the elopement alarm system. Example 2 R13 admitted to the facility on [DATE] with diagnoses including anxiety disorder and dementia. R13's Minimum Data Set (MDS) quarterly assessment dated [DATE] has a Brief Interview of Mental Status (BIMS) score of 11 indicating R13 has moderate cognitive impairment. R13's Elopement Risk Review, dated 7/9/24, indicates the resident is an elopement risk. R13's Physician Orders, dated 10/10/24, include Code alert bracelet visualize placement of code alert device and test for proper functioning every night shift start date 1/1/24 and check placement of code alert each shift start date 1/1/24. R13's comprehensive care plan states, in part: The Resident is an elopement risk as exhibited by: Expresses desire to leave facility to purchase cigarettes on 9/7/23. Resident has impaired safety awareness. Date initiated 9/6/23. Wander alert: device # Right wrist. Date initiated 9/6/23. R13 went to a hospital on 10/7/24 and readmitted to the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Explanation and Compliance Guidelines: . 6. Residents who smoke will be further evaluated using the Smoking Evaluation to determine supervision need and intervention . 10. All safe smoking measures will be documented on the care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on the care plan . R219 admitted to the facility on [DATE], and has diagnoses that include osteomyelitis (inflammation of bone caused by infection), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down). R219's Admission Minimum Data Set (MDS) Assessment, dated 10/8/24, shows that R219 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R219 is cognitively intact. Section GG shows R219 is independent with dressing, personal hygiene, toileting, eating and ambulation. R219's Care Plan, dated 10/2/24, states, in part: . Focus: The resident is a smoker. Date Initiated: 10/2/24. Goal: The resident will not suffer injury from unsafe smoking practice through the review date. Date Initiated: 10/2/24. Target Date: 10/15/24. Interventions: -Instruct resident about the facility policy on smoking: locations, times, safety concerns. Date Initiated: 10/2/24. -The resident can smoke UNSUPERVISED. Date Initiated: 10/2/24. -The resident requires SUPERVISION while smoking. Date Initiated: 10/2/24 . R219's CNA (Certified Nursing Assistant) Kardex, dated 10/10/24, states, in part: . SAFETY: . -The resident can smoke UNSUPERVISED. -The resident requires SUPERVISION while smoking . R219's Smoking Assessment, dated 10/2/24, states, in part: . 1. Smoking Care Plan Focus: The resident is a smoker. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: The resident will not suffer injury from unsafe smoking practices through the review date. Intervention: Instruct the resident about the facility policy on smoking: locations, times, safety concerns. Intervention: The resident can smoke UNSUPERVISED. Intervention: The resident requires SUPERVISION while smoking. Intervention: The resident requires a smoking apron while smoking. Intervention: The resident's smoking supplies are stored . On 10/10/24, at 10:24 AM, Surveyor observed CNA Kardex in R219's closet that indicated R219 can smoke unsupervised and requires supervision with smoking. Surveyor observed R219 go out to designated smoking area unsupervised. R219 had cigarettes and lighter in room. R219 had code to get out to smoking area. R219 indicated to Surveyor he can come out and smoke anytime he wants. R219 indicated he brings himself out, but staff brings other residents out. R219 lit cigarette and smoked with no safety concerns. R219 did not have a smoking apron on. R219 indicated he keeps his smoking supplies in his room. On 10/10/24, at 1:28PM, LPN BB (Licensed Practical Nurse) and asked if R219 requires supervision with smoking and LPN BB indicated not sure. Surveyor asked LPN BB where his smoking supplies are kept, and LPN BB indicated she did not know. Surveyor asked LPN BB how staff would know, and LPN BB indicated staff follow the CNA Kardex and care plan. On 10/10/24, at 5:34 PM, Surveyor interviewed DON B (Director of Nursing) and asked if residents that smoke require a smoking evaluation to determine safety and supervision and DON B indicated yes. DON B indicated smoking assessments should be completed on admission and the results are carried over to the care plan. Surveyor asked if it was determined for R219 to be supervised or unsupervised with smoking and DON B indicated she did not realize R219 smoked. Surveyor asked how staff would know if a resident required supervision or not and DON B indicated by the care plan. Surveyor asked how staff would know if R219 was supervised or unsupervised with smoking if the care plan and Kardex indicate both ways and DON B indicated they wouldn't.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not ensure a resident with a catheter receives appropriate treatment and services to prevent urinary tract infections for 1 of 5 residents (R29) reviewed for catheter care. Staff did not perform appropriate hand hygiene while providing catheter care. Hand hygiene was not performed in between dirty to clean. Staff placed dirty washcloths on bedside table. Staff did not disinfect bedside table after use. Evidenced by: The facility policy, entitled Hand Hygiene, dated 12/23/22, states, in part: . Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . Hand Hygiene Table: . -After handling contaminated objects- either soap and water or alcohol-based hand rub . -Before and after handling clean or soiled dressings, linens, etc. either soap and water or alcohol-based hand rub . -Before performing resident care procedures . either soap and water or alcohol-based hand rub . -After handling items potentially contaminated with blood, body fluids, secretions, or excretions . either soap and water or alcohol-based hand rub . - When, during resident care, moving from a contaminated body site to a clean body site . either soap and water or alcohol-based hand rub . Example 1 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R29 was admitted to the facility on [DATE] and has diagnoses that include Malignant Neoplasm of Brain (a fast growing, cancerous tumor that can spread to brain and spine), hydronephrosis with renal and ureteral calculous obstruction (a condition where a kidney swells due to a blockage in the ureter that prevents urine from draining), urinary tract infection, and cystitis (inflammation of the bladder that is usually caused by a bacterial infection). R29's Significant Change Minimum Data Set (MDS) Assessment, dated 9/27/24, shows that R29 has a Brief Interview of Mental Status (BIMS) score of 15, indicating R29 is cognitively intact. Section GG shows that R29 requires substantial/maximal assistance with toileting and showering/bathing. Section H shows R29 has an indwelling urinary catheter. R29's Physician's Orders dated 10/9/24 state, in part: . Perform Catheter Care every shift and PRN (as needed) for cath care. Order Date: 8/15/24. Start Date: 8/15/24. On 10/8/24, at 8:09AM, Surveyor observed CNA H (Certified Nursing Assistant) perform catheter care on R29. CNA H took a clean washcloth and placed in a basin, wrung it out and applied soap to washcloth. CNA H then cleansed meatus with clean soapy wash cloth, and then placed used wash cloth on bedside table with no barrier underneath of it. CNA H then took a clean dry washcloth and placed it in second basin, wrung it out and rinsed meatus. No hand hygiene performed in between washing and rinsing. CNA H then placed rinse used wash cloth on the bedside table with no barrier underneath it. CNA H at end of cares gathered supplies and did not disinfect bedside table and placed R29's remote back on table. On 10/8/24, at 8:17AM, Surveyor interviewed CNA H and asked when hand hygiene should be performed during catheter cares and CNA H indicated before putting on gloves, and after removing gloves. Surveyor asked CNA H if hand hygiene should be performed in between washing and rinsing and CNA H indicated yes, she should have. Surveyor asked CNA H if the used wet washcloths should have been placed directly on bedside table without a barrier and CNA H indicated no. Surveyor asked if the bedside table should have been disinfected after the dirty washcloths were on the table and CNA H indicated yes. On 10/8/24, at 10:09 AM, Surveyor interviewed DON B (Director of Nursing) and asked if she would expect hand hygiene to be performed in between washing and rinsing, going from dirty to clean and DON B indicated yes. Surveyor asked if it is acceptable to place used washcloths on bedside table without a barrier under them and DON B indicated no. Surveyor asked if DON B would expect the bedside table to be disinfected after the used wet washcloths had been removed from bedside table and DON B indicated yes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on observation, interview, and record review the facility did not ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice for 1 of 1 residents (R36) reviewed for oxygen. R36 did not have her oxygen tubing changed on a weekly basis. Evidenced by: Facility policy entitled, Oxygen Administration, dated 11/16/24, states, in part; Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.5.b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. R36 admitted to the facility on [DATE] with diagnoses that include, in part: metabolic encephalopathy and acute and chronic respiratory failure with hypercapnia. R36's Minimum Data Set (MDS), dated [DATE], indicates R36's Brief Interview of Mental Status (BIMS) is a 15, indicating that R36 is cognitively intact. R36's Physician Orders indicate: Oxygen at 4-6 L every shift. Titrate O2 (oxygen) to keep oxygenation above 90% every shift related to acute respiratory failure with hypoxia. Important to note: there was no order to change the oxygen tubing weekly. On 10/7/24 at 2:12 PM, Surveyor interviewed R36 during initial screen and R36 stated it had been a couple months since her oxygen tubing had been changed. Surveyor observed oxygen tubing which was undated. On 10/10/24 at 11:55 AM, Surveyor interviewed LPN Q (Licensed Practical Nurse) and asked if oxygen tubing needs to be changed routinely. LPN Q stated the tubing is changed as needed. LPN Q indicated he would change the tubing if it was stiff. Surveyor asked if the change of tubing is documented. LPN Q stated no. On 10/10/24 at 3:02 PM, Surveyor interviewed DON B (Director of Nursing) and asked if staff is expected to change oxygen tubing routinely. DON B stated it is done weekly. Surveyor asked if staff is expected to document the change in tubing. DON B stated yes, there is an order and it is signed out on the medication administration record. Surveyor asked if this is not documented has it been done? DON B stated unsure. Surveyor asked it the tubing is not dated, would staff know when it was last changed. DON B stated no.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not ensure that a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD), receives appropriate treatment and services to correct the assessed problem or attain the highest practical mental and psychosocial well-being for 4 of 4 residents (R) (R48, R11, R21, R17) reviewed out of 21 sampled residents. R11 reported having experienced trauma as a child to the facility in a trauma informed care assessment. R11's Comprehensive Care Plan does not include known triggers, personalized interventions, and/or goals related to her past history of trauma. R11 voiced concerns to Surveyor of having episodes of crying due to the trauma she faced as a child. R48's trauma informed care assessment indicated she has a history of trauma and her comprehensive care plan did not include known triggers, goals, or interventions related to her history of past trauma. R17 has a diagnosis of post-traumatic stress disorder indicating she has a history of trauma and her comprehensive care plan does not include known triggers, resident specific goals, or personalized interventions related to her history of past trauma. R21's trauma informed care assessment indicated he had a history of trauma and his comprehensive care plan was not individualized with triggers and person-centered interventions related to his history of past trauma. Evidenced by: (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Trauma Informed Care, dated 3/7/23, includes, in part: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally- competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may unclude: Natural and human caused disasters, accidents, war, physical, sexual, mental, and/or emotional abuse, rape, violent crime, history of imprisonment, history of homelessness, traumatic life events (death of a loved one, personal illness, etc.). Trauma Informed Care is an approach delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization . The facility will use a multi-pronged approach to identify a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessments tools such as Resident Assessment Instrument, Admission Assessment, the history and physical, the social assessment, and others . The facility will identify triggers which may re-traumatize resident with a history of trauma. Trigger-specific interventions will identify ways to decrease the effect of the trigger on the resident, and will be added to the residents care plan. While most triggers are highly individualized, somem common triggers may include, but are not limited to: experiencing a lack of privacy or confinement in crowded or small space, exposure to loud noises, or bright/flashing lights, certain sights, such as objects that are associated with their abuser, sounds/smells/ and physical touch . Trauma specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery . Example 1 R11 admitted to the facility on [DATE]. Her diagnoses include post-traumatic stress disorder. R11 most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/12/24 indicates R11's cognition is intact with a BIMS (Brief Interview For Mental Status) score of 15 out of 15. On 10/7/24 at 10:10 AM during initial screening R11 indicated she has a history of trauma that is hard to talk about. On 10/9/24 at 12:40 PM during an interview R11 stated, My triggers are male caregivers. I don't want them giving me showers or anything. I can't have them touching me. They can pass my pills. There are 3 or so that work here. I would like staff to tell me what they will do before they start touching me or my things. Sometimes I cry and they don't understand why. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's social services evaluation, dated 9/6/24, includes: reason for evaluation: admission . Trauma Informed Care: Natural disaster: happened to me . Experienced physical assault: happened to me, witnessed it . Unwanted sexual experiences: happened to me . Life threatening Illness or Injury: happened to me . Severe human suffering: happened to me . Sudden or unexpected death of someone close to you: happened to me . Violent or sudden death: happened to me . The resident was nearly struck by a tornado in 1980, found this terrifying . The resident has been molested by their father from the age of 7 to [AGE] years old. The resident attempted to tell their mother at 7 years old but was slapped for using foul language. The resident also witnessed the father molesting other children in their bed at night. The resident's father was an alcoholic and also physically abusive towards the mother. The resident attempted to intervene in the fights but feels guilty for not stopping them from taking place. The resident recounts one drunken eventing, the father beat the mother by kicking her in the stomach and threw her down the stairs while pregnant. The mother was rushed to the hospital but lost the infant immediately. The resident also walked into a friend's mother who was actively passing away. The resident found this to be a difficult experience. R11's Comprehensive Care Plan, initiated 9/6/24, includes: Resident has experienced trauma related to sexual abuse. Goal: The resident's past traumas will not negatively affect their day to day living . Interventions: Build trust with resident by using a calm voice and following up on what is being said. Empower by using positive statements. Encourage resident that this is a safe place. (It is important to note R11's comprehensive care plan does not include indications of what PTSD symptoms look like for R11, what symptoms to monitor R11 for, what triggers R11 has that re-traumatize her or make her think of her abuser, and R11's Care Plan does not contain individualized/personalized interventions staff can use for R11's PTSD if she were to experience a PTSD event.) On 10/09/24 at 12:54 PM CNA V (Certified Nursing Assistant) stated, I don't know if she has past traumatic experiences. I don't know of anything that triggers her. CNA V indicated there are male caregivers who work on R11's unit. On 10/09/24 at 12:56 PM RN F (Registered Nurse) stated, I don't know if she has past trauma or triggers to it. RN F named three male CNAs who work on this unit at times. On 10/09/24 at 1:00 PM SW D (Social Worker) indicated R11 reported to her that she has a history of trauma and does not generally share this. SW D indicated the assessment she uses does not ask for triggers and the interventions are not individualized related to the trauma experienced. SW D also indicated R11's Comprehensive Care Plan should reflect her assessment, should contain how R11's PTSD manifests, should contain what staff should monitor for, and have personalized interventions for staff to use if/when R11 was to experience a PTSD event. On 10/09/24 at 1:32 PM DON B (Director of Nursing) and Surveyor reviewed R11's social services evaluation and her care plan, dated 9/6/24. DON B stated, There should be a whole care plan just on her trauma. We definitely need to be addressing this. Thank you for bringing this concern forward. On 10/09/24 at 1:54 PM NHA A (Nursing Home Administrator) indicated R11's care plan needs to contain how R11's PTSD manifests, interventions, goals, monitoring, and triggers personalized to her diagnosis of PTSD and her reported history of trauma. Example 2 (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R48 admitted to the facility on [DATE]. R48's social services assessment, dated 8/5/24, includes: Traumatic event: . There was talk about the grandfather being abusive and may have been an alcoholic for some time. Aunt did mention discussion of something occurring. Old letters were found, that was written from the resident to her parents discussing a sexual assault that took place in the resident's early teen years. The resident's son passed away unexpectedly in 2015. The resident was living with a man, was saying goodbye, and fell down the stairs and broke her neck . R48's comprehensive care plan, initiated 7/20/23, includes: 8/12/24 resident experienced trauma related to (blank) . Goal: The resident's past traumas will not negatively affect their day to day living. Interventions: Build trust with resident by using a calm voice and following up on what is being said. Empower by using positive statements. Encourage resident that this is a safe place. It is important to note R48's care plan is not personalized. It does not state what sort of trauma R48 experienced, how it manifests, triggers, what staff should monitor, or personalized interventions related to R48's trauma and what they can do if it manifests. On 10/09/24 at 12:54 PM CNA V indicated she was unsure if R48 has a history of trauma, what triggers it, or what to do if R48's trauma is triggered. On 10/09/24 at 12:56 PM RN F indicated she works with R48 rarely and does not know if she has a history of trauma. RN F indicated it should be in the care plan if she does. On 10/09/24 at 1:00 PM SW D (Social Worker) indicated R48's family reported to her that she has a history of trauma. SW D indicated the assessment she uses does not ask for triggers and the interventions that are in R48's care plan are not individualized related to the trauma she experienced. SW D also indicated R11's Comprehensive Care Plan should reflect her assessment, should contain how R11's PTSD manifests, should contain what staff should monitor for, and have personalized interventions for staff to use if/when R11 was to experience a PTSD event. On 10/09/24 at 1:32 PM DON B (Director of Nursing) and Surveyor reviewed R48's social services evaluation and her care plan. DON B stated residents who report a history of trauma or have PTSD (Post-traumatic stress disorder) need to have a completed care plan including triggers, how the trauma/PTSD manifests, what staff should monitor for, and interventions to prevent re-traumatization and interventions staff can use if the resident's trauma/PTSD manifests. On 10/09/24 at 1:54 PM NHA A (Nursing Home Administrator) indicated residents who report a history of trauma or their family reports a history of trauma need a care plan that includes how the trauma manifests and how the trauma can be triggered, interventions on what to do if triggered, and what to monitor for. 49436 Example 3 (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R17 admitted to the facility on [DATE] with diagnoses including alcohol abuse in remission, depression, post-traumatic stress disorder (PTSD), dissociative identity disorder, dementia, panic disorder, psychotic disorder with delusions due to known physiological condition, and auditory hallucinations. R17's Minimum Data Set (MDS) annual assessment dated [DATE] has a Brief Interview of Mental Status (BIMS) score of 9 indicating R17 has moderate cognitive impairment. R17's comprehensive care plan states, in part: Resident has experienced trauma r/t (Related To) sexual assault. Goal: The resident's past traumas will not negatively affect their day to day living. Interventions: Build trust with resident by using a calm voice and following up on what is being said. Empower by using positive statements. Encourage resident that this is a safe place. The resident has a behavior problem r/t refusal of care PTSD and panic disorder. Goal: The resident will have few episodes of (SPCIFFY: behavior) (Specify: daily/weekly) by review date. Interventions: If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from the situation and take to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situation. Document behavior and potential causes. Praise any indication of the resident's progress/improvement in behavior. R17 was seen by geriatric psychiatry on 8/9/23. The geriatric psychiatry note states, in part: .R17 would largely benefit from nonpharmacologic intervention below .Aromatherapy (lavender/[NAME] balm essential oil or cream) for increased agitation/anxiety/irritability .Move patient to dayroom/near nurses station for increased therapeutic interpersonal contact .Loneliness/boredom appears to [sic] largest triggers for behaviors and distress .Stressors: .feeling lonely, does not have anyone to talk to . R17 was seen by a Doctor of Psychology (PsyD) on 4/11/24. The PsyD's note states, in part: .R17 was referred for psychological evaluation to address severe anxiety .Panic disorder likely related or triggered to COPD and respiratory issues needing someone to talk to immediately . Treatment recommendations: .Encouraging staff to avoid personalizing negative or degrading statements . Have R17 name 3 things she can see, 3 things she can touch, and 3 things she can hear can be helpful when R17 is having a panic attack or is in high emotional distress . R17 likely needs the presence of someone she has some familiarity with or trust with when having a panic attack or high emotional distress . Goals .Reduction in overall frequency, intensity and duration of the anxiety/panic episodes such that daily functioning improves Decreased frequency, intensity, and duration of suicidal ideation and increase ability to maintain safety when experiencing suicidal thoughts . It is important to note, R17's comprehensive care plan does not contain interventions specific to R17's traumas and does not contain triggers. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 11:38 AM, Surveyor interviewed SW D (Social Worker). SW D indicated she does not read the notes provided by mental health services. SW D indicated she does check in with the psychologist and discusses potential interventions. Surveyor asked SW D if recommendations from mental health services should be included in the resident's care plan and SW D indicated the resident's care plan should reflect those recommendations. 50228 Example 4 R21 admitted to the facility on [DATE] with diagnoses that include, in part: Multiple sclerosis, type 2 diabetes mellitus with diabetic neuropathy, and anxiety disorder. R21's Trauma Informed Care Evaluation, dated 5/8/23, indicates that R21 was in a flood (no date of occurrence). R21's care plan states, in part; Focus: Resident has experienced trauma r/t (related to) Date initiated: 3/1/24. Goal: The resident's past traumas will not negatively affect their day to day living. Important to note: the care plan has no indication of the type of trauma that the resident experienced, triggers for the resident, nor individualized, person-centered interventions.

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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 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** 38725 Based on interview and record review, the facility did not ensure that it provided routine drugs to its residents for 3 of 20 residents (R18, R220 and R17) reviewed for pharmacy services. R18 reported that his AM medications were given late on 10/5/24-10/6/24. R220 indicated he did not receive his Mounjaro September 4th and September 11th During noon medication administration, RN W (Registered Nurse), was going to administer AM and noon medications at the same time to R17. This is evidenced by: The facility's Policy and Procedure entitled Medication Administration dated 6/7/24 documents the following, in part: .10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation .b. Administer within 60 minutes prior to or after schedule time unless otherwise ordered by physician . Example 1 R18 is a long-term resident of the facility. R18's most recent MDS (Minimum Data Set) dated 9/3/24, documents a score of 13 on R18's BIMS (Brief Interview of Mental Status), which indicates that he is cognitively intact. On 10/7/24 at 11:06 AM, Surveyor interviewed R18. Surveyor asked R18 if he had any concerns about the facility or his care that he would like to share, R18 stated he had a male agency nurse this past weekend that was awful, didn't get AM medications until 2 PM. R18's Physician Orders document the following: Aspirin 81 Oral Tablet Chewable (Aspirin) Give 81 mg (milligrams) by mouth one time a day for Cardiovascular Risk Reduction -Scheduled for 0700 (7:00 AM) buPROPion HCl ER (extended release) (XL) (extra-long) Oral Tablet Extended Release 24 Hour (Bupropion HCl) Hydrochloride Give 150 mg by mouth one time a day for Mood -Scheduled for 0700 Cyanocobalamin Oral Tablet 1000 MCG (microgram) (Cyanocobalamin) Give 1 tablet by mouth one time a day for Vitamin B12 Deficiency (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Scheduled for 0700 Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 sprays in both nostrils one time a day for Allergic Rhinitis and Congestion -Scheduled for 0700 Folic Acid Oral Tablet 1 MG (Folic Acid) Give 1 mg by mouth one time a day for Folate Deficiency Anemia -Scheduled for 0700 Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (milliliter) (Insulin Glargine) Inject 16 unit subcutaneously one time a day for DM II -Scheduled for 0700 Multivitamin w/Minerals Give 1 tablet by mouth one time a day for Supplement -Scheduled for 0700 Omeprazole Oral Capsule Delayed Release 20 MG (Omeprazole) Give 1 capsule by mouth one time a day for GERD -Scheduled for 0700 Potassium Chloride ER Oral Tablet Extended Release (Potassium Chloride) Give 10 mEq (milliequivalents) by mouth one time a day for open capsule and sprinkle on food -Scheduled for 0700 Sertraline HCl Oral Capsule 200 MG (Sertraline HCl) Give 200 mg by mouth one time a day for Depression/Anxiety -Scheduled for 0700 Vitamin D Oral Tablet 50 MCG (2000 UT) (Cholecalciferol) Give 1 tablet by mouth one time a day for Supplement -Scheduled for 0700 Zinc Sulfate Oral Tablet 220 (Zn) MG (Zinc Sulfate) Give 50 mg by mouth one time a day for Supplement -Scheduled for 0700 Furosemide Oral Tablet 20 MG (Furosemide) Give 20 mg by mouth two times a day for diuretic (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Scheduled for 0800 (8:00 AM) Visine Advanced Relief Ophthalmic Solution 0.05-0.1-1-1% (Tetrahydrozoline-Dextran Polyethylene Glycol-Povidone) Instill 2 drop in both eyes two times a day for Apply 2 drops in both eyes BID (twice a day) -Scheduled for 0700 Simethicone Oral Tablet Chewable 125 MG (Simethicone) Give 1 tablet by mouth three times a day for flatulence to be given after meals; Encourage to CHEW tablet for best result -Scheduled for 0700 and 1130 R18's MAR (Medication Administration Record) documents that all the above medications were signed out on 10/5/24 and 10/6/24 by the same initials. These initials were verified with the Agency staff list, confirming the nurse was an Agency staff nurse. R18's Medication Admin Audit Report documents the following administration times: Aspirin 81 Oral Tablet Chewable (Aspirin) Give 81 mg (milligrams) by mouth one time a day for Cardiovascular Risk Reduction -Administered 10/5/24 at 1356 (1:36 PM) buPROPion HCl ER (extended release) (XL) (extra-long) Oral Tablet Extended Release 24 Hour (Bupropion HCl) Hydrochloride Give 150 mg by mouth one time a day for Mood -Administered 10/5/24 at 1357 (1:37 PM) Cyanocobalamin Oral Tablet 1000 MCG (microgram) (Cyanocobalamin) Give 1 tablet by mouth one time a day for Vitamin B12 Deficiency -Administered 10/5/24 at 1357 (1:37 PM) Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 sprays in both nostrils one time a day for Allergic Rhinitis and Congestion -Administered 10/5/24 at 1357 (1:37 PM) Folic Acid Oral Tablet 1 MG (Folic Acid) Give 1 mg by mouth one time a day for Folate Deficiency Anemia -Administered 10/5/24 at 1356 (1:36 PM) Lantus Solostar Subcutaneous Solution Pen-injector 100 UNIT/ML (milliliter) (Insulin Glargine) Inject 16 unit subcutaneously one time a day for DM II -Administered 10/5/24 at 1402 (2:02 PM) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multivitamin w/Minerals Give 1 tablet by mouth one time a day for Supplement -Administered 10/5/24 at 1356 (1:36 PM) Omeprazole Oral Capsule Delayed Release 20 MG (Omeprazole) Give 1 capsule by mouth one time a day for GERD -Administered 10/5/24 at 1419 (2:19 PM) Potassium Chloride ER Oral Tablet Extended Release (Potassium Chloride) Give 10 mEq (milliequivalents) by mouth one time a day for open capsule and sprinkle on food -Administered 10/5/24 at 1355 (1:55 PM) Sertraline HCl Oral Capsule 200 MG (Sertraline HCl) Give 200 mg by mouth one time a day for Depression/Anxiety -Administered 10/5/24 at 1356 (1:36 PM) Vitamin D Oral Tablet 50 MCG (2000 UT) (Cholecalciferol) Give 1 tablet by mouth one time a day for Supplement -Administered 10/5/24 at 1419 (2:19 PM) Zinc Sulfate Oral Tablet 220 (Zn) MG (Zinc Sulfate) Give 50 mg by mouth one time a day for Supplement -Administered 10/5/24 at 1356 (1:38 PM) Furosemide Oral Tablet 20 MG (Furosemide) Give 20 mg by mouth two times a day for diuretic -Administered 10/5/24 at 1353 (1:53 PM) Visine Advanced Relief Ophthalmic Solution 0.05-0.1-1-1% (Tetrahydrozoline-Dextran Polyethylene Glycol-Povidone) Instill 2 drop in both eyes two times a day for Apply 2 drops in both eyes BID -Administered 10/5/24 at 1419 (2:19 PM) Simethicone Oral Tablet Chewable 125 MG (Simethicone) Give 1 tablet by mouth three times a day for flatulence to be given after meals; Encourage to CHEW tablet for best result -Administered 10/5/24 at 1419 (2:19 PM) for the 0700 administration time -Administered 10/5/24 at 1419 (2:19 PM) for the 1100 administration time -Administered 10/6/24 at 1317 (1:17 PM) for the 1100 administration time (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 11:29 AM, Surveyor interviewed RN M (Registered Nurse). Surveyor asked RN M if medication is scheduled at 0700 when should they be administered, RN M said between 6-8 AM; if medication is scheduled at 0800 when should they be administered, RN M replied between 7-9 AM; if medication is scheduled at 1100 when should they be administered, RN M stated between 10 AM-12 PM; if medication is scheduled at 1130 when should they be administered, RN M said between 1030 AM-1230 PM. Surveyor asked RN M should the same medication be given back to back if late, RN M said no. When Surveyor asked RN M what should you do if this situation comes up, RN M explained to call Provider and follow their instructions and give only dose at that time, unless instructed otherwise. On 10/10/24 at 11:30AM, Surveyor interviewed LPN N (Licensed Practical Nurse). Surveyor asked LPN N if medication is scheduled at 0700 when should they be administered, LPN N said an hour before to an hour after; if medication is scheduled at 0800 when should they be administered, LPN N replied an hour before to an hour after; if medication is scheduled at 1100 when should they be administered, LPN N stated an hour before to an hour after; if medication is scheduled at 1130 when should they be administered, LPN N said an hour before to an hour after. Surveyor asked LPN N should the same medication be given back-to-back if late, LPN N stated no. Surveyor asked LPN N what should you do if this situation comes up, LPN N stated to call the Provider, describe the situation, and follow their instructions. On 10/9/24 at 3:48 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would you expect medications to be administered timely, DON B replied all meds should be given timely. Surveyor asked DON B what would you expect staff to do if the first dose of a medication wasn't administered and now the next dose is due, DON B explained they should not be given at the same time and they should call the Provider for further instructions. On 10/10/24 at 5:34 PM, Surveyor interviewed DON B. Surveyor asked DON B should AM (scheduled at 0700, 0800, 1100, 1130) medication be administered at 1400, DON B stated no. 41788 Example 2 R220 was 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 using it for energy), essential hypertension (high blood pressure, a condition in which the force of the blood against the artery walls is too high), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). R220's Quarterly Minimum Data Set Assessment, dated 10/5/24, shows that R220 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R220 is cognitively intact. Section GG shows R220 requires supervision or touch assistance with toileting and toileting transfer. It shows R220 requires partial to moderate assist with lower body dressing. R220's Care Plan, dated 7/14/21, states, in part: . Focus: Diabetes- At risk for complications R/T (related to) diagnosis of INSULIN DEPENDENT- Daily &/or Sliding Scale. Date Initiated: 7/14/21. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Will be free of serious complications R/T DX's (diagnoses) as MD (medical doctor) follows sx's (symptoms) and labs through next review Date. Date Initiated: 7/14/21. Revision on: 8/20/24. Target Date: 5/1/26 Interventions: -Medication/Treatments as ordered . Date Initiated: 7/14/21 . R220's Physician Orders, dated 10/9/24, states, in part: . Tirzepatide [Mounjaro] subcutaneous solution pen-injector 10mg(milligrams)/0.5 mL (milliliters). Inject 10 mg subcutaneously one time a day every Wednesday for T2DM (Type 2 Diabetes Mellitus). Order Date: 6/11/24 Start Date: 6/12/24 . R220's MAR (Medication Administration Record) shows: Tirzepatide Subcutaneous Solution Pen-Injector 10mg/0.5mL (Tirzepatide). Inject 10mg subcutaneously one time a day every Wed. for T2DM. Start Date: 6/12/24 . On 9/4/24- it was not administered, refers reader to see nurse notes. On 9/11/24- it was not administered, refers reader to see nurse notes . R220's Progress Notes, dated 9/4/24, 8:59PM, states, in part: . Note Text: Tirzepatide Subcutaneous Solution Pen-Injector 10mg/0.5mL. Inject 10mg subcutaneously one time a day every Wed. for T2DM. Medication on order, Resident aware, MD notified . R220's Progress Note, dated 9/11/24, at 8:57PM, states, in part: . Note Text: In regard to Mounjaro medication: Medication is not on hand, called Pharmerica to ensure medication will be coming tonight . Will administer medication when it arrives . Of Note: No documentation Mounjaro was administered. On 10/9/24, at 12:27PM, Surveyor interviewed RN F (Registered Nurse) and asked what it means if an 8 is documented on MAR (Medication Administration Record). RN F indicated resident refused the medication. Surveyor asked if R220 ever refuses medications and RM F indicated no. When Surveyor asked RN F what it means if a 4 is documented on the MAR. RN F indicated the resident did not receive the medication and staff should look at progress notes for reason why the medication was not administered. Surveyor asked RN F if the physician should be updated if a medication was not administered or refused and RN F indicated yes. Surveyor asked RN F what the process is for a medication that is not available. RN F indicated if the medication is not in the med cart we go to contingency. If the med is not in contingency, we call the pharmacy, and the pharmacy will send the medication that day. Surveyor asked RN F if it is acceptable for a resident to not receive a medication due to unavailability in house and RN F indicated no. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24, at 1:15 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated she would expect nurses to follow physician orders; it is not acceptable for a resident to not receive a medication due to unavailable in house. 49436 Example 3 R17's Physician Orders include: Spiriva HandiHaler Inhalation capsule 19 mcg inhale one orally daily Tylenol 500 mg one tablet by mouth at 7:00 AM and 1:00 PM; Neurontin 600 mg one tablet at 7:00 am and Noon On 10/9/24 at 11:52 AM, Surveyor approached RN W (Registered Nurse) who was standing at her medication cart on the unit. Surveyor requested to watch the noon medication administration. RN W agreed. Surveyor explained the process of medication administration observation to RN W. RN W stated she had not started medication administration on the unit yet. At 12:23 PM, RN W started to prepare medications for R17. RN W removed the Spiriva HandiHaler from the box. RN W was inspecting the HandiHaler and looking at her computer. After a few minutes, RN W reached into the box and removed a packaged capsule. RN W opened the HandiHaler to the area where the capsule should be placed and continued inspecting the HandiHaler. RN W opened the area underneath where the capsule should be placed in the HandiHaler, applied gloves, opened the capsule and then poured the powder from the capsule into the base of the HandiHaler. RN W continued to look at the HandiHaler. RN W opened the internet browser on her computer and searched for a video on how to use the HandiHaler. After reviewing the video, RN W poured out the powder and cleaned the HandiHaler. RN W proceeded to correctly load the HandiHaler. RN W then proceeded with gathering R17's pills. RN W removed the bottle of Tylenol 500mg from the medication cart and poured out 2 pills and removed the medication card of Neurontin 600 mg and removed 2 pills. RN W stated since she had not given the AM doses yet, she was going to include these 2 AM doses with the Noon doses. RN W continued to proceed with preparing the rest of R17's medications. Surveyor stopped RN W prior to entering R17's room. Surveyor interviewed RN W about medication administration. RN W agreed the AM doses were not at the right time and by giving R17 the AM and noon doses together, she would not be following physician orders. RN W stated she did not know what to do about the AM doses of medication because they need to be given. RN W removed the AM doses from the prepared medications. At 12:50 PM, RN W offered R17 her medications. R17 refused all medications during this medication pass. It is important to note, RN W worked on this unit the day prior, 10/8/24 for the day shift, and had signed she had given all medications to R17, including the Spiriva HandiHaler.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility failed to ensure the medication regimen was free from unnecessary medications for 3 of 5 residents (R13, R17, and R36) reviewed for unnecessary medications. R13 receives an antipsychotic without an appropriate diagnosis. R17 receives an antipsychotic without an appropriate diagnosis R36 receives Trazodone and Duloxetine. The care plan does not list behavior triggers or interventions specific to the resident. This is evidenced by: The facility policy titled Use of Psychotropic Medication dated 4/16/24, states in part: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnoses and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medications(s) . A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . The indications for use of any psychotropic drug will be documented in the medical record . For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosis by the physician .Non-pharmacological interventions that have been attempted and the target symptoms for monitoring call be included in the documentation .Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs. The resident's symptoms and therapeutic goals shall be clearly and specifically identified and documented. Example 1 R13 admitted to the facility on [DATE] with diagnoses including major depressive disorder, generalized anxiety disorder and dementia. R13's Physician Orders dated 10/10/24 include Seroquel (an antipsychotic medication) 25 MG by mouth one time a day for Mood. It is important to note Mood is not an acceptable indication for antipsychotic use. On 10/10/24 at 2:49 PM, Surveyor interviewed DON B (Director of Nursing). DON B agreed Mood is not an appropriate indication of use for an antipsychotic medication. Example 2 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17 admitted to the facility on [DATE] with diagnoses including depression, post-traumatic stress disorder, dissociative identity disorder, dementia, panic disorder, psychotic disorder with delusions, and auditory hallucinations. R17's Physician Orders dated 10/10/24 include Quetiapine Fumarate (an antipsychotic medication) 25 mg by mouth two times a day for depression. It is important to note, depression is not an acceptable indication for antipsychotic use. On 10/10/24 at 2:49 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated depression is not an appropriate indication of use for an antipsychotic medication. 50228 Example 3 R36 admitted to the facility on [DATE] with diagnoses that include, in part: schizoaffective disorder-depressive type, depression, and anxiety disorder. R36's Minimum Data Set (MDS), dated [DATE], indicates R36's Brief Interview of Mental Status (BIMS) is a 15, indicating that R36 is cognitively intact. R36's physician's orders include: *Duloxetine HCL Oral Capsule Delayed Release Sprinkle 30 mg Give 1 capsule by mouth at bedtime related to anxiety disorder. Start date 9/11/24 *Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 mg Give 60 mg by mouth one time a day for fibromyalgia/neuropathic pain related to anxiety disorder. Start date 9/11/24 *Trazodone HCl Oral tablet Give 25 mg by mouth every 24 hours as needed for sleep. Start date 9/9/24 R36's care plan states, in part: Focus-The resident uses antidepressant medication Trazodone Duloxetine r/t (related to). Date initiated 8/23/24. Goal-The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions-Administer trazodone and duloxetine medications as ordered by physician. Monitor/document side effects and effectiveness each shift. Monitor/document/report PRN (As Needed) adverse reactions to trazodone and duloxetine therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (Activities of Daily Living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia, appetite loss, wt loss, n/v (nausea/vomiting), dry mouth, dry eyes. Important to note: R36's care plan does not list targeted behaviors to monitor for the resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 10:43 AM, Surveyor interviewed DON B (Director of Nursing) and asked if facility would expect care plans of residents on psychotropic medications to have individualized targeted behaviors. DON B stated yes. On 10/10/24 at 3:56 PM, Surveyor interviewed RN G (Registered Nurse) and asked about R36's targeted behaviors. RN G stated, I am not aware of her whole history. We do cares in pairs for a reason, but I am not sure what her concerns are. Surveyor asked if there are documented targeted behaviors. RN G stated there is nothing written in the care plan.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review the facility did not ensure that residents were free from significant medication errors for 2 of 20 residents (R18, R220) reviewed for pharmacy services. R18 reported that his morning medications were given late, into afternoon weekend of 10/5/24-10/6/24. This included his insulin. R220 did not receive scheduled insulins on 9/16/24, 9/22/24, and 10/3/24. This is evidenced by: The facility's Policy and Procedure entitled Medication Administration dated 6/7/24 documents the following, in part: .10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, f. Right documentation .b. Administer within 60 minutes prior to or after schedule time unless otherwise ordered by physician . Example 1 R18 is a long-term resident of the facility. R18's most recent Minimum Data Set (MDS) dated [DATE], documents a score of 13 on R18's Brief Interview of Mental Status (BIMS), which indicates that he is cognitively intact. On 10/7/24 at 11:06 AM, Surveyor interviewed R18. Surveyor asked R18 if he had any concerns about the facility or his care that he would like to share, R18 stated he had a male agency nurse this past weekend that was awful, didn't get morning (AM) medications until 2 PM. R18's Physician Orders document the following: Accu checks TID prior to meals. Freestyle Libre of BS finger poke. before meals for DM II -Scheduled for 0700 and 1100 (7:00 AM and 11:00 AM) HumaLOG KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units, subcutaneously with meals for DM2 Inject 1-5 units under skin 3 times daily with meal per sliding scale -Scheduled at 0700 and 1100 Lisinopril Oral Tablet 5 MG (milligrams) (Lisinopril) Give 0.5 tablet by mouth one time a day for HTN Give 2.5 mg of Lisinopril -Scheduled for 0700 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Medication Administration Record (MAR) documents that all the above medications were signed out on 10/5/24 and 10/6/24 by the same initials. These initials were verified with the Agency staff list, confirming the nurse was an Agency staff nurse. R18's Medication Admin Audit Report documents the following administration times: Accu checks (blood sugar) TID (three times a day) prior to meals. Freestyle Libre of BS finger poke. before meals for DM II -Administered 10/5/24 at 1418 (2:18 PM) for 0700 administration time -Administered 10/5/24 at 1418 for 1100 administration time -Administered 10/6/24 at 1317 (1:17 PM) for 1100 administration time HumaLOG KwikPen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units, subcutaneously with meals for DM2 Inject 1-5 units under skin 3 times daily with meal per sliding scale -Administered 10/5/24 at 1402 (2:02 PM) for 0700 administration time -Administered 10/5/24 at 1419 (2:19 PM) for 1100 administration time -Administered 10/6/24 at 1316 (1:16 PM) for 1100 administration time Of note, R18 received his AM and lunchtime accu check at the same time and his AM and lunchtime insulin 10 minutes apart on 10/5/24. Lisinopril Oral Tablet 5 MG (milligrams) (Lisinopril) Give 0.5 tablet by mouth one time a day for HTN Give 2.5 mg of Lisinopril -Administered 10/5/24 at 1419 (2:19 PM) R18's blood sugar results were as follows: 10/5/24 at 1402= 226 10/5/24 at 1418= 128 10/5/24 at 1418= 166 10/5/24 at 1419= 266 R18's blood pressure results were as follows: 10/5/24 at 1419= 126/70 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/6/24 at 0816 (8:16 AM) = 128/70 On 10/10/24 at 11:29 AM, Surveyor interviewed RN M (Registered Nurse). Surveyor asked RN M if medication is scheduled at 0700 when should they be administered, RN M said between 6-8 AM; if medication is scheduled at 0800 when should they be administered, RN M replied between 7-9 AM; if medication is scheduled at 11:00 when should they be administered, RN M stated between 10 AM-12 PM; if medication is scheduled at 1130 when should they be administered, RN M said between 10:30 AM-12:30 PM. Surveyor asked RN M should the same medication be given back to back if late, RN M said no. Surveyor asked RN M what should you do if this situation comes up, RN M explained to call Provider and follow their instructions and give only dose at that time, unless instructed otherwise. Surveyor asked RN M what type of negative outcome could occur with a significant medication error, RN M stated he could become hypoglycemic (low blood sugar). On 10/10/24 at 11:30 AM, Surveyor interviewed LPN N (Licensed Practical Nurse). Surveyor asked LPN N if medication is scheduled at 0700 (7:00 AM) when should they be administered, LPN N said an hour before to an hour after; if medication is scheduled at 0800 (8:00 AM) when should they be administered, LPN N replied an hour before to an hour after; if medication is scheduled at 1100 (11:00 AM) when should they be administered, LPN N stated an hour before to an hour after; if medication is scheduled at 1130 (11:30 AM) when should they be administered, LPN N said an hour before to an hour after. Surveyor asked LPN N should the same medication be given back-to-back if late, LPN N stated no. Surveyor asked LPN N what should you do if this situation comes up, LPN N stated to call the Provider, describe the situation, and follow their instructions. Surveyor asked LPN N what type of negative outcome could occur with a significant medication error, LPN N said low blood sugar. On 10/9/24 at 3:48 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would you expect medications to be administered timely, DON B replied all meds should be given timely. Surveyor asked DON B what would you expect staff to do if the first dose of a medication wasn't administered and now the next dose is due, DON B explained they should not be given at the same time and they should call the Provider for further instructions. On 10/10/24 at 5:34 PM, Surveyor interviewed DON B. Surveyor asked DON B should AM (scheduled at 0700, 0800, 1100, 1130) medication be administered at 1400 (2:00 PM), DON B stated no. Surveyor asked DON B could administering two doses of insulin back-to-back cause a hypoglycemic event, DON B replied yes. 41788 Example 2 R220 was 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 using it for energy), essential hypertension (high blood pressure, a condition in which the force of the blood against the artery walls is too high), and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R220's Quarterly Minimum Data Set Assessment, dated 10/5/24, shows that R220 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R220 is cognitively intact. Section GG shows R220 requires supervision or touch assistance with toileting and toileting transfer. It shows R220 requires partial to moderate assist with lower body dressing. R220's Care Plan, dated 7/14/21, states, in part: . Focus: Diabetes- At risk for complications R/T (related to) diagnosis of INSULIN DEPENDENT- Daily &/or Sliding Scale. Date Initiated: 7/14/21. Goal: Will be free of serious complications R/T DX's (diagnoses) as MD (medical doctor) follows sx's (symptoms) and labs through next review Date. Date Initiated: 7/14/21. Revision on: 8/20/24. Target Date: 5/1/26 Interventions: -Medication/Treatments as ordered . Date Initiated: 7/14/21 . R220's Physician Orders, dated 10/9/24, states, in part: . Novolin R Flex Pen Injection Solution Pen Injector 100 unit/mL(milliliters) (Insulin Regular Human) Inject 12 units subcutaneously three times a day for diabetic management mealtime- prime the pen with 2 units before every injection. Order Date: 5/2/24. Start Date: 5/5/24 Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 unit/mL .Inject 56 units subcutaneously in the morning for diabetes Prime with 2 units. Order Date: 5/2/24. Start Date: 5/3/24 . Insulin Regular Human Injection Solution Pen-Injector 100 unit/mL . Inject as per sliding scale: if 0-150= 0 units, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, subcutaneously three times a day for T2DM (Type 2 Diabetes Mellitus). Notify provider for glucose >400. Order Date: 4/9/24. Start Date: 4/12/24 . R220's September 2024 MAR shows: 9/16/24 - R220 did not receive his Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 unit/mL .Inject 56 units subcutaneously in the morning for diabetes Prime with 2 units. September 16th, at 7:00 AM, it is documented (4) R220 did not receive insulin and see nurse notes. Of note- there is no documentation in nurse notes as to why R220 did not receive insulin. 9/22/24 - R220 did not receive his 8:00 AM or his 12:00 PM Insulin Regular Human Injection Solution Pen-Injector 100 unit/mL . Inject as per sliding scale: if 0-150= 0 units, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, subcutaneously three times a day for T2DM (Type 2 Diabetes Mellitus). Notify provider for glucose >400. 9/22/24 at 8:00 AM, it is documented (8) R220 refused his insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/22/24 at 12:00 PM, it is documented (4) R220 did not receive insulin and see nurse notes. Of note- there is no documentation in nurse notes as to why R220 did not receive insulin. 9/22/24 - R220 did not receive his 8:00 AM- Novolin R Flex Pen Injection Solution Pen Injector 100 unit/mL(milliliters) (Insulin Regular Human) Inject 12 units subcutaneously three times a day for diabetic management mealtime- prime the pen with 2 units before every injection. 9/22/24 at 8:00 AM, it is documented (4) R220 did not receive his insulin and see nurse notes. Of note- there is no documentation in nurse notes as to why R220 did not receive insulin. 10/3/24 - R220 did not receive his 7:00 AM- Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 unit/mL .Inject 56 units subcutaneously in the morning for diabetes Prime with 2 units. 10/3/24 at 7:00 AM, it is documented (4) R220 did not receive his insulin and see nurse notes. Of note- there is no documentation in nurse notes as to why R220 did not receive insulin. On 10/8/24 at 1:34 PM, Surveyor interviewed R220. R220 indicated he did not receive his insulins two times last month. On 10/9/24 at 12:27 PM, Surveyor interviewed RN F (Registered Nurse) and asked what it means if an 8 is documented on MAR (Medication Administration Record). RN F indicated resident refused the medication. Surveyor asked if R220 ever refuses medications and RM F indicated no. Surveyor asked RN F what it means if a 4 is documented on the MAR. RN F indicated the resident did not receive the medication and look at progress notes for reason why the medication was not administered. Surveyor asked RN F if the physician should be updated if a medication was not administered or refused and RN F indicated yes. Surveyor asked RN F what the process is for a medication that is not available. RN F indicated if the medication is not in the med cart we go to contingency. If the med is not in contingency, we call the pharmacy, and the pharmacy will send the medication that day. Surveyor asked RN F if it is acceptable for a resident to not receive a medication due to unavailability in house, and RN F indicated no.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and record review, the facility did not ensure that food is stored and prepared in a clean and sanitary environment, which has the potential to affect all 64 residents residing in the facility. Surveyor observed a layer of dust on the wall in the dry food storage area directly above food that was no longer sealed by the manufacturer. Surveyor observed food items in the reach in coolers in the main kitchen to be undated or beyond the use by date. Surveyor observed 2 nicked spatulas in circulation with utensils. Surveyor observed the microwave in the main kitchen to be unclean with dried-on particles. Surveyor observed staff's partially consumed, personal water bottles to be in the refrigerator with resident's food. Residents were obtaining ice from the ice chest by themselves, which could cause contamination. Evidenced by: Example 1 dust Facility policy, titled Food Storage, effective date [DATE], includes, in part: Food will be stored in an area that is clean, dry, and free from contaminants . On [DATE] at 9:01 AM, during initial tour of the kitchen, Surveyor and DM O (Dietary Manager) observed a layer of dust on the wall in the dry storage area. DM O indicated the room needs to be cleaned and there is potential for dust to fall into the opened boxes. On [DATE] at 11:45 AM during an interview NHA A (Nursing Home Administrator) indicated the walls above the dry storage should be free of dust and dirt. Example 2 undated/outdated food Facility policy, titled Food Storage, effective date [DATE], includes, in part: Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated .All foods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen, or discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] around 9:15 AM, during initial tour of the kitchen, Surveyor and DM O observed in the reach in coolers the following: an expired container of tuna, expired container of pureed green beans, a container of cranberry sauce and a container of gravy without a label or use by date, a container of minced garlic that had a label indicating opened ,d+[DATE] and use by ,d+[DATE]. DM O indicated food should not be in circulation past the expiration date or the use-by date. DM O also indicated that all food should be labeled with a manufacturer's expiration date or a use by date. On [DATE] at 11:45 AM during an interview, NHA A (Nursing Home Administrator) indicated food should not be in circulation past the expiration date or use-by date. NHA A indicated all food should be labeled and dated. Example 3 nicked spatulas On [DATE] around 9:25 AM, during initial tour of the kitchen, Surveyor and DM O (Dietary Manager) observed 2 nicked spatulas in the utensil drawer. DM O indicated they should not be in circulation and discarded them. On [DATE] at 11:45 AM, NHA A indicated nicked spatulas should be thrown out. Example 4 unclean microwave Facility policy, titled Equipment Safety, effective date [DATE], includes, in part: All equipment should be cleaned properly, following the instructions in the equipment manual . On [DATE] around 9:30 AM, during initial tour of the kitchen, Surveyor and DM O observed the microwave to be unclean with visible dried-on particles, three different colors, on the top inside and along the inside wall. DM O indicated staff should be covering food when microwaving and they should clean it after a spill or at least daily. On [DATE] at 11:45 AM, NHA A indicated the microwave should be cleaned prior to warming up resident food. Example 5 resident/staff food On [DATE] around 9:15 AM, during initial tour of the kitchen, Surveyor and DM O observed 2 water bottles partially consumed without a name or date. DM O indicated the water bottles belonged to staff and should not be stored with residents' food. On [DATE] at 11:45 AM, NHA A indicated staff food items and resident food items should not be stored together. 41788 Example 6 ice (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R219 admitted to the facility on [DATE], and has diagnoses that include osteomyelitis (inflammation of bone caused by infection), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down). R219's Admission Minimum Data Set (MDS) Assessment, dated [DATE], shows that R219 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R219 is cognitively intact. Section GG shows R219 is independent with dressing, personal hygiene, toileting, eating and ambulation. On [DATE] at 11:18AM, Surveyor interviewed R219. R219 indicated to Surveyor that this morning he had to go find the ice chest; it is usually at end of the hallway for the residents to get ice out of it. R219 indicated every day he goes down to the ice chest with his cup and fills his cup with ice. On [DATE] at 12:20 PM, Surveyor interviewed CNA Y (Certified Nursing Assistant) and asked when ice gets passed. CNA Y indicated twice a shift. Surveyor asked where the ice chest is kept, and CNA Y indicated in the nurses' station now, but we share the ice chest with the other hall and sometimes it sits out at end of the hallway. Surveyor asked CNA Y if she has ever seen residents go in the ice chest and get their own ice. CNA Y indicated yes. CNA Y indicated the staff are to monitor the ice chest as residents can contaminate it with getting the ice themselves. On [DATE] at 3:03 PM, R220 indicated he has seen residents go in and out of the ice chest to get ice. R220 showed Surveyor a picture on his phone that showed a resident with his cup getting ice out of the ice chest. On [DATE] at 10:09 AM, Surveyor informed DON B (Director of Nursing) of R219 stating he goes and gets ice from ice chest and CNA Y reported having seen residents in ice chest getting their own ice. DON B indicated that would be contaminating the ice.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation and interview, the facility did not follow their standard transmission-based precautions to be followed to prevent spread of infections for 2 of 5 residents (R18 and R26) reviewed for infection control processes during catheter care, 1 sampled resident (R219) and 1 supplemental resident (R46) reviewed for infection control processes during wound care, and 1 supplemental resident (R55) reviewed for infection control processes during blood sugar check. R18 had three breaches with infection control during catheter care observation. The registered nurse did not wear a gown, did not use a proper barrier, and did not cleanse hands when indicated by professional standards of practice. During observation of R219's wound care, Surveyor observed poor hand hygiene because hands were not cleaned when indicated by standards of practice. R26 had a breech with infection control when staff did not use enhanced barrier precautions during personal cares. R55 had breach in infection control during medication administration observation when a nurse touched items in the room while wearing a contaminated glove. R46 had breach in infection control during wound care observation when a barrier was not used when indicated. This is evidenced by: The facility's Policy and Procedure entitled Enhanced Barrier Precautions dated 12/23/22, documents the following in part: .Enhanced barrier precautions refers to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO (Multi-drug resistant organism) as well as those at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical device) .c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves .i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling [NAME] devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO .4. High-contact resident care activities include .g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, h. Wound care: any skin opening requiring a dressing . The facility's Policy and Procedure entitled Catheter Care dated 4/12/23 does not speak to the infection control concerns identified. Example 1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18 is a long-term resident of the facility. R18's most recent Minimum Data Set (MDS) dated [DATE], documents a score of 13 on R18's Brief Interview of Mental Status (BIMS), which indicates that he is cognitively intact. R18 has the following diagnoses: urinary retention (indwelling catheter in place) and colostomy (in place). On 10/8/24 at 1:42 PM, Surveyor observed RN W (Registered Nurse) perform catheter care for R18. RN W only wore gloves throughout R18's catheter care. At no time did .she put on a gown. RN W placed dirty wash cloths that had been used for catheter care on the bare floor, not in any type of barrier (bag) or on any type of barrier (chux). Upon completion of R18's cares, RN W removed her gloves, threw them in the trash, then picked up each basin of water dumped out in bathroom sink, and then completed hand hygiene. On 10/8/24 at 1:55 PM, Surveyor asked RN W what PPE (Personal Protective Equipment) should be worn for enhanced barrier precautions, RN W said gown, gloves, and to wash hands with soap and water. Surveyor asked if she should have had a gown on, RN W stated didn't know about residents' enhanced barrier precautions, didn't get that information in report, this is my first time on this hall. Surveyor asked RN W when you took the gloves off prior to emptying basins, should you have washed your hands; RN W indicated she should have washed her hands. Surveyor asked RN W if there could have been a better place to put the used washcloths besides on the floor; RN W indicated she should have put the dirty washcloths in a bag instead of on the floor. Of note, there is proper signage outside R18's door with 3-drawer bin with PPE in it. On 10/10/24 at 4:15 PM, Surveyor interviewed IP G (Infection Preventionist). Surveyor asked IP G would you expect hand hygiene to be performed when gloves are removed during catheter care, IP G said yes. Surveyor asked IP G where would you expect staff to put dirty wash cloths after being used for catheter care, IP G explained there are multiple things that you could do, have an empty trash bag there to put it, an empty trash can, or just a chux/barrier (towel). Surveyor asked IP G what PPE should be worn when providing catheter care, IP G stated enhanced barrier precautions so gown and gloves. On 10/10/24 at 5:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect hand hygiene be performed when gloves are removed during catheter care, DON B said yes. Surveyor asked DON B where would you expect staff to put dirty washcloths after being used for catheter care. DON B stated on a barrier. Surveyor asked DON B what PPE would she expect her staff to wear when they are doing catheter care, DON B stated enhanced barrier precautions. 41788 Example 2 The facility policy, entitled Hand Hygiene, dated 12/23/22, states, in part: . Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . Hand Hygiene Table: . -After handling contaminated objects- either soap and water or alcohol-based hand rub . -Before and after handling clean or soiled dressings, linens, etc . either soap and water or alcohol-based hand rub . -After handling items potentially contaminated with blood, body fluids, secretions, or excretions . either soap and water or alcohol-based hand rub . - When, during resident care, moving from a contaminated body site to a clean body site . either soap and water or alcohol-based hand rub . R219 admitted to the facility on [DATE], and has diagnoses that include osteomyelitis (inflammation of bone caused by infection), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), and osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down). R219's Admission Minimum Data Set (MDS) Assessment, dated 10/8/24, shows that R219 has a Brief Interview of Mental Status (BIMS) score of 15 indicating R219 is cognitively intact. Section GG shows R219 is independent with dressing, personal hygiene, toileting, eating and ambulation. R219's Treatment Administration Record (TAR) for October 2024, states, in part: . Wound Care: Right knee (surgical)- Wash wound with wound cleanser; pat dry; apply non-adherent dressing; cover with ABD dressing; Wrap in ACE bandage. Every day shift for wound care Start Date: 10/8/24 . On 10/8/24 at 1:57 PM, Surveyor observed IP G (Infection Preventionist) perform wound care for R219. IP G performed hand hygiene and applied gloves. IP G set supplies up on bedside table with a barrier under them and then grabbed bedside table and pulled it closer to him and resident. IP G then began cleansing wound area with those same gloves on. IP G did not remove gloves and perform hand hygiene before cleansing wound. IP G cleansed wound area and then grabbed new dressings and opened them without performing hand hygiene. IP G placed dressings on wound. On 10/8/24 at 2:30 PM, Surveyor interviewed IP G, and asked when hand hygiene should be performed during wound care. IP G indicated before entering the room, after bandage removal, if I touched something and after cleansing the wound. Surveyor asked if IP G did perform hand hygiene after cleansing the wound and IP G indicated no, and he should have. Surveyor asked if hand hygiene should have been performed after he grabbed the bedside table with his gloved hands and IP G indicated he should have performed hand hygiene and applied new gloves. (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	10/10/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/9/24 at 10:35 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would expect hand hygiene to be performed after going from a dirty to clean area and DON B indicated yes. Surveyor asked if a staff with gloved hands grabs a bedside table and pulls it over to him/her should gloves be removed and hand hygiene be performed before cleansing the wound and DON B indicated yes. 49436 Example 3 The facility policy titled Enhance Barrier Precautions dated 12/23/22, states, in part: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO) Enhanced barrier precautions refer to the use of gown and gloved for use during high-contact resident care activities for resident know to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) . Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves . An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheter, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO . High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care . R26 admitted to the facility on [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis. R26's Physician Orders dated 10/10/24 include hemodialysis Monday, Wednesday, Friday, and monitor port-a-cath site to right upper chest wall for s/s (Signs and Symptoms) infection, edema, bleeding every shift. It is important to note, R26's Physician Orders do not include orders for enhanced barrier precautions but R26 should have an enhanced barrier precaution order. R26's medical record for October 2024 indicates R26 had an indwelling foley catheter upon readmission from the hospital on 10/3/24 and the foley catheter was removed on 10/8/24. On 10/8/24 at 12:11 PM, Surveyor observed CNA FF (Certified Nursing Assistant) leave R26's room. Surveyor interviewed CNA FF about enhanced barrier precautions. CNA FF stated she changed R26's gown and brief. CNA FF indicated she did not know R26 was on enhanced barrier precautions. She saw the enhanced barrier precaution sign outside the door and thought it was for R26's roommate. CNA FF indicated she did not wear a gown while performing high-contact activities (brief change with peri-care and dressing) for R26. (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	10/10/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 11:45 AM, Surveyor interviewed IP G (Infection Preventionist) regarding enhanced barrier precautions. IP G indicated anyone with indwelling medical devices should be on enhanced barrier precautions. Surveyor asked IP G about the enhanced barrier precaution sign outside of the door of a room with 2 residents. IP G indicated staff would have to ask which resident is on enhanced barrier precautions to ensure they use enhanced barrier precautions for the right resident. On 10/9/24 at 3:48 PM, Surveyor interviewed DON B (Director of Nursing) about enhanced barrier precautions. DON B indicated gowns should be worn for residents on enhanced barrier precautions. 50228 Example 4 On 10/9/24 at 4:34 PM, Surveyor observed RN G (registered nurse) performing medication administration. RN G gathered the medication along with supplies to perform a blood sugar test. At R55's bedside, RN G donned gloves and performed a finger-stick blood glucose test. Following the test, RN G touched the following items with her contaminated gloves: R55's over the bed table, R55's bedroom door, the top of the medication cart, and a canister of disinfectant wipes. Surveyor asked RN G if gloves are contaminated following a blood sugar test. RN G states yes. Surveyor asked if it is appropriate to touch items with contaminated gloves. RN G stated no. On 10/9/24 at 4:56 PM, Surveyor interviewed DON B (director of nursing) and asked if staff are expected to remove gloves and perform hand hygiene after performing blood sugar testing, prior to touching other surfaces. DON B stated yes. Example 5 On 10/8/24 at 11:10 AM, Surveyor observed LPN N (Licensed Practical Nurse) perform wound care for R46. LPN N sprayed wound cleanser on the wound, then set the cleanser bottle on the floor next to the resident. Following wound care, LPN N picked up the bottle of wound cleanser from the floor and set the bottle on the resident's cabinet with additional wound supplies. Surveyor asked LPN N if there was a barrier on the floor where the bottle had been set. LPN N stated no. Surveyor asked if the floor is considered contaminated. LPN N stated yes. Surveyor asked if it is appropriate to set the bottle on the bare floor. LPN N stated no, I forgot to place a barrier. On 10/9/24 at 4:56 PM, Surveyor interviewed DON B and asked if staff are expected to place wound care supplies on a barrier. DON B stated yes. Surveyor asked DON B if wound supplies should be placed on the floor. DON B stated no.