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	03/25/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 2 sampled residents (R25) and 1 of 1 (R7) supplemental residents reviewed for self- administration of medications. R7 was observed during medication administration to have his medications put into a Mighty Shake and left with R7 in the dining room to take independently. R7 does not have an assessment for self-administration of medications. R25 was observed to have a cup of medications left on her bedside table for her to take independently. R25 does not have an assessment for self-administration of medications. Evidenced by: The facility's policy titled Resident Self- Administration of Medication dated 5/1/24 states in part, .3. When determining if self- administration is clinically appropriate for a resident, the interdisciplinary team should, at a minimum consider the following: a. The medications appropriate and safe for self- administration; b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections; c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; d. The resident's capability to follow directions and tell time to know when medications need to be taken, including the dose, timing, and signs of side effects, and when to report to facility staff . Example 1 R7 was admitted to the facility 8/4/05 with diagnoses that include schizoaffective disorder (a mental health condition that includes schizophrenia and mood disorder symptoms), bipolar disorder, and unspecified psychosis not due to a substance or known physiological condition (a mental state characterized by a loss of touch with reality and may involve hallucinations, delusions, disordered thinking and behavioral changes). R7's most recent Minimum Data Set (MDS) dated [DATE] states that R7 has a Brief Interview of Mental Status (BIMS) of 00 out of 15, indicating that R7 has severe cognitive impairment. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 8:15 AM, Surveyor observed medication administration for R7 with LPN E (Licensed Practical Nurse). Surveyor observed LPN crush R7's medications, which included senna, lorazepam (anti-anxiety medication), cefprozil (antibiotic), divalproex delayed release (anti-convulsant), and olanzapine (anti-psychotic), and mix them in a Mighty Shake. LPN E then gave R7 the shake while he was eating breakfast in the dining room. LPN E then left the dining room. Surveyor remained in the dining room and observed R7. On 3/6/25 at 8:33 AM, R7 remains in the dining room with shake. On 3/6/25 at 8:50 AM, LPN E returns to the dining room, checks on R7, and leaves the dining room. LPN E did not encourage or assist R7 with drinking the shake. On 3/6/25 at 8:52 AM, Surveyor observed R7 take 2 sips of the shake. On 3/6/25 at 9:02 AM, the CNA (Certified Nursing Assistant) removed R7 from the dining room, as he was done eating. Surveyor observed the CNA return R7's shake to LPN E. On 3/6/25 at 9:08 AM, the shake has not been returned to R7. On 3/6/25 at 9:17 AM, Surveyor interviewed LPN E. Surveyor asked LPN E if R7 had an assessment for self-administration of medications, LPN E stated that R7 doesn't have an order, but R7 takes the mediations in the shake. Surveyor asked LPN E if R7 took all of his medications today, LPN E stated no. On 3/11/25 at 12:51 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if residents without a self-administration assessment should be left alone with their medications, DON B stated no. Surveyor requested a copy of R7's medication self-administration assessment, DON B reported that R7 does not have one, as he is unable to self-administer medications. 36253 Example 2: R25 was admitted to the facility on [DATE] and has diagnoses that include Type II Diabetes, pulmonary embolism (blood clot in the lungs), seizure disorder, severe protein calorie malnutrition and coronary artery disease status post single-vessel CABG (Coronary Artery Bypass Graft; to improve blood flow to the heart by bypassing narrowed or blocked arteries). Her admission Minimum Data Set (MDS), dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 15, indicating R25 was cognitively intact. On 3/5/25 at 11:21 AM, Surveyor observed R25 in her room, lying in her bed. The head of R25's bed was elevated and her over-the-bed table was straddling the bed. On the table was a cup of multiple medications. Surveyor attempted to ask R25 questions, but R25 did not answer. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:25 AM, Surveyor interviewed RN F (Registered Nurse), who stated that she had left the medications there for R25 at approximately 8:30 AM after breakfast. RN F stated that R25 can take her own medications without supervision. Surveyor and RN F went back to R25's room and RN F looked at the medications and indicated they were: Omeprazole, Folic Acid, Metoprolol, Iron, multivitamin, Thiamin, Topamax, and Vitamin D. Surveyor requested any self-administration of medication assessments the facility had for R25, which were not provided. On 3/11/25 at 12:51 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if residents with out a self- administration assessment should be left alone with their medications, DON B stated no.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility did not immediately notify and consult with the resident's physician when a change in the resident's physical, mental, or psychosocial status occurred for 1 of 24 residents (R71) reviewed for change in condition. R71 was was sent to the ED (Emergency Department) with a change in condition. The ED documented, Skin: Severe candidal rash around SP (suprapubic) cath (catheter) and into bilateral groin. R71 was diagnosed with Candidiasis intertrigo (a fungal infection that occurs in skin folds) involving the groin and area around SP (suprapubic) catheter and prescribed Nystatin. The facility did not document the rash nor notify the provider. As evidenced by The facility policy, Notification of Change, dated 10/24/23, documents, in part, as follows: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Need to alter treatment significantly means a need to .commence a new form of treatment to deal with a problem. R71 was admitted to the facility on [DATE] with diagnoses including, but not limited to: paranoid schizophrenia (characterized by persistent delusions and hallucinations) and mild cognitive impairment (subtle changes in thinking and memory). R71's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R71 has a Brief Interview of Mental Status (BIMS) of a 15 out of 15, which indicates he is cognitively intact. R71 does not have inattention or altered level of consciousness. R71 display disorganized thinking that comes and goes and changes in severity. R71's comprehensive care plan indicates the following: (Dated Initiated 1/2/14) Self care deficit and risk for falls R/T (related to) schizophrenia, anxiety Goal: Will be neat and clean Interventions: (Date Initiated: 8/1/23) .Assist with catheter care. Empty every shift and record output. (Date Initiated: 1/2/14) Assist as needed with washing and dressing. (Date Initiated: 9/20/16) Cue PRN (as needed) assist of one for personal hygiene. On 12/15/24, R71 was was sent to the ED (Emergency Department) with a change in condition that includes, in part, as follows: The ED documented, in part, Skin: Severe candidal rash around SP (suprapubic) cath (catheter) and into bilateral groin. R71 was diagnosed with Candidiasis intertrigo (a fungal infection that occurs in skin folds) involving the groin and area around SP (suprapubic) catheter and prescribed Nystatin. The facility did not document any changes to R71's skin around his SP catheter nor notify the provider regarding the rash. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 5:20 PM, Surveyors spoke with DON B (Director of Nursing). Surveyor stated to DON B, the hospital noted a severe candidal rash around R71's SP catheter site. Would you have expected staff to notify the provider of this rash? DON B stated, yes, I would expect that.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observation, interview, and record review, the facility did not ensure that each resident has a safe, clean, comfortable and homelike environment for daily living for 1 of 24 sampled Residents (R51), 2 of 2 supplemental residents (R424 & R67) and 5 of 6 shower rooms. This had the potential to affect more than a limited number of residents in the facility. Surveyor observed R51's footboard on her bed and the wall next to her bed to contain many dried particles and not homelike. R424 and R67 voiced concerned about the shower cleanliness. Surveyor observed 5 out of 6 shower rooms as being unkept with visible black and brown substance in the shower area. As evidenced by: The facility policy, Safe and Homelike Environment, dated 10/23/24, indicates, in part, as follows: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment . Environment refers to any environment in the facility that is frequented by residents, including, (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. Homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible . A determination of homelike should include the resident's opinion of the living environment. Orderly is defined as an uncluttered physical environment that is neat and well-kept. Housekeeping and maintenance services will be provided as necessary to maintain a sanity, orderly and comfortable environment. R51 was admitted to the facility on [DATE] with diagnoses including, but not limited to, the following: Alzheimer's disease, dementia, delusional disorders, restlessness and agitation. R51's most recent Minimum Data Set (MDS) dated [DATE] documents R51 is severely cognitively impaired. R51 has an Activated Power of Attorney for Health Care (APOAHC). On 12/16/24, the facility has a Grievance Summary voiced by R51's APOAHC. The grievance includes in the following: Grievance Details: The resident's (R51) HCPOA (Health Care Power of Attorney) reports that the resident's bed frame was dirty and her room smelled. Summary of Investigation: The resident's HCPOA reported the concern to the facility. Social Services reviewed the resident's behavior history. Summary of Findings: The resident has a history of stuffing food down the toilet and smearing her meals on her walls. Summary of Actions Taken: Social Services informed the housekeeping supervisor of the concern, who attended to the bed. It is important to note, R51's HCPOA expressed concern with the cleanliness of R51's room on 12/16/24. Surveyor observed ongoing concerns regarding the cleanliness of R51's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 10:30 AM, Surveyor spoke with R51. R51 was unable to answer Surveyor's questions regarding the environment. Surveyor observed R51's foot board to contain many dried substances throughout the entire footboard. Surveyor observed the wall next to R51's bed to also contain many dried particles throughout the length of the wall next to her bed. On 3/5/25 at 10:40 AM, Surveyor spoke with LPN MM (Licensed Practical Nurse). Surveyor asked LPN MM to walk to R51's room with Surveyor. Surveyor asked LPN MM is R51's footboard clean. LPN MM stated, No. Surveyor asked LPN MM, is R51's wall next to her bed clean. LPN MM stated, No. LPN MM added, it could be food or it could be feces. LPN MM stated, she will get get Housekeeping to clean them. On 3/12/25 at 10:10 AM, Surveyor spoke with Hskp NN (Housekeeper) and Hskp Spv OO (Housekeeping Supervisor). Surveyor asked Hskp NN, what it your process for cleaning a room. Hskp NN stated, she starts in the bathroom by cleaning all surfaces and the toilet. Hskp NN stated, then she cleans the room, overbed tables and floors every day. Hskp NN stated, in R51's room, she now cleans the footboard and wall every day. Surveyor asked her when cleaning the footboard and wall started. Hskp NN stated, she just did a deep clean in R51's room the other day (clarified 3/5/25) so we need to check the footboard and wall more often. Hskp Spv OO stated, when she started in September there was food stuck on R51's floor and doors due to R51 throwing food. Surveyor asked Hskp Spv OO, should resident rooms be clean, free from debris on surfaces and homelike. Hskp Spv OO stated, yes, they should all be cleaned every day. On 3/12/25 at 5:35 PM, Surveyor spoke with DON B (Director of Nursing) and NHA A (Nursing Home Administrator). Surveyor asked NHA A and DON B, should residents' rooms be clean. NHA A stated, yes. NHA A stated, R51's footboard and wall should be clean and free from dried particles. 49434 Example: 2 R67 was admitted to the facility on [DATE] with diagnoses that include, in part: congestive heart failure and hypertension (high blood pressure). R67 most recent Minimum Data Set, with Assessment Reference Date of 2/4/25, states that R67 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R67 is cognitively intact. Section GG indicates R67 requires partial/moderate assistance with showering and bathing herself. On 3/5/25 at 10:16 AM, Surveyor interviewed R67. R67 states that she is unable to shower at the facility because it is too cold and dirty. R67 also states the shower floor and shower itself are not clean. On 3/11/25 at 8:09 AM, Surveyor made observations of the Aspen Hall shower room, which is R67's hall shower. Surveyor notes nothing in the room appears clean. There is a visible dark-colored residue on the shower head. The floor is covered in multiple colors of visible residue, some light and some dark. The toilet itself, that is contained within the shower itself, appears unclean, with a dark residue surrounding the bottom of the toilet. Example: 3 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R424 was admitted to the facility on [DATE] with diagnoses that include, in part: acute infarction of spinal cord (stroke within the spinal cord or the arteries that supply it), chronic obstructive pulmonary disease (lung disease that damages lung tissue causing difficulty breathing), and quadriplegia (paralysis affecting all four limbs and torso). R424 most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 2/18/25, states that R424 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R424 is cognitively intact. Section GG indicates R424 is dependent on staff for tub/shower transfers and for showering/bathing herself. On 3/11/25 at 8:05 AM, Surveyor was called into R424's room. R424 states that she is concerned about the shower cleanliness. R424 states the showers are disgusting and that there is trash on the floor, nothing is clean, and the shower head and toilet are both dirty. R424 states the shower is so dirty she does not want to shower at the facility anymore. On 3/11/25 at 8:09 AM, Surveyor made observations of the Aspen Hall shower room, which is R424's hall shower. Surveyor notes nothing in the room appears clean. There is a visible dark-colored residue on the shower head. The floor is covered in multiple colors of visible residue, some light and some dark. The toilet itself, that is contained within the shower itself, appears unclean, with a dark residue surrounding the bottom of the toilet. 44552 Example 4: On 3/11/25 at 2:13 PM, Surveyor observed all the shower rooms at the facility. Surveyor observed Aspen hallway shower room. Surveyor observed black substance around the toilet. Surveyor observed a dark substance on the floor. Surveyor observed [NAME] hallway shower room. Surveyor observed black substance in the shower area and shower room was unkept. Surveyor observed Elm hallway shower room. Shower room light was blinking on and off. CNA S (Certified Nursing Assistant) indicated the light has been that way for a while. CNA S indicated he tries to not look at the light because it bothers him. CNA S indicated CNA's are expected to pick up shower rooms after each shower and that housekeeping does a deep clean. Surveyor observed Cedar hallway shower room. Surveyor observed brown/black grime in shower area and a piece of the wall fixture was missing. Surveyor observed the bathroom fan was loud. Surveyor observed Pine hallway shower room and observed brown substance on the shower chair. On 3/12/25 at 8:00 AM, DON B (Director of Nursing) indicated they are working on making the shower rooms more homelike and comfortable. DON B indicated the shower rooms should be picked up and cleaned after each shower.

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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 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** 42038 Based on interview and record review, the facility did not make prompt efforts to document, investigate, and resolve grievances a resident may have for 1 of 8 residents reviewed for grievances (R73). R73 and her family voiced grievances to the facility. The facility did not complete appropriate interviews, audits, education, or provide follow up with to R73 or her family after the conclusion of the investigation. Evidenced by: The facility's policy titled Resident and Family Grievances, no date, states in part .10. Procedure: .d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. i. Steps to resolve the grievance may involve forwarding the grievance to department manager for follow up .g. In accordance with the resident's rights to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. ii. The steps take to investigate the grievance. iii. A summary of pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decision was issued . R73 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes mellitus, heart failure, depression, and malignant neoplasm of transverse colon (a type of colorectal cancer that develops in the transverse colon). Of note, R73 discharge to the hospital on 2/9/25 and has not returned to the facility. R73's most recent Minimum Data Set (MDS) dated [DATE] states that R73 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R73 is cognitively intact. On 1/1/25, R73's daughter reported a grievance to a facility staff member. The facility's Grievance Summaries form states, in part, the following: Incident date: 1/1/25 Reported date: 1/3/25 Resolved Date- Resolved By: 1/1/25- SSA X (Social Services Assistant). Grievance Details: Issues with oxygen & returning from the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary Investigation: The resident's daughter reported the concern to the facility, and it was investigated via a series of statements given by witnesses. Summary of Findings: The situation appears to be the result of poor communication on the part of all parties. The Nurse in question was attempting to help and expected the CNAs to be familiar with both the oxygen set up and the facility staff to ask help as needed. The nurse felt intimidated and belittled by family and EMS (Emergency Medical Services), which further inhibited her ability to help. The CNA was attempting to help but did not feel she was getting proper support from her nurse. She interpreted her nurse's request for help as her not wanting to do anything. In the end, the resident did receive the necessary equipment. Summary of Actions Taken: All parties attempted to secure oxygen for the resident, with one of the nurses setting up oxygen in the resident's room with the help of CNAs and EMS. Social Services took statements from the involved parties. The nurse and CNA will be educated on effective communication strategies going forward. On 3/12/25 at 10:47 AM, Surveyor interviewed SW H (Social Worker) regarding this incident. Surveyor asked SW H if she was the Grievance Officer, SW H stated yes. Surveyor asked SW H if there was any documentation of any other interviews regarding this incident, SW H stated that only the staff that were involved were interviewed. Surveyor asked if there was any documentation regarding the education regarding the incident, SW H stated no. Surveyor asked SW H how she can ensure that the education was provided, SW H stated that she cannot. Surveyor asked SW H if the family/ complainant was contact regarding the incident, SW H stated that there was a phone call. Surveyor asked if there was any documentation about the communication with the family, SW H stated no. Surveyor asked if the complainant was satisfied with the resolution, SW H stated that she cannot recall. The facility's Grievance Summaries form states, in part, the following: Incident date: 1/22/25 Reported date: 1/22/25 Resolved Date- Resolved By: 1/22/25- SSA X. Grievance Details: Resident claims that the facility is not responding to the call light in a timely manner. Summary Investigation: The resident reported the concern to her care team. Summary of Findings: The care team coached the resident to time the call light response time and found the nurse and CNA responded in a timely manner. Summary of Actions Taken: There are no actions to be taken at this time, as the staff responded appropriately according to facility expectations. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 10:47 AM, Surveyor interviewed SW H regarding this concern. Surveyor asked SW H if it was an appropriate intervention to have R73 monitor her own call light wait times, SW H reported that R73's care team (Managed Care Organization) instructed her to do that, but it is not appropriate. Surveyor asked SW H if the facility completed call light audits, SW H reported that R73's call light was answered timely and there was no other follow up needed. Surveyor asked SW H if anyone followed up with R73, SW H reported not to her knowledge. Surveyor asked SW H if there was any documentation indicating that R73 agreed or disagreed with the resolution, SW H stated no. The facility's Grievance Summaries form states, in part, the following: Incident date: 1/22/25 Reported date: 1/23/25 Resolved Date- Resolved By: 1/23/25- SW H. Grievance Details: The resident's care team reported that the family cannot contact facility staff in the evening. Summary Investigation: The HCPOA (Health Care Power of Attorney) stated that they are unable to access staff members in the evening. Summary of Findings: There were no missed calls from the HCPOA for 2.5 weeks. Summary of Actions Taken: The phone log was reviewed by the receptionist at the front desk. On 3/12/25 at 10:47 AM, Surveyor interviewed SW H regarding this incident. Surveyor asked SW H if there was a conversation with R73's HCPOA regarding her concerns, SW H stated no. Surveyor asked SW H if the facility's policy indicated that they are not to contact complainants, SW H stated no. Surveyor asked if there was any follow up with R73's HCPOA, SW H stated no. The facility's Grievance Summaries form states, in part, the following: Incident date: 2/7/25 Reported date: 2/7/25 Resolved Date- Resolved By: 2/7/25- NHA A (Nursing Home Administrator) Grievance Details: The resident reports frustration with the CNAs follow up when she tells the resident she will be back to help her. Summary Investigation: The resident reports that other CNAs, including her current one [CNA name], are helpful and attend to her in a timely manner. Summary of Findings: The resident reports that other CNAs, including her current one [CNA name], are helpful and attend to her in a timely manner. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary of Actions Taken: Staff meet resident's needs by working together. In this case, CNA [CNA name] stepped in to assist and met resident's need immediately. On 3/12/25 at 11:06 AM, Surveyor interviewed SW H and SSA X regarding this incident. SSA X reported to Surveyor that he conducted the investigation regarding this complaint. Surveyor asked SSA X if there were any documented staff interviews, SSA X reported that he spoke with the accused CNA a little bit. Surveyor asked SW H if she would expect that staff be interviewed, SW H stated that they could do that. Surveyor asked SSA X and SW H if there was any education provided to staff, SW H reported that there was no education provided. Surveyor asked SSA X if there was any follow up with the resident, SSA X stated that he did speak with the resident. Surveyor asked SW H if the facility offers written documentation of the results of the grievance to the complainant, SW H stated that if they request it, they can have a written copy. Surveyor asked SW H how the facility would know if a complainant is in agreement with the findings of the investigation, SW H stated that they would talk about it. Surveyor asked if these conversations are documented anywhere, SW H stated that she has not been documenting the conversations. Surveyor requested copies of any education provided to staff, any interviews received from staff, and any documentation of conversations with complainants regarding the above grievances. The facility did not provide any additional documentation.

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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** 42038 Based on observation, interview and record review, the facility must ensure the assessment accurately reflects the resident's status, this affected 2 of 20 residents (R17 and R8) reviewed for Minimum Data Set (MDS). R17's most recent MDS indicates that R17 is receiving hospice services. R17 has not signed up for nor received hospice services. R8's MDS indicated that R8 had a pressure injury. R8 has not had a pressure injury since being admitted to the facility. This is evidenced by: The facility policy titled MDS 3.0 Completion dated 1/18/23 states in part: Policy: Residents are assessed, using a comprehensive assessment process to identify care needs and to develop an interdisciplinary care plan .4. Care Plan Team Responsibility for Assessment Completion: a. Interdisciplinary Responsibility for Completion of MDS Sections: i. The responsibility of all sections of the MDS will be clearly assigned .ii. Persons completing part of the assessment must attest to the accuracy of the section they have completed by signature and indication of the relevant sections . Example 1 R17 was admitted to the facility on [DATE] with diagnoses that include malignant neoplasm (cancerous tumor) of anus, type 2 diabetes mellitus, and neuropathy (nerve damage). R17's MDS dated [DATE], section O states that R17 is on hospice care. R17's MDS states that R17 has a Brief Interview of Mental Status (BIMS) of 13 out of 15, indicating that R17 is cognitively intact. On 3/5/25 at 10:27 AM, Surveyor interviewed R17. Surveyor stated that the computer indicated that R17 is receiving hospice services and asked R17 if he was receiving hospice services, R17 became upset stating that he was not receiving services and that he can't imagine that they (the facility) would sign him up and not tell him. Surveyor reported to R17 that the computer could be wrong and that a resolution would be found. On 3/10/25 at 11:14 AM, Surveyor interviewed MDS Coordinator I. Surveyor asked MDS Coordinator I how she is made aware of changes that need to be reflected in the MDS, MDS Coordinator I stated that most of her information comes from the IDT (Interdisciplinary Team) meeting every morning. Surveyor asked MDS Coordinator I how she is made aware that a resident signs on to hospice services, MDS Coordinator I reported that the hospice provider gives her a slip regarding the change. Surveyor asked MDS Coordinator I, if R17 was ever placed on hospice services, MDS Coordinator I stated no and she is not sure how that got put in there; it was a clerical error. Surveyor asked MDS Coordinator I when she was made aware of the error, MDS Coordinator I stated that she was made aware on 3/7/25. Surveyor asked MDS Coordinator I if the MDS should reflect the resident's actual medical diagnoses and treatment, MDS Coordinator I stated yes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1:00 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if R17 was ever receiving hospice, as it was marked on the MDS, DON B stated no, it never should have been marked. Surveyor asked DON B if the MDS should reflect the resident's actual medical diagnoses and treatment, DON B stated yes. 49434 Example 2: R8 was admitted to the facility on [DATE] with diagnoses that include, in part: post-traumatic stress disorder, manic depression, chronic obstructive pulmonary disease (Lung disease causing damage to lung tissue and difficulty breathing), venous insufficiency (valves in veins become damaged allowing blood to flow backwards), venous stasis ulcer (skin wound caused by fluid buildup in skin from poor vein function), and non-pressure chronic ulcer of unspecified part of unspecified lower leg. R8's Admission Minimum Data Set (MDS), dated [DATE], states R8 has a Brief Interview of Mental Status (BIMS) of 13 out of 15, indicating that R8 is cognitively intact. Section M indicates the resident has an unhealed pressure injury at stage 1 or higher. On 3/5/25 at 2:37 PM, Surveyor interviewed R8 and asked about her pressure injury, as indicated on the computer. R8 indicated the only wound she had was on her right shin. Surveyor conducted record review for R8. Surveyor found that R8 was admitted with a venous stasis ulcer on her anterior right shin. No evidence was found of a pressure injury as reported on the MDS in R8's electronic medical record. On 3/11/25 at 1:00 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the MDS should reflect the resident's actual medical diagnoses and treatment, DON B stated yes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on interview and record review, the facility did not ensure that a resident who is unable to carry out Activities of Daily Living (ADL's) received the necessary services to maintain personal hygiene for 1 of 20 residents (R51) reviewed for ADLs. R51 is scheduled to receive a shower on Mondays and Thursdays. The facility has no documentation that R51 was offered or declined a shower on the following dates: 2/6/25, 2/24/25, 3/3/25, and 3/6/25. Evidenced by: R51 was admitted to the facility on [DATE] with diagnoses including, but not limited to, the following: Alzheimer's disease, dementia, delusional disorders, restlessness and agitation. R51's most recent Minimum Data Set (MDS) dated [DATE] documents R51 is severely cognitively impaired. R51 has an Activated Power of Attorney for Health Care (APOAHC). R51's comprehensive care plan documents the following: (Date Initiated: 8/14/23) Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Dementia. Goal: The resident will maintain current level of function through the review date. Interventions: .(Date Initiated: 8/14/23) Resident chooses to practice self determination when it comes to personal cares and showers, she does continue to refuse cares at times. (Date Initiated: 8/14/23) Resident does refuse care including showers at times, education provided to resident and POA (Power of Attorney) regarding resident's refusals and risk associated with refusals. (Date Initiated: 11/8/24) Bathing/Showering: The resident requires assistance x 1 (1 assist) for bathing/showering every Monday evening and is able to assist with upper and lower body extremities as needed. R51's Certified Nursing Assistant (CNA) Kardex documents, in part, as follows: Bathing: Bathing Monday PM and Thursday PM On 12/16/24, the facility has a Grievance Summary voiced by R51's APOAHC. The grievance includes in the following: Grievance Details: The resident's HCPOA (Health Care Power of Attorney) reports he is concerned she is not receiving regular showers. Summary of Investigation: The resident's HCPOA reported the concern to the facility. Social Services investigated the resident's chart to confirm the task was being completed. Summary of Findings: The resident has been offered her showers and baths but does appear to refuse them quite often. Summary of Actions Taken: Social Services confirmed the resident had been given a choice and provided the HCPOA with education on the resident's right to refuse care and bathing. It is important to note, R51's HCPOA expressed concern regarding R51 not receiving showers. Based on record review, this is an ongoing concern. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 10:30 AM, Surveyor spoke with R51. R51 was unable to answer Surveyor's questions regarding showers. Surveyor reviewed shower documentation for the past month. There is no documentation that R51 was offered or received a shower on the following dates: 2/6/25, 2/24/25, 3/3/25, and 3/6/25. There is also no documentation that R51 refused a shower on these dates. On 3/12/25 at 5:38 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, do you expect residents to receive showers as scheduled. DON B stated, yes, she expects staff to re-approach three (3) times and have the nurse sign off on the paper copy that the resident has refused after three (3) attempts. DON B stated, staff document in PCC (PointClickCare) and also on paper.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview, and record review, the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This has the potential to affect 1 of 21 sampled residents (R74) reviewed for activities. R74 does not speak English, Spanish only. Facility does not offer R74 activities appropriate for R74's culture/ethnicity. Evidenced by: The facility policy entitled, Activities, dated 12/23/22, states, in part: .Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. Definitions: Activities refer to any endeavor, other than routine ADLs (activities of daily living), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical cognitive, and emotional health. Policy Explanation and Compliance Guidelines: . 2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Promote or enhance physical activity. c. Promote or enhance cognition. d. Promote or enhance emotional health. e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. f. Reflect resident's interests and age. g. Reflect cultural and religious interests of the residents. h. Reflect choices of the residents . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate- activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. c. Program of Activities- to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend . R74 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain cells to die) and major depressive disorder. R74's Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/25 section C shows no Brief Interview for Mental Status (BIMS) score recorded, indicating R74's cognitive status was not assessed or deemed not applicable during the assessment period. R74's Care Plan states, in part: .Focus- R74 enjoys the following activities: resting, watching tv, listening to relaxing music, coloring. Date Initiated: 1/23/25. Revision on: 1/23/25. Goal: The resident will express satisfaction with activities and activity involvement through the review date. Date Initiated: 10/29/24. Revision on: 11/26/24. Target Date: 12/11/24. Interventions: -R74's activity preferences: resting, watching tv, listening to relaxing music, coloring. Date Initiated: 10/29/24. Revision on: 1/23/25. -Staff will assist in assuring there is coloring supplies or music playing for resident when appropriate. Date Initiated: 10/29/24. Revision on: 1/23/25 . Focus: The resident has an interpretation need. Date Initiated: 10/21/24. Goal: No goal listed. Interventions: No interventions listed. Focus: The resident has a communication problem r/t (related to) Spanish speaking only. The resident does not speak English. Date Initiated: 10/22/24. Revision on: 2/11/25. Goal: The resident will be able to make basic needs known through translation on a daily basis through the review date. Date Initiated: 10/22/24. Revision on: 2/11/25. Target Date: 4/7/25. Interventions: -Interpreter line is (Phone number and code) Language code: 1 (Spanish). If the primary number is unavailable, please call (alternative number). Date Initiated: 3/5/25 . (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide translator as necessary to communicate with the resident. Translator is available by phone 24 hours a day. Date Initiated: 10/22/24. Revision on: 11/26/24 . R74's Activity Evaluation, dated 1/23/25, states, in part: . D. Daily Routine/Daily Preferences: 1. Typical morning leisure routine: resting, watching tv, listening to music, coloring. 2. Typical afternoon leisure routine: resting, watching tv, listening to music, coloring. 3. Typical evening leisure routine: resting, watching tv, listening to music, coloring . Goals/Care Planning: . 4. Choose an appropriate plan of care based on evaluation: Resident enjoys independent activities in his/her room. 5. Activities Care Plan: Focus: R74 enjoys the following activities: resting, watching tv, listening to relaxing music, coloring Goal: The resident will express satisfaction with activities and activity involvement through the review date. Intervention: R74 activity preferences: resting, watching tv, listening to relaxing music, coloring. Intervention: Staff will assist in assuring there is coloring supplies or music playing for resident when appropriate . On 3/5/25 at 2:18 PM, Surveyor observed R74 laying in bed talking out loud in Spanish. R74 was wide awake and appeared to be restless by moving legs around and attempting to sit up several times. On 3/10/25 at 10:01 AM, Surveyor observed R74 sitting in dining area on [NAME] at a table with a jug of water in front of her and the television on. The game show, The Price is Right was on. No closed caption in Spanish noted. On 3/10/25 at 10:01 AM, Surveyor interviewed CNA Y (Certified Nursing Assistant) and asked what R74's normal routine is during the day. CNA Y indicated R74 gets up in the morning and sits in the day room for most of the day and before CNA Y's shift ends R74 gets laid down for a while. Surveyor asks what activities R74 typically participates in, and CNA Y indicated R74 typically just sits in dining area on Willow. Surveyor asked CNA Y what activities R74 likes, and CNA Y indicated she does not know. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 10:14 AM, Surveyor interviewed CNA Z and asked what activities R74 participates in. CNA Z indicated R74 sits in front of the television or colors if staff sets her up. CNA Z indicates R74's normal routine is sitting in dining area most days. CNA Z indicated R74 is the only Spanish-speaking resident in the facility. On 3/10/25, at 10:20 AM, Surveyor interviewed LPN AA (Licensed Practical Nurse) and asked what activities R74 participates in. LPN AA indicated the staff will pull R74 out for bingo and if singers come R74 is taken out for that. On 3/10/25, at 11:37 AM, Surveyor interviewed FM BB (Family Member). FM BB indicated the staff will set R74 up to color, but she gets bored with that. R74 has no patience for coloring. FM BB indicated R74 gets frustrated easily and starts screaming names at staff due to the lack of understanding the communication and dementia. FM BB indicated R74 wants 1:1 communication where she can communicate with others. R74 gets frustrated because she does not have that communication with others. FM BB indicated R74 tells him she feels alone and no one in the facility cares for her. No other residents speak Spanish, so R74 has no one to converse with. FM BB indicated R74 enjoys cooking, folding clothes, house chores, and watching television. Surveyor asked FM BB what R74's normal day is like at the facility and FM BB indicated coloring if the staff set her up with the supplies to color. Surveyor asked FM BB if the facility sets up the television in closed captioning in Spanish for R74 and FM BB indicated no, the staff just turn on the animal channel or old shows. FM BB indicated again most times R74 is just sitting in the dining area. FM BB indicated he comes to see R74 every day between 3 and 6 PM and his wife comes in earlier. FM BB indicated R74 feels people are laughing at her and don't care about her because she cannot understand them. FM BB indicated this is another reason why he wants R74 transferred to another facility that has staff and other residents that speak Spanish. FM BB indicated he feels it has been very hard on R74 being at this facility. On 3/11/25 at 9:29 AM, Surveyor observed R74 laying in bed calling out in Spanish. On 3/11/25 at 2:17 PM, Surveyor observed R74 in activities. R74 was sitting with a blank piece of paper in front of her and talking nonstop in Spanish. Other residents were making rainbows with colored construction paper on the piece of paper. Two CNAs, CNA T and CNA SS, approached R74, one on each side of R74. R74 looking from one CNA to the other while speaking in Spanish. Surveyor approached both CNAs and asked what R74 was saying. CNA T indicated she does not know. CNA SS indicated she does not know but showed Surveyor a lavender translation ball she purchased from TikTok Shop. CNA SS indicated she sets it to Spanish when communicating with R74. While Surveyor was observing CNA SS did not attempt to use translation ball to try to understand what R74 was saying. On 3/12/25 at 2:43 PM, Surveyor observed R74 laying in bed speaking out loud in Spanish. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 8:11 AM, Surveyor interviewed SW H (Social Worker). SW H indicated she will be taking a turn filling in for activities along with other staff members until the activities position is filled by the facility. Surveyor asked what activities R74 participates in, and SW H indicated television. Surveyor informed SW H of the observation of R74 in front of television with no closed captioning in Spanish. Surveyor asked if that would be beneficial for R74, and SW H indicated its more for imagery. SW H indicated family suggested the animal channel or old tv shows. Surveyor informed SW H The Price Is Right was on the television. Surveyor asked if it would be beneficial for closed captioning in Spanish be set for R74 and SW H indicated we can try that. SW H indicated R74 enjoys napping, bingo, and activities with translation services. Surveyor asked if translation services are used during activities and SW H indicated she tried one time, and the service did not work as it stated R74 was not making sense. SW H indicated R74 means one thing, but it comes out another way. Surveyor asked SW H about R74's activity preference of listening to music. SW H indicated R74 has a radio in her room. Surveyor asked if Spanish music gets turned on for R74, and SW H indicated whatever music comes in with the antenna. Surveyor asked if it would be beneficial for R74 to have a radio station that is in Spanish. SW H indicated if it was classical without English language. Surveyor asked if facility has offered CDs in Spanish; SW H indicated no, we could ask the family. On 3/12/25 at 9:03 AM, Surveyor interviewed DON B and asked if television not in closed caption, in Spanish, would be appropriate for R74 who speaks Spanish only. DON B indicated no, not if it is not in closed captioning in Spanish. Surveyor asked if bingo and normal activities would be appropriate for R74. DON B indicated no, maybe with an interpreter. DON B indicated other activities of R74's interest and activities appropriate for R74's culture/language should be offered.

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F 0684 Level of Harm - 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** 49434 Based on observation, interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 3 of 20 sampled residents (R41, R73 & R37). R41 and R73 are being cited at severity level 3 (actual harm) R37 is being cited at severity level 2 (potential for more than minimal harm). R41 has diagnoses of congestive heart failure and protein calorie malnutrition. The facility failed to complete a RN assessment and monitor R41 for complications of her congestive heart failure (CHF) and protein calorie malnutrition. R41 was receiving a diuretic (a medication to remove excess fluid from the body via the kidneys) related to her CHF the facility failed to asses R41's weight response inlight of diuretic therapy. The facility failed to weigh the resident according to physician order, notify the physician of weight loss or gain of 3 lbs. in a day or 5 lbs. in a week. R41 had a weight loss of 13.2 lbs from 12/30/24-1/4/25 (6 days), and a weight gain of 4 lbs. from 1/4/25-1/5/25 (one day). R41 was ultimately hospitalized for acute exacerbation of her congestive heart failure on 2/22/25, requiring IV (intravenous) diuresis (removal of excess fluid within the body). R73 was taking an anticoagulant medication. The facility failed to adequately monitor R73's anticoagulant medication side effects and complete an RN assessment when bleeding occurred. R73 experienced a nose bleed that was unable to be stopped, had a drop in blood pressure, and was not sent to the emergency department until the next morning. This ultimately resulted in R73 being admitted to the hospital on 2/9/25, requiring 1 unit of blood and intravenous vitamin K to improve R73's ability to clot. Facility staff were not following physician orders for wound care treatment for R37. This is evidenced by: (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility policy entitled, Weight Monitoring, dated 11/1/23, states, in part: Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Compliance Guidelines: . Siginficant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem . 3. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the exten possible: a. Identified causes of impaired nutritional status b. Reflect the resident' spersonal goals and preferences c. idnentify resident-specific interventions d. time frame and parameters for monitoring e. Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or new causes of nutrition-related problems are identified f. If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate . 5. A weight monitoring schedule will be developed upon admission for all residents: . c. Residents with weight loss- monitor weight weekly d. If clinically indicated - monitor weight daily . 6. Weight Analysis: The newly recorded weight should be compared to the previous recorded weight 7. Documentation. a. The physician should be informed of a significant change in weight and may order nutritional interventions . c. Meal consumption information should be recorded and may be referenced by the interdisciplinary team as needed . e. The Registered Dietitian or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes. f. Observations pertinent to the resident's weight status should be recorded in the medical record as appropriate . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility policy entitled, Hydration (Food/Fluid) Monitoring, dated 10/30/24, states, in part: Policy: The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. Definitions: Sufficient fluid means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health . Compliance Guidelines: . 2. Identification/assessment: . *It is recommended that doctor's orders are obtained for fluid intake amounts, where renal or cardiac distress exists and excess fluids may be contraindicated . 4. Care plan implementation: The resident's goals and preferences regarding hydration will be reflected in the resident's plan of care. b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to: i. Offer the resident a variety of fluids during and between meals. ii. Provide assistance with drinking. iii. Ensure beverages are available and within reach. iv. Evaluate resident's medications that may place the resident at risk for dehydration. v. Offer alternative fluids such as broths, popsicles, gelatin, and ice cream. vi. Address underlying causes of dehydration or fluid imbalance. vii. 5. Monitoring/revision: a. Monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. b. The resident will be monitored for signs and symptoms of dehydration . c. The resident will be monitored for signs and symptoms of fluid overload: i. peripheral edema (noticeable swelling in the legs and arms) . iv. Shortness of breath, cough, presence of rales (fine, high pitched lung sounds indicating fluid in the lungs) such as in pleural effusion (excess fluid build up around the lungs) of CHF (congestive heart failure)) . d. The resident will be monitored for signs and symptoms of electrolyte imbalance: i. irregular or fast heart rate ii. Unexplained fatigue or lethargy . vii. Confusion . e. The resident will be monitored for conditions that may increase fluid needs: . v. New cardiac medication or diuretic f. The resident will be monitored for complications associated with interventions . h. The physician will be notified of: i. Signs and symptoms of dehydration, fluid overload, electrolyte imbalance, or conditions that may increase fluid needs. ii. Lack of improvement toward goals. iii. Any complications associated with interventions. 6. Documentation: a. Record observations pertinent to the resident's hydration status in the nurses' notes. b. Record beverage intake in designated locations (meal intake records, MAR (Medication Administration Record) as indicated). c. Record output in designated locations (MAR or output record) . f. Document assessments in designated locations . The facility policy entitled, Notification of changes, dated 8/27/24, states, in part: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Changes of condition require an evaluation, using the SBAR (Situation, Background, Assessment, Recommendation) Communication Form and Progress Note Evaluation) ensure proper documentation and notification has been made. Definitions: . Need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (such as adverse drug reaction) . The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: .3. Circumstances that require a need to alter treatment. This may include: a. New Treatment. b. Discontinuation of current treatment due to: i. adverse consequences . iii. Exacerbation of a chronic condition. Interact, a Change of Condition standard of practice, Version 4.0 tool states in part: Weight gain - report immediately 3 pounds in 3 days or 5 pounds in 7 days with heart failure, chronic renal failure, or other volume overload state. Example 1 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R41 was admitted to the facility on [DATE], with diagnoses that include: congestive heart failure (inadequate heart beats causing poor circulation and fluid buildup into the lungs), protein calorie malnutrition, atrial fibrillation, myocardial infarction (heart attack), deficiency of B group vitamins, dementia, malignant neoplasm of skin (skin cancer), and hypertension (high blood pressure). R41's Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 3/3/25, states that R41 has a Brief Interview for Mental Status (BIMS) of 7 out of 15, indicating that R41 is severely cognitively impaired. Section GG indicates R41 requires setup or clean-up assistance to eat. Section K indicates R41 does not have a swallowing disorder, had a height of 59 inches on admission, and weighed 68 lbs. as of most recent weight from the date of assessment. Nutritional approaches on admission and while a resident is indicated to be a mechanically altered diet. Section L indicates R41 has no dental concerns. R41's Comprehensive Care Plan, states, in part: Focus: The resident has dehydration or potential fluid deficit r/t (related to) HF (Heart Failure), poor appetite. Created date: 12/24/24. Goals: The resident will drink/take in a minimum of (SPECIFY)cc's each 24-hour period. Start Date: 1/24/25. (Of note: The care plan does not specify how much fluid R41 should be consuming). The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Created date: 12/23/24. Interventions: Ensure The resident has access to (SPECIFY: nectar thick liquids, no ice.y fluids i.e. cold water, thickened apple sauce) whenever possible. Start date: 3/6/25. (Of note: this intervention started after Survey entrance). Monitor vital signs as ordered/per protocol and record. Notify MD of significant abnormalities. Start date: 1/24/2025. Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Focus: The resident has nutritional problem or potential nutritional problem r/t (related to) noted dementia, protein-cal (protein calorie) malnutrition, afib (atrial fibrillation), CHF (Congestive Heart Failure), B vit def (Vitamin B deficiency), malignant skin (Skin cancer), multiple fx L/R leg (multiple fractures of left and right leg), HTN (hypertension), HLD (hyperlipidemia), osteoporosis, dysphagia, NSTEMI (Non-ST Elevation Myocardial Infarction (Heart Attack)). Created date: 12/24/24. Malnourished.Involuntary wt (weight) loss r/t decreased appetite/recent hospitalization AEB (as evidenced by) >5% wt loss x 1 mo (month); Swallowing difficulty r/t dysphagia dx AEB pureed texture, NTL (nectar thick liquids). Goals: The resident will maintain adequate nutritional status as evidenced by gradual wt gain, no s/sx of malnutrition, and consuming at least 75% of at least 2 meals daily through review date. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Monitor/record/report to MD PRN (as needed) s/sx (signs/symptoms) of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Created date: 12/24/24. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Created date: 12/24/24. Obtain weights per MD order/facility protocol. Created date: 12/24/24. Provide and serve diet as ordered; 2000ml FR (1080ml dietary). Created date: 12/24/24. Monitor intake and record q (every) meal. Created date: 12/24/24. RD (Registered Dietician) to evaluate and make diet change recommendations PRN. Created date: 12/24/24. On 12/23/24 R41 weighed 85lbs. R41's Weight Physician Orders state, in part: Obtain weight upon admission, then weekly for four weeks, then monthly every evening shift for baseline weight for 1 day weight and every day shift every Mon (Monday) for weight for 4 weeks weight and every day shift every 1 month(s) starting on the 1st for 7 day(s) for monthly weights. Start date: 12/24/24. End date: 1/20/25. R41's Medication Physician Orders state, in part: Lasix Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for edema until 12/25/24 23:59 (11:59 PM) and Give 1 tablet by mouth one time a day for edema until 12/27/24 23:59. Start date: 12/25/24. End date: 12/26/24. On 12/26/24 R41 weighed 87lbs A Medical Practitioner Note indicates the following. Date of service was 12/26/24. In the hospital, ENT (Ear, Nose and Throat) recommended a soft diet for six weeks and speech therapy recommended soft and bite-sized solids. Liquid consistency was discussed between hospital staff and FM LL (Family Member), R41's activated healthcare power of attorney, and thin liquids were initiated which R41 tolerated well. R41 was admitted for rehab in the presence of multiple medical comorbidities leading to a functional decline. R41 was admitted to the facility for skilled nursing and rehab. The assessment and plan indicate R41 was admitted for subacute rehabilitation and in the section marked CHF the note states: Monitor fluid input and output, mobility, maintenance with physical therapy, diuretics as needed, clinical and lab monitoring. Monitor further symptoms such as edema, weight gain, and shortness of breath. Physician orders: Chlorthalidone Oral Tablet (Chlorthalidone). Give 12.5 mg (milligrams) by mouth one time a day for HTN (hypertension), BLE (bilateral lower extremity) edema (swelling). Start date: 12/27/24. End date: 1/20/25. Start daily weights. Call if change of #3 (3 pounds) in 1 day or #5 (5 pounds) in a week. One time a day for HTN (hypertension). Start date: 12/27/24. End date: 1/20/25. Of note: R41's weight was not recorded or monitored according to physician orders on 12/27/24. On 12/28/24 R41 weighed 86.4 lbs On 12/29/24 R41 weighed 86 lbs (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 12/30/24, R41 weighed 86 lbs. On 12/31/24, R41 weighed 83.9 lbs On 1/1/25, R41 weighed 77 lbs. Of note: This is a 6.9 pound loss in 1 day and a 9lb weight loss in 2 days. There is no evidence the facility notified the physician of this loss per physician orders or completed a cardiorespiratory assessment for R41. On 1/2/25, R41 weighed 75.8 lbs. On 1/3/25, R41 Weighed 73.4 lbs On 1/4/25, R41 Weighed 72.8 lbs Of note: Between 12/30/24 and 1/4/25, R41 lost 13.2 lbs in 5 days. R41 was receiving diuretic therapy at this time however there is no evidence the facility assessed R41's intake versus output, addressed the increased weight loss with the physician/nurse practitioner per physician orders, or assessed R41's cardiorespiratoty status. On 3/12/25 at 9:15 AM, Surveyor interviewed NP HH (Nurse Practitioner). Surveyor asked NP HH about the weight loss from 12/30/24 to 1/4/25 and what she would expect facility staff to do. NP HH indicates she would expect staff to reweigh and assess R41, then notify a provider. Surveyor asked NP HH what interventions she could have put in place to stop, or slow R41's weight loss. NP HH indicated she was not the NP to see her on 12/26 but she may have considered adjusting the diuretic order and using a consistent scale and consistent weight method. On 1/5/25, R41 weighed 78.6 lbs Of Note: This is a 5.8 lbs weight gain in a day. There is no evidence the facility assessed R41's intake versus output, addressed the increased weight loss with the physician/nurse practitioner per physician orders, or assessed R41's cardiorespiratoty. On 1/6/25, R41 weighed 77.4 lbs On 1/7/25, R41 weighed 78.0 lbs On 1/8/25, R41 weighed 77.8 lbs On 1/9/25, R41 weighed 76.4 lbs On 1/10/25, there is no weight recorded for R41. On 1/11/25, R41 weighed 76.0 lbs On 1/20/25, R41 was discharged from the hospital back to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/20/25, R41's Clinical Transfer Report for R41's hospital admission. R41 was admitted to the hospital with diagnosis of hemorrhagic shock due to a GI (Gastrointestinal) bleed related to taking Xarelto (anticoagulant), elevated troponin (enzyme released by the heart muscle when it is damaged), and atrial fibrillation (irregular heart rhythm). In the hospital, R41's NT-proBNP (B-type natriuretic peptide: a protein released by your heart when it is working harder to pump blood), resulted on 1/20/25, shows a value of 35, 000, indicating an exacerbation of congestive heart failure. (Of note: The normal value for this test for stable heart failure is less than 450). Patient instructions state, in part: Reduce SODIUM in your diet to 2000 mg or less every day . Weigh yourself first thing every morning and write it down .CALL YOUR PROVIDER IF your weight goes up 5 pounds in a week OR your weight goes up 2 pounds from one day to the next; if you have increased shortness of breath; you have feet, ankle or abdominal swelling . Of Note: These patient instructions were not added to R41's physician orders or clarified by the facility. Weigh yourself first thing every morning and write it down. CALL YOUR PROVIDER IF your weight goes up 5 pounds in a week OR your weight goes up 2 pounds from one day to the next; if you have increased shortness of breath; you have feet, ankle or abdominal swelling . On 1/20/25, R41 weighed 72.8 On 1/21/25, R41 weighed 68.6 On 1/22/25, R41 weighed 68.3 There are no weights recorded for 1/23 or 1/24/25 On 1/25/25, R41 weighed 72.8 There are no weights recorded for 1/26, 1/27, 1/28 and 1/29/25 On 1/30/25, R41 weighed 70.8 On 1/31/25, R41 weighed 68.6 There are no weights recorded for 2/1, 2/2 and 2/3. On 2/4/25, R41 weighed 73.0 On 2/5/25, R41 weighed 73.2 On 2/6/25, R41 weighed 74.0 R41's Physician Orders state, in part: Monitor weight 3x weekly MWF (Monday Wednesday Friday) one time a day every Mon, Wed, Fri for weight monitoring. Start date: 2/7/25. End date: 2/14/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Of note: R41's weight was not recorded or monitored according to physician orders on 2/7/25, 2/10/25, 2/14/25, On 2/11/25, R41 weighed 73.0 On 2/12/25, R41 weighed 73.8 On 2/17/25, R41 weighed 73.4 On 2/18/25, R41 weighed 74.4 On 2/19/25, R41 weighed 74.0 On 2/22/25 at 9:00 AM, a Nurses Note is written, that states: Resident had a witnessed fall in the back common area with head injury. Nose, mouth bleeding, bump above right eye, having leg pain. POA (Power of Attorney) and DON (Director of Nursing) notified. Waiting for on call NP (Nurse Practitioner) to call back. 911 was called and EMTs (Emergency Medical Technicians) took her to [Hospital Name]. On 2/22/25 at 1:25 PM, a Nurses Note is written that states: Writer called [Hospital Name] to get report of resident from fall this morning. Resident does not have any acute injuries from fall, but O2 (Oxygen) sats (saturation) are running low, in the 80's (Normally 94-99) and they are continuing to monitor the resident. Nurse from [Hospital Name] will call back . On 2/22/25, R41 was admitted to the hospital with diagnosis of Acute Respiratory Failure with Hypoxia due to Acute Exacerbation of Chronic HFpEF (Heart failure with Preserved Ejection Fraction- Heart Failure without loss of cardiac output) and a fall. R41's Hospital Discharge Packet states, in part: . Hospital Course: Patient received some IV (intravenous) diuresis in ED (emergency department). Creatinine (waste product of muscle metabolism filtered out of blood by kidneys) up-trended without meeting criteria for AKI (Acute Kidney Injury/kidneys not functioning properly), but this improved with conversion to PO (by mouth) diuretic .on 2/26 thoracentesis (Procedure utilizing needle to remove fluid from the space around the lungs) performed with 950 mL removed and subsequent resolution of O2 need. Nutritional Assessment: Is this patient clinically malnourished?: Yes. Context of Malnutrition: Chronic Illness. Severe Malnutrition: Yes. Underweight, BMI <18.5: Yes. Weight Loss: >7.5% in 3 months. Body Fat: Severe Depletion. Muscle Mass: Severe Depletion . R41's Physician Orders state, in part: Torsemide Oral Tablet 20 MG (Torsemide) Give 1 tablet by mouth one time a day for heart failure related to unspecified diastolic (congestive) heart failure. Start date: 2/27/25. End date: 3/5/25. 2000ml Fluid Restriction every day shift for Fluid restriction Dietary = 840ml (breakfast & lunch) Nursing = 340ml AND every evening shift for Fluid restriction Dietary = 240ml (dinner) Nursing = 340ml AND every night shift for Fluid restriction Nursing 240ml AND every night shift for Fluid restriction. Add total fluid consumed for the day and record. Start date: 2/28/25. Active order. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Obtain weight daily. Have weight completed in the morning before breakfast one time a day for Heart Failure. Alert NP/MD if weight gain is >3 lbs. a day or >5 lbs in a week. Start date: 2/28/25. End date: 3/5/25. Of note: R41's weight was not recorded or monitored according to physician orders on 3/2/25. 3/4/25: 66.8 lbs. 3/5/25: 67.4 lbs. Of note: R41's weight was not recorded or monitored according to physician orders on 3/7/25, 3/8/25, and 3/9/25. R41's Physician Orders state, in part: ~Torsemide Oral Tablet 10 MG (Torsemide) Give 10 mg by mouth one time a day for fluid overload. Start date: 3/7/25. Active order. (Diuretic medication). ~Encourage fluids; 120 mL TID (three times a day) c (with) medication pass three times a day for hydration. Start date: 3/10/2025. Order Pending Confirmation. ~Obtain Weight daily. Have weight completed in the morning before breakfast. One time a day every Mon, Wed, Fri for Heart Failure. Update NP on 3/12/25. Start date: 3/7/2025. Active order. On 3/11/25 at 8:10 AM, Surveyor interviewed LPN JJ. Surveyor asked LPN JJ if she is familiar with R41's hall. LPN JJ indicates she always works the day shift on this hallway. Surveyor asked LPN JJ to describe R41's fluid intake. LPN JJ indicates R41 has poor fluid intake, is currently on a fluid restriction, but staff do try to help her hit her max for fluid intake. Surveyor asked LPN JJ if R41 is getting enough fluids. LPN JJ indicates she is not. On 3/11/25 at 8:24 AM, Surveyor interviewed CNA II. Surveyor asked CNA II if she is familiar with R41's hall. CNA II indicates she frequently works her hall. asked CNA II to describe R41's fluid intake. CNA II indicates that R41 needs to be encouraged to drink and that she tries to go into R41's room as often as she can to encourage her to drink. Surveyor asked CNA II if she thinks R41 drinks enough fluids. CNA II indicates R41 does not get enough fluids. On 3/12/25 at 5:20 PM, Surveyor interviewed DON B (Director of Nursing). Prior to starting this interview, Surveyor asked DON B if she would like to conduct this interview in her office, so she had access to a computer. DON B declined. Surveyor asked DON B what some of the interventions are they have put in place to prevent R41's weight loss. DON B indicates she does not have everyone's care plan memorized but is aware she is losing weight. Surveyor asked DON B about R41's 13.2 lbs. weight loss from 12/30/24 to 1/4/25, and what she would expect staff to do. DON B indicates she would expect staff to always reweigh the resident to confirm the weight, conduct an assessment, and notify the physician. Surveyor asked DON B about R41's weight gain from 1/4/25 to 1/5/25 and what she would expect staff to do. DON B indicates she would expect staff to follow physician orders for provider notification, reweigh the resident, assess the resident, and then notify the provider if ordered. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R41 had orders for daily weights - these were not completed as ordered and R41 had weights outside of MD parameters requiring immediate MD notification. R41 continued to lose weight without providing appropriate interventions to help her gain weight as was her goal. On 2/22/25, she was admitted to the hospital for acute exacerbation of her heart failure after initially being transported to the emergency room after a fall. The facility failed to complete a comprehensive system assessment in a resident with a known history of CHF and respiratory failure. The facility failed to notify the physician of changing weights. The facility failed to implement interventions to increase R41's food and fluid intake. R41 was sent to the hospital and found to have an acute exacerbation of CHF requiring aggressive diuresis, thoracentesis, and medical intervention. Example 2 R73 was admitted to the facility on [DATE] with diagnoses that include, in part: other complication of kidney transplant, chronic obstructive pulmonary disease (lung disease causing damage to lung tissue and difficulty breathing), peripheral arterial disease (Poor blood circulation in the lower arms and legs) type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema (Diabetes causing vision loss), heart failure, cerebral infarction (stroke), hypertension (high blood pressure) and moderate protein-calorie malnutrition. R73's Physician Orders state, in part: Eliquis (Blood thinner) Oral Tablet 5 MG (Milligrams) (Apixaban) Give 1 tablet by mouth two times a day for Pulmonary Embolism (Blood clot in lungs). Start date: 12/24/24. Active Order. R73's Comprehensive Care Plan does not contain any monitoring for adverse events of anticoagulant medication. R73's Medication Administration Record (MAR) indicates R73 received her dose of Eliquis twice a day from 12/25/24 through 2/8/25 as ordered by the physician, except when R73 was hospitalized . Blood pressure and heart rate monitoring were completed with each dose. (Of note: R73's Medication Administration Record and Treatment Administration Record)TAR) contain no documentation related to monitoring the signs and symptoms of anticoagulant (blood thinners) adverse events). On 2/8/25 at 7:31 AM, R73's blood pressure was assessed alongside her anticoagulant administration according to physician order. R73's blood pressure was 84/56. No further assessment was completed for R73, and the physician was not notified of R73's low blood pressure. On 2/8/25 at 7:04 PM, R73's blood pressure was assessed alongside her anticoagulant administration according to physician order. R73's blood pressure was 89/43. No further assessment was completed for R73, and the physician was not notified of R73's low blood pressure. On 2/9/25 at 1:35 AM, a Nurses Note is written by LPN TT (Licensed Practical Nurse) that states: patient reports having a nosebleed. Nose was assessed and nosebleed stopped by patient applying pressure with paper towel PRN (as needed) nasal spray was given to moisturize nostrils. Patient is being monitored for nose bleeds. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/9/25 at 2:58 AM, a Nurses Note is written by LPN UU that states, in part: At approximately 2315 (11:15 PM), the resident activated the call light requesting loperamide (antidiarrhea medication), stating she had been asking for it all night. Thirty minutes later, the call light was used again, and the resident requested creams for her shoulders and feet. Another 30 minutes later, the resident activated the call light again, requesting nasal spray due to a slight bloody nose . The nasal spray was administered, and the bleeding stopped. However, 30 minutes later, the resident activated the call light again for nasal spray, as it appeared she had been picking at her nose .Patient is frequently rounded on by nurses and assistive staff. On 2/9/25 at 9:55 AM, a SBAR Communication Evaluation is written by LPN VV that states, in part: Situation: Patient has a nose bleed. Reported to this nurse by NOC (Night Shift) nurse that nose had been bleeding all night. Patient is on blood thinners. Resident is in facility for post-acute care .Notifications: Provider: 2/9/25 at 7:28 AM. (Of note: Provider notification made around 7 hours after initial nose bleed began and around 24 hours after initial low blood pressure). On 2/9/25 at 10:57 AM, a document titled, ED (Emergency Department) Transfer Summary was completed by an outside hospital registered nurse. This document states, in part: .History of the present illness: [ED Nurse Name], RN: Patient presents to the ED via EMS (Emergency Medical Services) from [Facility Name] SNF (Skilled Nursing Facility) for Bloody Nose. Pt (Patient) bloody nose started last night sometime, denies hitting her head or falling. Pt is on anticoagulants. Pt arrives with nose clamp applied; no active bleeding observed when clamp removed by RMD (Resident Medical Doctor) at bedside upon arrival. Pt also reports several months of diarrhea, cough, and chills. Pt reports she is at SNF for rehab (rehabilitation) for L (left) foot pain . EMS reports pt is normally hypertensive (High blood pressure) at baseline, 108/55. All other VSS (Vital Signs Stable) . (Of note: R73's blood pressure on arrival to the emergency department was 95/57 with a pulse of 104). Summary (events, concerns, course of treatment): Nose stopped bleeding after self-removing clamp. Intermittent nose dripping due to patient blowing nose/picking nose . Small amount of black/bloody stool noted on brief change. Lab results were significant for a Hemoglobin (Protein that carries oxygen in red blood cells) of 7.1 (Normal is 11.7-13.8 gm/dL) and Hematocrit (Amount of red blood cells compared to the total blood cell count) of 23 (Normal is 36-48%). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/9/25 at 3:13 PM, a document titled, History and Physical - [Hospital Name] General Medicine Service is signed by an outside hospital physician. This document states, in part: HPI (History of Present Illness) [Resident Name] . admitted for epistaxis (nose bleed) and melena (blood in stool) concerning for potential GI (gastrointestinal) bleed . The epistaxis began spontaneously on the[sic] evening of 2/8 and reports having clots. No history of epistaxis. The patient is on apixaban for chronic, severe PAD (peripheral arterial disease). She had a nose clamp applied by EMS and when removed in the ED there was no active bleeding appreciated. There has been a small amount of intermittent nose bleeding that occurs when the patient blows/picks nose. During care in the ED, she was noted to have a small amount of black/bloody stool and had a stool guaiac completed which was positive for blood. She was noted to have a hemoglobin of 7.1 so the patient was given 1u (unit) of PRBCs (Packed Red Blood Cells) in the ED. She has some unspecified diffuse epigastric pain to palpation . No previous report of blood or black stools. No use of NSAIDs (non-steroidal anti-inflammatory medications, which can cause GI bleeds) . Feels fatigued . This document notes an INR (International Normalized Ratio/lab checks blood clotting time) lab of 2.2 (Normal is between 0. 8 and 1.2) on 2/9/25 at 10:12 AM. The section of this document titled Assessment & Plan states, in part: . #Epistaxis #Anemia . -Holding anticoagulation, consider resuming tomorrow -IV (intravenous) vitamin K (vitamin that is essential for normal blood clotting) for INR 2.2, suspect related to malnutrition CKD/ESRD (Chronic Kidney Disease/End Stage Renal Disease) . #C/f (Clinical features) GI bleed #Melena #Unspecified epigastric abdominal pain #Hx of colon cancer .Favor epistaxis as cause for melena, however, given GI history, vague abdominal pain, and recent seemingly worsening fatigue and generalized malaise. -GI consulted -Holding anticoagulation, consider resuming tomorrow . On 2/9/25 at 8:27 AM, a Gastroenterology Inpatient Consultation note is written by an outside hospital physician. This note states, in part: Pt was in her normal state of

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253 Based on observation, interview and record review, the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable for 3 of 3 residents reviewed for pressure injuries (R25, R65, and R61). R25 is being cited at severity level 4 (Immediate Jeopardy). R65, is being cited at severity level 3 (actual harm) and R61 is being cited at level 2 (potential for more than minimal harm). R25 was at risk for developing pressure injuries related to immobility and history of poor nutrition. The facility failed to implement aggressive pressure injury interventions; failed to implement orders timely; failed to provide risk and benefits despite knowledge of R25 refusing repositioning. Surveyors observed R25's treatment to not be in accordance with orders and facility staff did not wear the appropriate PPE (Personal Protective Equipment). R25 developed an in-house unstageable pressure injury on her sacrum on 2/8/25 and required transfer to the hospital on 3/6/25 where R25's sacrum wound was assessed as stage IV and infected. Facility failure to ensure R25 received care consistent with professional standards of practice to prevent pressure injuries from developing or deteriorating, created a finding of immediate jeopardy that began on 3/7/25. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the immediate jeopardy on 3/12/25 at 5:12 PM. The immediate jeopardy was removed on 3/13/25. However, the deficient practice continues at a scope/severity of G (actual harm/isolated) as the facility continues to implement its action plan and as evidenced by the following. R65 was at risk for pressure injury (PI) development. On 2/11/25 NP C (Nurse Practitioner) ordered Apply skin prep to R (right) foot two times a day for blanchable redness with intact skin. NP C assessed R65 on 2/17/25 noting no lesion on exposed skin. On 3/3/25 during a routine visit, NP C discovered R65 has an Unstageable PI to the right later heel. NP C stated, she always checks R65's heels for any signs of PI's as he is at high risk for PI's due to his positioning. R65 is continually in a fetal position on his left or right side due to bilateral knee contractures. NP C stated, the facility did not notify her or any provider regarding this Unstageable PI. NP C stated, R65 will not allow for frequent repositioning; he needs pillow placement and offloading. The facility staff did not implement appropriate offloading interventions until after the PI was discovered. Despite facility staff applying skin prep to the PI twice daily, nursing staff did not identify the Unstageable PI, assess and measure the PI, and notify the provider. R65 stated staff were not turning and repositioning him every 2 hours and have not provided risks and benefits regarding not repositioning at least every 2 hours. Surveyor observed R65's PI uncovered and open to air. CNA G (Certified Nursing Assistant) stated she noted R65's dressing was off approximately 1.5 hours prior to Surveyor's observation and did not notify the nurse. Surveyor observed R61 laying on specialized air mattress with 3 layers of sheets and chux pad under R61. R61 is at risk for pressure injuries. Findings include The facility's policy, titled Pressure Injury Prevention and Management states, in part: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. *Licensed nurses will conduct a pressure injury risk evaluation, using the Braden, on all residents upon admission/re-admission, weekly for four weeks, then quarterly or whenever the resident's condition changes significantly. *The Braden will be used in conjunction with other risk factors not captured by the risk evaluation tool. Examples of risk factors include, but are not limited to: Impaired/decreased mobility and decreased functional ability, comorbid conditions, resident refusal of some aspects of care and treatment cognitive impairment, exposure of skin to urinary and fecal incontinence, and malnutrition. *Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. *After completing a thorough assessment evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. *Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment *Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i.) Redistribute pressure (such as positioning, protecting and/or offloading heels, etc.); ii.) minimize exposure to moisture and keep skin clean; iii.) Provide appropriate, pressure-redistributing, support surfaces; iv.) Provide non-irritating surfaces; and v.) Maintain or improve nutrition and hydration status, where feasible *Interventions will be documented in the care plan and communicated to all relevant staff. *Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: i.) Changes in resident's degree of risk for developing a pressure injury, ii.) New onset or recurrent pressure injury development iii.) Lack of progression towards healing iv.) Resident non-compliance and v.) Changes in the resident's goals and preferences comma such as end of life or in accordance with his/her rights. According to National Pressure Injury Advisory Panel (NPIAP) <https://npiap.com/page/PressureInjuryStages> Definitions of staging state: Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Example 1 R25 was admitted to the facility on [DATE], from the hospital and has diagnoses that include Type II Diabetes, pulmonary embolism (blood clot in the lungs), seizure disorder, severe protein calorie malnutrition and coronary artery disease status post single-vessel CABG (Coronary Artery Bypass Graft; to improve blood flow to the heart by bypassing narrowed or blocked arteries). Her hospital discharge paperwork indicates she had been in the hospital from 9/2/24 to 10/25/24 in part due to septic shock and infection of the post CABG sternal wound. Her admission Minimum Data Set (MDS), dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 15, indicating R25 was cognitively intact. The functional abilities section of this MDS (section GG) also indicated R25 was independent rolling side to side, sitting to lying, lying to sitting and sitting to standing. Additionally, this MDS indicated R25 needed supervision with chair to bed transfers, could walk 10 feet with supervision, and could walk 50 feet with maximal assistance. R25's care plan states, Focus: the resident has actual impairment of the chest related to infection of surgical site after CABG (initiated 2/1/25). Goal: the resident will maintain or develop clean and intact skin by the review date. Interventions: assist to turn and/or reposition every 2-3 hours (initiated 10/26/24), pressure reduction mattress (initiated 10/26/24), monitor skin during cares, report to nurse any changes (initiated 10/26/24). Additionally, R25's care plan states, Precaution: Enhanced barrier precaution related to impaired skin integrity. Goal: resident will remain free from infection or infectious concerns through review date. Interventions: follow enhanced barrier precaution protocol when coming in contact with resident (initiated: 11/12/24). R25's nutrition care plan states, Focus: The resident has nutritional problem or potential nutritional problem related to .severe malnutrition, history of morbid obesity status post gastric bypass .severe protein calorie malnutrition (dated 10/27/24). Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight with no significant adverse triggers, no signs or symptoms of malnutrition .Interventions: Administer medications as ordered .honor food preferences .I cannot have a PEG (Percutaneous endoscopic gastrostomy/feeding tube) placed given my previous bypass surgical procedure history .I desire to not have additional portions or nutritional supplements at this time. I am willing to try prostat supplement at this time (dated 2/7/25) On 11/26/24, R25 was sent to the hospital due to confusion and aphasia. She was found to have a late acute to subacute ischemic infarction. Additionally, her sternal wound was growing MSSA (Methicillin-susceptible Staphylococcus aureus, a type of bacterial infection) and Pseudomonas (bacteria). R25 remained at the hospital until 12/30/25 at which point she was admitted back to the facility to a different room. A facility skin check on 1/14/25 states R25 has redness around coccyx, dry and fragile, irritation/redness. On 1/14/25, the facility conducted a Braden (scale for predicting pressure sore risk) on R25 which resulted in a score of 15, indicating R25 was at risk for pressure injury development. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility occupational therapy documentation, dated 1/17/25, indicates R25 had become totally dependent on staff, requiring maximum assistance for toileting, mobility and transfers during ADLs (activities of daily living). Additionally, a physical therapy note, dated 1/17/25 states, Discussed with patient and IDT (Interdisciplinary Team) patient participation in therapy, goals, and plan of care. Educated patient on performing activities including bed mobility, at end of bed, and attempting transfers with therapy team. Patient showed fair-poor understanding and continued to decline out of bed or end of bed acts during discussion and for therapy this date. R25 was sent back to the hospital on 1/19/25 due to hypotension R25 returned to the facility on [DATE] with additional diagnoses of metabolic encephalopathy and continued protein calorie malnutrition. On 1/31/25, the facility began monitoring for signs and symptoms of malnutrition such as emaciation, muscle wasting, noticeable fat loss, fluid accumulations such as edema or ascites, nausea or vomiting, constipation or diarrhea, new wounds or worsening of wounds, infection. This was monitored 3 times daily. As part of the re-admission assessment, the facility noted that R25 did not have any additional wounds other than her known abdominal and chest wounds (from admission on 10/25/24). The facility conducted a Braden assessment on 2/2/25 with a resulting score of 11. On 2/8/24, the facility identified an open area on R25's coccyx and noted the wound to be an unstageable pressure injury, 5 cm x 4 cm (L x W) with 20% slough 80% eschar. Of note, this pressure injury was not added to R25's care plan, nor were any additional interventions added to her care plan to specifically address her coccyx wound. A note by NP C (Nurse Practitioner), dated 2/10/25 states, Pressure ulcer of sacral region, stage 3. New wound noted by nursing to coccyx with evaluation today. 100% slough. Treatment orders provided to floor nurse including Medihoney to wound bed followed by alginate and bordered foam to be changed 3x/week and as needed. Offloading mattress to be ordered. Prostat nutritional supplement 30 ml each day for wound healing was ordered and tracked for R25 beginning 2/11/25. R25 had refused all supplements, extra portions and additional protein in meals to this point. A 2/3/25 nutritional note states, in part, She (R25) doesn't want greasy food or spaghetti. Her food preferences/intakes vary pending on the day. She is aware of alternative menu, declines wanting a weekly menu. She doesn't want any nutritional supplement anymore (previously had Juven but she had it too much, other supplements not desired). No desire having additional portions with meals. She does want apple/grape juice as preference. Her son will bring food for her (mostly restaurant food) almost daily. Pudding/Jello/water in her room as preference .independent with meal setup assistance. On 2/17/25, R25's coccyx wound measured 5cm x 4cm, noted as an unstageable with slough and eschar. Further assessment notes by NP C state, Patient seen today resting in bed appearing comfortable. DON (Director of Nursing) present doing wound care today. Surgical wound assessed and overall appears cleaner with no further eschar to wound edges. Coccyx wound had already been changed at time of my visit and not visualized today. Patient without any fevers or chills. Appetite poor however improved from previous. R25 tested positive for COVID on 2/22/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/25/25, the wound is assessed as 7 cm x 3 cm, unstageable with 50% slough, 50% eschar. Further details of this assessment state, Consultation with NP this date regarding concerns with wound decline. Peri-wound is red and resident has increased pain. Measurements are larger. Continues to be unstageable. NP ordered labs and change in treatment order and will see resident on Monday 3/3 for further evaluation. Resident provided education on importance of repositioning. Resident states she cannot lay on her side due to her chest wounds. Worked with resident to position with pillow wedging to relieve some pressure on bottom. Resident also re-educated on need for optimal nutrition to support wound healing and resident verbally understood. On 3/3/25, the facility assessed R25's coccyx wound to be 9 cm x 8.8 cm with 50% slough 50% eschar and described as a suspected deep tissue. Further notes on the assessment state, Resident signed on with hospice with intent of better pain control. Medical Director has been alerted of wound and the unavoidable nature of issue. New wound orders given by NP. Resident is unable to fully perform turning and repositioning d/t (due to) nature of additional wounds on body. A note by NP C, dated 3/3/25 at 8:45 AM states, Pressure ulcer of sacral region, unstageable. Worsening pressure ulcer to coccyx now unstageable. There is significant amount of drainage and patient with significant pain. She continues on offloading mattress. Very poor nutrition nutritional status with high risk for nonhealing of multiple wounds. Treatment nurse to continue weekly wound assessment with treatment plan as directed. Orders given today for Dakin's dampened gauze packing followed by dry dressing. Hospice discussed today with informational meeting to be set by social worker. In addition, a facility progress note details an order by NP C on 3/3/25 at 11:42 AM, stating, NP ordered wound culture for resident to be completed. Writer contacted Simple Labs in regards to having a supply of wound culture swabs sent .Simple Labs informed writer that they could take up to 2 days to be delivered, but that the order was placed. Wound culture to be collected upon arrival of swabs. No further actions to note. Resident started hospice on 3/4/25. On 3/5/25 A note by MD PP (Medical Doctor), who is also the facility's Medical Director, states, It appears that the patient has developed a Candida ulcer in the sacrum. Had sudden onset and this is an unavoidable ulcer secondary to her chest wounds and inability to maintain nutritional status as well. She has very poor oral intake along with the fact that she is not a candidate for a PEG tube due to her chest wounds and she cannot also have positional change associated to offload secondary to her chest wounds. She has very low albumin and prealbumin. Repositioning is not effective due to her chest wounds. She has now signed onto hospice as well. Her wound is unavoidable. According to the State Operations Manual to determine unadvoidable would show the facility did the following: Conducted an accurate and comprehensive assessment including evaluating the resident ' s clinical condition and risk factors for the concern being investigated; Based on information gathered through resident assessments, with resident/representative input, developed a person centered care plan, defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; Implemented the care plan, and monitored resident responses to the interventions; and (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provided ongoing review and revision of the care plan and interventions as necessary. If the facility has not done one or more of the above bulleted items, this would be considered avoidable. It should be noted R25 was at risk for PI development and despite the facility discovering an unstageable PI, R25's reluctance to reposition, the facility did implement or revise R25's care plan to ensure robust care plan interventions were implemented to prevent further decline in R25's skin/PI. It should be noted that the facility addresses resident repositioning in their Electronic Health Record (EHR). For R25, facility staff documented repositioning daily in 2025 as follows: 1/1: 3x 1/2: 3x 1/3: 2x 1/4: 2x 1/5: 3x with one refusal 1/6: 2x 1/7: 3x 1/8: 2x 1/9: 3x 1/10: 3x 1/11: 3x 1/12: 2x 1/13: 2x 1/14: 3x 1/15: 2x 1/16: 2x 1/17: 1x 1/18: 3x (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1/19/25 through 1/31: Hospital 2/1: 2x 2/2: 4x 2/3: 2x 2/4: 2x 2/5: 3x 2/6: 2x 2/7: 3x 2/8: 3x 2/9: 2x 2/11: 3x with 1 refusal 2/12: 2x 2/14: 3x 2/15: 1x 2/16: 2x 2/17: 2x 2/18: 2x 2/19: 4x 2/20: 1x 2/21: 2x 2/22: 2x 2/23: 2x 2/24: 2x 2/25: 2x (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/26: 2x 2/28: 5x with 5 resident refusals 3/1: 3x with 1 resident refusal 3/2: 7x with 3 resident refusals 3/3: 6x 3/5: 4x 3/6: 5x No repositioning or refusals were documented for 2/13, 2/27, and 3/4. On 3/5/25 at 11:20 AM, Surveyor observed R25 in her bed. Surveyor attempted to ask R25 questions to which R25 responded with inaudible and incoherent answers and words. The head of R25's bed was up and it appeared that she could move very little. On 3/6/25 at 9:56 AM, Surveyor observed wound care on R25. R25 had the following wound care orders: Wound care: Coccyx wound Cleanse with wound cleanser; pat dry; apply dakins [sic](1/4 strength) moistened gauze; apply hydralock dressing; apply ABD; secure with tape. Every day shift for wound care to coccyx. It is important to note that R25 is on EBP (Enhanced Barrier Precautions), requiring staff to wear gloves, gown, and mask while performing cares. RN F (Registered Nurse) and CNA G (Certified Nursing Assistant) entered R25's room without performing hand hygiene and without wearing a gown. RN F removed the old mepilex dressing that was saturated with purulent and bloody drainage. RN F then cleansed the wound with wound cleanser. Surveyor observed R25's wound. The wound was slightly larger than a golf ball and was deep. The wound had a large flap of slough hanging from it. The wound bed was mostly slough covered (approximately 75%) with necrotic tissue (approximately 25%). The peri wound was bright red. RN F changed her gloves and did not perform hand hygiene. RN F applied the Dakin's-soaked gauze, skin prep applied to peri- wound, hydralock applied, and covered with a mepilex. RN F changed her gloves, but did not perform hand hygiene and began incontinence care, as R25 was incontinent of stool. RN F changed her gloves, but did not perform hand hygiene and performed catheter care on R25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor observed that R25 was on an air mattress and had several layers underneath her. Prior to wound care R25 had a fitted sheet, a draw sheet, and an incontinence brief. After wound care, R25 had a fitted sheet, a folded blanket, and an incontinence brief. R25 was calling out in pain throughout the entire wound care. RN F reported that R25 was premedicated, but did not stop wound care at any time. On 3/6/25 at 10:28 AM, Surveyor interviewed CNA G. Surveyor asked CNA G what type of PPE (Personal Protective Equipment) should be worn in a room that has EBP, CNA G reported that they should wear a gown, gloves, and a mask. Surveyor asked CNA G if she should have been wearing a gown during wound care, CNA G stated yes. On 3/6/25 at 10:28 AM, Surveyor interviewed RN F. Surveyor asked RN F what PPE should be worn in a room with EBP, RN F stated gloves and mask, but that she wasn't sure about a gown. RN F and Surveyor reviewed the EBP sign on R25's door. Surveyor asked RN F if she should have had a gown on, RN F stated yes. Surveyor asked RN F if she had any missed opportunities for hand hygiene, RN F stated yes, she should have performed hand hygiene before starting wound care. Surveyor asked RN F if she should have performed hand hygiene after taking off soiled gloves and before applying clean gloves, RN F stated yes. Surveyor asked RN F if R25's order was for an ABD pad, RN F stated yes and she should have applied an ABD pad to the wound. A progress note dated 3/6/25 at 2:23 PM states, Per resident and family request, resident is being sent to emergency room for pain management and evaluation. Documentation from the hospital, dated 3/7/25 notes R25's wound as a Sacral stage 4 infected pressure injury with [NAME] purulence, odor and extensive undermining from 7-11 o'clock (deepest 8cm). The documentation states, Staff aware of 50ml of [NAME] purulence milked from left lateral and superior wound bed. Unable to completely irradiate related to pain, thus stopped wound manipulation with goals of comfort. This documentation did not refer to or mention the wound as being a [NAME]-type ulcer. On 3/10/25 at 11:42 AM, Surveyor interviewed NP C (Nurse Practitioner) who indicated that typically when she makes an order for an air mattress, it likely means that the resident had the standard mattress and not an air mattress at that time. When asked about the delay in getting the wound culture, NP C indicated that she was not concerned about it and did not think it was going to reveal anything and indicated lab supplies were not always readily available for such wound cultures. Additionally, NP C stated that she was questioning whether R25's wound was a Kennedy ulcer. When asked when she began questioning this, NP C stated it would have been in one of her notes. When asked if it was her 3/3/25 note, NP C stated, Yes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/10/25 at 1:41 PM, Surveyor interviewed IP D (Infection Preventionist), who is an LPN (Licensed Practical Nurse) and the facility's wound care nurse. IP D stated that the redness that was noted on R25's coccyx on 1/14/25 cleared up and was not noted after that date. IP D stated that R25 cannot turn on her side due to her sternal surgical wound. R25 also stated that the facility spoke with MD PP (Medical Doctor) regarding R25's pressure injury and asked for the doctor to note the wound as unavoidable. IP D stated that R25 could be offloaded with the help of pillows but could not go beyond approximately 45 degrees when on her side due to pain, but this would offload the wound some and provide some relief. IP D indicated that R25 was able to pull herself over with the sidebars on her bed and wedge pillows under herself. IP D indicated that he had witnessed R25 doing it herself, but couldn't recall the last time he visualized this. IP D indicated it was the around the first week of March that R25 started losing the ability to reposition herself, but also stated that after R25's first hospital stay (return 12/30/24), she became completely bed bound. IP D indicated that he was not aware if nurses or CNAs were checking in on R25 and documenting repositioning. IP D also indicated that R25 was on an air mattress when she first came to the facility on [DATE]. When asked why NP C would order an air mattress if she already had one, IP D stated he was not sure, but could speak with maintenance regarding the placement of all mattresses in the facility. Additionally, IP D stated that his note on the 3/3/25 assessment of R25's wound as suspected deep tissue injury was a mistake and it should have read unstageable. Of note, facility orders show an order for low loss air mattress Frequent repositioning, dated 10/26/24. The facility was unable to provide further detail of this or if an air mattress was in place at this time. On 3/11/25 at 9:50 AM, Surveyor requested, from maintenance, any records relating to R25 and air mattress placement. Maintenance provided Surveyors with a work order, dated 2/18/25, which reads, Resident needs air mattress, resident room-[number]. This was requested by SSA X (Social Services Assistant). This was the only record provided to Surveyors. No other work orders or mattress orders/placements were provided. On 3/11/25 at 10:00 AM, Surveyor interviewed SSA X who stated that he had put in the work order for an air mattress on 2/18/25 because he believed R25 was on an inappropriate mattress. When asked if that meant she was on the standard mattress issued to all residents upon admission, SSA X stated, I don't believe she was on an air mattress, which is why we put the work order in. It should be noted that documentation issued to Surveyors indicates the facility's standard mattress (Proex pressure redistribution mattress) is listed as effective through state 2 wound therapy. Surveyor again interviewed IP D on 3/11/25 at 10:10 AM. When Surveyor described the work order, IP D stated that when R25 went to the hospital back in December 2024, she had stated that she did not want to come back, so her room was given to another resident. IP D suggested that when R25 came back to the facility, she was placed in another room, which only had the facility's standard mattress and would make sense that NP C would have to create another order for an air mattress on 2/10/25. Additionally, IP D indicated that the wound culture that NP C ordered on 3/3/25 and gathered on 3/6/25 was discarded by hospice as R25 was discharged from their care when she went to the hospital. Facility census records show R25 was originally in room [number]. When she was discharged to the hospital on 11/26/24 and returned on 12/30/24, she was returned to room [different room number] where she remained until her most recent hospital stay, beginning on 3/6/25. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/11/25 at 2:32 PM, Surveyor interviewed MD PP who stated that he looked at R25's wound on 3/5/25 but does not remember what it looked like or when it started, but that it was a Kennedy ulcer. MD PP indicated that the problem with R25 is that she could not be repositioned. It should be noted MD PP did not clasify this PI as a Kennedy terminal ulcer (KTU) on 3/5/25. On 3/12/25 at 11:29 AM Surveyor interviewed CNA II who stated that R25 needed a lot of help with repositioning but that she refused most times this was offered. CNA II stated that staff were to ask her every 2 hours to be repositioned. CNA II stated they would use pillows underneath both sides of R25 and her knees and they would chart when she refused repositioning. On 3/12/25 at 11:58 AM, Surveyor interviewed CNA S who stated that R25 was unable to reposition herself and needed staff to reposition her side to side every 2 hours. CNA S stated that R25 would refuse and would use her call light later to then request repositioning. CNA S stated that R25 always refused to get out of bed but he could get her to reposition in bed when she refused by explaining to her the reasons she needed to be repositioned and that they didn't want the wound on her bottom to get worse. CNA S also stated that when R25 would refuse, he would let the nurse know so she could document the refusal. On 3/12/25 at 12:55 PM, RN U stated that R25 was not good at repositioning herself. RN U stated she does not recall if R25 was on a repositioning program or was to be repositioned regularly. On 3/12/25 2:13 PM Surveyor interviewed DON B (Director of Nursing) who indicated that that the nursing standard for repositioning a resident with a wound like R25's is every 2 hours. DON B stated that it is her expectation is that staff would be repositioning R25 every 2 hours, documenting refusals or letting the charge nurse know so that they can document the refusal. DON B stated that staff had attempted to use pillows to wedge R25 off her bottom but that she would pull the pillows out. DON B stated that she had not given R25 any risks and benefits regarding her repositioning in relation to the sacrum wound. DON B stated that the facility did not put the air mattress into place for R25 when it was ordered and although there was a delay, that delay did not cause any harm to R25. Additionally, DON B indicated that the wound culture ordered on 3/3/25 was not expected to be gathered for 2-3 days due to waiting on supplies from the lab they use. When asked if this process could have been expedited another way, DON B indicated that it's the same issue everywhere with supplies. R25 was admitted with a history of wound infection and malnutrition. R25 began to decline after multiple hospital stays. R25 was admitted with orders for an air mattress. After returning to a different room from a hospital stay on 12/30/24, R25 was without the air mattress. An unstageable pressure injury was discovered on R25's coccyx on 2/8/25. Orders were placed again for an air mattress on 2/10/25, which was not put into place until 2/18/25. The facility did not care plan any additional measures for R25 when her coccyx wound appeared and facility staff were not consistently repositioning R25, as was expected by DON B and R25's care plan. Staff stated R25 would refuse repositioning, but this was documented only 11 times between 1/1/25 and her exit from the facility on 3/6/25. R25's wound deteriorated from 2/8/25 until she was sent to the hospital on 3/6/25. Hospital documentation details the wound had progressed to a stage 4 and was infected. A wound culture that was ordered on 3/3/25 was not gathered until 3/6/25. Facility staff was observed on 3/6/25 performing wound care incorrectly and without the required PPE. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The failure to ensure R25 received care consistent with professional standards of practice to prevent pressure injuries from developing or deteriorating led to serious harm for R25, which created a finding of Immediate Jeopardy. The facility removed the jeopardy on 3/13/25 when it completed the following: ~If R25 returns to facility, the following actions will be taken by Director of Nursing and/or Designee upon return: *Care Plan review to ensure robust and individualized interventions are in place and appropriate for residents' current condition, will be reviewed for changes if applicable *Review documentation in resident's medical record as it relates to turn and repositioning by staff for opportunity, updates to PCC (EMR) Tasks / POC charting to reflect current documentation needs *Upon resident's return, the need for a Risk vs. Benefit discussion will be evaluated based on residents' condition and completed if applicable at time of readmission For all other residents on 3/13/2025: ~Skin Evaluations completed on active in-house residents by Director of Nursing and/or Designee on 3/12/2025 with no additional significant results. ~Braden Risk Evaluations completed and reviewed on active in-house residents by the Director of Nursing and/or Nursing Managem [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure that the residents environment remained free of accidents and hazards for 1 of 7 residents (R61) reviewed for accidents. Surveyor observed R61's bed was not in the lowest position and staff reported the bed was broken. Surveyor observed R61's fall mats and call light not in place. Evidenced by: The facility policy, Accidents and Supervision, dated 12/22, states, in part; .The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents .3. Implementing interventions to reduce hazard(s) and risk(s) . R61 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, stroke, anxiety disorder, and other seizures. R61's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/5/25, indicates R61 has a Brief Interview for Mental Status (BIMS) score of 04, indicating R61 is severely cognitively impaired. R61 has an activated power of attorney (POA). R61's Comprehensive Care Plan, states, in part; .The resident is resistive to care r/t anxiety trauma with falling in shower at home, dementia 1/10/25 .The resident is at risk for falls, accidents and incidents r/t chronic diseases not able to stand 6/3/24 .staff to ensure bed in lowest position when pt in bed 8/23/24 .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed . 6/3/24. Special instructions: .bed in lowest position with floor mats at bedside . On 3/6/25 at 9:08 AM, Surveyor talked with POA O, R61's Power of Attorney. POA O indicated R61 is supposed to have fall mats but does not have them. POA O indicated R61's bed is supposed to be in the lowest position when she is in bed, but he has observed this not in place as well. On 3/6/25 at 10:30 AM, Surveyor observed R61. R61 was sleeping in bed. R61's bed was in the highest position, no fall mats observed, and call light was not in reach. On 3/6/25 at 10:35 AM, Certified Nursing Assistants (CNA's) came into R61's bedroom. CNA S and CNA T indicated R61's bed is broken so it can not be lowered. Both CNA's indicated call light should be in place, and they were unsure of floor mats. Surveyor and CNAs (CNA T & CNA S) looked in R61's bedroom and could not locate fall mats. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 3:51 PM, MD Q (Maintenance Director) indicated he did not know R61's bed was broken. MD Q indicated he would fix the bed immediately. MD Q indicated staff should report to him when something is broken. On 3/6/25 at 3:52 PM RN U (Registered Nurse) indicated R61's bed should be in the lowest position and call light within reach for fall interventions. RN U indicated she has not seen fall mats in R61's bedroom. RN U indicated staff should report to the maintenance department when something is not working properly. On 3/12/25 at 8:33 AM, DON B (Director of Nursing) indicated fall interventions should be followed and in place. DON B indicated staff should have reported R61's bed to maintenance and the facility is working on a system to report maintenance issues. DON B indicated R61's bed should be in the lowest position and call light within reach. DON B indicated if it states R61 should have fall mats then R61 should have fall mats. The facility failed to ensure that a residents environment remains free of accidents and hazards by following interventions per the residents care plan.

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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** 30992 Based on observation, interview, and record review, the facility did not ensure that residents with an indwelling catheter received the appropriate care and services to prevent a urinary tract infection (UTI) for 1 of 2 residents (R65) reviewed for catheters as catheter bags were observed to be uncovered and resting on the floor. Surveyor observed R65's indwelling urinary catheter bag to be resting in direct contact with the floor. Evidenced by: The Centers of Disease Control and the Healthcare Infection Control Practices Advisory Committee - Guidelines for Prevention of Catheter-Associated Urinary Tract Infections 2009 indicate in part: . III. Proper Techniques for Urinary Catheter Maintenance . B. Maintain unobstructed urine flow. 1. Keep the catheter and collecting tube free from kinking. 2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. R65 was admitted to the facility 11/4/24 with diagnoses including, but not limited to, the following: cerebral infarction (stroke), contractures bilateral knees (when muscles, tendons, joints tighten or shorten causing a deformity), reduced mobility (inability to move freely), osteoarthritis (degenerative disease that worsens over time causing pain and stiffness) of knee. R65's most recent Minimum Data Set (MDS) dated [DATE] documents, a score of 13 on his Brief Interview of Mental Status (BIMS), which indicates R65 is cognitively intact. R65's comprehensive Care Plan documents, in part, as follows: (Date Initiated: 12/17/24) Focus: The resident has Indwelling Catheter: Neurogenic bladder Goal: (Note diagnosis for catheter is urinary retention) The resident will show no s/sx (signs/symptoms) of urinary infection through review date. Interventions: Check tubing for kinks each shift; Monitor for s/sx of discomfort on urination and frequency; Monitor/document for pain/discomfort due to catheter; Monitor/record/report to MD (Medical Doctor) for s/sx UTI (Urinary Tract Infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature), behavior, change in eating patterns. On 3/11/25 at 9:05 AM, Surveyor observed R65's uncovered indwelling urinary catheter bag to be resting in direct contact with the floor. On 3/11/25 at 9:06 AM, Surveyor spoke with CNA G (Certified Nursing Assistant). Surveyor asked CNA G to walk with Surveyor to R65's room. Surveyor asked CNA G, should R65's uncovered catheter bag be in direct contact with the floor. CNA G stated, no. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 6:27 PM, Surveyor asked DON B (Director of Nursing) if it acceptable for a catheter bag to be in direct contact with the floor. DON B stated, no. DON B stated, R65's catheter bag should not be resting in direct contact with the floor.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure that a resident who requires dialysis receives such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 1 sampled resident (R24) reviewed for dialysis. The facility failed to provide ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. The facility staff were not fluent in the emergency plan for a resident bleeding from their dialysis fistula site. This is evidenced by: The facility's policy titled Hemodialysis with an implementation date of 2/15/23, includes, in part: Policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis . Purpose: The facility will ensure that each resident receives care and services for the provision of hemodialysis . consistent with professional standards of practice. This will include: The ongoing evaluation of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility . Compliance Guidelines: . d. Nutritional/fluid management including documentation of weights . f. Dialysis after reactions/complications and/or recommendations for follow-up observations and monitoring, and/or concerns related to the vascular access site . 7. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications . 11. The nurse will ensure the dialysis access site . is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill . According to Clinical Journal of the American Society of Nephrology article titled Diagnosis, Treatment, and Prevention of Hemodialysis Emergencies dated February 2017, .Vascular Access Hemorrhage: Hemorrhage from an AV access is an uncommon but potentially fatal complication if it is not recognized promptly and acted on with an appropriate intervention. Most fatal vascular access hemorrhages occur outside of the dialysis facility, but occasionally, they rupture at the dialysis unit (120). Patients and their families should be educated about the recognition and emergent management of a bleeding AV access . In the event of bleeding from vascular access site, direct continuous pressure with a finger for 15-20 minutes is the most effective method of controlling the bleeding. In the event of rupture of a PSA or aneurysm away from dialysis unit or hospital, direct pressure with a finger at the site of bleeding is the best method of controlling bleeding. Patients should be advised to continue holding direct pressure until emergency medical help arrives and avoid applying a tourniquet, towel, or BP cuff to the extremity . Diagnosis, Treatment, and Prevention of Hemodialysis Emergent .: Clinical Journal of the American Society of Nephrology R24 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes mellitus without complications, end stage renal disease, unspecified severe protein-calorie malnutrition, and dependence on renal dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's most recent Minimum Data Set (MDS) dated [DATE] states that R24 has a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating that R24 is cognitively intact. R24's care plan initiated on 5/23/24 includes goals and interventions for nutritional needs related to comorbidities including end stage renal disease, but does not include a dialysis focus, goal, or any interventions or tasks related to dialysis services, assessment of the vascular access port, monitoring of complications, or steps for staff to take if R24 is bleeding from her dialysis fistula. R24's Physician Orders include, in part: Monitor Port-a-cath site to right upper chest wall for S/S (signs/symptoms) of infection, edema (swelling), bleeding every shift for preventative measures. Start Date: 10/30/24. No end date . Hemodialysis at (Dialysis clinic name) . Monday, Wednesday, Friday . Resident to bring dialysis communication log with them to each appointment . R24'S Medication Administration Record (MAR) indicates, in part: Monitor Port-a-cath site to right upper chest wall for S/S (signs/symptoms) of infection, edema (swelling), bleeding every shift for preventative measures. Start Date 10/30/24. No end date. The MAR for January 2025 indicates 16 instances of blank documentation. R24's Weights and Vitals Summary Report for December 2024 indicates vital signs were taken on 12/9/24, 12/11/24, 12/13/24, and 12/27/24. No other dates have recorded vital signs, and no weights are indicated on the report. R24's Weights and Vitals Summary Report for January, 2025 indicates vital signs were taken on 1/6/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/11/25, 1/16/25, 1/18/25, 1/20/25, 1/25/25. No other dates have recorded vital signs and no weights are indicated on the report. R24's Weights and Vitals Summary Report for February 2025 indicates vital signs were taken on 2/4/25 and 2/19/25. No other dates have recorded vital signs, and no weights are indicated on the report. R24's Weights and Vitals Summary Report for March 2025 was requested but not provided to surveyor. On 3/10/25 at 8:32 AM, Surveyor interviewed R24 who stated that the facility does not take her weights or monitor her vital signs for dialysis treatment and do no assess or monitor her vascular access port. Surveyor reviewed R24's dialysis communication log with R24 and noted missing vital signs and weight pre-dialysis on 12/24/25, missing vital signs and weight post-dialysis on 2/7/25, 1/13/25, 1/10/25, 12/11/24, 12/4/24, 12/2/24, 11/29/24, 11/26/24, 10/23/24, 10/21/24; missing vital signs both pre-dialysis and post-dialysis on 12/19/24; and no monitoring sheets at all in the communication log from 10/23/24 to 11/26/24. On 3/10/25 at 2:46 PM, Surveyor interviewed CNA K (Certified Nursing Assistant) and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula, CNA K stated she would go get the nurse. On 3/11/25 at 10:32 AM, Surveyor interviewed CNA T and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula, CNA T stated she would call for a nurse. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 12:27 PM, Surveyor interviewed CNA L and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula, CNA L stated she would get the nurse right away. It is important to note that the CNAs interviewed stated they would leave R24 in her room alone while bleeding out of her dialysis site. No mention was made of applying pressure to stop the bleeding. On 3/11/25 at 4:30 PM, Surveyor interviewed LPN DD (Licensed Practical Nurse) and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula. LPN DD stated she would hold pressure and send them out to the hospital if the bleeding didn't stop. On 3/11/25 at 4:35 PM, Surveyor interviewed LPN N and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula. LPN N stated she would take a look to see where the bleeding was coming from, and then send them to the hospital. LPN N said she would also notify the doctor, the family, and the DON (Director of Nursing). 3/12/25 at 8:47 AM, Surveyor interviewed DON B (Director of Nursing) and asked if she would expect that the nursing staff, including CNAs, would be oriented and know how to provide care for the residents. DON B answered yes, that was her expectation. Surveyor asked DON B if staff had been trained on how to provide care for dialysis patients. DON B stated that dialysis training probably needs to be redone with staff, but they have a binder that explains what they are supposed to do before and after the resident goes out to dialysis appointments. Surveyor asked DON B what monitoring is provided for residents who are on dialysis. DON B replied that when they come back from dialysis, they have orders that they should be monitoring the fistula for thrill and bruit. (Thrill and bruit are palpable sensation and auditory sound heard over a blood vessel. Thrill and bruit are important to monitor for dialysis patients, as they ensure the fistula is working properly). Surveyor asked DON B if it was her expectation that they be monitored with pre and post vital signs. DON B answered yes, they should be monitoring the vital signs of dialysis residents before and after dialysis appointments. DON B stated that vital signs are documented in PCC (Point Click Care, a software for electronic health records) and that the facility has new vital sign machines that automatically input the vital signs in when they are used by staff. Surveyor asked DON B if it was her expectation that her staff know how to care for complications or a dialysis emergency. DON B answered that yes that was her expectation. R24 is receiving dialysis services three times per week. R24 is not being consistently monitored before and after dialysis services. R24's care plan does not indicate how to handle an emergency situation with R24's dialysis port and staff were not able to appropriately verbalize how to handle an emergency situation.

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility failed to ensure other alternatives were tried prior to installing/utilizing side rails. The facility failed to have a system in place to assess for risk of entrapment between the mattress and side rail and failed to identify and recognize that the use of side rails with an air mattress increases the risk for entrapment for 3 (R2, R424, and R9) of 3 supplemental residents and 8 (R61, R20, R65, R25, R17, R423, R6, and R24) of 21 sampled residents reviewed for bed rails. The facility failed to ensure a system was in place regarding the use of bed rails/enabler bars prior to surveyors entering the facility. The facility failed to ensure alternatives were tried prior to installing side rails/enabler bars, failed to provide assessments, failed to provide risks and benefits, failed to obtain informed consent, and failed to identify and recognize side rails with the use of an air mattress increase the risk for entrapment. This created a finding of immediate jeopardy that began on 3/5/25. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were notified of the immediate jeopardy on 3/12/25 at 5:10 PM. The immediate jeopardy was removed on 3/25/25. However, the deficient practice continues at a scope/severity of E (potential for harm/pattern) as the facility continues to implement its action plan and as evidenced by the following. Evidenced by The facility policy, Proper Use of Bed Rails, dated 5/24, states, in part; .It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Definitions: Bed Rails .Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars .Policy Explanation and Compliance Guidelines: Resident Assessment .1. As part of the resident's comprehensive assessment, the following components will be considered .a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms b. Size and weight c. Sleep habits d. Medications e. Acute medical or surgical interventions f. Underlying medical conditions g. Existence of delirium h. Ability to toilet self safely i. Cognition j. Communication k. Mobility l. Risk of falling .Informed Consent .Appropriate Alternatives .Installation and Maintenance of Bed Rails .c. Observing ongoing precautions such as following manufacturer's equipment alerts and recalls and increasing resident supervision, especially with the use of air-filled mattresses or therapeutic air-filled beds that may present a different entrapment risk than rail entrapment .Ongoing Monitoring and Supervision .d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails . According to the Food and Drug Administration (FDA), The FDA recommends the following actions to prevent deaths and injuries from entrapment and falls from adult portable bed rails: . When installing and using bed rails: (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Confirm that the age, size, and weight of the person using the bed rails are appropriate for the bed rails used. Install bed rails using the manufacturer's instructions to ensure a proper fit. Ensure that the safety strap or bed rail retention system is permanently attached to the rail and secured to the bed frame according to the manufacturer's instructions. Regularly inspect the mattress and bed rails for gaps and areas of possible entrapment. Regardless of mattress width, length, and depth, the bed frame, bed rail and mattress should leave no gap wide enough to entrap a patient's head or body. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. Check bed rails regularly to make sure they are still installed correctly as rails may shift or loosen over time. When in doubt, call the manufacturer of the bed rails for assistance. https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-consumers-and-caregivers-about-adult-portable-bed-rails On 3/12/25 at 8:33 AM, DON B indicated the facility identified a concern with side rail system during facility mock survey at the end of February. Surveyor asked for the date of mock survey. DON B indicated DON B didn't know offhand, but it was done some time in February. DON B indicated the facility was going to complete audit and remove side rails on the day the survey team entered the building on 3/5/25 but got busy with survey. DON B indicated she understands what it looks like, but that was the date the facility was going to work on side rails. Surveyor asked about resident progress notes from 3/7/25 and if the facility started working on assessments and removing the side rails on 3/7/25. DON B indicated 3/7/25 was the date many side rails were removed. DON B indicated there was not a process in place for side rails/half rails/transfer bars. There was nothing in place prior to 3/7/25 and this is why the facility has the plan to correct. DON B indicated there were no assessments completed prior to 3/7/25. DON B indicated NHA A has the plan from facility mock survey in February. DON B provided surveyor documentation of the assessments that will be completed moving forward. DON B indicated moving forward assessment will be completed prior to installing side rails. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed documentation DON B provided. Effective 3/7/25 facility implemented Transfer Bar Use Assessment Form. Form states, in part; .complete this form as you go through the decision making process of determining whether a transfer bar is appropriate for a particular resident height .weight .Reason Transfer Bar is being considered .Benefits to using the transfer bar .Evaluation of potential risks of using transfer bar(s) .other areas of potential risk .mobility and transfer assessment .interdisciplinary team recommendations/therapy or nursing .transfer bar informed consent for use .potential risks and negative outcomes. The facility also now utilizes a form titled Transfer Bar/Mattress Safety Assessment. Maintenance completes this form .reason for assessment .type of bed .type of mattress gap assessment .general safety assessment . On 3/12/25 at 11:05 AM, Surveyors requested any additional assessments, documentation, and manufacturer's recommendations for side rails. NHA A and DON B indicated there are no assessments or documentation prior to 3/7/25. NHA A indicated the facility does not utilize true side rails, but rather grab bars. NHA A indicated they identified a concern with the system during facility mock survey and the plan was to correct the system. NHA A indicated the system was corrected on 3/7/25 when they removed side rail bars and completed assessments for residents who were identified appropriate for side rails. Surveyor reviewed facility Plan of Correction from facility mock survey, states, in part; .Dates: February 4th, 5th, and February 11th 2025 .F700 Bed rails .The facility failed to assess the risk for entrapment for residents within the facility. Majority of bed with bed rails and no evaluation . On 3/12/25 at 1:31 PM, MD Q (Maintenance Director) indicated prior to 3/7/25, he did not complete any kind of measurements or assessments of side rails. MD Q indicated on 3/7/25 the facility removed side rails and completed assessments for residents who have side rails currently. MD Q indicated prior to 3/7/25 the facility would leave side rails on the beds when residents would discharge, and they would be left on bed for next resident. MD Q indicated he now documents his measurements on the assessment form. MD Q is not aware of anything he should be mindful of when installing side rails to beds with air mattresses. On 3/12/25 at 2:01 PM, PTA R (Physical Therapy Assistant) indicated she helped complete side rail assessments for two residents on 3/7/25. PTA R indicated she was not aware of any system or assessment in place prior to 3/7/25 for side rails. PTA R indicated the Transfer Bar Use Assessment Form includes risks and benefits of side rails and alternatives are offered/discussed before using a side rail now. PTA R indicated all residents who have side rail bars should now have assessments and measurements. On 3/11/25 at 9:00 AM, LPN P (Licensed Practical Nurse) indicated she did not realize the concern with side rails and the risk for entrapment. LPN P indicated on 3/7/25 the facility took off many resident side rails and now there is an assessment that must be completed prior to installing side rails. LPN P indicated there was not an assessment or a process prior to 3/7/25. Surveyors completed sweep of facility on 3/12/25 at 10:00 AM for side rails. Surveyors identified 11 residents who are utilizing air mattresses with side rails. Example 1 (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R61 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, stroke, anxiety disorder, and other seizures. R61's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/5/25, indicates R61 has a Brief Interview for Mental Status (BIMS) score of 04 indicating R61 is severely cognitively impaired. R61 has an activated power of attorney. R61's Comprehensive Care Plan, states, in part; .Bed Mobility .The resident is totally dependent on 1 staff for repositioning and turning in bed .Transferring .The resident is totally dependent on 2 staff for transferring via hoyer .Resident is Fall Risk . On 3/6/25, Surveyor observed R61 lying in bed. R61 was observed to have an air mattress with side rails. It is important to note, there is no documentation for R61 of risks and benefits, alternatives tried, measurements, assessments, or signed consents for the use of side rails. On 3/11/25 at 8:04 AM, DON B indicated R61 does not have any assessments or documentation for side rails because R61 no longer has side rails. DON B indicated R61's side rails were taken off on 3/7/25. On 3/12/25 at 12:29 PM, POA O (Power of Attorney) indicated R61 has always had side rails on air mattress bed while residing at facility. POA O indicated POA O never signed a consent or had a discussion with facility on risks and benefits. POA O indicated he was told a long bar could be considered a restraint, but not the side rails that are currently being used. Example 2 R20 was admitted to the facility on [DATE] with diagnoses including obesity, abnormalities of gait and mobility, lack of coordination, repeated falls, and unspecified open wound. R20's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/5/25 indicates R20 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R20 is cognitively intact. R20 is own person. R20's Comprehensive Care Plan, states, in part; .Bed Mobility Assist of 1 with turning side to side and sitting up laying down in bed. Assist of 2 with boost up in bed . On 3/6/25 Surveyor observed R20 to have air mattress with side rails. It is important to note, there is no documentation for R20 of risks and benefits, alternatives tried, measurements, assessments, or signed consents for the use of side rails. On 3/11/25 at 8:04 AM, DON B indicated R61 does not have any assessments or documentation for side rails because R61 no longer has side rails. DON B indicated R61's side rails were taken off on 3/7/25. 30992 Example 3 R65 was admitted to the facility 11/4/24 with diagnoses including, but not limited to, the following: cerebral infarction (stroke), contractures bilateral knees (when muscles, tendons, joints tighten or shorten causing a deformity), reduced mobility (inability to move freely), osteoarthritis (degenerative disease that worsens over time causing pain and stiffness) of knee. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R65's most recent Minimum Data Set (MDS) dated [DATE] documents, a score of 13 on his Brief Interview of Mental Status (BIMS), which indicates R65 is cognitively intact. R65 is his own person. R65's comprehensive care plan states, in part, as follows: Focus area: (Date Initiated: 11/4/24; Date Revised: 3/9/25) The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) CVA (cerebrovascular accident); Goal: The resident will improve current level of function in ADL's (Activities of Daily Living) through the review date. Interventions: The resident requires hoyer transfer by (2) staff with bathing/showering 2 times a week and as necessary. Bed Mobility: The resident requires assist by (1) staff to turn and reposition in bed as necessary. Resident is able to reposition independently from side to side but needs reminders from staff and assistance at times. Contractures: Provide skin care to keep clean and prevent skin breakdown. Keep knee extended as much as resident can tolerate, no pain, while in bed. Use a pillow in between knees. Transfer: The resident requires dependent assist/hoyer by (2) staff to move between surfaces. It is important to note, R65 has a history of falls from bed. On 2/11/25, R65's Physician Orders document an air mattress was put in place. On 3/11/2025 at 5:28 AM, R65's Progress Notes document the following: Change of Condition (Res had fall from bed last night) Resident found down in room at 2:45 AM; no injuries noted and resident denies pain and injury. Per resident I slipped out of bed, help me get up. Resident assessed for injuries, neurological exam completed, and VS (vital signs) obtained. Resident assisted back to bed with the assist of two staff; care ongoing. Note, R65's fall from bed puts him at increased risk of entrapment. On 3/12/25 at 10:45 AM, Surveyor observed R65 to have bilateral enabler bars with an air mattress. Surveyor observed a gap in between mattress and enabler bars of approximately one (1) inch. On 3/12/25 at 11:00 AM, Surveyor spoke with R65. R65 stated his air mattress was put in place just a couple of days ago when he returned from the hospital on 3/7/25. Surveyor asked R65, did the facility go over a consent form with you regarding using enabler bars with an air mattress. R65 stated, no. Surveyor asked R65, did the facility discuss the risks and benefits of using enabler bars with an air mattress. R65 stated, no. Surveyor asked R65, did the facility attempt alternatives prior to installing the bilateral enabler bars. R65 stated, no. Surveyor asked R65, have you ever become stuck (entrapped) in between an enabler bar and mattress. R65 stated, no. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/12/25 at 1:30 PM, Surveyor spoke with MD Q (Maintenance Director). Surveyor asked MD Q if he has done any assessments for R65's air mattress being used with bilateral enabler bars. MD Q stated, no. MD Q stated, if assessments are done he takes a couple measurements. MD Q added, he measures from the bottom of the mattress to the bottom of the siderail and the inside top of the mattress to the siderail with the resident in bed. MD Q stated this is a new process started 3/7/25. Surveyor asked MD Q, when was R65's air mattress put in place. MD Q stated, he knows the facility swapped his air mattress to a larger size. MD Q stated, R65 had a 36 or 38 air mattress and now he has a 42 mattress that was put in place a few days ago. MD Q stated, R65 had an air mattress in place prior to 3/7/25. MD Q stated he was going to check for the original work order. Surveyor asked Maintenance Q if he has measured gaps between the air mattress and enabler bars. MD Q stated, no. Surveyor asked MD Q, when you measure what are looking for? MD Q stated, pinch points or large enough gaps. Surveyor asked MD Q, what size of a gap is acceptable. MD Q stated, he's not sure and will look it up. MD Q stated, the Transfer Bar use Assessment Form was just started on 3/7/25. MD Q stated, there's no Transfer Bar use Assessment for R65. Surveyor asked MD Q, what's the process started 5/7/25. MD Q stated, stated, he uses a tape measure to measure gaps. Note, no additional information was provided to Surveyor. On 3/12/25 at 2:00 PM, Surveyor spoke with PTA R (Physical Therapy Assistant). Surveyor asked PTA R, have other alternatives been attempted prior to installing the air mattress with bilateral enabler bars. PTA R stated, no. Surveyor asked PTA R, does R65 require assistance to turn and reposition in bed. PTA R stated, yes. PTA R stated, R65 can use an enabler bar to assist staff with turning and repositioning, however, he does need assistance with turning and repositioning. PTA R added, R65 uses the bilateral enabler bars to help staff, we want to encourage as much help as the residents can give to keep up their muscles and strength. Surveyor asked PTA R, given R65's bilateral knee contractures and falls from bed would you consider him at high risk for entrapment. PTA R stated, she has not seen him in a little bit. PTA R added, R65 had good movement with his upper body and arms, however, he doesn't tolerate any stretching at all, it's very painful for him. PTA R stated. she is unable to answer that question. PTA R stated, the facility just started a new process for assessing residents with air mattresses and side rails/enabler bars on 3/7/25. PTA R stated, she has not done any assessments for R65. It is important to note, there is no documentation for R65 of risks and benefits, alternatives tried, measurements, assessments, or signed consents for the use of side rails. R65 stated she had never signed any consent to use enabler bars with an air mattress, educated regarding the risk and benefits and alternatives attempted. 36253 Example 4 R25 was admitted to the facility on [DATE]. On 3/5/25 at 11:21 AM, Surveyor observed R25 in her bed. She was lying on an air mattress with attached circulating pump and partial bedrails on either side of the bed. Facility maintenance documentation shows this air mattress was put into place on 2/18/25. Surveyor attempted to interview R25, but she was unable to answer any questions. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note dated 3/7/25 at 4:38 PM states, IDT (Interdisciplinary Team) review of resident need for t-bars per facility policy. Bars removed from resident bed and resident provided with education on safety/risk of use of t-bars. It should be noted that R25 discharged from the facility to the hospital on 3/6/25. On 3/12/25 at 1:00 PM, Surveyor requested any evaluations, assessments and risks and benefits for R25 and the use of the partial side rails before 3/5/24 when Surveyors were in the facility. The facility was unable to provide this requested documentation. 42038 Example 5 R17 was admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of anus, type 2 diabetes mellitus, and neuropathy. R17's MDS dated [DATE], section O states that R17 is on hospice care. R17's MDS states that R17 has a BIMS of 13 out of 15, indicating that R17 is cognitively intact. R17's MDS also states that he requires 1 assist to turn and reposition in bed. On 3/12/25 at 1:46 PM, Surveyor interviewed R17 and noted that R17 has 1/4 side rails to each side of his bed and is on an air mattress. Surveyor asked R17 if he uses the side rails on his bed, R17 reported that he brought the right one from home and uses it to help himself sit on the edge of the bed. R17 reported that he doesn't like the left one because it moves too much, but he uses it when he rolls on his side. Surveyor asked R17 if facility staff discussed the risks and benefits of using side rails with him, R17 reported that they had talked to him recently. Surveyor asked if he had given consent for the side rails, R17 stated that he did last week. It is important to note that R17's Transfer Bar/ Mattress Safety Assessment, Transfer Bar Use Assessment Form, and Transfer Bar Informed Consent for Use were completed on 3/7/25. Example 6 R2 was admitted to the facility on [DATE] with diagnoses that include spastic diplegic cerebral palsy (neurological disorder that affects movement and causes overly toned muscles), rheumatoid arthritis, neuropathy (nerve damage that usually occurs in feet and hands), and paraplegia (loss of motor and sensory function of the lower half of the body). R2's most recent MDS dated [DATE] states that R2 has a BIMS of 14 out of 15, indicating the R2 is cognitively intact. The MDS states that R2 requires substantial/ maximal assistance for bed mobility. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/12/25 at 1:50PM, Surveyor interviewed R2. Surveyor noted that R2 is laying on an air mattress and has enabler bars. Surveyor asked R2 how long she has had the enabler bars, R2 stated that she wasn't sure. R2 reported that it is hard for her to turn in bed without them. R2 reported to Surveyor that they took one of the rails off and that the nurse agreed with her that she needed both rails. Surveyor asked R2 if the facility she was assessed for the use of the bed rails, R2 stated that she was last week. Surveyor asked if the facility discussed the risks and benefits of using the rails with her, R2 reported that they did last week. Surveyor asked if she gave consent for the rails, R2 stated yes, last week. It is important to note that R2's Transfer Bar/ Mattress Safety Assessment, Transfer Bar Use Assessment Form, and Transfer Bar Informed Consent for Use were completed on 3/7/25. 49434 Example 7 R423 was admitted to the facility on [DATE] with diagnoses that include, in part: cerebrovascular accident (stroke), nontraumatic chronic subdural hemorrhage (brain bleed between the brain and the outer layer of the membrane around the brain), and dementia. R423's Admission Minimum Data Set, with Assessment Reference Date of 2/19/25, states that R423 has a Brief Interview for Mental Status (BIMS) of 7 out of 15, indicating that R423 is severely cognitively impaired. Section GG states R423 has impairment on one side of her upper extremities and utilizes a walker and wheelchair for mobility. GG0170 indicates R423 is dependent (meaning helper does all the effort) on staff for all mobility including rolling left and right, moving from sitting to lying and lying to sitting, moving from siting to standing, transferring between the bed and a chair, transferring to a toilet, transferring to a tub or shower, and walking 10 feet. R423's Comprehensive Care Plan states, in part: . The resident has an interpretation need . Resident's preferred language is: Hmong .The resident is at risk for falls, accidents and incidents r/t (related to) CVA[sic], Dementia, and Alzheimer's . Language board provided to the resident to facilitate communication . Nursing to keep resident within sight during time resident is in W/C (wheelchair) if CNA (Certified Nursing Assistant) is busy . Room change to facilitate closer observation . SS (Social Services) to conference with family concerning resident specific preferences r/t (related to) sitting on the floor, sleeping on the floor, environment . A progress note, dated 3/1/25, indicates the R423 was found sitting on the floor with blankets wrapped around her and the resident had been trying to get out of bed several times. A progress note, dated 3/1/25 at 5:43 PM, indicates R423 continues to have neurological checks completed related to her recent unwitnessed fall. The note also indicates the resident continues to self-transfer on this shift and had been found getting up from her wheelchair and attempting to ambulate. A progress note, dated 3/2/25 at 11:34 PM, indicates R423 continues to have neurological checks completed related to her unwitnessed fall. The note also indicates R423 was experiencing agitation on the PM shift and was given PRN (as needed) Haldol (antipsychotic). However, R423 continued to be restless, attempting self-transfers, and the facility initiated 1 to 1 monitoring on this shift. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note, dated 3/3/25 at 9:57 PM, indicates R423 continues on neurological checks related to her recent fall and that the resident remains on 1 to 1 monitoring on this shift due to impulsivity and her attempts to transfer independently. On 3/5/25 at 10:15 AM, Surveyor observed R423 lying in her bed. R423's bed was in the low position with a floor mat on the floor. Surveyor noted that R423 had an air mattress on her bed with grab bars installed on both sides. On 3/5/25 at 3:10 PM, Surveyor observed R423's bed with the air mattress and grab bars still in place. On 3/10/25 at 4:20 PM, Surveyor observed R423's bed had an air mattress installed with dial set to 120 and grab bars attached. On 3/12/25 at 10:30 AM, Surveyor observed R423's bed still had the air mattress on her bed with the grab bars installed. Surveyor notes the gap between the mattress and the grab bar is large enough for the Surveyor to fit their arm in between the mattress and the grab bar. (Of note: No evidence was found, and no evidence could be provided regarding a bed rail evaluation for R423. Surveyor also found no evidence of risks and benefits being provided to R423's activated healthcare power of attorney or evidence that alternatives to the grab bars were attempted prior to their installation). Example 8 R424 was admitted on [DATE] with diagnoses that include, in part: acute infarction of the spinal cord (stoke occurring within the spinal cord instead of the brain), transient ischemic attack (stroke that completely resolves within 24 hours), and quadriplegia (from of paralysis affecting all four limbs and torso). R424's Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 2/19/25, states that R424 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R424 is cognitively intact. Section GG states R424 has impairment in both of her upper extremities and one side of her lower extremities along with an electric wheelchair for mobility. GG0170 indicates R424 requires partial/moderate assistance with rolling left and right. GG0170 also indicates R424 is dependent (meaning helper does all the effort) on staff for most mobility including moving from sitting to lying and lying to sitting, moving from siting to standing, transferring between the bed and a chair, transferring to a toilet, and transferring to a tub or shower. On 3/12/25, Surveyor was provided with a document titled, Transfer Bar Use Assessment Form. This form indicates R424 requested a transfer bar for safety and for mobility/transferring assistance. Potential risks and benefits are indicated to be discussed with the resident along with the completion of a mobility transfer assessment. Therapy evaluation is indicated to be conducted by physical therapy. Transfer bars are indicated to be recommended for the left and right side of R424's bed. PTA R signed this form on 3/7/25. (Of note: This form does note make any statements or references to safety in regard to using a transfer bar with an air mattress). (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/12/25, Surveyor was provided with a document titled, Transfer Bar Informed Consent for Use. This document states, in part: .It is the policy of this facility to use transfer bar only after an individualized resident assessment evaluation and care planning by an interdisciplinary team, determine it is beneficial and appropriate for use to treat the resident's medical symptoms, assist the resident in attaining or maintaining the highest possible physical and psychosocial wellbeing and after attempts of using alternatives have proven inadequate or inappropriate . One question asked on this form states: Alternatives attempted that failed to meet resident needs: is marked n/a. Another question asked on this form states: Alternatives considered but not attempted because they were considered inappropriate: is marked lack of transfer bars. This document indicates recommendation of left and right transfer bars with R424's initials and signatures indicating they voluntarily consent to the use of transfer bars and is dated 3/7/25. This documented is signed by PTA R on 3/7/25. (Of note: This form does note make any statements or references to safety in regard to using a transfer bar with an air mattress). On 3/12/25, Surveyor was provided with a document titled, Transfer Bar/Mattress Safety Assessment. R424'S name and room number are indicated at the top of the assessment; however, the date of assessment, resident height, and resident weight is blank. The section that states, Reason for Assessment: has nothing checked. The section titled, Device Information includes the following information, type of bed: Standard, type of mattress: Air Mattress, and type of device: Transfer bar. The section titled, Gap Assessment, states, in part: The gap between the mattress and the lowermost portion of the bed rail can be no greater than 2.5 inches or 1.75 for this resident. The gap between the inside surface of the bed rails and the mattress can be no greater than 4.5 inches or 3 1/8 for this resident . Each zone listed in this section is marked, Pass. The section titled, General Safety Assessment has not been completed. The signature line states, Signature and Title, which is signed but illegible and it appears that no title was provided. This document is dated 3/7/25. 50285 Example 9 R6 was admitted to the facility on [DATE] with diagnoses that include, in part, Alzheimer's disease, age related osteoporosis with current pathological fracture, unspecified dementia with agitation, depression, and adult failure to thrive. R6's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/17/25, indicates R6 has a Brief Interview for Mental Status (BIMS) score of 5 indicating R6 is severely cognitively impaired. R6 has an activated power of attorney. R6's Comprehensive Care Plan, states, in part; .Bed Mobility: The resident requires partial assistance by 1 staff to turn and reposition in bed as necessary . 1 assist, uses bilateral hand rails to improve independence. 2 assist prn . Transfer: The resident requires max assistance of 1 to move between surfaces at a stand pivot level. R6 was assessed on 11/16/24 as a moderate risk for falls. On 3/5/25 at 3:55 PM, Surveyor observed R6 lying in bed. R6 was observed to have an air mattress with side rails. It is important to note, there is no documentation for R6 of risks and benefits, alternatives tried, measurements, assessments, or signed consents for the use of side rails. On 3/11/25 at 8:04 AM, DON B indicated R6 does not have any assessments or documentation for side rails because R6 no longer has side rails. DON B indicated R6's side rails were taken off on 3/7/25. (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/13/25 at 11:24 AM, Surveyor interviewed POA EE (Power of Attorney). POA EE stated she had never signed a consent or been provided education on the risks and benefits of the use of side rails. Example 10 R24 was admitted to the facility on [DATE] with diagnoses that include, in part, Type 2 diabetes mellitus, depression, dependence on renal dialysis, acquired absence of left leg below knee, end stage renal disease, and insomnia. R24's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 2/2/25 indicates R24 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R24 is cognitively intact. R24 is her own person. R24's Comprehensive Care Plan, states, in part: Bed Mobility: The resident requires assistance by 2 staff to turn and reposition in bed . Transfer: The resident is dependent upon staff assist of 2 and Hoyer lift . Skin integrity: Pressure redistribution mattress. R24 was assessed on 1/13/25 as a moderate risk for falls. On 3/5/25 at 10:31 AM,

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 38725 Based on interview and record review, the facility did not ensure that a review of the residents' total program of care to include signing monthly physician orders were completed for 9 of 11 residents (R17, R9, R20, R65, R6, R24, R2, R25, and R61) reviewed. R17 did not have Physician Orders signed monthly. R9 did not have Physician Orders signed monthly. R20 did not have Physician Orders signed monthly. R65 did not have Physician Orders signed monthly. R6 did not have Physician Orders signed monthly. R24 did not have Physician Orders signed monthly. R2 did not have Physician Orders signed monthly. R25 did not have Physician Orders signed monthly. R61 did not have Physician Orders signed monthly. This is evidenced by: The Facilities Policy and Procedure entitle Physician Visits and Physician Delegation dated 10/16/24 documents the following, in part: f. Remind the physician to date and sign all orders .2. The Physician should .c. Review the resident's total program of care including medications and treatments at each visit . Example 1 R17 had no signed Physician Orders for October 2024, November 2024, December 2024, January 2025, or February 2025. Example 2 R9 has signed Physician's Orders on 2/28/25. No signed Physician Orders for October 2024, November 2024, December 2024, and January 2025. Example 3 R20 has signed Physician's Orders on 2/28/25. No signed Physician Orders for October 2024, November 2024, December 2024, and January 2025. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 4 R65 has signed Physician's Orders on 2/16/25 and 11/6/24. No signed Physician Orders for October 2024, December 2024, and January 2025. Example 5 R6 has signed Physician's Orders on 2/16/25 and 10/17/24. No signed Physician Orders for November 2024, December 2024, and January 2025. Example 6 R24 has signed Physician's Orders on 2/16/25 and 10/17/24. No signed Physician Orders for November 2024, December 2024, and January 2025. Example 7 R2 has signed Physician's Orders on 2/16/25 and 10/17/24. No signed Physician Orders for November 2024, December 2024, and January 2025. Example 8 R25 has signed Physician's Orders on 2/16/25 and 10/17/24. No signed Physician Orders for November 2024, December 2024, and January 2025. Example 9 R61 has signed Physician's Orders on 2/16/25 and 10/17/24. No signed Physician Orders for November 2024, December 2024, and January 2025. 3/25/25 at 5:47 PM, Surveyor asked DON B (Director of Nursing) for assistance locating the signed monthly Physician Orders. DON B stated the system (electronic health record) wasn't set to tell the Physician that they needed to sign monthly, there may be others are in a pile in medical records somewhere. On 3/25/25 at 6:11 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if every resident should have signed Physician Orders monthly, DON B stated, Yes. On 3/25/25 at 6:33 PM, Surveyor interviewed INHA YY (Interim Nursing Home Administrator). Surveyor asked INHA YY would you expect each resident to have signed Physician Orders monthly, INHA YY stated, Yes.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 38725 Based on interview and record review, the facility did not ensure that residents were seen by a physician or physician extender (NP- Nurse Practitioner, PA- Physician Assistant) for 3 of 11 residents (R9, R20, and R2) reviewed. R9 did not have Provider visits timely. R20 did not have Provider visits timely. R2 did not have Provider visits timely. This is evidenced by: The Facilities Policy and Procedure entitled Physician Visits and Physician Delegation dated 10/16/24 documents, in part: .h. Ensure a progress note is present to reflect the date and time of the physician visit, an indication as to whether new orders were written or no new orders were received and any special discussions between the resident and/or family and physician during the visit .2. The Physician should .d. Date, write and sign progress note for each visit .h. At the option of the physician, required visits in SNFs (Skilled Nursing Facilities), after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist . Example 1 R9 did not have record of being seen by a Provider in February 2025, January 2025, December 2024, November 2024, or October 2024. Example 2 R20 did not have record of being seen by a Provider in October 2024. R20 was seen by a Physician Extender in November 2024 (Nurse Practitioner) and December 2024 (Physician Assistant). It is important to note that alternating visits between Physician and Physician Extender were not followed for R20. Example 3 R2 did not have record of being seen by a Provider in October 2024. On 3/25/25 at 6:11 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B should each resident be seen by the appropriate Provider timely, DON B stated, Yes. On 3/25/25 at 6:33 PM, Surveyor interviewed INHA YY (Interim Nursing Home Administrator). Surveyor asked INHA YY would you expect each resident to be seen by the appropriate Provider timely, INHA YY stated, Yes.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview and record review, the facility does not have nursing staff with the appropriate cultural competencies to communicate effectively while providing care to residents with communication needs and ensuring that devices are utilized per the care plan. This has the potential to affect 2 of 20 sampled residents (R74 & R423) and 1 of 12 supplemental residents (R9). The Facility does not ensure R74 is receiving communication in a language she can understand. The Facility does not ensure R423 is receiving communication in a language she can understand. The Facility does not ensure R9 is receiving communication in a language she can understand. Evidenced by: The facility policy entitled, Non-Discrimination-Language Assistance Services, dated 2/1/25, states, in part: . Policy: It is the policy of this facility to take reasonable steps to ensure that individuals with Limited English Proficiency (LEP) (including companions with LEP) are not discriminated against and have access to language assistance services and meaningful communication involving their medical conditions, treatment, and other vital documents . Definitions: Individuals with limited English proficiency means an individual whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English . Language assistance services may include, but are not limited to: 1. Oral language assistance, including interpretation in non-English language provided in person or remotely by a qualified interpreter for an individual with limited English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with limited English proficiency; . Machine translation means automated translation, without the assistance of or review by a qualified human translator, that is text-based and provides instant translations between various languages, sometimes with an option for audio input or output . Qualified interpreter for an individual with limited English proficiency means an interpreter who via a remote interpreting service or an on-site appearance: . Compliance Guidelines: 1. The facility will identify the language and communication needs of the individual with LEP during the pre-screening and admission process. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility will include in the notice of nondiscrimination that the facility provides language assistance services . in an accurate and timely manner, and protect the privacy and the independent decision-making ability of the individual with LEP . 5. Language assistance will be provided in-person or remotely by a qualified interpreter and/or the use of qualified bilingual or multilingual staff; . 9. The facility will be in compliance with respect to an individual if it exercises the option to: . b. Document the individual's primary language and: i. Provides all materials and communications in that individual's primary language; . 14. All staff will be provided notice of this policy, and staff that may have direct contact with individuals with LEP will be trained in effective communication techniques, including the effective use of an interpreter . The facility's Resident Rights information sheet for residents, states, in part: . Resident Rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1.Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States . 2. Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: a. The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition . 4. Respect and dignity. The resident has a right t o be treated with respect and dignity, including: .c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences . Example 1: R74 was admitted to the facility on [DATE] and has diagnoses that include cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain cells to die) and major depressive disorder. R74's Quarterly Minimum Data Set (MDS) Assessment, dated 1/25/25 section C shows no Brief Interview for Mental Status (BIMS) score recorded indicating R74's cognitive status was not assessed or deemed not applicable during the assessment period. R74's Care Plan states, in part: .Focus: The resident has an interpretation need. Date Initiated: 10/21/24. Goal: No goal listed. Interventions: No interventions listed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: The resident has a communication problem r/t (related to) Spanish speaking only. The resident does not speak English. Date Initiated: 10/22/24. Revision on: 2/11/25. Goal: The resident will be able to make basic needs known through translation on a daily basis through the review date. Date Initiated: 10/22/24. Revision on: 2/11/25. Target Date: 4/7/25. Interventions: -Interpreter line is [Phone number & code] Language code: 1 (Spanish). If the primary number is unavailable, please call [Phone number]. Date Initiated: 3/5/25 . -Monitor/document/report PRN (as needed) any changes in: Ability to communicate, Potential contributing factors for communication problems, Potential for improvement. Date Initiated: 10/22/24. -Provide translator as necessary to communicate with the resident. Translator is available by phone 24 hours a day. Date Initiated: 10/22/24. Revision on: 11/26/24 . Focus: At risk for/risk of Social Isolation r/t (related to) dementia. Date Initiated: 10/28/24. Goal: Resident will be able to identify feelings of isolation through next review date. Date Initiated: 10/28/24. Revision on: 11/26/24. Target Date: 12/11/24. Interventions: -Discuss causes of perceived or actual isolation. Date Initiated: 10/28/24. -Observe for barriers to social interaction (e.g. illness, incontinence, decreasing ability to form relationships, lack of transportation, money, support system, or knowledge). Date Initiated: 10/28/24 . On 3/11/25 at 9:42 AM, Surveyor observed CNA M (Certified Nursing Assistant) complete a bed bath with R74. During the bed bath R74 was speaking in Spanish and looking at CNA M throughout the entire process. At times R74 was raising her voice and getting irritated with CNA M. Surveyor asked CNA M what R74 was saying and CNA M indicated she could pick up on only a few words that R74 was saying. One was cold. CNA M did take her phone out of her pocket one time during the bed bath and put it on Google translation to know what R74 was saying. The rest of the time CNA M kept repeating I know. I am almost done. Surveyor observed R74 getting worked up and CNA M telling R74 to relax. As R74 kept speaking in Spanish with a raised voice, CNA M kept repeating, Yes, yes. At one point R74 said something in a lower voice and just stared at CNA M. Surveyor asked CNA M what R74 said, and CNA M indicated I don't know. On 3/11/25 at 10:16 AM, Surveyor interviewed CNA M and asked how CNA M knows if R74 was saying to stop, that hurts, or if asking CNA M something. CNA M indicated she does not know, CNA M can understand only a few Spanish words. CNA M indicated this was her first time working with R74. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 2:17 PM, Surveyor observed R74 in activities. R74 was sitting with a blank piece of paper in front of her and talking nonstop in Spanish. Other residents were making rainbows with colored construction paper on the piece of paper. Two CNAs, CNA T and CNA SS approached R74, one on each side of R74. R74 looking from one CNA to the other while speaking in Spanish. Surveyor approached both CNAs and asked what R74 was saying. CNA T indicated she does not know. CNA SS indicated she does not know but showed Surveyor a lavender translation ball she purchased from Tik tok Shop. CNA SS indicated she sets it to Spanish when communicating with R74. While Surveyor was observing CNA SS did not attempt to use translation ball to try to understand what R74 was saying. On 3/10/25 at 10:01 AM, Surveyor interviewed CNA Y. CNA Y indicated R74 does not speak English, making it very difficult to communicate with her. CNA Z speaks Spanish and helps CNA Y with communication at times. CNA Y indicates she does not understand R74 most times and it makes it hard to know what R74 wants. CNA Y indicated R74 could be yelling she is in pain, or she does not want to get up while CNA Y is getting R74 up. CNA Y indicated she would not know it. R74 gets frustrated by the look on her face, and at times R74 tries to shake CNA Y off and push hand away. CNA Y indicated the staff can call a family member when R74 is yelling, or staff can use Google translation on their phones. On 3/10/25 at 10:14 AM, Surveyor interviewed CNA Z and asked how staff understands R74 making needs known. CNA Z indicated she does not know how staff know. CNA Z indicated sometimes staff will come and get CNA Z to translate as she speaks Spanish. CNA Z indicated she knows R74 gets frustrated especially when she repeats herself over and over. Surveyor asked CNA Z if there are other Spanish speaking residents and CNA Z indicated no. On 3/10/25 at 11:37 AM, Surveyor interviewed FM BB (Family Member). FM BB indicated the staff will set R74 up to color, but she gets bored with that. R74 has no patience for coloring. FM BB indicated R74 gets frustrated easily and starts screaming names at staff due to the lack of understanding the communication and dementia. FM BB indicated R74 wants 1:1 communication where she can communicate with others. R74 gets frustrated because she does not have that communication with others. FM BB indicated R74 tells him she feels alone and no one in the facility cares for her. No other residents speak Spanish, so R74 has no one to converse with. FM BB indicated R74 enjoys cooking, folding clothes, house chores, and watching television. Surveyor asked FM BB what R74's normal day is like at the facility and FM BB indicated coloring if the staff set her up with the supplies to color. Surveyor asked FM BB if the facility sets up the television in closed captioning in Spanish for R74 and FM BB indicated no, the staff just turn on the animal channel or old shows. FM BB indicated again most times R74 is just sitting in the dining area. FM BB indicated he comes to see R74 every day between 3 and 6 pm and his wife comes in earlier. FM BB indicated R74 feels people are laughing at her and don't care about her because she cannot understand them. FM BB indicated this is another reason why he wants R74 transferred to another facility that has staff and other residents that speaks Spanish. FM BB indicated he feels it has been very hard on R74 being at this facility and he is glad R74 will be leaving the facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 8:11 AM, Surveyor interviewed SW H (Social Worker). SW H indicated she will be taking a turn filling in for activities along with other staff members until the activities position is filled by the facility. Surveyor asked what activities R74 participates in, and SW H indicated television. Surveyor informed SW H of the observation of R74 in front of television with no closed captioning in Spanish. Surveyor asked if that would be beneficial for R74, and SW H indicated its more for imagery. SW H indicated family suggested the animal channel or old tv shows. Surveyor informed SW H The Price Is Right was on the television. Surveyor asked if it would be beneficial for closed captioning in Spanish be set for R74 and SW H indicated we can try that. SW H indicated R74 enjoys napping, bingo and activities with translation services. Surveyor asked if translation services are used during activities and SW H indicated she tried one time, and the service did not work as it stated R74 was not making sense. SW H indicated R74 means one thing, but it comes out another way. Surveyor asked SW H about R74's activity preference of listening to music. SW H indicated R74 has a radio in her room. Surveyor asked if Spanish music gets turned on for R74, and SW H indicated whatever music comes in with the antenna. Surveyor asked if it would be beneficial for R74 to have a radio station that is in Spanish. SW H indicated if it was classical without English language. Surveyor asked if facility has offered CDs in Spanish; SW H indicated no, we could ask the family. On 3/12/25 at 9:03 AM, Surveyor interviewed DON B (Director of Nursing) and asked what the process for communication between staff and residents who are non-English speaking consists of. DON B indicated the facility has a translation service with the number posted. Surveyor asked if the expectation is for staff to utilize the service during cares, activities, or just conversing with R74. DON B indicated yes. Surveyor informed DON B of concerns with observations of activities and bed bath. DON B indicated it is her expectation that staff use translation service on speaker during cares to communicate with R74. Surveyor asked how would staff know if R74 is trying to tell them to stop, something hurts or is asking a question. DON B indicated staff wouldn't if staff was not using the translation services. Despite an interpreter line being available to staff, they did not demonstrate cultural competency to communicate effectively with R74, who is a non-English speaking resident to plan for and provide care that is appropriate to the culture and the individual. 49434 Example 2: R423 was admitted to the facility on [DATE] with diagnosis that include, in part: cerebral infarction (stroke), nontraumatic chronic subdural hemorrhage (chronic brain bleed), and dementia. R423's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 2/19/25, indicates R423 has a Brief Interview for Mental Status (BIMS) score of 7 out of 15 indicating R423 is severely cognitively impaired. Section V indicates the Communication care area was triggered and addressed in the care plan. R423's Comprehensive Care Plan states, in part: Focus: The resident has an interpretation need. The resident has an interpretation need. Date Initiated: 3/5/25. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: The resident will communicate via interpreter. Date Initiated: 3/5/25. Interventions/Task: Resident's preferred language is: Hmong. Date Initiated: 3/5/25. The resident has translation needs. (Interpreter: call . Date Initiated: 3/5/25. (Of note: Survey entrance date was 3/5/25.) Focus: The resident is at risk for falls, accident and incidents r/t (related to) CVA[sic] (stroke), Dementia, and Alzheimer's. Date Initiated 2/12/25. Interventions: Language board provided to the resident to facilitate communication. Date Initiated: 2/14/25. On 3/5/25 at 10:15 AM, Surveyor observed R423's room and noted the bed in a low position, floor mat in place, grab bars, and a possible air mattress setup. No interpreter signs were noted at this time. On 3/5/25 at 3:10 PM, Surveyor observed R423's room and notes an interpreter sign is now present on the door. On 3/10/25 at 4:20 PM, Surveyor observed R423's room and found several documents written in only English. The meal menu provided to the resident is also only in English. Surveyor also noted a sign with two different phrases on it for sitting and lying down with the phrases written in English and another language, which Surveyor assumes to be Hmong. On 3/11/25 at 8:10 AM, Surveyor interviewed LPN JJ (Licensed Practical Nurse). Surveyor asked LPN JJ if she is familiar with R423's hall. LPN JJ indicates she always works the day shift on this hallway. Surveyor asked LPN JJ how she communicates with R423. LPN JJ indicates she uses sign language to communicate with R423, indicating several signs with her hands for bathroom and eating. LPN JJ also indicates that when family is visiting at the facility, they also help to interpret. On 3/11/25 at 8:24 AM, Surveyor interviewed CNA II. Surveyor asked CNA II how she communicates with R423. CNA II indicates she uses body language to communicate with R423, and also demonstrates hand signals for bathroom and eating. Surveyor asked CNA II if R423 speaks any English. CNA II states, no. Despite an interpreter line being available to staff, they did not demonstrate cultural competency to communicate effectively with R423 who is a non-English speaking resident to plan for and provide care that is appropriate to the culture and the individual. 50285 Example 3: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9 was admitted to the facility on [DATE] with diagnoses that include, in part, essential hypertension, unspecified osteoarthritis, anxiety disorder, pain, and shortness of breath. R9's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/30/25, indicates R9 has a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 is severely cognitively impaired. R9's Comprehensive Care Plan, states, in part; .Focus: The resident has a communication problem r/t (related to) language barrier, resident does not speak English, Resident speaks Russian. Date Initiated: 5/14/23. Revision on 3/5/25 Interventions: Anticipate and meet needs. Date Initiated: 5/14/23 . Provide translator as necessary to communicate with the resident. The resident only speaks a mix of Russian and Ukrainian, so results may vary. Date Initiated: 5/14/23. Revision on: 2/11/25. The resident is able to communicate by gestures, body language and pointing. Date Initiated: 5/14/23. Revision on 2/11/25. On 3/11/25 at 12:27 PM, Surveyor interviewed CNA L (Certified Nursing Assistant) and asked how she communicates with R9. CNA L stated that she attempts to sound out the common Russian phrases that are posted in R9's room. Surveyor asked CNA L if she had ever used the interpreter line. CNA L stated that she had not. On 3/11/25 at 12:29 PM, Surveyor interviewed CNA S and asked how he communicates with R9. CNA S stated that he doesn't usually work with R9. Surveyor asked how he would communicate with any non-English speaking resident. CNA S stated usually there is a sign in the resident's room for the interpreter phone number with that language. On 3/11/25 at 12:36 PM, Surveyor interviewed CNA M and asked how she communicates with R9. CNA M stated she would ask the nurse if there is an interpreter in the building or if there is staff available to interpret the extension in that language. Surveyor asked CNA M if she had ever used the interpreter line. CNA M stated that she had not. On 3/12/25 at 8:47 AM, Surveyor interviewed DON B (Director of Nursing) and asked if she expected staff to utilize the interpreter line to communicate with non-English speaking residents. DON B answered yes, that was her expectation. Despite an interpreter line being available to staff, they did not demonstrate cultural competency to communicate effectively with R9, who is a non-English speaking resident to plan for and provide care that is appropriate to the culture and the individual.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 38725 Based on interview and record review, the facility did not complete a performance review of every nurse aide at least once every 12 months for 4 of 5 Certified Nursing Assistants (CNAs) reviewed. CNA ZZ did not have an annual performance evaluation completed. CNA AAA did not have an annual performance evaluation completed. CNA BBB did not have an annual performance evaluation completed. CNA CCC did not have an annual performance evaluation completed. This is evidence by: The Facilities Policy and Procedure entitled Annual Employee Evaluation dated 5/2/23 documents, in part: Purpose: To comply with federal regulations, all employees will receive an annual evaluation of their work performance . Example 1 CNA ZZ's hire date was 11/28/22. CNA ZZ did not have an annual performance evaluation completed. Example 2 CNA AAA's hire date was 12/29/22. CNA AAA did not have an annual performance evaluation completed. Example 3 CNA BBB's hire date was 9/28/21. CNA BBB did not have an annual performance evaluation completed. Example 4 CNA CCC's hire date was 10/11/22. CNA CCC did not have an annual performance evaluation completed. On 3/25/25 at 6:11 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B how often are CNA evaluations to be done, DON B said yearly. Surveyor asked DON B should all CNA's have an up-to-date evaluation, DON B stated, Yes. On 3/25/25 at 6:33 PM, Surveyor interviewed INHA YY (Interim Nursing Home Administrator). Surveyor asked INHA YY how often would you expect your CNA's evaluations to be done, INHA YY said yearly. Surveyor asked INHA YY would you expect all your CNAs to have an up-to-date evaluation, INHA YY stated yes.

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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. 36253 Based on observation, record review, and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect all 66 residents. Nutritional supplements were observed without the appropriate thaw dates. Dietary staff did not report when the dishwasher did not reach the necessary PPM (Parts Per Million). Findings include: Example 1 On 3/5/25 at 10:42 AM, Surveyor observed 7 Sysco Mighty Shakes in one of the facility kitchen's refrigerators. The shakes were completely thawed and did not have any thaw dates noted. The shakes state on the container that they need to be discarded within 14 days of being thawed. On 3/5/25 at 10:43 AM, Surveyor interviewed DM V (Dietary Manager) who stated that she thought the shakes were dated when pulled from the freezer but noted they had not been. Example 2 The facility uses a low-temperature, sanitizing dishwasher. A document, titled, Dish Machine Temperature Log, hangs near the dishwasher and states that the PPM for the chlorine needs to be 50-100 PPM. On 3/10/25 at 4:39 PM, Surveyor observed the Dish Machine Temperature Log. On 3/10/25, it was noted that the PPM of the dishwasher for first observation of the day was 10. On 3/12/25 at 1:23 PM, Surveyor interviewed CDM W (Certified Dietary Manager), who stated that she was not notified when the PPM of the dishwasher was only 10, but would expect to be notified immediately to address any issues. CDM W indicated that she was already in the process of addressing the issue and that all dietary staff will be educated on how to appropriately test the PPM of the dishwasher and to report any questionable findings immediately.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 36253 Based on observation and interview, the facility did not ensure garbage and refuse was disposed of properly. This has the ability to affect all 66 residents. Garbage and litter was found near the facility's main dumpster area. Findings include On 3/5/25 at 10:31 AM, Surveyor observed in the facility's main exterior garbage area, along with DM V (Dietary Manager), 13 used gloves strewn around the two dumpsters, two bags of garbage lying on the ground (one was halfway lodged under one of the dumpsters), and what appeared to be hundreds of cigarette butts on the ground. At this time, Surveyor interviewed DM V who stated that the garbage had been there for over a week and needed to be removed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 50285 Based on observation, interview, and record review, the facility did not ensure the facility-wide assessment developed by the facility included all relevant details to ensure the facility provided care and services to residents to meet their individual needs within the facility's identified resources. This has the potential to affect all 66 residents residing at the facility. The facility assessment must reflect the resident population, the resources needed to care for this population as well as staff competencies to care for the resident population residing within the facility. The facility has several residents who do not speak English as their primary language, the staff did not have the competencies to communicate with these residents or to ensure their ethnic, cultural, and activity needs were being met. The facility has residents who require dialysis; the staff did not have the skill set or competencies to care for residents post dialysis. The facility has an infection prevention and control program (ICIP) however several breaches were identified within the IPCP; the Infection Preventionist did not have the competence/skill set to recognize a trend/outbreak of ESBL (Extended-Spectrum Beta-Lactamase, a group of enzymes produced by certain bacteria that make them resistant to a wide range of antibiotics) on a unit. Residents were identified with pressure injuries (PIs) at an advanced stage and PI interventions were not in place. The facility assessment did not address equipment needs for residents with assist/transfer bars and/or how to assess residents for the use of the equipment. Evidenced by: The State Operations Manual indicates the facility assessment must address or include the following: The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven methods that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under S 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. The Facility Assessment, approved 10/18/24, with most recent revision date of 1/16/25, states in part: . Purpose: The purpose of this assessment is to determine what resources are necessary to care for our residents competently . Scope: The facility's resident population, including but not limited to: . The care required by the resident population using . pertinent facts that are present within that population, consistent with and informed by individual resident assessments. The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population. The physical environment, equipment . necessary to care for this population; and any ethnic, cultural or religious factors that may potentially affect the care provided by the facility, including but not limited to, activities and food and nutrition services . Example 1: The Facility Assessment indicates the ability to care for residents with a preferred language of English or Hmong. The facility currently has residents whose primary language is Spanish, Russian, and Hmong. The Facility Assessment does not address Spanish or Russian speaking residents. Surveyors made several observations of staff being unable to communicate with R74 who speaks Spanish, R423 who speaks Hmong, and R9 who speaks Russian. The facility has an interpertator line; however, staff did not know to use the line to communicate with residents. Observations were made with residents and staff unbale to effectively communicate. The facility has not ensured nursing staff have the appropriate cultural competencies to communicate effectively while providing care to residents with communication needs and ensuring that devices are utilized per the care plan to communicate with R74, R423, and R9 in their preferred language and staff indicated they would not know if R74, R423, or R9 were trying to communicate a change in their condition. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F726. Example 2: The Facility Assessment indicates the ability to care for residents receiving dialysis services. R24 receives dialysis services; however, the staff did not consistently document pre and post dialysis monitoring, nor were they able to consistently explain what they would do in case of complications or an emergency involving a dialysis patient. On 3/10/25 at 2:46 PM, Surveyor interviewed CNA K (Certified Nursing Assistant) and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula; CNA K stated she would go get the nurse. On 3/11/25 at 10:32 AM, Surveyor interviewed CNA T and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula; CNA T stated she would call for a nurse. On 3/11/25 at 12:27 PM, Surveyor interviewed CNA L and asked what she would do if she walked in and saw a resident bleeding from their dialysis fistula; CNA L stated she would get the nurse right away. It is important to note that the CNAs interviewed stated they would leave R24 in her room alone while bleeding out of her dialysis site. No mention was made of applying pressure to stop the bleeding. The facility staff failed to demonstrate the skills and competencies necessary to care for dialysis residents, putting those residents at risk. Cross-reference F698. Example 3: The Facility Assessment indicates the ability to care for residents with pressure injuries. However, two residents were found to have advanced stage pressure injuries. R25 was at risk for developing pressure injuries related to immobility and history of poor nutrition. The facility failed to implement aggressive pressure injury interventions; failed to implement orders timely; failed to provide risks and benefits despite knowledge of R25 refusing repositioning. R25's treatment was observed by surveyors to not be in accordance with physician orders and the facility staff did not wear the appropriate Personal Protective Equipment (PPE). R25 developed an in-house unstageable pressure injury on her sacrum on 2/8/25 and required transfer to the hospital on 3/6/25 where R25's sacrum wound was assessed as a stage IV and found to be infected. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R65 was at risk for pressure injury (PI) development. On 3/3/25 during a routine visit, NP C (Nurse Practitioner) discovered R65 had an Unstageable PI to the right lateral heel. The facility staff did not implement appropriate offloading interventions until after the PI was discovered. Despite facility staff applying skin prep to the PI twice daily, nursing staff did not identify the Unstageable PI, assess and measure the PI, and notify the provider. R65 stated staff were not turning and repositioning him every 2 hours and have not provided risks and benefits regarding not repositioning at least every 2 hours. Surveyor observed R65's PI uncovered and open to air. CNA G (Certified Nursing Assistant) stated she noted R65's dressing was off approximately 1.5 hours prior to Surveyor's observation and did not notify the nurse. The facility staff failed to implement appropriate interventions based on the comprehensive assessment of a resident and failed to demonstrate the skills and competencies necessary to ensure residents receive care, consistent with professional standards of practice, to prevent pressure injuries and does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure injuries receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing or worsening. Cross-reference F686. Example 4: The Facility Assessment indicates the ability to provide infection prevention and control services. Several breaches in infection control were observed by Surveyors. The Infection Preventionist failed to recognize and control an ESBL outbreak on one unit. R223 had extended-spectrum beta-lactamase (ESBL), a multi-drug-resistant organism (MDRO) in R223's urine. ESBL is spread easily through hands and surfaces. The facility failed to ensure R223 was placed in proper transmission-based precautions. R32, R44, and R47 also tested positive after R223 was diagnosed with ESBL. Three of the residents resided on the same hall. Facility had no evidence precautions were put into place for R223, R32, R44, and R47 with confirmed ESBL. Staff did not complete hand hygiene according to Standards of Practice during cares for R25 and R74. Staff did not handle soiled linens appropriately. During R74's bed bath, staff threw dirty, soiled clothing and linens on the floor. Staff did not complete hand hygiene for residents prior to eating. Facility did not provide evidence the infection control policies get reviewed annually. These multiple areas of deficient practices indicate the staff did not have the appropriate skills and competencies required for infection prevention and control. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F880. Example 5: The Facility Assessment did not address equipment such as bed rails and/or enabler bars. The facility assessment did not indicate staff education regarding the use of bed rails and/or enabler bars, or how to assess for risk of entrapment. 11 residents were observed to have bed rails/enabler bars on their beds, including those with air mattresses. The facility failed to ensure a system was in place to address the safe use of these assistive devices; failed to ensure alternative options were tried prior to installation; assessments were not completed; risk and benefits were not provided; and consents were not obtained prior to installing bed rails/enabler bar/assistive devices on the beds. The facility did not identify and recognize the use of siderails with an air mattress increases the risk for entrapment. On 3/12/25 at 5:42 PM, NHA A (Nursing Home Administrator) indicated understanding regarding the need for the facility assessment to include all staff training and competencies necessary to care for their resident population. Cross-reference F700. The facility assessment did not accurately reflect the resident population or the resources needed to care for the residents residing within the facility.

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. R223 had a multi-drug resistant organism (MDRO) in her urine. R32, R44, and R47 later tested postived for the same MDRO. Hand hygiene was not performed per standards of practice for (R25 and R74). Residents (R223, R32, R44, & R47) are being cited at severity level 3 (actual harm), and (R25 and R74) are being cited at severity level 2 (potential for more than minimal harm). R223 had extended-spectrum beta-lactamase (ESBL) a MDRO, in R223's urine. ESBL is spread easily through hands and surfaces. The facility failed to ensure R223 was placed in proper transmission-based precautions. R32, R44, & R47 also tested positive after R223 was diagnosed with ESBL. Three of the residents resided on the same hall. Facility had no evidence precautions were put into place for R223, R32, R44, & R47 with confirmed ESBL. Staff did not complete hand hygiene according to Standards of Practice during cares for R25 & R74. Staff did not handle soiled linens appropriately. During R74's bed bath, staff threw dirty, soiled clothing and linens on the floor. Staff did not complete hand hygiene for residents prior to eating. Facility did not provide evidence the infection control policies get reviewed annually. This is evidenced by: The facility policy titled, Infection Prevention and Control Program, dated 10/4/23, states in part: POLICY: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . Policy Explanation and Compliance Guidelines: 1. The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases . 3. Surveillance: (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as a leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility . 4. Standard Precautions: . b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE . 5. Isolation Protocol (Transmission- Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Centers for Disease Control) guidelines. b. Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards . 12. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room . 16. Staff Education: a. All staff receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function. b. All staff shall demonstrate competence in relevant infection control practices . 18. Annual Review: a. The facility will conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures . The facility policy titled, Infection Outbreak Response and Investigation, dated 12/23/22, states, in part: . (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Policy: The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional infections. Definitions: Outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time . Policy Explanation and Compliance Guidelines: 1. Prompt recognition of outbreak: a. Changes in condition and/or signs and symptoms of infection will be reported according to procedures for infection reporting. b. The following triggers shall prompt an investigation as to whether an outbreak exist: . ii. A sudden cluster of infections on a unit or during a short period of time (i.e. three or more cases) . 2. Implementation of infection control measures: . c. Standard precautions will be emphasized. Transmission-based precautions will be implemented as indicated for the particular organism. d. Staff will be educated on the mode of transmission of the organism, symptoms of infection, and isolation or other special procedures. This includes special environmental infection control measures that are warranted based on the organism and current CDC guidelines . The facility policy titled, Handwashing/Hand Hygiene, dated 9/21, states, in part: . Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . c. Before and after direct contact with residents; . e. Before performing any non-surgical invasive procedures; . h. Before handling clean or soiled dressings, gauze pads, etc. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	i. Before moving from a contaminated body site to a clean body site during resident care; j. After contact with a resident's intact skin; k. After contact with blood or bodily fluids; l. After handling used dressings, contaminated equipment, etc.; m. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident; n. After removing gloves; . 9. The use of gloves does not replace hand washing/hand hygiene . According to <https://www.cdc.gov/esbl-producing-enterobacterales/about/index.html> Extended-spectrum beta-lactamase (ESBL)-producing Enterobacterales are resistant to common antibiotics and may require complex treatments. Infections caused by ESBL-producing Enterobacterales can occur both in and outside of healthcare settings. Good hand hygiene and infection prevention practices can help reduce infection risk. Enterobacterales are a group of bacteria that cause infections in healthcare settings and communities. Some species are also a normal part of the human gut. Some Enterobacterales produce enzymes called extended-spectrum beta-lactamases (ESBLs). Extended-spectrum beta-lactamases (ESBLs) break down certain antibiotics, making some infections caused by ESBL-producing Enterobacterales difficult to treat. ESBL-producing Enterobacterales infections occur in healthcare settings like hospitals and nursing homes. These infections may also occur in healthy people. ESBL-producing Enterobacterales can spread from person to person through dirty hands and surfaces. Reducing the risk healthcare workers should: Wash their hands often with soap and water or using alcohol-based hand sanitizer. Wash their hands after using the bathroom and before eating or preparing food. Remind people (including healthcare staff) to clean their hands before touching the patient or handling medical devices. Healthcare providers should always follow core infection control practices to reduce the risk of spreading these germs to patients. Treatment and recovery: ESBL-producing Enterobacterales infections are resistant to many prescribed antibiotics, such as penicillin's and cephalosporins. These infections might require hospitalization and intravenous (IV) antibiotics. According to <https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html> Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) How to implement personal protective equipment (PPE) use in nursing homes to prevent spread of multi-drug resistant organisms (MDROs). Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status; infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. Standard Precautions, which are a group of infection prevention practices, continue to apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Example 1 R223 admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3 (kidneys have mild to moderate damage, meaning they're less effective at filtering waste and fluid from your blood) and malignant neoplasm (cancerous tumor) of right kidney. R223 had a urinalysis (UA) and culture and sensitivity (C&S) on 1/1/25, which showed R223 was positive for a urinary tract infection (UTI). R223's culture showed 1) Escherichia coli (bacteria that causes UTIs) >100, 000 COL/ML (colony forming units in milliliter of urine) and 2) Proteus mirabilis ESBL (Gram negative bacterium that causes variety of infections including UTIs.) (ESBL-extended-spectrum beta-lactamase- an enzyme produced by certain bacteria that makes them resistant to many commonly used antibiotics, making it harder to treat) producing Proteus mirabilis are resistant to several antibiotics) >10,000- 50,000 COL/ML. Result phoned, read back, and faxed/electronically transmitted . Positive for ESBL. This organism is an extended-spectrum beta-lactamase producer. These organisms may not clinically respond to treatment with cephalosporins, extended-spectrum penicillin or aztreonam. Isolation precautions may be required. Facility's surveillance list for residents for month of January 2025 shows: R223- Onset Date- 1/11/25. Site- GU (GENITOURINARY) SYSTEM. Symptoms- trouble urinating and burning. Diagnostics/Results- UTI. Type of isolation- N/A (NOT APPLICABLE). Treatment & Intervention- Ceftriaxone Sodium Injection solution reconstituted 1 gram. HAI (healthcare acquired infection) /CAI (community acquired infection)- HAI. Completion Well Date- 1/14/25. *Note: Per CDC guidelines Enhanced Barrier Precautions (use of gloves and gown during high contact resident care) recommended. Example 2 R32 admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3 and metabolic encephalopathy (a condition where the brain's function is impaired due to an underlying metabolic disturbance). R32 had a UA and C&S on 2/3/25, which showed R32 was positive for a UTI. R32's urine culture showed 1) Citrobacter freundii complex-ESBL (gram negative bacteria that can cause various infections, including a UTI). 50,000-100,000 COL/ML. Positive for ESBL. This organism is an extended-spectrum beta-lactamase producer. These organisms may not clinically respond to treatment with cephalosporins, extended-spectrum penicillin or aztreonam. Isolation precautions may be required. 2) Enterococcus faecium (a gram-negative bacterium, is resistant to many standard therapies, including antibiotics) -10,000-50,000 COL/ML. Facility's surveillance list for residents for month of February 2025 shows: (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	R32 (100 hallway)- Onset Date- 2/5/25. Site- GU. Symptoms- Multiple organisms noted in UA: ESBL (50, 000- 100,000) and Enterococcus faecium (10,000-50,000COL/ML) Burning with urination, public tenderness, foul smelling urine, darkened discolored urine. Diagnostics/Results- UTI. Type of isolation- N/A. Treatment & Intervention- Macrobid Oral Capsule 100mg (milligrams). HAI/CAI- HAI. Completion Well Date- 2/9/25. *Note: Per CDC guidelines Enhanced Barrier Precautions (use of gloves and gown during high contact resident care) recommended. Example 3 R44 admitted to the facility on [DATE] and has diagnoses that include neuromuscular dysfunction of bladder (a condition where bladder control is lost due to damage to the nerves resulting in difficulties with urination) and hemiplegia (severe weakness/complete paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting left dominant side. R44 had an UA and C&S on 2/18/24, which showed R44 was positive for a UTI. R44's urine culture showed Proteus vulgaris-ESBL (a rod-shaped, gram-negative bacterium that can cause urinary tract and wound infections) 50,000-100,000 COL/ML. Positive for ESBL. This organism is an extended-spectrum beta-lactamase producer. These organisms may not clinically respond to treatment with cephalosporins, extended-spectrum penicillin or aztreonam. Isolation precautions may be required. Please refer to your infection control policy. Result phoned, read back, and faxed/electronically transmitted to . Facility's surveillance list for residents for month of February 2025 shows: R44 (Hallway 100)- Onset Date- 2/20/25. Site- GU. Symptoms- ESBL Culture results= 50,000 through 100, 000 col/ml. NP (Nurse Practitioner) informed-wants to keep medication active for resident. Diagnostics/Results- UTI. Type of isolation- N/A. Treatment & Intervention- Cefpodoxime Proxetil Oral Tablet 100 mg. HAI/CAI- HAI. Completion Well Date-2/27/25. *Note: Per CDC guidelines Enhanced Barrier Precautions (use of gloves and gown during high contact resident care) recommended. Example 4 R47 was admitted to the facility on [DATE] and has diagnoses that include end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids) and dependence on renal dialysis (a medical procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so). R47 had an UA and C&S on 2/17/25 that showed R47 was positive for an UTI. R47's urine culture showed Klebsiella oxytoca-ESBL (a gram-negative, rod-shaped bacteria that can cause a range of infections, from mild diarrhea to life-threatening bacteremia and meningitis). Positive for ESBL. This organism is an extended-spectrum beta-lactamase producer. These organisms may not clinically respond to treatment with cephalosporins< extended-spectrum penicillin or aztreonam. Isolation precautions may be required. Please refer to your infection control policy. Result phoned, read back, and faxed/electronically transmitted to . (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Facility's surveillance list for residents for month of February 2025 shows: R47 (Hallway 100)- Onset Date- 2/22/25. Site- GU. Symptoms- Klebsiella Oxytoca 50,000=100,000 COL/ML (Positive for ESBL). Confusion, pubic pain. Diagnostics/Results- ESBL-UTI. Type of isolation- N/A. Treatment & Intervention- Cipro Oral Tablet 500 mg. Give after dialysis. HAI/CAI- HAI. Completion Well Date- 2/27/25. *Note: Per CDC guidelines Enhanced Barrier Precautions (use of gloves and gown during high contact resident care) recommended. On 3/10/25 at 10:01 AM, Surveyor interviewed CNA Y (Certified Nursing Assistant) and asked if CNA Y had received any education on PPE, handwashing, and precautions. CNA Y indicated staff received education on handwashing and PPE for norovirus outbreak. Surveyor asked if CNA Y was aware of any residents with MDRO's and what care requirements would include for these residents. CNA Y stated she was not aware of residents with MDROs or what precautions would be required for these residents. On 3/10/25 at 10:14 AM, Surveyor interviewed CNA Z who indicated education on PPE and handwashing was received only in orientation. Surveyor asked if CNA Z was aware of any residents with MDRO's and what care requirements would include for these residents. CNA Z stated she was not aware of residents with MDROs or what precautions would be required for these residents. On 3/10/25 at 10:20 AM, Surveyor interviewed LPN AA (Licensed Practical Nurse) who indicated education on PPE may have been a few months back, but she could not remember. Surveyor asked LPN AA if she was aware of residents on MDRO's LPN AA stated she was not aware of residents with MDROs, LPN AA stated a resident with an MDRO would require transmission-based precautions. On 3/11/25 at 12:02 PM, Surveyor interviewed IP D (Infection Preventionist) regarding R223's ESBL infection. Surveyor asked IP D when the facility received R223's lab results indicating R223 had ESBL in the urine what did facility do? IP D indicated MDRO Precautions would have been put into place for R223. Surveyor showed IP D the facility line list under type of isolation the line list indicates isolation precautions were documented as N/A. IP D indicated he does not know why he put N/A in there, he thought he had put precautions into place but can't remember for sure. Surveyor asked if any staff training was provided at that time. IP D indicated staff get trained at orientation on PPE (Protective Personal Equipment), hand washing and on peri cares. IP D indicated precaution signs would be placed as needed and if staff have any questions they are to come to me. Surveyor asked if there are any other times staff should receive education on infection prevention and IP D indicated if there were concerns with infection control and if failure to use infection prevention measures. Surveyor asked IP D if any education would be provided to staff with an outbreak and IP D indicated yes, on what the outbreak was and the necessities for the outbreak. Surveyor asked what is meant by necessities and IP D indicated for COVID outbreak- the PPE and hand washing, and for GI (gastrointestinal) outbreak and respiratory would be same ballpark and to keep everyone as safe as possible. Surveyor asked about R32, R44, and R47's lab results showing positive for ESBL. IP D referred Surveyor to DON B (Director of Nursing). (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	On 3/12/25 at 9:03 AM, Surveyor interviewed DON B. Surveyor requested March 2025 line list. DON B indicated she would get Surveyor a copy. Surveyor asked DON B regarding R223's ESBL infection. Surveyor asked DON B when the facility received R223's lab results indicating R223 had ESBL in the urine what did facility do? DON B indicated she will have to get back to Surveyor. Surveyor asked DON B about R32, R44, and R47's positive ESBL, what precautions were put into place, what cleaning and disinfecting went into effect, and if education was provided to staff on hand washing, PPE, ESBL/precautions. DON B indicated she will get back to Surveyor. Surveyor asked if poor hand hygiene or lack of PPE use could contribute to the spread of ESBL and DON B indicated yes. On 3/12/25 at 5:44 PM, Surveyor interviewed DON B and asked if there were concerns after R223 had an ESBL infection. DON B indicated yes this would be a concern. DON B indicated the facility tracks MDROs by line lists and mapping of symptoms. Surveyor asked DON B would you expect the positive cases of ESBL on the 100 hallway within the month of February to be recognized as a concern. DON B indicated it should have been recognized. Surveyor asked DON B if she would expect education to be provided to staff on MDROs, hand hygiene and precautions to be put into place. DON B indicated yes, and she would have to check with the educator to see if education was provided. DON B indicated it is a concern to have multiple cases of MDROs on the same hallway. The concern would be the spread to others and of course the concern of antibiotic resistance. Surveyor asked DON B would you expect the IP to follow outbreaks and DON B indicated yes. On 3/12/25 at 5:56 PM, Surveyor interviewed IP D. IP D indicated he would expect education to be provided to staff regarding ESBL, hand washing, peri cares and PPE/precautions. IP D indicated having 4 positive cases of ESBL within a short period of time in the facility is concerning with possible spread of a MDRO. IP D indicated he would expect residents with ESBL to be on precautions and he cannot pinpoint if the R223, R32, R44, & R47 residents were put on precautions and if so what for. IP D indicated he has no documentation to show the residents were on precautions. On 3/17/25 at 8:27 AM, Surveyor interviewed NP C (Nurse Practitioner) and asked NP C if she was aware of multiple cases of ESBL in the facility starting in January 2025 and in the month of February 2025. NP C indicated she would have to go back and look, at this time NP C indicated she does not know. Surveyor asked NP C if this were something she would want to be notified of and NP C indicated yes, if it were her patients. Surveyor asked NP C in her opinion how would this be a concern for the facility. NP C indicated they would want to know why this is occurring and see if their infection control practices need to be changed. Surveyor asked NP C how she would expect the facility to address multiple cases of ESBL in the facility. NP C indicated by making sure with the cases of ESBL precautions are being met and review who has been taking care of those residents. I would expect the facility to follow the proper precautions which would include gown and gloves and the standard precautions for ESBL. Example 5 R25 admitted to the facility on [DATE] and has diagnoses that include Diabetes Mellitus (a disease that result in too much sugar in the blood). R25's Quarterly Minimum Data Set (MDS) Assessment, dated 2/4/25, shows R25 has a Brief Interview of Mental Status (BIMS) score of 14 indicating R25 is cognitively intact. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	On 3/6/25 at 9:56 AM, Surveyor observed wound care on R25 with CNA G (Certified Nursing Assistant) and RN F (Registered Nurse). It is important to note that R25 is on EBP (Enhanced Barrier Precautions), requiring staff to wear gloves, gown, and mask while performing cares. RN F (Registered Nurse) and CNA G entered R25's room without performing hand hygiene and without wearing a gown. RN F removed the old Mepilex dressing that was saturated with purulent and bloody drainage. RN F then cleansed the wound with wound cleanser. RN F changed her gloves and did not perform hand hygiene. RN F applied the Dakin's-soaked gauze, skin prep applied to peri- wound, Hydralock applied, and covered with a Mepilex. RN F changed her gloves, but did not perform hand hygiene and began incontinence care, as R25 was incontinent of stool. RN F changed her gloves, but did not perform hand hygiene and performed catheter care on R25. On 3/6/25 at 10:28 AM, Surveyor interviewed CNA G. Surveyor asked CNA G what type of PPE (Personal Protective Equipment) should be worn in a room that has EBP, CNA G reported that they should wear a gown, gloves, and a mask. Surveyor asked CNA G if she should have been wearing a gown during wound care, CNA G stated yes. On 3/6/25 at 10:28 AM, Surveyor interviewed RN F. Surveyor asked RN F what PPE should be worn in a room with EBP, RN F stated gloves and mask, but that she wasn't sure about a gown. RN F and Surveyor reviewed the EBP sign on R25's door. Surveyor asked RN F if she should have had a gown on, RN F stated yes. Surveyor asked RN F if she had any missed opportunities for hand hygiene, RN F stated yes, she should have performed hand hygiene before starting wound care. Surveyor asked RN F if she should have performed hand hygiene after taking off soiled gloves and before applying clean gloves, RN F stated yes. Example 6 R74 admitted to the facility on [DATE] and has diagnoses that include cerebral infarction (also known as an ischemic stroke, a condition where blood flow to the brain is interrupted, causing brain cells to die) and unspecified symptoms and signs involving cognitive functions and awareness. R74's Quarterly MDS Assessment, dated 1/25/25, section C shows no BIMS score recorded, indicating R74's cognitive status was not assessed or deemed not applicable during the assessment period. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	On 3/11/25 at 9:42 AM, Surveyor observed CNA M give R74 a bed bath. CNA M did not change gloves and perform hand hygiene after washing R74's peri area and then reaching into clean rinse basin for wash cloth to rinse R74's peri area. CNA M removed gloves during bed bath and reached into her pocket for her phone and accessed Google Translate to ask R74 what she was saying without performing hand hygiene. CNA M then applied new gloves without hand hygiene and continued with bed bath. CNA M threw a soiled brief and gown on R74's floor along with the used washcloths and towels. CNA M kept same soiled gloves on and began dressing R74. During this time, CNA M grabbed the bed remote, grabbed R74's slippers out from under the bed, opened R74's door and grabbed the EZ stand from out in the hallway, picked up the soiled brief, the gown and used washcloths from bed bath off the floor and threw to another area on the floor to get the EZ stand up to the bed. CNA M then transferred R74 into the wheelchair and adjusted R74's clothing once in wheelchair with the same dirty gloves on. CNA M opened R74's drawer and grabbed R74's brush and ponytail holder and brushed R74's hair and put her hair in a ponytail with same dirty gloves on. CNA M transferred R74 halfway down the hallway and then stopped at a hand sanitizer mounted on wall, removed gloves and used hand sanitizer, then continued to take R74 to lounge area. On 3/11/25 at 10:16 AM, Surveyor interviewed CNA M and asked if there were missed hand hygiene opportunities during R74's bed bath. CNA M indicated after peri care, when she went in and out of room, and before taking R74 down the hallway. CNA M indicated gloves and hand hygiene should have been done 4 to 5 times during bed bath but R74 was rushing her. CNA M indicated hand hygiene should have been performed before brushing R74's hair and before grabbing bed remote, EZ stand and wheelchair. Surveyor asked CNA M if it is appropriate to throw dirty laundry on the floor and CNA M indicated that is what they do here. CNA M indicated it is not appropriate, but the facility does not have bins in the rooms to place laundry in. Surveyor asked CNA M if she received any education on PPE, precautions or hand washing. CNA M indicated no. On 3/12/25 at 9:03 AM, Surveyor interviewed DON B (Director of Nursing) and asked if dirty clothes, used wash clothes and towels and soiled briefs should be thrown on the floor while performing a bed bath. DON B indicated no. DON B indicated the facility has special containers the dirty clothes go in on each unit. Surveyor asked what staff should do with dirty clothing and linens etc. during care and DON B indicated staff should put dirty linens and clothing in a plastic bag. Surveyor informed DON B of observation of CNA M with missed hand hygiene opportunities during bed bath and dirty clothing and linens being thrown on R74's floor. DON B indicated that is not appropriate. DON B indicated she would have expected hand hygiene any time gloves get changed, after peri cares, before leaving room, before handling bed remote, wheelchair, EZ stand and resident. Example 7 The facility did not provide evidence the infection control policies get reviewed annually. -Infection Outbreak Response and Investigation- dated 12/23/22. -Management of Respiratory Syncytial Virus (RSV)- dated 12/1/22. -COVID-19 Vaccination- 5/16/23. -Influenza Vaccination- 8/30/23. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Few	-Pneumococcal Vaccine- 8/30/23. -Antibiotic Stewardship Program- 10/4/23. -Infection Control Surveillance-10/4/23. -Hand washing- 9/21. Surveyor asked IP D and DON B for evidence polices were reviewed annually. No evidence was brought to Surveyor. On 3/10/25 at 1:30 PM, Surveyor interviewed IP D and asked how often Infection Control Policies are to be reviewed. IP D indicated the DON B and NHA A (Nursing Home Administrator) review them yearly. Surveyor asked IP D if there is evidence of this and IP D indicated he would have to check with DON B. On 3/12/25 at 9:03 AM, Surveyor asked DON B if there were evidence the Infection Control Policies were reviewed annually. DON B indicated she would see if there were a sheet signed for annual review. 50285 Example 8 On 3/6/25 at 8:04 AM, Surveyor observed CNA GG (Certified Nursing Assistant) passing hall trays on [NAME] Hallway. No hand hygiene was being offered to residents before eating. On 3/6/25 at 9:18 AM, Surveyor interviewed CNA GG and asked when it was appropriate to complete hand hygiene. CNA GG stated that she performs hand hygiene before and after completing cares with the resident. Surveyor asked CNA GG if hand hygiene should be offered to the residents before eating. CNA GG stated yes. Surveyor asked CNA GG if she had offered the residents hand hygiene before she gave them their meal trays. CNA GG stated that she had not because there was no hand sanitizer available. Example 9 On 3/11/25 at 7:40 AM, Surveyor observed CNA M passing hall trays on [NAME] Hallway. No hand hygiene was being offered to residents before eating. On 3/11/25 at 8:35 AM, Surveyor interviewed CNA M and asked when it was appropriate to complete hand hygiene. CNA M stated she performs hand hygiene when her hands are visibly soiled and when providing cares to residents. Surveyor asked CNA M if hand hygiene should be performed before eating. CNA M stated yes. Surveyor asked CNA M if she had offered the residents hand hygiene before giving them their meal trays. CNA M stated she had not. On 3/12/25 at 8:47 AM, Surveyor interviewed DON B (Director of Nursing) and asked if she expected that staff offer hand hygiene to the residents before eating. DON B replied that yes, that was her expectation.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on interview and record review, the facility did not ensure they followed their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 2 of 10 sampled Residents (R11 and R21) and 1 of 1 supplemental (R73) reviewed for antibiotic stewardship. R73 was treated with an antibiotic for a urinary tract infection (UTI) and urinalysis (UA) showed R73 did not have a UTI. R11 and R21 were treated prophylactically with antibiotics. Evidenced by: The facility policy entitled, Antibiotic Stewardship Program, dated 12/23/22, states, in part: . Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance: . 1a. Infection Preventionist- coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff . 4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: . ii. Laboratory testing shall be in accordance with standards of practice. iii. The facility uses the (CDC's (Centers for Disease Control) NHSN (National Healthcare Safety Network) Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections . b. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made . ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families . 11. Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to: . c. Antibiotic use protocols/algorithms. d. Data collection forms for antibiotic use, process, and outcome measures . g. Records related to education of physicians, staff, residents, and families . McGeer revised criteria indicates the following: . Urinary tract infection (UTI) surveillance definitions . UTI without indwelling catheter. Must fulfill both 1 AND 2. 1. At least one of the following signs or symptoms. - Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate. - Fever or leukocytosis, and greater than or equal to 1 of the following: - Acute costovertebral angle pain or tenderness; suprapubic pain; gross hematuria; new or marked increase in incontinence; new of marked increase in urgency; new or marked increase in frequency. - If no fever or leukocytosis, then greater than or equal to 2 of the following: - Suprapubic pain; gross hematuria; new or marked increase in incontinence; new of marked increase in urgency; new or marked increase in frequency. 2. At least one of the following microbiological criteria. - Greater than 10^5 cfu/ml (colony forming unit per milliliter) of no more than 2 species of organisms in a voided urine sample. - Greater than or equal to 10^2 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter. UTI with indwelling catheter: Must fulfill both 1 AND 2. 1. At least one of the following signs or symptoms. - Fever, rigors, or new-onset hypotension, with no alternate site of infection. - Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- New onset suprapubic pain or costovertebral angle pain or tenderness. - Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis or prostate. 2. Urinary catheter specimen with greater than or equal to 10^5 cfu/ml of any organism(s). Example 1 R73 was admitted to the facility on [DATE] and has diagnoses that include retention of urine and neuromuscular dysfunction of bladder (a condition where bladder control is lost due to damage to the nerves or brain that control bladder function). R73's UA, dated 1/24/25, does not show R73 has a UTI. It shows there is bacteria present in the urine with a note next to the entry- The presence of bacteria is not necessarily indicative of urinary tract infections. WBC (white blood cells) value is 51-100, reference range is <=5/hpf (high power field), Nitrate- value- negative, reference range- negative and ph (measures the acidity or alkalinity of urine) value- 5.0 and reference range is 5.0-8.0. On 1/25/25 at 03:45 (3:45 AM) R73's progress note indicates: ED (emergency department) after visit summary given intravenous fluids symptoms improved and has UTI .ED discharge orders see at orders [sic]. The facility's resident surveillance list shows- -R73 Date of Onset- 1/25/25. Site- GU (Genitourinary) system. Signs/Symptoms/Criteria- Pain when urinating, mental changes, frequency/urgency. Diagnostics/Results- UTI. Type of Isolation- N/A (not applicable). Treatment & Intervention: Nitrofurantoin Monohyd (monohydrate) Macro Oral Capsule 100 mg (BID- Twice a day). HAI/CAI (healthcare acquired infection/community acquired infection)- HAI. Completion Well Date- 2/1/25. On 3/10/25 at 1:30 PM, Surveyor interviewed IP D (Infection Preventionist). Surveyor asked IP D if R73 should have been treated with an antibiotic for UTI. IP D indicated while looking at R73's UA results absolutely not, R73 did not have a UTI but family wanted her on antibiotic. Surveyor asked if IP D provided education to R73's family on risk versus benefits of treating with antibiotics with R73 not meeting criteria and IP D indicated he would look for documentation. Example 2 R11 was admitted to the facility on [DATE] and has diagnoses that include chronic kidney disease stage 3 (kidneys have mild to moderate damage, meaning they're less effective at filtering waste and fluid from your blood) and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). The facility's February Resident Surveillance List shows: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-R11 Date of Onset- 2/15/25. Site- GU. Signs/Symptoms/Criteria-Chronic UTI Prevention. Diagnostics/Results-Prophylactic. Type of Isolation- N/A. Treatment & Intervention: Nitrofurantoin Macrocrystal Oral Capsule 100 mg. HAI/CAI- HAI. Completion Well Date- Consistent Usage. R11's February and March Medication Administration Record (MAR) shows: -Nitrofurantoin Macrocrystal Oral Capsule. Give 100 mg by mouth one time a day for UTI prevention. Start Date- 2/15/25. R11 received Nitrofurantoin 2/15/25- 3/12/25 (current). On 3/10/25 at 1:30 PM, Surveyor interviewed IP D (Infection Preventionist). Surveyor asked IP D if he had a conversation with PCP on R11's prophylactic use on risks and benefits/antibiotic stewardship and IP D indicated nothing is documented. Example 3 R21 admitted to the facility on [DATE] and has diagnoses that include type 2 diabetes mellitus and pressure ulcer of sacral region, unspecified stage. The facility's January Resident Surveillance List shows: -R21- Date of Onset- 1/22/25. Site- Skin. Signs/Symptoms/Criteria-Stage 2 pressure sore with placement high in probability of infection. Diagnostics/Results-Prophylactic. Type of Isolation- N/A. Treatment & Intervention: Doxycycline Hyclate oral tablet 100 mg (BID). HAI/CAI- HAI. Completion Well Date- TBD (To be determined)- End with wound resolution. R21's January Medication Administration Record (MAR) shows: -Doxycycline Hyclate Oral Tablet 100 mg. Give 1 tablet by mouth two times a day for antibiotic. Start Date- 12/31/24. January MAR shows R21 received doxycycline 1/1/25- 1/9/25 bid and one time on 1/11/15. Then 1/22/25 R21 received one time and 1/23/25-1/31/25 bid. On 3/10/25 at 1:30 PM, Surveyor interviewed IP D (Infection Preventionist). Surveyor asked IP D if he had any documentation with PCP on R21's prophylactic use and IP D indicated no. Surveyor asked why R21 was on prophylactic antibiotics and IP D indicated he would find out. (Of note: the facility's infection preventionist did not know why R21 was on a prophylactic antibiotic.) On 3/12/25 at 2:40 PM, IP D informed Surveyor that the NP (Nurse Practitioner) will fax over communication regarding R21's doxycycline. Per IP D, R21 was on doxycycline by dermatology for hidradenitis suppurativa (acne inversa- a chronic skin condition featuring small painful lumps in places such as armpits or groin). IP D did not provide any further documentation regarding R21. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 1:30 PM, Surveyor interviewed IP D (Infection Preventionist) and asked if it is appropriate to treat prophylactically with antibiotics. IP D indicated not based on nursing home recommendations but when primary care physician (PCP) orders prophylactic antibiotics, my hands are tied. Surveyor asked IP D if he had a conversation with the PCP regarding antibiotic stewardship and prophylactic use. IP D indicated no. On 3/12/25 at 9:03 AM, Surveyor interviewed DON B and asked if it is appropriate to treat with prophylactic antibiotics and DON B indicated no, but the physicians do prescribe it. Surveyor asked if DON B would expect a conversation to take place with physicians on antibiotic stewardship and risks versus benefits and DON B indicated yes. Surveyor asked DON B if she would expect to see documentation on physician education and DON B indicated yes.