STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525172	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home and Care Center	1414 N Prospect Ave Milwaukee, WI 53202

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700 Based on interview and record review, the facility did not ensure residents who use psychotropic drugs have a comprehensive assessment and PRN (as needed) orders are limited to 14 days for 3 (R23, R18, and R9) of 7 residents reviewed for psychotropic medications. *R23 signed consent for Trazodone was expired and an assessment for sleep was not completed on a quarterly basis. *R18 Medication orders in Point Click Care (PCC) - Healthcare software, did not limit the timeframe for PRN psychotropic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner *R9 Medication orders in Point Click Care - Healthcare software, did not limit the timeframe for PRN psychotropic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner Findings include: The facility policy, titled Use of Psychotropic Medications, dated [DATE], documents, Procedure: 2. The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological approaches, will be determined by: a. Assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment. 9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). 1.) R23 was admitted to the facility on [DATE] with pertinent diagnosis of dementia, anxiety, and insomnia. R23's Annual Minimal Data Set (MDS) dated : [DATE], documents a Brief Interview for Mental Status (BIMS) of 13, which indicates R23 is cognitively intact. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's Cognitive Loss/Dementia Care Area Assessment (CAA) dated [DATE] documents: R23 is alert. Memory deficits noted. Cognitive skills for daily decision making are moderately impaired. Resident has health care power of attorney that is activated. Will proceed to plan of care at this time. Brief Interview for Mental Status (BIMS) of 13, which indicates cognitively intact. R23's depression and insomnia care plan documents: On medication for these disorders. Behavioral health solutions (BHS), a company that evaluates and treats R23's mental health diagnosis, visits every 3 months. BHS's last scanned in visit was dated: [DATE]. The follow up visit notes dated [DATE] documents: No medication changes currently. Current order for Trazodone found in during record review. Medication administration record documents: Trazodone Tablet 50 milligrams, Give 1 tablet by mouth at bedtime for sleep and major depressive disorder. R23's physician order dated [DATE] documents: Trazodone Tablet 50 milligrams, Give 1 tablet by mouth at bedtime for sleep and major depressive disorder. R23's MAR (Medication Administration Record) documents that R23 received Trazadone per the above physician order from [DATE] until [DATE]. Surveyor noted that the only signed consent for Trazodone that was scanned into PCC was dated for [DATE]. The dated signature on the consent was [DATE], and that was documented as: not to exceed fifteen (15) months from the date of signature. Surveyor asked NHA (Nursing Home Administrator)-A for any additional information related to current consent for R23's Trazodone. On [DATE], at 11:06 AM, Surveyor interviewed Social Worker-I regarding R23's Trazodone consent. Surveyor informed Social Worker-I that R23's Trazodone was expired and last signed, [DATE]. Social Worker-I acknowledged that R23's Trazodone consent form was expired. Social Worker-I stated the power of attorney for R23 was emailed a new consent form this morning to sign a new one. On [DATE], at 11:19 AM, Surveyor interviewed Registered Nurse (RN) Unit Manager-E, who stated a sleep assessment for R23 was to be completed quarterly. RN Unit Manager-E acknowledged that RN Unit Manager-E was the person that would complete the assessment. RN Unit Manager-E stated the sleep assessment was forgotten and that it needed to be completed, as the dated sleep assessment in PCC for R23 was [DATE]., Surveyor stated concerns to Unit Manager-E that the sleep assessment was not completed in a timely manner or every quarter. On [DATE], at 11:24 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the above findings. Surveyor informed NHA-A that there was a concern with the completion of the quarterly sleep assessments for R23. Surveyor also informed NHA-A of the concern that R23's d consent for Trazodone was expired. No additional information was provided about why the facility did not ensure that R23's consent for Trazodone was expired and why the sleep assessments were not completed on a quarterly basis. 49011 2.) R18 was readmitted to the facility on [DATE] with a diagnoses include ankylosing spondylitis of unspecified sites in spine, obstructive sleep apnea, and major depressive disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Significant Change Minimum Data Set (MDS) with an assessment reference date of [DATE] indicated R18 had a Brief Interview for Mental Status score of 15 (cognitively intact). R18 makes decisions for themselves. R18's MDS was marked as R18 having no behaviors during the look back period and always being incontinent of bowel and bladder. R18's physician orders dated [DATE] documents: Trazodone 50 mg (milligram) tablet as needed (PRN) every 24 hours was prescribed. Surveyor noted that R18's Trazadone physician's order did not have a stop date for the PRN medication. The order was not in place during R18's previous stay at Facility. Surveyor noted according to the State Operations Manual, the need to limit the timeframe for PRN psychotropic medications, which are not antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner. Surveyor noted that a stop date was not documented. R18's Consultation Report dated [DATE], documents: Has a PRN order for a sedative/hypnotic, which has been in place for greater than 14 days without a stop date. The Consultation Report has the recommendation to discontinue PRN. The physician signed the report on [DATE] and the Director of Nursing (DON)-B signed the report on [DATE], the same day the PRN was discontinued. On [DATE], at 10:29 AM, Surveyor interviewed DON-B about the PRN trazadone order that was in place two months without a stop date and was told they would look into it. On [DATE], at 11:35 AM, Surveyor flowed up with Nursing Home Administrator (NHA)-A regarding the psychotropic PRN medication and asked for the policy. On [DATE], at 12:13 PM, the NHA-A reported to Surveyor that DON-B has no further information, and the policy was given to Surveyor. No additional information was provided. 51016 Vohen, [NAME] E. 3.) R9 was admitted on [DATE] with the diagnosis chronic obstructive pulmonary disease (COPD), chronic kidney disease, and cognitive impairment. R9's Quarterly Minimum Daily Set (MDS) with the assessment reference date of [DATE], documents a Brief Interview for Mental Status (BIMS) score of 3, indicating that R9 is severely cognitively impaired. R9's significant change of condition MDS with an assessment reference date of [DATE]. R9 returned to the facility after a short hospital stay on [DATE] with diagnosis of COPD, acute respiratory failure with hypoxia, metabolic encephalopathy, bradycardia, and paroxysmal atrial fibrillation. R9's medical record documented that R9 was placed on hospice [DATE]. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's mood interview in the [DATE] MDS indicated no response. R9's behavior assessment in the [DATE] MDS indicated no behavior symptoms present. R9's physician order dated [DATE] documents: Ativan oral tablet 0.5 MG (Lorazepam) give 1 tablet by mouth every 1 hours as needed for agitation/restlessness. The order did not have a stop date for the PRN (as need)medications. R9's pharmacy recommendation dated [DATE], documents: Physician declined the consultant pharmacist's recommendation for R9 from [DATE] to evaluated (evaluate?) ongoing PRN lorazepam use but did not provide the basis for disagreeing with the recommendation. Rationale for Recommendation: CMS requires that PRN orders of non-antipsychotic drugs be limited to 14 days ****unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN use**** Recommendation: Please follow up with to provide the basis for declining the recommendation. References: 42 CFR 483, Subpart B-Requirement for Long Term Care Facilities. Signed by the Consulting Pharmacist on [DATE]. Signature from DON-B on [DATE] with comment: MD updated will D/C (discontinue) PRN lorazepam at this time. On [DATE], at 11:38 AM, Surveyor interviewed NHA-A. Surveyor informed the NHA-A about R9's lorazepam order from [DATE] with no PRN stop date and pharmacist's comments in their recommendations. NHA-A informed Surveyor, that NHA-A was going to speak to DON-B about what was found out about a similar issue and why the Lorazepam order had no end date. Surveyor asked if DON-B who was looking into a similar issue could speak to the Surveyor. On [DATE], at 12:17 PM, NHA-A informed Surveyor, NHA-A had no other information related to R9's Ativan order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50700 Based on observation, interview, and record review, the facility did not store and prepare food in accordance with professional standards for food service safety potentially affecting all 74 residents that eat food prepared by the facility. * In the facility's main kitchen, observations of partially used and undated food were observed in the walk-in cooler. Food items observed in the facilities main kitchen's cooler were open to air. Open food was observed in the fridge on the 4th floor with no open or use by date. * [NAME] and hair restraints were not being utilized by kitchen staff, while they worked in the kitchen areas. * A large white scoop was observed in a bin holding sugar granules and not in the holder. Findings include: The facility policy and procedure titled Food Safety Requirements-Use and storage of food and beverage brought in for residents, food procurement, dated February 2024 documents: Centers for Medicaid and Medicare Services (CMS)- Definitions- D. Food Contamination refers to the unintended presence of potentially harmful substances, including, but not limited to microorganisms, chemicals or physical objects in the food. Food Storage Observations: On 1/14/2025, at 9:33 AM, Surveyor observed in the produce cooler tortilla shells and pie crust, both not labeled or dated with an open or used by date. Surveyor observed the tortilla shells package torn open on one side and open to the air. Surveyor interviewed Kitchen Manager-C, who observed that the package was open, and stated that the food is supposed to be wrapped and dated after opening. Kitchen Manager-C stated staff are educated on food storage and that the food should have been wrapped and dated. On 1/15/2025, at 12:13 PM, Surveyor made observations of the fourth-floor fridge that was in the kitchenette in the dining area. Surveyor observed butter in the fridge that was opened and partially used and not labeled or dated. A [NAME] was observed in the freezer that was opened and partially eaten with no open or used by date. On 1/15/2025, at 11:24 AM, Surveyor observed tortilla shells in the produce cooler that was not labeled or dated. Surveyor observed partially used sugar in a paper package that was opened, wrapped in saran wrap and located in the dry food storage area without a of open or used by date. On 1/14/2025, at 9:33 AM, Surveyor observed a scoop in a container that contained sugar granules. Surveyor interviewed Kitchen Manager-C, who observed and removed the scoop out of the sugar bin and stated that the scoop should be hung up. Kitchen Manager-C was observed to then place the sugar scoop in the scoop holder on the wall and out of the contained sugar granules. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hair Restraints: On 1/14/2025, Surveyor requested a policy on hair restraint use in the kitchen area from the facility. Surveyor was informed that the facility did not have a policy on the use of hair restraints in the kitchen. On 1/14/2025, at 9:28 AM, Surveyor observed a shelf hanging on the wall upon entry to the kitchen area with disposable hair nets and beard nets available. Surveyor observed a maintenance employee inside of the kitchen area with a ladder by the food preparation table area. Surveyor observed no hair restraint or beard restraint being worn by the maintenance employee. On 1/15/2025, at 11:02 AM, Surveyor observed Cook-D, with facial hair on Cook-D's chin and cheek areas, with growth noted with length past the stubble stage and hair on Cook-D's head. Surveyor observed Cook-D to not be wearing a hair restraint or a beard net. Surveyor observed Cook-D bring thickener over to the food preparation area where food was currently being used to prepare pureed for the lunch meal. On 01/16/2025, at 03:12 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and the Director of Food Services-M of the above concerns. No additional information received at this time.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51016 Based on record review and interview, the facility did not ensure the communication of services between hospice and the facility for 2 (R9 & R43) of 3 residents reviewed for hospice care. The required hospice election statement, admissions agreement, recertification orders, communication notes from hospice nurses or certified nursing assistants were not available to the facility staff in the hospice binder or resident's medical records. * R9 was placed on hospice 8/3/24. Hospice provided no access to R9's hospice charting to facility staff, until Surveyor informed facility staff that all the documentation required by hospice was not found in the hospice binder or medical record for R9. The only document observed by the Surveyor in the hospice binder for R9 was a plan of care dated 9/4/24. *R43 was placed on hospice on 12/20/2024. The hospice binder for R43 had only 3 pieces of paper for communication in it: The order sheet, facility notification of admission, and the plan of care. The plan of care from hospice had no dates for team visits filled out. Findings include: The facility's hospice policy titled Hospice Services dated as last revised 11/4/24 documents: The facility staff will provide and arrange for hospice services for all patients deemed eligible and desiring hospice services. Procedure number 8: The facility staff will work with the hospice team in integrating the hospice practice with the delivery of care. The facility's hospice contract titled, {Company} Hospice and Palliative care and dated as revised 3/2022 documents: Section C. Hospice will furnish a copy of Patient's plan of care to the facility at the time of the resident's admission into the Hospice program. In addition, for patient residing in the facility, Hospice will also provide Facility with (i) a copy of the patient's hospice election form and any advance directives specific to patient. (ii) a copy of the physician's certification and recertification of the terminal illness specific to patient. (iii) instructions on how to access the Hospice's twenty-four (24) hour on-call system. (v) Hospice medication information specific to patient, and (vi) copies of Hospice physician and attending physician, if any, orders specific to patient. Part IV Quality Improvement (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Each part agrees to reasonably participate in the other's ongoing quality improvement and utilization review programs to the extent they relate to the hospice, and room and board services furnished pursuant to this Agreement. The ongoing evaluation of services provided by the facility hereunder will be accomplished by the joint quality improvement process, focused audits, provider and patient surveys, and Interdisciplinary Team meetings. In addition, Facility and Hospice shall each designate in writing a representative to communicate with each other verbally and/or in writing (only when immediate receipt of the written communication is possible) to ensure that the needs of the Patient are addressed and met twenty-four (24) hours a day. The Hospice and Facility representatives shall document and keep written records of all such communications and shall document that the services provided are furnished in accordance with the terms of this Agreement. In addition, such representatives shall also meet when appropriate to review working relationships between Hospice and the Facility and make recommendations for improving the contractual agreement between the parties. Discussions and recommendations regarding the parties' contractual agreement and working relationships shall be considered advisory to the Facility and Hospice and not binding on either party 1.) R9) was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD), chronic kidney disease, and cognitive impairment. R9's Quarterly Minimum Daily Set (MDS) with an assessment reference date of 11/9/24 documents a Brief Interview for Mental Status (BIMS) was a score of 3, indicating that R3 is severely impaired. R9's medical record documented that R9 was placed on hospice services 8/3/24. On 01/16/25, at 12:38 PM, Surveyor interviewed Health Information Clerk (HIC)-G about R9's hospice services. Surveyor asked where R9's hospice binder is located so that facility staff can coordinate care for R9. HIC-G informed Surveyor that HIC-G is responsible for putting together hospice binders and filing paperwork that is provided from hospice services. HIC-G showed Surveyor the hospice chart for R9. On 01/16/25, at 12:46 PM, Surveyor reviewed R9's hospice chart. The last hospice plan of care or documentation in R9's hospice chart located by Surveyor was dated 09/04/24. On 01/16/25, at 12:48 PM, Surveyor showed HIC-G's R9's hospice chart and asked where the rest of the hospice documentation was located as Surveyor was unable to locate any communication documentation in R9's hospice chart. HIC-G informed Surveyor that R9's hospice company hasn't sent any documentation to scan into R9's hospice binder. Surveyor asked HIC-G how facility staff communicates with R9's hospice team. HIC-G informed Surveyor that R9's hospice team normally sends documentation so that it can be scanned into the medical record and printed out for the hospice chart. Surveyor asked HIC-G if the facility has any other documents besides the care plan and the order for a PRN medication in the miscellaneous section of R9's medical record. HIC-G informed Surveyor that the facility did not have any other additional documentation from R9's hospice company. HIC-G stated that other hospice providers send the facility documentation to scan into resident's medical records but that R9's hospice company does this differently. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked HIC-G what that difference was. HIC-G informed Surveyor that R9's hospice staff do not chart at the nurse's station or even stop to drop off documentation like the other hospice companies do. Surveyor asked if HIC-G found more hospice documentation for R9 in the R9's paper hard chart. HIC-G informed Surveyor that there was no additional documentation in R9's paper hard chart. HIC-G informed Surveyor that the facility is going to have R9's hospice company fax over all their notes now. Surveyor asked HIC-G is this because R9's hospice does not have any information here since September 2024. HIC-G stated that all the hospice documentation that the facility has is what the Surveyor found in R9's chart. On 01/16/25, at 1:00 PM, Surveyor observed HIC-G and other staff looking through the hospice charts. Surveyor asked HIC-G if they found more information from R9's hospice. HIC-G informed Surveyor that the facility is having the hospice company send the information for R9's medical record over to the facility. urveyor asked HIC-G to clarify if there was no other hospice information for R9 in the R9's medical record. HIC-G informed Surveyor that there were no additional hospice records and that the facility is in the process of getting additional documentation. On 01/16/25, at 01:16 PM, Surveyor met with Nursing Home Administrator (NHA)-A. Surveyor informed NHA-A, that the Surveyor had concerns with the communication between R9's hospice company and the facility. Surveyor informed NHA-A, that the hospice chart and medical record was missing required documentation needed for collaborative care. NHA-A informed Surveyor that NHA-A would check with the nursing supervisor to find more information on the matter. On 01/16/25, at 01:51 PM, NHA-A and Director of Nursing (DON)-B brought R9's hospice chart into the conference room. DON-B showed the Surveyor there were plan of care updates in R9's hospice chart, current up to 01/2025. Surveyor asked DON-B, if there was any other communication documentation in the hospice binder. DON-B asked Surveyor to clarify, Surveyor informed DON-B, that the Surveyor found no other items or information such as visit summaries, communication from hospice nursing assistants or hospice nurses, coordination of care meetings, hospice election statement, admissions agreement, recertification orders. Surveyor informed DON-B that the certified nursing assistant plan of care was placed today and dated 1/16/25 at 1:20:05. DON-B informed the Surveyor that DON-B would investigate this. On 01/16/25, at 02:52 PM, Surveyor interviewed DON-B. DON-B informed the Surveyor the facility was getting access to the hospice portal from a director at R9's hospice company. DON-B informed Surveyor, that the facility did not currently have access to the hospice charting or communications in R9's hospice electronic medical record. DON-B informed the Surveyor, that R9's hospice binder has not been updated yet. DON-B informed the Surveyor that R9's hospice binder would be updated as soon as the facility obtained access to the hospice electronic medical record. On 01/16/25, at 03:02 PM, during the daily exit meeting, Surveyor informed Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A, Director of Social Services (DOSS)-J, and (President)-J of the above findings. Surveyor explained the concern about R9's hospice company and the lack of communication and information available to the facility staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked DON-B who was the point of communication person with hospice for the facility. DON-B informed Surveyor that the point of communication person for hospice is social services. DOSS-J nodded in agreement. DON-B assured the Surveyor the facility was working on obtaining communication documentation into R9's facility hospice record. No additional information was provided to as to why the facility did not ensure that the communication of services between hospice and the facility for R9 was in place. 50700 2.) R43 was admitted to the facility on [DATE], with a pertinent diagnosis of dementia. R43 was began hospice services on 12/19/2024, with a diagnosis of senile degeneration of the brain. R43's significant change in condition Minimum Data Set (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) a score of 00, indicating that R43 has severe cognitive impairment. Section C documents a score of 2, for R43's cognitive patters for ability to express self, which indicates sometimes R43 understands and sometimes is understood. On 01/14/2025, at 9:22 AM, Surveyor observed R43 in a common dining room. R43 was using repetitive words of: go to bed. Surveyor asked questions to R43, but R43 did not answer any questions appropriately when surveyor spoke to R43. On 01/16/2025, at 11:24 AM, Surveyor interviewed LPN (licensed practical nurse)-K about R43's hospice services. LPN-K informed Surveyor that facility staff only knows about R43's hospice visits when hospice staff verbalizes it, because R43's hospice company does not utilize the hospice binder to communicate with staff. LPN-K stated that the hospice nurse will come in one time a week and the aide will come in two times a week to see R43. LPN-K could not find any documentation in R43's hospice binder related to communication between the hospice and facility staff. LPN-K observed along with Surveyor that there were only 3 documents in R43's hospice binder. The 3 pieces of documentation for communication between hospice and the facility were: The order sheet, facility notification of admission, and the plan of care. LPN-K could not give any additional information or documentation that documented communication between hospice and facility staff. Surveyor noted that no additional documentation or dated visits were added since 12/19/2024, which was the date of admission for R43 onto hospice. On 01/16/2025, at 1:33 PM, Surveyor interviewed Registered Nurse (RN) Unit Manager-E about R43's hospice services. RN Unit Manager-E stated that R43's hospice staff will drop off weekly notes to be scanned in by Health Information Clerk (HIC)-F. Surveyor asked RN Unit Manager-E to look in Point Click Care (PCC) for any communication that was scanned in, as Surveyor was unable to locate any in R43's electronic medical record. RN Unit Manager-E could not find any documentation that was scanned into PCC regarding R43's hospice services communication. On 01/16/2025, at 1:37 PM, Surveyor interviewed Health Information Clerk (HIC)-F who stated she did not receive any consults or communication from R43's hospice services hospice because if documentation had been received HIC-F would have scanned them into PCC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525172	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home and Care Center	1414 N Prospect Ave Milwaukee, WI 53202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/2025, at 1:47 PM, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above findings. Surveyor explained concerns to NHA-A and DON-B about the lack of communication between hospice and the care staff at the facility. NHA-A stated that they will get copies of the communication documents from R43's hospice and then will place them into the hospice binder and scan them into PCC. On 01/16/2025, at 2:53 PM, Surveyor interviewed DON-B who stated that after DON-B was talking with hospice, the facility would now be getting access to the hospice Electronic Medical Records (EMR) portal. DON-B stated that access to EMR will give staff real time access to R43's record and would set up for communication between hospice and staff at the facility. No additional information was provided as to why the facility did not ensure that communication of services between hospice and the facility for R43 occurred.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 20025 Based on interview and record review, the facility did not ensure 34 staff received annual N95 respirator fit testing. Surveyor reviewed the facility's infection control program. On 1/21/25 at 8:27 a.m. Surveyor received a list of staff with the dates of their last N95 fit test. Surveyor noted staff members were overdue for their annual fit test. Findings include: The facility's Covid 19 Respiratory Protection Program policy dated 2/5/21 documents: . 2. Selection d. The program administrator will conduct a risk assessment to identify which workers are at risk of exposure to any airborne hazards (e.g. SARS-Co-V-2). Such workers could include: any staff (whether clinical or not_ in close contact (less than 6 feet) with patients or residents with confirmed or suspected COVID-19 (e.g. during bathing, dressing, toileting, and direct clinical care); clinical staff performing aerosol-generating procedures (e.g. respiratory therapy, open suctioning of airways, BiPaP and CPAP); cleaning staff; maintenance staff; and visiting practitioners (e.g. physicians or physical therapists who do not normally work at that facility). 4. Fit Testing a. All employees required to wear respirators must pass an initial fit test before using their respirator. Additionally, workers who are required to wear a respirator will be fit-tested : i. Annually. ii. When there are changes in the employee's physical condition that could affect respiratory fit (e.g. obvious change in body weight, facial scarring, etc). iii. When using a new make, model. or size of respirator. d. All fit tests will be documented and be retained until the next fit-test is administered. On 1/16/25 at 9:30 a.m. Surveyor interviewed IP (infection preventionist)-L and DON (Director of Nursing)-B regarding the infection control program. Surveyor asked to see a list staff and their respirator fit testing dates. DON-B stated the staff responsible for that document is out having surgery. DON-B stated she would look for the spreadsheet and provide it so Surveyor. On 1/16/25 at 3:00 p.m. during the daily exit meeting with the facility, DON-B provided Surveyor with a document with staff names and the dates of their last fit test. Surveyor noticed there were staff with no date of a fit test being performed and staff with overdue dates for fit testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor explained to DON-B the concern with the missing dates or overdue dates and DON-B explained she would look into it. On 1/21/25 at 10:37 a.m. DON-B provided Surveyor with a document with list of staff and their fit test dates. The list was updated with new dates but Surveyor observed there to still be a concern with overdue dates. DON-B stated this is all the information she has. The document indicates two staff in the finance department have overdue dates, six staff in environmental services have overdue dates, twenty direct care staff (including CNA (certified nursing assistant)s and LPN (licensed practical nurse)s) have overdue dates, two kitchen staff have overdue dates, two staff in activity department have overdue dates and 2 staff in plant operation have overdue dates. On 1/21/25 at 10:38 a.m. Surveyor interviewed NHA (Nursing Home Administrator)-A regarding the concerns with the staff fit test dates. Surveyor explained to NHA-A the concern many staff are overdue for their fit test. NHA-A stated she understood the concern and had no additional information to provide.