STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525179	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of Kenosha (the)	3100 Washington Rd Kenosha, WI 53144

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not ensure allegations of mistreatment that resulted in serious bodily injury were reported to the State Agency for 1 (R65) of 2 reportable incidents reviewed. R65 was transferred from the wheelchair to the bed with the assistance of Certified Nursing Assistant (CNA)-X. R65's Care Plan indicated R65 transferred with the use of a sit-to-stand lift. CNA-X did not follow R65's Care Plan and R65 sustained a fractured right tibia and fibula. This incident was not reported to the State Agency. Findings include: The facility policy and procedure entitled Abuse Policy undated, states: Definitions: . Neglect is defined . as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility failed to provide them to the resident that has resulted or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in, physical harm, pain, mental anguish, or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving the resident and one staff member. Procedures: . (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the required regulatory agencies immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. VII. External Reporting: 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall complete and submit a DQA form F-62617, notifying DQA that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. This report shall be made immediately. The term 'immediately' as it is used in this policy in relation to reporting abuse, neglect, exploitation, mistreatment, misappropriation of resident property, and suspicion of a crime shall be defined as, 'following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the resident or residents involved' or not later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause suspicion do not result in serious bodily injury. R65 was admitted to the facility on [DATE] with diagnoses of malnutrition, anorexia receiving the majority of nutrition through a gastrostomy tube, diabetes, polyneuropathy, adult failure to thrive, and depression. R65's Admission Minimum Data Set (MDS) assessment dated [DATE] indicated R65 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12 and was dependent on staff for eating and toileting hygiene and needed substantial/maximal assistance with bed mobility. R65 did not have an activated Power of Attorney. R65's Activities of Daily Living Care Plan revised on 2/21/2024 indicated R65 was to transfer with the assist of two staff with a sit-to-stand mechanical lift. On 3/11/2024 at 3:45 PM in the progress notes, nursing charted R65 complained of pain to the right leg and when asked to lift the leg, R65 started to scream. Tramadol was administered at 2:58 PM and R65 was transported to the hospital for evaluation and treatment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Incident Report was initiated by Registered Nurse Supervisor (RN Sup)-AA on 3/11/2024. RN Sup-AA documented RN Sup-AA was approached by staff to assess R65 due to R65 being transferred from the wheelchair to the bed and during the transfer R65 started to cry out in excruciating pain from the right knee down to the right foot. R65 told RN Sup-AA that R65 wanted to go to bed, and the CNA wanted to get the lift, but R65 told the CNA R65 did not want to use the lift because they had been doing pivot transfers with therapy. R65 told RN Sup-AA that during the transfer the left leg moved crossing behind the right leg and R65 heard a pop/snap-like noise and immediately felt severe pain from the right knee down to the ankle. In a statement by CNA-X to RN Sup-AA, CNA-X stated R65 requested to be transferred back into bed from the wheelchair. CNA-X told R65 it would be a minute because CNA-X had to got and get the lift. R65 told CNA-X that R65 was being transferred in therapy by a pivot transfer, so CNA-X decided that they could do a pivot transfer. CNA-X attempted to transfer R65 using a gait belt and stood R65 up and began the pivot transfer. R65's left leg moved behind R65's right leg and when R65 was lowered to the bed, R65 yelled out in pain. R65 sustained a displaced bicondylar fracture of the right tibia and a fracture of the shaft of the right fibula. The incident of CNA-X not transferring R65 per R65's Care Plan resulting in a fracture of the right tibia and fibula was not reported to the State Agency. In an interview on 4/24/2024 at 11:56 AM, Surveyor asked Nursing Home Administrator (NHA)-A why the incident with R65 on 3/11/2024 was not reported to the State Agency. NHA-A stated NHA-A and Regional Consultant (RC)-N discussed the incident and determined the incident was not intentional and did not fit the definition of abuse. NHA-A stated they utilized a flow chart that indicated the incident was not a reportable event. Surveyor shared with NHA-A that the flow chart they used was not for Nursing Home use. NHA-A stated they had not seen that stipulation on the flow chart. No further information was provided at that time.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview, and record review the facility did not revise resident care plans for 2 (R65, R235) of 18 resident care plans reviewed and did not ensure care conferences were held quarterly to get resident input in their care. *R235's care plan was not revised to include showers two times a week as discussed with facility and R235's guardian. R235 did not receive a shower two times a week. *R65 did not have care conferences to ensure participation in the development of a care plan on a quarterly basis. Findings include: 1.) R235 was admitted to the facility on [DATE] and has diagnoses that include spastic diplegic cerebral palsy, acute kidney failure, severe protein-calorie malnutrition, expressive language disorder, nontraumatic ischemic infarction of muscle, left ankle, and foot, neuromuscular dysfunction of bladder, peripheral vascular disease, muscle weakness, and cognitive communication deficit. R235's admission minimum data set (MDS) dated [DATE] indicated R235 had severely impaired cognition with a brief interview of mental status (BIMS) score of 0 and the facility assessed R235 needing total assist with 1 staff member for shower/bed bath, toileting hygiene, and personal hygiene. R235 has an indwelling catheter, incontinent of bowel and wore adult briefs for protection. R235 had upper and lower extremity impairments and required a Hoyer lift with two staff members for transfers. R235's activities of daily living (ADL) self-care performance care plan initiated on 1/1/32024 with the following intervention: . -PERSONAL HYGIENE: the resident requires substantial/max assistance by (1) staff. Shower: Tuesday PM . R235's Care Kardex the certified nursing assistants (CNAs) use to see what cares residents need has the following care intervention: -Personal Hygiene/Oral Care: PERSONAL HYGIENE: the resident requires substantial/ max assistance by (1) staff. Shower Tuesday PM On 2/19/2024 R235's guardian filed a grievance with the facility requesting R235 have a bed bath twice a week because R235's hair is greasy and unkept and smells like R235 has not had a bath in a while. The Summary states that the plan of care was revised with the guardian on 2/22/2024. Surveyor noted that R235's care plan or care kardex were never revised to include R235's bed bath twice a week as discussed between Social Services (SS-BB) and R235's guardian on 2/22/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R235's February 2024 medication administration record (MAR) and had the following order: COMPLETE: Assessment>Nursing: skin observation tool, every day shift every Monday for SHOWER DAY SKIN MONITORING (start 1/15/2023) at 6:15 AM. Staff signed out completed on 2/5/2024, 2/12/2024, and 2/19/2024. Surveyor reviewed R235's March 2024 MAR and had the following order: COMPLETE: Assessment>Nursing: skin observation tool, every day shift every Tuesday for SHOWER DAY SKIN MONITORING (start 1/15/2023) at 6:15 AM. Staff signed out completed on 3/12/2024, and 3/19/2024. On 4/22/2024 at 3:32 PM Surveyor interviewed Social Services (SS)-BB who stated when a grievance gets reported it gets dispersed to the appropriate care team. In regard to R235's showers the concern would have been sent to the unit manager. SS-BB stated any follow up would be done with the staff member addressing the concern or SS-BB to follow up if needed. On 4/23/2024 at 12:45 PM Surveyor interviewed licensed practical nurse (LPN)-Z who was the unit manager at the time of R235 was admitted to the facility. LPN-Z did not recall R235 or concerns regarding increase in showers. Surveyor asked LPN-Z what the process would be in addressing a grievance and following through with the interventions that resulted with the conclusion of a grievance. LPN-Z stated would address the concern regarding what the issue was and if the care plan of care Kardex had to be revised, it would be changed and communicated to staff regarding the changes implemented. LPN-Z also stated that it should be put on the 24 hour board to alert of a change. LPN-Z stated that she then follows up with the person filing the grievance and gives back to SS-BB so the grievance can get closed out. LPN-Z stated that she would also monitor charting of staff to make sure the intervention is being completed. On 4/23/2024 at 2:13 PM Surveyor interviewed SS-BB who stated SS-BB recalls talking with R235's guardian frequently and reviewing the plan of care for R235. SS-BB did not recall any concerns related to the care plan that R235's guardian had. On 4/23/2024 at 3:23 PM Surveyor shared concerns with nursing home administrator (NHA)-A, director of nursing (DON)-B, regional director of operations-M, and regional consultant-N about R235's care plan not being revised for R235 to get a bed bath two times a week per R235's guardian request and R235 did not receive a shower two times a week. No further information was provided at this time. 38253 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) The facility policy and procedure entitled Care Plan Conferences undated, states: POLICY: The facility will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and family discussions/input. PROCEDURE Note: Care plan meetings are typically composed of the resident, family, and/or the resident's durable power of attorney, the charge nurse or unit manager, the nursing assistant principally responsible for the resident, the social worker, activities director, and dietitian or dietary manager. The resident physician, appropriate therapist, and the medical director may also be in attendance (this may vary). 1. Care plan may be written prior to the care plan meeting, knowing that input from resident or family may require it to be revised. 2. Care conferences are scheduled routinely per facility schedule. 3. Each resident's plan of care is reviewed at least quarterly. 4. All attendees are documented. 5. The resident and/or family are invited to attend the care conference. A written invitation is sent to the families by Social Services or designee. R65 was admitted to the facility on [DATE] with diagnoses of malnutrition, anorexia receiving the majority of nutrition through a gastrostomy tube, diabetes, polyneuropathy, adult failure to thrive, and depression. R65's Admission Minimum Data Set (MDS) assessment dated [DATE] indicated R65 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12 and was dependent on staff for eating and toileting hygiene and needed substantial/maximal assistance with bed mobility. R65 did not have an activated Power of Attorney. In an interview on 4/21/2024, Surveyor asked R65 if R65 participated in care conferences to discuss their wishes as it relates to their care plan. R65 stated care conferences did not happen very often. On 4/7/2023 at 1:18 PM in the progress notes, Social Services charted a care conference was set up for R65 on 4/13/2023 at 11:30 AM to be held in R65's room. R65 was given a piece of paper with the scheduled care conference and Social Services explained to R65 what the care conference was. Social Services let R65 know that family members could be invited to attend if R65 wished. On 4/14/2023 at 9:24 AM in the progress notes, Social Services charted the care conference was to be rescheduled due to R65 being out to an appointment. On 5/4/2023 at 11:15 AM, a care conference was held with Social Services, nursing, therapy, Business Office Manager, R65 and R65's family member. Surveyor noted this was R65's first care conference since admission. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/2023 at 11:02 AM in the progress notes, Social Services charted a care conference was set up for R65 on 9/28/2023 at 11:00 AM to be held in R65's room. R65 was given a piece of paper with the scheduled care conference and Social Services explained to R65 what the care conference was. Social Services let R65 know that family members could be invited to attend if R65 wished. No documentation was found of R65 having a care conference on 9/28/2023. Surveyor noted the last care conference had been on 5/4/2023, over four months prior and not on a quarterly basis. On 1/3/2024 at 11:45 AM, a care conference was held with the nursing manager, Social Services, the dietician, and R65. Surveyor noted 8 months had elapsed since the last documented care conference. On 2/17/2024 at 11:58 AM in the progress notes, Social Services charted a quarterly care conference for R65 was scheduled for 3/14/2024 at 11:30 AM in the small conference room. R65 was informed of the date, time, and location and encouraged R65 to invite family to join. Surveyor noted R65 was in the hospital from 3/11/2024- 3/15/2024. No documentation was found of R65 having a care conference after 1/3/2024. In an interview on 4/22/2024 at 3:42 PM, Surveyor asked Social Services (SS)-BB about R65's care conferences. SS-BB stated R65 had a care conference scheduled in 3/2024 when R65 went to the hospital and that may have to be followed up on. Surveyor shared with SS-BB that the only documentation of care conferences in R65's medical record occurred on 5/4/2023 and 1/3/2024. Surveyor asked SS-BB if the care conferences would be documented anywhere other than the medical record. SS-BB stated R65 had a care conference scheduled for 9/28/2023 but there was not documentation that a care conference was held and if there was a conference, it should be in the record. SS-BB stated SS-BB was not the social worker at that time and SS-BB could not find any additional documentation of care conferences happening between 5/2023 and 1/2024. SS-BB stated care conferences should be held every quarter. On 4/24/2024 at 11:59 AM, Surveyor shared with Nursing Home Administrator-A the concern R65 did not have quarterly care conferences from 5/2023 through 1/2024. No further information was provided at that time.

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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** 49011 Based on observation, interview, and record review the facility did not ensure that residents with pressure injuries received necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 8 (R50, R64, R65, R67, R70, R73, R78 and R235) of 9 residents reviewed for pressure injuries. * R78 developed a stage 4 pressure injury to the right posterior ankle despite the Facility knowing the resident was at risk for pressure injuries because the resident wore PRAFO boots. The Facility failed to perform checks each shift to monitor the skin under the boot to prevent skin issues from developing. The Facility failed to obtain written orders on length of time the PRAFO (contractor/LE (lower extremity) braces) boots should be worn. The resident's plan of care did not include interventions related to the PRAFO boots and was not updated for over a month regarding right posterior heel pressure wound after the discovery of the wound. A comprehensive assessment of the wound was not documented until the wound doctor saw R78 on 2/5/2024. This created a finding of Immediate Jeopardy (IJ) at a scope and severity of a J (immediate jeopardy/isolated) that began on 1/30/2024. On 04/24/24 at 09:37 AM the Surveyor notified the Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A and Facility Consultants about the immediate jeopardy. The immediate jeopardy was removed on 4/24/24 when the facility implemented their action plan. The deficient practice continues at a scope and severity of a G (actual harm/isolated) for the following examples regarding Residents R65, R235 and R64. * R65 was admitted to the facility from the hospital with an unstageable pressure injury on the coccyx. The pressure injury was not assessed on the day of admission. The pressure injury deteriorated to a stage 4 pressure injury with multiple courses of antibiotics after R65's admission. The resident developed multiple infections related to possible soiled dressing from stool that were not addressed in the treatment record to change dressings as needed. R65's air mattress was observed set to a higher weight load than what R65 weighed. Additionally, the wound physician indicated part of the issue with R65's wound involved offloading pressure. The facility did not establish a clear, individualized plan of care regarding repositioning for R65. * R50's air mattress was set to 550 pounds on several observations during the survey and R50's most recent weight is 185.9 pounds. * R235's guardian filed a grievance requesting R235 have an established repositioning schedule to prevent the development of a pressure injury. The facility did not establish an individualized repositioning schedule, and R235 developed a facility acquired, stage 3 pressure injury. * R70's air mattress was set to 550 pounds on several observations during the survey and R70's most recent weight is 152.2 pounds. * R64 was admitted to the facility with a sacral pressure injury and a chronic left heel pressure injury. The left heel was healed and then reopened on 11/11/23. The wound was not comprehensively assessed by a Registered Nurse (RN) until 11/13/23 when it was unstageable. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/7/24 through 2/13/24 R64 was hospitalized and underwent an incision to the bone with partial resection of left calcaneus and incision and drainage of left Achilles abscess. The resident was readmitted [DATE] and the wound was not comprehensively assessed by a RN until 2/19/24. During survey, R64 was observed on day 1 and day 2 without offloading interventions in place. *R67's air mattress was observed to be set to 210 pounds on multiple days of the survey despite R67 weighing 144 pounds. R67 is at risk for pressure injuries. *R73 was observed during multiple days of the survey to have their feet resting against the foot board of the bed and expressing discomfort from the pressure/position. R73 is at risk for pressure injuries. Findings include: The Facility Policy and Procedure titled Pressure Ulcers/Skin Integrity/Wound Management implemented 1/30/2023, revised 1/24/2024 documents (in part) . Policy: A system is in place for the prevention, identification, treatment and documentation of pressure and non-pressure wounds . Procedure . 2. Assessment and Treatment It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission, and that factors that may have influenced its development, the potential for development of additional ulcers, or for the deterioration of the pressure ulcer(s) be recognized, assessed, and addressed as follows: a. Differentiate the type of ulcer (pressure-related versus non-pressure-related) because interventions may vary depending on the specific type of ulcer. b. Determine the ulcer's stage. c. Describe and monitor the ulcers characteristics. d. Monitor the progress toward healing and for potential complications. e. Determine if infection is present. f. Assess, treat, and monitor pain, if present; and g. Monitor dressings and treatments. 3. Treatment/Management (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Residents with risk for or who have a loss of skin integrity will receive the appropriate treatment/services, and residents who are determined to be at risk for or who have loss of skin integrity will receive appropriate treatment/services . 4. Documentation a. Assessment i. Assessment information should identify specific factors that might increase the risk of pressure ulcer development or affect healing of a pressure ulcer such as: 1. Decreased mobility . 4. Use of restraints . 6. Non-compliance or history of non-compliance. 7. Altered sensory perception . 10. History of pressure ulcers . ii. For a resident who was admitted with a pressure ulcer or who developed one may include the following documentation. 1. Ulcer site and characteristics at the time of admission or onset, including measurements . b. Care Planning . iii. The care plan should address prevention of any skin breakdown, including sheering or friction, repositioning or off-loading; pressure relief equipment; and the care and treatment to be provided to the resident for a pressure ulcer or non-pressure wound behaviors and preferences. iv. If a resident refuses or resists staff interventions, the care plan should reflect efforts to seek alternatives as well as education to resident and/or family regarding the risks. This education should be documented. v. Care plan interventions should be revised if there is recurring skin breakdown, a lack of progress toward healing, or if the resident acquires a new ulcer . 1.) R78 was admitted to the facility on [DATE] from (name of hospital in Illinois) where they had been since 11/9/2023. R78 has diagnoses that include acute cystitis without hematuria, fusion of spine-thoracic region, paraplegia, morbid (severe) obesity due to excessive calories, muscle weakness, need for assistance with personal care, depression, and anxiety disorder. Braden assessment on 12/1/24 indicates R78 is at mild risk for pressure injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the discharge paperwork from the hospital R78 discharged from indicates R78 Occupational Therapy was working with R78 on the use of bilateral lower extremity PRAFO orthotics to prevent plantar flexion contractures. The orthosis wear schedule is noted to be 4 hours on/off with R78 being dependent in a supine position to don/doff orthotics. Precautions noted: If redness, swelling, numbness or tingling occurs, please remove splint, and notify OT. The documentation indicates orthotics were donned throughout session. The paperwork indicates R78 has a wound on their buttocks. There was no order for the PRAFO orthotics on admission on 12/1/23. On 04/23/24 at 10:42 AM Surveyor spoke with DON-B and requested a physician order for the PRAFO orthotic and to talk to therapy about monitoring of the PRAFO orthotic for effectiveness. Surveyor was told will try to find if someone is still here from therapy to help with that. No order to the PRAFO orthotic was provided to Surveyor. On 04/23/24 at 03:32 PM DON-B told Surveyor there is no actual order for the PRAFO orthotics. On 12/1/23 the facility initiated a care plan with a focus area the resident is resistive to care AEB refusing scheduled medications, wound treatments and occasional therapy services r/t anxiety with new admission and debilitating comorbidities causing immobility and decreased independence. The Focus indicates it was revised on 12/18/23. Goals indicate: the resident will participate in care by performing/participating in self-care needs (ostomy care, med management, and therapy) w/less than 2-3 refusals by the next review date. Initiated 12/1/23, revised 1/2/24, target date 5/30/24. Interventions/Tasks include: - Allow the resident to make decisions about treatment regime, to provide sense of control, Date Initiated: 12/1/23. - Encourage as much participation/interaction by the resident as possible during care activities, Date Initiated: 12/1/23. - Give clear explanation of all care activities prior to an (sic) as they occur during each contact, Date Initiated: 12/1/23. - If possible, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed upon time, Date Initiated: 12/1/23. - Praise the resident when behavior is appropriate, Date Initiated: 12/1/23 - Provide resident with opportunities for choice during care revision, Date Initiated: 12/1/23. Surveyor noted this plan of care was not updated to address if R78 was refusing to remove the PRAFO orthotics or not allowing staff to check R78's skin under the PRAFO. There is no intervention on the care plan to discuss risks and benefits with R78 regarding decisions to refuse care. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R78's skin was assessed on 12/4/23 (3 days after admission) by the facility. The skin impairment wound form dated 12/4/23 indicates R78 has a pressure injury on their sacrum that is an unstageable pressure injury. Measurements of wound indicate wound measured by (name of wound physician practice) wound MD. See note. The assessment for wound tissue bed, to indicate tissue percentages, is blank along with details regarding pain and treatment. R78 is noted to have a second wound on the right buttock that is a stage 3. The measurement of the wound also indicates wound measured by (name of wound physician practice) wound MD. See note. The assessment for wound tissue bed to indicate tissue percentages is blank along with details regarding pain and treatments. The skin evaluation indicates there is a stage 2 pressure injury to the left ankle that is documented as resolved. The notes indicate for skin ulcer/injury treatments: pressure reducing device for bed, turning/repositioning program, nutrition, or hydration to manage skin problems, pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet, applications of ointments/medications other than to feet. Barriers to wound healing include paraplegia, HTN (hypertension), obesity. Current wound/skin integrity interventions indicate: Resident assessed by (name of wound physician practice) wound MD and wound team. Resident admitted to facility with preexisting pressure wounds to sacrum, R (right) buttock, and L (left) posterior ankle resolved. Resident wears bilateral ankle contractor braces, foam dressings continued for bilateral posterior ankles and R lateral foot where there is blanchable redness. Resident requires extensive assistance of two with repositioning in bed, off-loading positioning wedges are being used. Bilateral half side rails in place to allow resident to assist with repositioning. Air mattress in place. Currently eating 51-100% of meals. Wound physician (MD)-Q's wound evaluation dated 12/4/23 indicates wound present on back and buttock. Left and right lower extremity normal. The sacrum wound is unstageable measuring 2.5 x 2.2 x 0.7 40% necrotic tissue, 30% slough, 30% granulation tissue. Recommendations were to offload wound, reposition per facility protocol, group 2 mattress. This area was debrided by MD-Q. The right lower buttock, stage 3 measured 3.5 x 4.5 x 0.1. 10% slough, 60% granulation tissue, 30% skin. Recommendations to off load wound, reposition per facility protocol. There was no evaluation noted of R78's bilateral ankles. Surveyor noted orders for-Foam dressing to R lateral foot for protection. Every day shift every Mon, Wed, Fri - start 12/6/2023, d/c 2/23/2024. -Foam dressing to R/L posterior ankles for protection. Every day shift every Mon, Wed, Fri - start 12/6/2023, d/c 2/23/2024. On 04/24/24 at 08:38 AM Surveyor spoke with Director of Nursing (DON)-B to confirm where the order for Foam dressing to R/L posterior ankles for protection. Every day shift every Mon, Wed, Fri. came from. DON-B shared the wound doctor looked at the posterior heels after resident was admitted and during that initial assessment these recommendations were given verbally. The foam was an intervention, not an order from Wound Doctor-Q. -Check skin integrity under ankle contractor braces. Every, day shift - start 12/5/2023, d/c 2/23/2024. Review of R78's treatment administration record indicates the time for this treatment order is 6:15 AM. Facility documentation shows that staff monitored the skin only once daily from 12/5/23 to 2/23/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/8/24 a treatment order was added to complete nursing assessment skin observation tool every day shift every Friday for shower day skin monitoring. Surveyor noted there were no physician orders for R78 to wear the PRAFO orthotics or documentation the physician was consulted with regarding the wearing of the braces. Further, none of the recommendations that were noted in the discharge paperwork from occupational therapy regarding a donning and doffing schedule and signs and symptoms to monitor for with the use of the PRAFO orthotic for R78 were recorded. Review of the physical therapy evaluation dated 12/2/24 does not include reference or assessment of R78's PRAFO orthotics. On 12/4/24 the physical therapy summary of daily skilled services references passive stretches BLE (bilateral lower extremities) with PRAFO boot removal, ankle, knee, and hip ROM (range of motion) practiced with hold at the end of each movement to provide stretch, managed well. Repositioned in bed with roll side to side with max a (assist) x 2, placed PRAFO boots, wedges to deweight (sic) the sacral area and scooted up in bed with max a x2 with pts (patients) support with the headboard. On 12/8/23 R78 expressed concerns with positioning schedule. With physical therapy noting R78 is to be positioned Q (every) 2 hours for skin breakdown prevention. R78's interdisciplinary team conference was held on this date. Review of R78's physical therapy notes from 12/2/23-1/29/24 indicate occasional reference to R78 wearing the PRAFO orthotics however, the use of the orthotics do not appear to be documented as an ongoing part of the physical therapy evaluations. On 1/11/24 physical therapy notes: splint and brace program established/trained: PRAFO boot donning and doffing and skin check - nursing able to manage. The note also references a restorative program being established. On 04/24/24 at 12:07 PM Surveyor spoke to the Rehab Director-FF at the Facility about a discharge recommendation made by one of the physical therapists on 1/11/2024 that states splint and brace program established/trained: PRAFO boot donning and doffing and skin check-nursing able to manage. Rehab Director-FF shared they did not know what that means, will try to reach out to the Physical Therapist that made the note. Surveyor noted no additional information was provided and Surveyor was not able to speak to Therapist. On 1/25/24 physical therapy references R78 is taking the PRAFO boots off for a couple of hours when the wife visits and performs skin check. Review of the Skin impairment/Wound evaluation assessment completed on 1/29/2024 documents presence of a pressure injury to the sacrum. Surveyor notes there is no assessment of documentation on the skin impairment/wound evaluation of the bilateral areas on R78's ankles. only the one wound, no documentation of skin concerns to the bilateral lower extremities. A progress note written on 1/30/2024 at 9:03 pm indicates writer approached by pts spouse with skin concerns to bilateral Achilles. Upon assessment pressure injury noted to right Achilles and 2 small abrasions noted to left Achilles. NP (nurse practitioner) updated, NOR (new order) for medihoney daily to right Achilles and skin prep BID (twice daily) to left Achilles. txs (treatments) placed. pt tolerated well no complaints of pain or discomfort noted at this time. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Facility Skin Impairment/Wound Evaluation assessment was completed on 1/30/2024 that identifies a new stage 4 pressure injury to R78's right Achilles. The wound is measured as 1.5 by 2.0; no depth and no tissue description are included. On 04/23/24 at 11:32 AM Surveyor placed call to Licensed Practical Nurse (LPN)-U who was there when Family Member-V reported the skin change. LPN-U remembers Family Member-V telling them about it. They measured the area, and the other LPN updated the Nurse Practitioner. They got an order and let the supervisor know. Surveyor asked if LPN-U remembered what the wound looked like, LPN-U does not remember just knows they measured it and put a dressing on. On 04/23/24 at 11:34 AM Surveyor left a message for the other LPN who was there when Family Member-V reported the wound, a call back was not received. On 04/23/24 at 11:30 AM Surveyor called the charge nurse on duty when the skin change was reported on, 1/30/2024, no call back was received. The following orders were entered into the Treatment Administration Record (TAR) Cleanse Right Achilles with NS, pat dry apply medihoney and cover with dry gauze one time a day, start 1/31/2024, d/c (discontinue) 2/6/2024. Surveyor notes the treatment obtained from the Nurse Practitioner was entered and first signed out on 1/31/2024 the day after the Stage 4 pressure injury was identified. There is no description of the wound to identify the tissue type and if the tendon was visible at this time. On 04/23/24 at 12:34 PM Surveyor spoke with Family Member-V who would take the boots off. Family Member-V did not know how long the boots should be off daily, there was no order they knew of. When asked how often Family Member-V looked at R78's feet leading up to the discovery, Family Member-V stated being at facility five days a week Monday through Friday for a couple hours in the evening. The boots would be removed then and [NAME] lotion was put on R78's feet by Family Member-V. On 1/30/2024 when Family Member-V took the boots off, the dressing was 1/2 off and there was drainage on it, Family Member-V indicated they saw the wound and got the nurse. Surveyor asked Family Member-V about other opportunities when R78's feet could be observed. Family Member-V stated R78 should get a shower once a week and they should be cleaning R78 up other days. R78 was seen on 2/5/2024 by (name of wound physician practice) Wound Doctor-Q and the right posterior Achilles was added as a 3rd pressure wound. The wound was classified as a stage 4 of the right, posterior, Achilles tendon ankle. Etiology: pressure. Additional wound detail provided by Wound Doctor-Q states it is a medical instrument (boot) pressure sore. The wound size was (L x W x D): 2.6 x 3.1 x 0.6 cm. Exudate: Light Sero - sanguineous Thick adherent devitalized necrotic tissue: 40 % Slough: 20 % Other viable tissues: 40 % (Tendon) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DRESSING TREATMENT PLAN Santyl apply once daily with Gauze island w/ bdr (border) over Recommendations: Off-Load Wound; Float Heels in Bed; Pressure Off-Loading Boot DEBRIDEMENT PROCEDURE completed. Review of R78's record indicates the intervention. On 2/5/24 the TAR was updated to include apply bilateral prevlon (sic) boots. Document refusals every shift. Surveyor noted this did not get added to R78's care plans until 3/1/24. On 04/23/24 at 11:00 AM Surveyor spoke with the (name of wound physician practice) Wound Doctor-Q via telephone and clarified that the tendon was visible before debridement procedure was completed on 2/5/2024. Wound Doctor-Q stated it was visible right away. R78 is then seen weekly by the (name of wound physician practice) Wound Doctor-Q. Notes each week 2/12/24 - 4/15/24 indicate that the wound decreased in size and continued to improve. The final note stated: Wound Size (L x W x D): 1.4 x 0.9 x 0.1 cm Granulation tissue: 100 % Wound progress: Improved evidenced by decreased surface area. Dressing(s) same Same recommendations No treatment needed by wound doctor, assessment only. On 4/22/24 at 11:49 AM Surveyor observed wound assessment provided by Wound Doctor-Q. Upon entering R78's room resident was wearing Prevalon boots on both feet, had a pressure relieving wedge under hip and another at upper back area. Wound Doctor-Q assessed right posterior ankle wound as smaller than last measurement, stated that no treatments needed, Facility should continue same dressing. Surveyor noted when the doctor asked if R78 needed lidocaine for pain management during wound evaluation R78 replied that resident does not feel pain from sternum down due to paralysis. On 04/22/24 at 12:44 PM Surveyor interviewed R78 about the orthotics R78 wore before developing the stage 4 pressure wound and those R78 is wearing now. R78 stated being admitted to Facility with a different type of boot meant to prevent drop foot, they had a hard sole with kick stands. R78 stated being in them for quite some time. R78 brought the boots which R78 got from (name of rehabilitation hospital program/lab) and continued to use them to prevent foot drop. R78 said that the boots had added padding where pressure wound started and thinks that the padding wore down and that was the problem. R78 states that Family Member-V pointed the skin change out to staff on 1/30/2024 in the evening. R78 stated that staff were not taking boots off and assessing feet daily. Family Member-V would take boots off in the evening and put lotion on feet. That is when the pressure wound was found on the back of the heel area. Per R78 they never refused any precautions, recommendations, or treatments. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/23/24 at 09:05 AM Surveyor spoke with Director of Nursing (DON)-B who confirmed R78 had the contractor boots (PRAFO orthotics) since admission and that two-nursing staff were in with R78 when Family Member-V informed them of the skin change. Surveyor asked DON-B for additional documentation or progress notes about the checking of skin integrity up to 1/30/2024. On 04/23/24 at 09:54 AM Surveyor spoke with Registered Nurse (RN)-W. RN-W signed the Treatment Administration Record (TAR) on 1/30/2024 for Check skin integrity under ankle contractor braces every, day shift. When RN-W was asked if staff checked under braces every day, RN-W replied yes, especially shower days. Surveyor noted 1/30/24 was not R78's Friday shower day. RN-W stated that if they signed it out on TAR then they did it and does not remember any skin impairment at that time. If a skin impairment was found, RN-W would complete a skin impairment eval and the unit manager is alerted. On 04/23/24 at 11:18 AM Surveyor followed up with R78 regarding the pressure wound. Per R78 Family Member-V was cleaning up feet and noticed that the callus on back of heel had turned to a wound. R78 states he was getting a shower once a week and made no refusals, actually wanted more showers that's why Family Member-V would give bed baths and clean up. When asked about daily skin checks, R78 shared he does not remember anyone from Facility taking boots off and looking at skin every day. R78 could not remove boots by himself, Family Member-V took them off nightly to give R78 a break from wearing them. On 04/23/24 at 01:59 PM Surveyor informed DON-B, Nursing Home Administrator (NHA)-A and the consultants that there was a very serious concern related to R78's facility acquired pressure injury. Surveyor shared concerns with R78 developing an avoidable, facility acquired stage 4 pressure injury when the facility did not get physician orders for R78's wearing of the PRAFO orthotics and assessed how long R78 should be wearing the orthotics daily to prevent possible skin breakdown. On 4/24/24 a progress note dated 4/23/2024 at 6:13 pm, signed by the facility therapy Physiatrist-GG was provided to the Surveyor stating Discussed with DON and leadership. Patient had arrived here in Dec from previous facility with rigid PRAFO boots, which (R78) had worn until developed some skin breakdown on back of distal leg/ankle. The use of these boots, which was well-tolerated at the previous facility, was reasonable to help prevent soft tissue injury and plantar flexion contracture for the patient. Surveyor noted that there are no details about how long to wear the boots or interventions to prevent skin breakdown and this was obtained by the Facility after they were informed of the serious concern. There is no documentation provided to the Surveyor to indicate Physiatrist-GG had assessed or consulted on R78's use of the PRAFO orthotics prior to R78 developing the stage 4 pressure injury to the right ankle. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/24/24 the Facility provided a late entry progress note to Surveyor stating LATE ENTRY FOR 1/31/24 Writer and (LPN-O) went to assess resident skin concerns to right achilleas (sic). Wound observed and assessed. Skin appears slightly open 0.2 cm x 0.2 x 0.1cm with slight purple hue periwound (sic). Total wound measured at approximately 1.5 cm x 2 cm. NP updated on wound. Orders to continue current treatment until seen by wound MD. Resident offered additional education on offloading and given offloading device options to try. At this time feels most comfortable offloading with pillows as (R78) directs staff to adjust, resident was urged to use device that would effectively float heels to relieve any pressure, and educated to ensure that heels are not touching surface because from what (R78) showed as preference pillows did not offer effective offloading. (R78) also decline to stop utilizing PRAFO boots despite education of prevelon (sic) boot benefits. We did confirm that (R78) had extra padding in the PRAFO boot. (R78) clarified wants them on at all times and Family Member-V will remove for a couple hours in the evening. On 04/24/24 at 09:58 AM Surveyor called LPN-U and asked about the PRAFO boots being worn after the pressure injury was discovered. LPN-U stated (R78) requested to continue to wear the PRAFO boots then switched on 2/5/2024 to the Prevalon boots after the wound doctor educated on the risks and benefits. Surveyor noted there is no indication facility staff discussed the risks and benefits of wearing the PRAFO with R78 at any time prior to Wound Doctor-Q's assessment of R78's right ankle, facility acquired pressure injury. On 04/24/24 at 10:05 AM Surveyor asked R78 when he started to wear the Prevalon boots and R78 can't remember, just knows switched to Prevalon boots at some point. Surveyor notes that Facility did not get physician orders on when or how long to wear the PRAFO boots only a recommendation for foam dressing to posterior ankles for protection every mon, wed, fri. R78's skin was only assessed daily not per shift. The Facility did not clarify with physicians' orders at admission for wearing the PRAFO orthotics. R78 continued to wear the orthotics after the pressure wound developed, Facility provided no evidence of risk analysis given to R78. There was no plan of care intervention for the PRAFO boots for Certified Nursing Aides (CNAs) even though the Facility recognizes resident wore from admission and had a pressure wound to the left posterior heel upon admission. On 4/25/24 the facility submitted additional documentation to review/consider regarding R78's Right Achilles Pressure Injury. Submitted was a pamphlet regarding a Pressure Relieving Ankle Foot Orthosis Instructions for wearing your Pressure Relieving Ankle Foot Orthosis (PRAFO) Surveyor noted this pamphlet is from a Prosthetic and Orthotic Department in a hospital in [NAME] Canada and it is not from the hospital or physician who originally ordered the PRAFO prior to admission. The facility highlighted the section asking When should the PRAFO be worn? A PRAFO should ideally be worn at all times, only being removed for wound care and showering, unless otherwise indicated by your doctor. Surveyor noted it is not even clear if the pictured PRAFO boot is the model R78 was using. Additionally, it is noted the facility did not give the doctor the opportunity to indicate otherwise when wearing the PRAFO as it was never assessed on discussed with a facility physician for orders for use. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* DON/designee will audit all brace/splint monitoring orders and wearing schedules three times per week to ensure completion. * DON/Nurse Managers will audit skin checks for braces/splints three times weekly to ensure compliance. * Results of audits will be reviewed through the QAPI process and make changes as necessary. The deficient practice continues at a scope and severity of a G (actual harm/[NAME][TRUNCATED]

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F 0689 Level of Harm - 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** 38253 Based on observation, record review, and interview, the facility did not ensure that residents received adequate assistance devices to prevent accidents for 2 (R65 and R67) of 7 residents reviewed for accidents. *R65 was transferred using a pivot transfer when R65's Care Plan indicated R65 transferred using a sit-to-stand lift. R65 sustained a broken tibia and fibula. *R67 was observed to not not have a fall mat in place per Care Plan. Findings include: The facility policy and procedure entitled Fall Prevention Program dated 5/2023 states in part: Procedure: 1. A care plan for fall prevention will be implemented and maintained to assure the safety of residents who are at risk. The program will be inclusive of measures which determine the individual needs of each resident by assessing the risk of falls, and implementation of appropriate staff interventions to assure adequate supervision is provided, and that assistive devices are utilized when necessary. Fall Incident Reports will be reviewed, and quality issues identified to assure the on-going effectiveness of the prevention program. 6. Fall prevention strategies will be utilized for residents at risk for falls including individualized interventions in accordance with the assessed needs of each resident. 1.) R65 was admitted to the facility on [DATE] with diagnoses of malnutrition, anorexia receiving the majority of nutrition through a gastrostomy tube, diabetes, polyneuropathy, adult failure to thrive, and depression. R65's Significant Change Minimum Data Set (MDS) assessment dated [DATE] indicated R65 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R65 did not have an activated Power of Attorney. R65's Activities of Daily Living Care Plan was initiated on 6/23/2023 and had the following interventions in place on 3/11/2024: -Bed mobility: 1 assist extensive with bilateral side rails. -Eating: Setup and clean up assist/cue and encourage for meals. Offer alternative if R65 declines meal. Enteral nutrition via pump overnight. -Transfer: 2 assist with sit-to-stand mechanical lift On 3/11/2024 at 3:45 PM in the progress notes, nursing charted R65 complained of pain to the right leg and when asked if R65 could lift the leg, R65 started to scream. Tramadol was given at 2:58 PM and an ambulance was contacted for transfer to the hospital. (continued on next page)

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	525179	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor of Kenosha (the)	3100 Washington Rd Kenosha, WI 53144

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Emergency Department Provider Note dated 3/11/2024 documented R65 presented to the emergency department complaining of right leg pain. R65 stated R65 was being transferred from the wheelchair to the bed when during the transfer the right leg became trapped between the left leg and the bed. R65 felt a pop and extreme pain in the leg. X-rays were taken of the right leg and knee with results showing a fracture of the right tibia and fibula. On 3/15/2024 at 3:09 PM in the progress notes, nursing charted R65 was readmitted to the facility after being treated for a right tibia/fibula fracture and has an external fixation device to the right lower extremity. The device is not to be touched and to only lift the leg from the bottom for repositioning. R65 is non-weight bearing to the right lower leg. Surveyor reviewed the facility investigation of R65's right tibia and fibula fracture. The investigation was started by Registered Nurse Supervisor (RN Sup)-AA. The investigation form stated RN Sup-AA was approached by staff on 3/11/2024 to assess R65 due to R65 being transferred from the wheelchair to the bed when R65 started crying out in excruciating pain from the right knee down to the right foot. R65 told RN Sup-AA that R65 was in the wheelchair and wanted to go to bed. R65 told RN Sup-AA the Certified Nursing Assistant (CNA) wanted to get the lift and R65 told the CNA R65 did not want to use the lift as R65 had been doing pivot transfers with therapy. R65 told RN Sup-AA during the transfer R65's left leg crossed behind the right leg and R65 heard a pop snap-like noise and immediately felt severe pain from the right knee down to the ankle. CNA-X completed a statement on the investigation form which stated CNA-X answered R65's call light where R65 requested to be transferred back to bed from the wheelchair. CNA-X told R65 it would be a minute because CNA-X needed to get the lift. R65 told CNA-X that R65 was being transferred by pivot transfer. CNA-X knew that R65 was being transferred in therapy by a pivot transfer so CNA-X decided that CNA-X could do a pivot transfer with R65. During the transfer, CNA-X positioned CNA-X in front of R65 with a gait belt around R65's waist. CNA-X stated R65 stood up and transferred towards R65's right side which was R65's dominant side and R65's leg moved during the transfer crossing behind R65's right leg and when R65 was lowered to the bed, R65 started to yell out in pain. CNA-X immediately notified the RN to assess R65. The investigation was continued by Director of Nursing (DON)-B. DON-B wrote up a summary of the event. CNA-X was suspended pending an investigation on 3/11/2024. Statements were obtained from R65, CNA-X, and RN Sup-AA. It was determined by the facility that CNA-X did not follow R65's plan of care. In an interview on 4/21/2024 at 10:33 AM, R65 stated a caregiver was transferring R65 from the wheelchair to the bed and instead of using the sit-to-stand lift, the CNA lifted R65 by herself. R65 stated R65's right leg went under the bed which the CNA could not see and put R65 in bed. R65 stated both bones below the knee broke. Surveyor asked R65 to clarify how the CNA moved R65 from the wheelchair. R65 stated the CNA physically picked R65 up. R65 stated R65 used to weigh a lot less but had been gaining weight so the CNA would have been able to pick up R65 but not at that time. Surveyor observed R65's right leg with external fixators in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/23/2024 at 9:22 AM, Surveyor asked RN Sup-AA to review the incident on 3/11/2024 where R65 sustained a fractured tibia and fibula. RN Sup-AA stated RN Sup-AA did the investigation of the incident and interviewed CNA-X to find out what happened. RN Sup-AA stated CNA-X said CNA-X was going to transfer R65 and was going to get the lift when R65 said no, R65 had been doing pivot transfers in therapy and R65 could transfer that way. RN Sup-AA stated CNA-X said CNA-X gave in to R65 and R65's legs got twisted in the turn. RN Sup-AA stated when R65 was talked to, R65 said R65 wanted to do a pivot transfer and thought R65 had broken the leg. RN Sup-AA stated R65 was in a lot of pain even after Tramadol was given so RN Sup-AA went to the Nurse Practitioner (NP) and the NP agreed to send R65 out without getting an x-ray first. RN Sup-AA stated the hospital said R65 had a fracture and a history of osteoporosis. RN Sup-AA an investigation was competed. RN Sup-AA stated RN Sup-AA got CNA-X's statement and R65's statement as part of the investigation. On 4/24/2024 at 11:56 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern CNA-X transferred R65 with a pivot transfer rather than using the sit-to-stand lift that was in R65's Care Plan and R65 sustained a fractured tibia and fibula during the transfer. NHA-A stated CNA-X did not follow R65's Care Plan. 22692 2.) R67 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction. On 4/22/24, Surveyor reviewed R67's care plan for risk for falls with a start date of 3/26/23 and noted the intervention floor mat to the right side of the bed was initiated 1/24/24. On 4/22/24, Surveyor reviewed R67's current Certified Nursing Assistant care card and noted under safety, it indicates floor mat at right side of bed. On 4/22/24, Surveyor reviewed R67's last fall risk assessment dated [DATE] and noted it indicated R67 was at high risk for falls. On 4/21/24 at 10:30 AM, R67 was observed in bed and no fall mat was observed on the right side of R67's bed. On 4/21/24 at 1:30 PM, R67 was observed in bed and no fall mat was observed on the right side of R67's bed. On 4/22/24 at 8:30 AM, R67 was observed in bed and no fall mat was observed on the right side of R67's bed. On 4/22/24 at 11:30 AM, R67 was observed in bed and no fall mat was observed on the right side of R67's bed. On 04/22/24 at 2:41 PM, Surveyor took Licensed Practical Nurse (LPN)-O into R67's room. LPN-O looked for R67's floor mat and did not find it. LPN-O indicated R67 should have a floor mat on the right side of his bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The above findings were shared with Administrator-A and Director of Nurses-B on 4/23/24 at 3:00 PM. Additional information was requested if available. None was provided.

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F 0690 Level of Harm - 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** 38253 Based on record review and interview, the facility did not ensure a resident with an indwelling catheter was assessed for removal of the catheter as soon as possible for 1 (R65) of 3 residents reviewed with indwelling catheters. *R65 was admitted to the facility with a urinary catheter and the catheter was not removed due to resident convenience with no conversation of risks or benefits documented. R65 was hospitalized [DATE] and 1/6/2024 with sepsis due to a catheter associated urinary tract infection. Findings include: R65 was admitted to the facility on [DATE] with diagnoses of malnutrition, anorexia receiving the majority of nutrition through a gastrostomy tube, diabetes, polyneuropathy, adult failure to thrive, and depression. R65's Significant Change Minimum Data Set (MDS) assessment dated [DATE] indicated R65 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15, had a Stage 4 pressure injury to the coccyx, and had an indwelling urinary catheter. R65 did not have an activated Power of Attorney. On 4/5/2024 at 8:23 PM in the progress notes, nursing charted R65 was admitted to the facility with diagnoses of failure to thrive, weakness, and urinary tract infection (UTI). R65 had a Foley catheter in place. R65's Urinary Catheter Care Plan was initiated on 4/5/2023 with the following interventions: -Monitor for signs/symptoms of catheter complications such as leaking, obstruction, etc. -Monitor/document for pain/discomfort due to catheter. On 4/6/2024 at 2:46 AM in the progress notes, nursing charted R65 was currently on cephalexin 500 mg four times daily for UTI with the last date of antibiotic on 4/11/2024. On 4/6/2023, R65 had a diagnosis of urinary retention. On 4/11/2023, R65 had a Urology consult. The Urologist charted R65 was seen for an inpatient consultation on 3/24/2023 for urinary retention. While R65 was in the hospital, R65 was unable to urinate, and a Foley catheter was placed. The Urologist charted R65 wants to continue with a chronic Foley catheter due to limited mobility and the Foley catheter makes R65's life easier. The Urologist charted R65 was to follow up with the Urologist in a month for a symptom check and discuss a possible voiding trial. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/11/2023, R65 had a Urology consult. The Urologist charted R65 was seen one month ago. The Urologist charted R65 wanted to continue with the Foley catheter. The catheter was exchanged and will come back in four weeks for the next catheter change. The Urologist discussed with R65 bladder management options and R65 wanted to continue with the chronic Foley catheter due to limited mobility and the Foley catheter makes R65's life easier. The Urologist charted R65 was to follow up with the Urologist in a month for a symptom check and discuss a possible voiding trial versus a catheter exchange. On 6/13/2023 at 6:15 AM in the progress notes, the Nurse Practitioner (NP) documented R65 had a diagnosis of urinary retention with a plan to attempt a voiding trial. No documentation was found that R65 had the catheter removed to attempt a voiding trial. On 6/16/2023 at 11:21 AM in the progress notes, Licensed Practical Nurse (LPN)-Z charted R65 was being sent to the emergency room due to altered mental status verbalizing wanting to harm self with no identified plan. R65 was currently being treated for an infection to the sacral wound and the physician would like further work up. The NP was updated and agreed to sending R65 to the hospital. The hospital Discharge Summary dated 6/23/2023 documented R65 was admitted with a diagnosis of sepsis due to UTI and osteomyelitis. The infective organism of the UTI was Escherichia coli and was catheter related. Escherichia coli is a bacteria found in fecal matter. R65 received intravenous antibiotics for the UTI as well as osteomyelitis of the Stage 4 sacral pressure injury. On 6/23/2023, R65's Urinary Catheter Care Plan was revised to include the catheter was maintained for wound treatment. Surveyor did not find any documentation by the Wound Physician that the indwelling urinary catheter was recommended for wound healing. On 8/1/2023, R65's diagnosis of urinary retention was removed from the diagnosis list. On 1/6/2024 at 9:34 PM in the progress notes, nursing charted R65 had nausea and vomiting twice and complained of pain in bilateral hands. Vital signs were blood pressure 69/41, pulse 122, oxygen saturation 96% on room air, temperature 98.2, and respirations 18. R65 was showing signs of being lethargic and was slow to answer questions. R65 tested negative for COVID-19. R65 stated they were not feeling well. 911 was activated and R65 was taken to the hospital. The hospital Discharge Summary dated 1/15/2024 documented R65 was admitted to the hospital for septic shock due to Escherichia coli in the urine with a catheter in place. R65 received intravenous antibiotics for the UTI. On 3/15/2024, R65 had an order for the antibiotic cephalexin 500 mg four times daily for five days for a UTI. On 4/5/2024, R65 had an order for the antibiotic Bactrim DS 800-160 mg twice daily for six administrations for a UTI caused by proteus mirabilis. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 4/21/2024 at 10:28 AM, Surveyor talked to R65 about having the Foley catheter. R65 stated R65 has had the catheter for a year because of urinary retention. R65 had fractured the right tibia and fibula with external fixators in place and stated R65 was unable to get up to go to the bathroom with the broken leg. R65 stated the catheter plugs up and then leaks into an incontinence product and when that happens, the catheter is changed out which sometimes can take a while for staff to change it. Surveyor asked R65 if R65 has had any infections with the catheter. R65 stated yes. In an interview on 4/23/2024 at 9:32 AM, Surveyor asked Registered Nurse Supervisor (RN Sup)-AA about R65's urinary catheter. RN Sup-AA stated R65 had a history of urinary retention so has had a chronic Foley catheter with chronic UTIs caused by lots of microorganisms. Surveyor asked RN Sup-AA if R65 had ever had a voiding trial to see if R65 still needed the catheter. RN Sup-AA did not know and stated LPN-Z was the unit manager recently and may know if a voiding trial was done. RN Sup-AA stated R65 has a large sacral wound and now has the external fixators on the leg so it would be appropriate for R65 to have a catheter. RN Sup-AA stated R65 sees the Urologist regularly. Surveyor shared with RN Sup-AA that no documentation was found showing R65 was given the risks and benefits of having a catheter. Surveyor asked RN Sup-AA if there had ever been that conversation. RN Sup-AA did not know but thought they had been trying to get the catheter out. RN Sup-AA stated R65 has had problems with clogging of the catheter which should be flushed when that happens. RN Sup-AA stated R65 was good about saying if the catheter was leaking and they try to irrigate the catheter and will change it out if it will not flush. In an interview on 4/23/2024 at 9:43 AM, Surveyor asked LPN-Z if R65 ever had a voiding trial to see if R65 could have the catheter removed. LPN-Z stated the facility had done a trial to get rid of R65's catheter but was not sure when that was done. Surveyor shared documentation was found of a voiding trial being done in the hospital discharge notes but no documentation was found of the facility attempting to remove the catheter. LPN-Z stated it was R65's preference to keep the catheter and it is for better healing of the wound as well. On 4/24/2024 at 11:59 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R65 had not had an attempt to remove the urinary catheter in the last year since admission and R65 developed sepsis twice requiring hospitalization and intravenous antibiotics; R65 had oral antibiotics twice for a UTI as well. Surveyor shared with NHA-A the concern no documentation was found of a conversation with R65 of the risk versus benefits of having an indwelling urinary catheter. No documentation was found that the catheter was in place due to wound healing. On 4/29/24 the facility provided additional information indicating a formal diagnosis of neurogenic bladder was obtained for R65. Surveyor reviewed and noted the information provided by the facility.