STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525262	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	430 Wilcox St Fort Atkinson, WI 53538

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide the opportunity for 1 (R15) of 12 residents reviewed to participate in the development and implementation of their person-centered plan of care. *R15's Activated Healthcare Power of Attorney (HCPOA) was not formally invited by the facility to participate in R1'5s Quarterly care conferences Findings Include: 1.) R15 was admitted to the facility on [DATE] with diagnoses of Cerebral Palsy and Chronic Obstructive Pulmonary Disease. R15's Quarterly Minimum Data Set (MDS) dated [DATE] documents R15's Brief Interview for Mental Status (BIMS) score to be a 10, indicating R15 is moderately cognitively impaired and unable to conduct daily decision making. R15 has an Activated HCPOA. On 4/07/2025, at 2:29 PM, Surveyor conducted a family interview via telephone with R15's Activated HCPOA. R15's Activated HCPOA told Surveyor they are generally pleased with the facility's care towards R15 but has wondered why the facility has not invited them to R15's quarterly care conferences. On 4/8/2025, Surveyor requested documentation of R15's quarterly care conferences that have taken place over the last 12 months. Surveyor notes the facility was unable to provide evidence care conferences were being held for R15 or that R15 and R15's Activated HCPOA were invited to attend care conferences. On 4/8/2025, at 11:34 AM, Surveyor conducted interview with Social Worker (SW)-D. Surveyor asked SW-D if a resident has an Activated HCPOA should the Activated HCPOA receive a formal invitation to attend quarterly care conferences. SW-D told Surveyor Activated HCPOAs should always be invited to attend quarterly care conferences. On 4/10/2025, at 3:20 PM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that Surveyor had not received any documentation of R15's quarterly care conferences. No additional information was provided at this time.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and record review the facility did not ensure they provided ongoing-re-evaluation of the need for a seatbelt while seated in a wheelchair for 1 (R24) of 1 residents reviewed for physical restraints. R24 uses a seatbelt to aide in positioning while seated in his wheelchair. The facility initially assessed the use of the restraint on 10/11/23 and has not re-evaluated the use of the seatbelt since then. Evidenced by: The facility policy, entitled Restraint Free Environment, (no date), states Each resident shall attain and maintain his; her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident had medical symptoms that warrant the use of the restraint. Physical restraints may include, but are not limited to: . d.) Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts, that the resident cannot remove and prevents the resident from rising. Compliance guidelines: 4.) A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint. 6.) Medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom by were ineffective, ongoing re-evaluation of the need for the restraint, and the effectiveness of the restraint treating the medical symptom. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint. R24 was originally admitted to the facility on [DATE] with diagnosis that included unspecified convulsions, and Cognitive Communication Deficit. A review of the most recent quarterly MDS (Minimum Data Set), dated 3/21/25 documents R24 has a BIMS (brief interview for mental status) score of zero indicating severe cognitive impairment. R24 has had a fall at the facility without injury and is frequently incontinent of urine and always incontinent of bowel. The MDS also documents there are no restraints being used with R24. A review of R24's current physician orders for April 2025 , documents and order to Remove self-release belt at meals with meals. This order was originally ordered on 11/7/23. On 4/9/25, at 3:30 p.m., Surveyor asked to review the most recent Restraint assessment for R24. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25, at 8:00 a.m., Surveyor was provided with the Pre- Restraint/Restraint Evaluation with the effective date of 10/11/2023. Section A documents - R24 is alert but does not comprehend surroundings. R24 slides down in chair and slumps when walking or sitting. R24 has poor balance while sitting and is unsteady on feet. R24 has a history of falls, vision is poor. Interventions: low bed/placing matt(s) bedside bed, visual or verbal reminders. Provide explanation: Seat belt is due to forward tilt, resident screened by therapy, able to release himself. Date of utilization decision: 10/12/2023. Was reviewed in IDT (Interdisciplinary Team) multiple times since admission to ensure not a restraint. Surveyor noted this was the only comprehensive assessment of the use of the seat belt for R24 in the medical record. R24's individual plan of care documents R24 is at risk for injury related potential physical restraint due to: Lap belt present on admission for positioning : Resident able to release per self. DX (Diagnosis) seizure and history TBI (traumatic brain injury). Date Initiated: 10/12/2023 Interventions included: o Maintain current physical functioning level. Date Initiated: 10/12/2023. Revision on: 03/31/2024 o Complete appropriate restraint and/or side rail assessment per living center policy. Date Initiated: 10/12/2023 o Education family/responsible party regarding risk of restraint use. Date Initiated: 10/12/2023 o Reassess for potential reduction. Date Initiated: 10/12/2023 o Release seatbelt BID (two times per day) to ensure operability. Date Initiated: 10/12/2023 A review of the Visual/ Bedside [NAME] Report, dated 4/14/25 documents under the ADL (activities of daily living) section R24 uses assistive devices wheelchair with dumped seat and self-releasing belt to aid in proper positioning. Ensure R24 can self-release and allow seatbelt free times. On 04/08/25, at 12:23 PM , Surveyor made observations of R24 seated in dining room. At this time it was observed R24 was getting assistance with his lunch meal with staff sitting to his right side. R24 was seated in his wheelchair and the seatbelt was in use. Staff did not release the seat belt during the lunch meal, as per the physician order. On 04/10/25, at 08:55 AM, Surveyor observed R24 seated in the wheelchair in the dining room. Staff was assisting R24 with the breakfast meal and were seated to R24's right side. Surveyor observed the seatbelt to be in use and staff did not release the seat belt during the breakfast meal. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/14/25, at 10:43 AM, Surveyor interviewed Director of Nursing (DON)- B regarding R24's use of the seatbelt when seated in the wheelchair. DON- B stated they asked R24 several times a day to release the belt himself and he can comply. Surveyor asked DON- B why R24 had the seatbelt in place. DON- B stated it is her understanding the main reason is R24 has seizures. Surveyor asked DON- B if R24 has been assessed since 10/11/23 for the appropriateness of the use of the seatbelt and if R24 still remains safe when it is in use. DON- B stated she could only locate the original assessment, and the use of the seat belt should be comprehensively assessed at least annually. Surveyor then shared there is a physician order that the seat belt is released at meals and observations were made on 4/8/25 at lunch and 4/10/25 at breakfast when the seatbelt was not released with staff present. DON- B was unable to provide any additional information. On 04/14/25, at 01:15 PM, Surveyor interviewed Medication Tech (MT)- K who stated she has worked with R24. Surveyor asked MT- K why R24 uses the seatbelt when he is in the wheelchair. MT- K responded she thinks it is for his safety because he will flip out of the wheelchair. Med Tech- K stated R24 can usually get the seatbelt undone if you ask him. As of the time of exit on 4/14/25, the facility was not able to provide any additional evidence they had continued to comprehensively assess R24's use of the seatbelt while seated in the wheelchair.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not develop and implement a baseline care plan that includes the instructions needed to provide effective and person-centered care for 1 (R25) of 1 residents reviewed. *R25 was admitted to the facility on [DATE] and did not have a baseline care plan initiated within 48 hours of admission. Findings include: The facility policy dated 3/1/2019, and titled Baseline Care Plan, documents, in part: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. The baseline care plan will: Be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders, physician orders, dietary orders, therapy services, social services. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. Interventions shall be initiated that address the resident's current needs. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. R25 was admitted to the facility on [DATE] with pertinent diagnosis that include: Fracture of right tibia status post open reduction and internal fixation surgery and major depressive disorder. R25's admission Minimum Data Set (MDS) assessment dated [DATE] documents R25 is cognitively intact. Surveyor reviewed R25's Electronic Medical Record (EMR) and did not locate a baseline care plan. Surveyor noted R25 had a diagnosis of major depressive disorder and was currently taking a medication to treat R25's depression. R25 did not have a baseline care plan with person-centered interventions addressing R25's Depression and Antipsychotic medication use. Surveyor noted R25 had a recent surgery on R25 right leg and had an active MD (medical doctor) order for a brace to be worn on R25's right leg. R25 did not have a baseline care plan with person-centered interventions addressing the need for R25's leg brace. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/08/25, at 12:58 PM, Surveyor interviewed Social Worker (SW)-D. Surveyor asked if R25 had a baseline care plan. SW-D indicated SW-D did not locate a baseline care plan for R25. SW-D indicated SW-D did meet with R25 the day of admission to review admission paperwork, code status, discharge planning and informed R25 of a care conference that would be held the following week. Surveyor asked if care planning was discussed. SW-D indicated again the admission paperwork, code status and discharge planning was discussed. SW-D stated a recent social services audit was completed in the middle of March. A process was developed for the baseline care plans. SW-D stated the process now is to complete the baseline care plan on admission. The Interdisciplinary Team will meet with the resident the day after admission and will go over the care plan. On 4/9/25, at 9:13 AM, Surveyor interviewed Registered Nurse (RN)-P. Surveyor asked who is supposed to initiate and enter the baseline care plan. RN-P stated management starts the baseline care plan as far as RN-P knows. On 4/10/25, at 10:14 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked who is supposed to initiate and enter the baseline care plan. DON-B stated DON-B did not know who is responsible for that. DON-B stated DON-B is still learning. DON-B indicated eventually it would probably be DON-B's responsibility but stated again DON-B was not sure who does the baseline care plan. Surveyor asked if R25 had a baseline care plan. DON-B did not locate a baseline care plan. Surveyor noted facility staff did not follow the facility's baseline care plan policy. On 4/14/25, at 1:04 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern R25 did not have a baseline care plan initiated and reviewed with R25 within 48 hours of admission. No further information was provided as to why the facility did not develop and implement a baseline care plan that includes the instructions needed to provide effective and person-centered care for R25.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 2 of 12 residents (R25 and R19) reviewed received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. *R25 has a history of depression and receives medication to treat depression. The facility did not have a care plan, with resident specific interventions in place, upon R25's admission to the facility. R25 displayed multiple behaviors of depression including social isolation, refusals of care, refusal of multiple meals, and meal intake was low since R25's admission. R25's primary Nurse Practitioner (NP)-H, was not notified of R25's low meal intake. Fifteen days after admission, facility staff documented R25 had a 30.4-pound weight loss which is 15. 7% of R25's body weight. NP-H was not notified of R25's significant weight loss. On 3/20/25, Dietician-C documented that facility staff would offer a trial of Prostat for supplemental calories and protein to support weight stability and recommended a possible psychological evaluation of R25. A physician order for Prostat was not placed at that time and Surveyor did not locate documentation that the Interdisciplinary Team (IDT) was consulted about R25's nutrition. R25 continued to display symptoms of depression and refusals of meals. From 3/27/25 through 3/31/25, R25's documented fluid intake (total amount of fluid drank by R25) was less than 500 milliliters (mls) per day and output (urine output) was minimal Dietician-C was not notified of R25's low fluid intake. NP-H was not notified of R25's low fluid intake and output. On 4/1/25, NP-H assessed R25 between 8 AM and 9 AM. NP-H documented that R25 appeared to be in distress and ordered STAT (immediate) labs to be drawn. These labs were not ordered as STAT. Results of the labs were not completed until after 6 PM on 4/1/25. The labs reported that R25 had a critical low potassium level of 2.2 and NP-H ordered that R25 should be sent to the hospital. R25 was hospitalized with severe sepsis (a life-threatening condition), C-diff infection, pulmonary embolism, and hypokalemia (low potassium). R25 required a stay in the intensive care unit and returned to the facility on 4/4/25. R25's meal and fluid intake continued to be low. R25 was sent to the emergency room again on 4/9/25 with dehydration and a low potassium level of 2.5. The facility's failure to recognize and treat R25's depressive symptoms and failure to recognize R25's significant weight loss created a finding of immediate jeopardy that began on 3/20/25 when Dietician-C noted a 15.7% weight loss in 15 days. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of the immediate jeopardy on 4/10/25 at 3:34 PM. The immediate jeopardy was removed on 4/11/25, however the deficient practice continues at a scope/severity level of D based on the following example: * R19 had a fall from the bed on 7/21/24. R19 was sent to the emergency room after the fall and diagnosed with a closed head injury. The facility policy states that neurological (neuro) checks should be completed after a fall with head injury. The facility did not provide evidence that neuro checks were completed after R19's fall. Findings include: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy, dated 10/1/2022 and titled, Behavioral Health Services documents in part: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning . The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the residents dignity, autonomy, privacy, socialization, independence, choice, and safety . the facility utilizes the comprehensive assessment process for identifying and assessing a residence mental and psychosocial status and providing person centered care period this process includes, but is not limited to: . Ongoing monitoring of mood and behavior. Care plan development and implementation. Evaluation .The resident, and as appropriate the resident's family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall: Have interventions that are person-centered, evidence based, culturally competent, trauma-informed, and in accordance with professional standards of practice. Provide for meaningful activities which promote engagement and positive, meaningful relationships Reflect the resident's goals for care. Account for the resident's experiences and preferences . Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated . Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition . examples of individualized, non-pharmacological interventions to help meet behavioral health needs of all ages may include, but are not limited to: ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite); . Pain relief . Assisting residents with access to therapies such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy . The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologist. The facility's policy dated 3/1/2019 and titled, Notification of Changes Policy documents, in part: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident's representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident . The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident's condition . The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment and preferences to address the changes . Requirements for notification of resident, the resident representative and their physician: . A significant change in the resident's physical, mental, or psychosocial status. A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications . Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions to or discontinuation of treatments . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.) R25 was admitted to the facility on [DATE] with diagnoses that include fracture of right tibia status post open reduction and internal fixation surgery, major depressive disorder, Gastro-esophageal reflux (GERD), Osteoarthritis, and Cellulitis of Right leg. R25's admission Minimum Data Set (MDS) assessment dated [DATE] documents that R25 is cognitively intact. R25 displays verbal behavioral symptoms directed toward others 4-6 days in a 7-day period. R25 has rejections of care 1 to 3 days in a 7-day period. R25 requires set up or clean-up assistance for eating. R25 is dependent for toileting, bed mobility, and transfers. R25 is frequently incontinent of bladder and always incontinent of bowel. R25's at risk for malnutrition care plan initiated on 3/4/25 documents that R25 is at risk related to potential inadequate food/beverage intake with history of depression, GERD and recent surgical intervention for [leg fracture]. Increased nutrition needs for wound healing. Patterns of unfavorable weight change. Interventions include: Diet as ordered. Monitor for [signs and symptoms] of depression. Monitor meal consumption daily, encourage meal and snacks intake as able. Offer food preferences. Encourage family/friends to bring in favorite food items. R25's Gastrointestinal distress due to GERD care plan initiated on 2/28/25 documents the following pertinent interventions: . Encourage patient to follow nutritional and hydration program . Labs per Physician order and [as needed] for change in condition/manifestation of clinical signs or symptoms . Monitor weights and appetite. Report any significant findings to Physician. R25's Refusal care plan initiated on 2/28/25 documents: [R25] sometimes have (sic) behaviors which include refusing cares, therapy, getting up into wheelchair for appointments, and medications. Interventions include: Give me my medications as my doctor has ordered. Let my physician know if my behaviors are interfering with my daily living. Make sure I am not in pain or uncomfortable and offer pain medications prior to therapy or getting up. Offer me something I like as a diversion. Please tell me what you are going to do before you begin. Speak to me unhurriedly and in a calm voice. R25's MD orders dated 3/3/25 include: -Cephalexin oral capsule 500 milligrams (mg). Give one capsule by mouth four times a day related to cellulitis of right lower limb until 3/13/25. -Oxycodone 5mg by mouth every 8 hours as needed for pain control related to pain in right leg. -Daily weight for 3 days upon admission. Every day shift for monitoring for 3 days. -Monitor-behavior symptoms (frequent crying, repeats verbalization, repeats movement, yelling/screaming, kicking/hitting, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care) every shift for monitoring. -Resident receives an antidepressant. Document number of times per shift that any of these behaviors occurred: states feel [sic] sad or depressed, crying, tearfulness, social isolation. -Fluoxetine HCL oral tablet 10mg. Give 1 tablet by mouth one time day for depression related to Major depressive disorder. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted that R25 has a diagnosis of Major Depressive disorder and is currently taking Fluoxetine (an antipsychotic/antidepressant medication). Surveyor could not locate a care plan with person-centered interventions for R25's Depression. On 4/10/25 at 9:30 AM, Surveyor interviewed Social Worker (SW)-D. Surveyor asked who is supposed to put a care plan in place for residents who are on an antipsychotic for depression. SW-D stated the previous MDS coordinator would typically place the care plan, but they no longer work for the facility. SW-D stated the nurse would enter the care plan. Surveyor asked if SW-D should be entering a depression care plan. SW-D stated SW-D has not played a part in that since being in the Social Work role. Surveyor asked if R25 should have a depression care plan. SW-D stated yes. On 4/10/25 at 10:14 AM, Surveyor interviewed DON-B. Surveyor asked who is supposed to put a care plan in place for residents who are on an antipsychotic for depression. DON-B stated Social Services. Surveyor asked if R25 should have a care plan for R25's diagnosed depression. DON-B stated yes. Surveyor asked if DON-B could locate a depression care plan for R25. DON-B stated DON-B thought R25 had one but did not locate one within the medical record. Surveyor noted the discrepancy between SW-D and DON-B in who is supposed to place a care plan for an antipsychotic medication. R25's Dietary note dated 3/4/25 documents, in part: . Current Diet order: Regular diet, regular texture, thin liquids. PO intake: 25-50% of meals consumed. Feeding Ability: Independent. Chewing/swallowing: no concerns noted. Supplements: [not applicable] . Food Preferences: Honor preferences as able, [R25] shared with [Director of Nursing] that [R25] likes raisin bran. Labs: hospital labs (2/27/25) . [Potassium] 4.7 [within normal limits]. Weight: Hospital wt.: 193 [pounds]. [R25] reports poor appetite, [R25] refuses nutrition interview and states to writer that you try to talk to me about this every day, I have more important things that I need to worry about right now. [R25] also has refused height and weight measurements when staff attempted since admission . No skin concerns noted. Will continue to attempt to obtain nutrition and weight history, preferences as able, will monitor for height and weight data to assess nutritional needs and monitor intake patterns for improvement vs need to consider supplementation. Goals are for nutrition intake to be adequate in meeting nutritional needs as evidenced by weight stability [without] significant change, improved or stable hydration status, labs and skin integrity. R25's Treatment Administration Record (TAR) documents that R25 refused daily weights three times since admission. On 3/6/25 at 8:50 AM, R25's electronic Medication Administration (eMAR) note for behavior monitoring documents: repeat verbalization, kicking/hitting, sexually inappropriate, rejection of care, social isolation. On 3/7/25 at 12:42 AM, R25's eMAR note for behavior monitoring documents: frequent crying, yelling, screaming, rejection of care. On 3/11/25 at 2:07 PM, R25's eMAR note for weight documents: Refused. On 3/14/25 at 7 AM, R25's eMAR behavior note documents: Frequent crying, repeat verbalization, yelling, screaming, abusive language. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted R25 had documented behaviors of depression including refusals and no new interventions were placed by facility staff to address these behaviors. On 3/14/25, R25's skin assessment documents a pressure injury. The facility documents a deep tissue injury (DTI) developed on R25's left heel. The facility implemented a DTI actual pressure ulcer care plan and implemented a treatment for R25's facility-acquired pressure injury. Surveyor reviewed R25's Meal Intake task. Surveyor noted that from admission [DATE]) until 3/21/25, R25 had 4 days where R25 had documentation of 3 meals consumed. All other days the resident refused at least one meal per day. Surveyor noted that with the meals eaten: 8 meals were documented as 0 to 25% consumed, 6 were documented as 26 to 50% consumed, 4 were documented as 51 to 75% consumed, and 7 were documented as 76 to 100% consumed. Surveyor noted that most of the meals consumed by R25 were less than 51% eaten. On 4/9/25 at 11:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-M. CNA-M stated R25 just doesn't eat. CNA-M indicated R25 almost always refuses R25's food. On 4/9/25 at 12:33 PM, Surveyor interviewed Medication Technician (MT)-L. MT-L indicated R25 would consistently refuse food. MT-L stated MT-L would offer alternatives but R25 was not always receptive. MT-L stated MT-L approached nursing staff about R25's appetite and lack of food taken in. MT-L stated MT-L told nursing staff that R25 needed supplements since R25 was not eating well enough. MT-L indicated MT-L does not think MT-L's concerns about R25's meal intake were taken seriously. Surveyor noted staff awareness and concerns about R25's meal intake. On 3/18/25 at 11:22 AM, facility staff documented a weight of 163 pounds. On 3/20/25 at 9:42 PM, Dietician-C completed a dietary note which documents in part: . [R25] is noted to have new pressure injury to [left] heel . Meal intake has been variable, [R25] has been refusing most meals over the past 2 days . Weight: (3/18/25): 163 [pounds] . Compared to documented dosing weight per hospital records, current weight reflects significant loss of 30.4 [pounds]/15.7% . Estimated Needs: . Calories: 1850-2220 kcal . Fluid: 2220 ml . [R25] continues to refuse conversation with writer regarding nutrition preferences and needs . [R25] has been refusing meals over the past couple of days and intake prior to that was variable ranging from 25% to 75% . Current weight reflects a significant loss of 15.7% compared to hospital measurements . Spoke with nursing staff this evening, nurse, [name of nurse] on duty will offer a trial of Prostat to [R25] when [nurse] does the next medication pass to see if [R25] would agree to taking this for supplemental [calories] and protein to support weight stability and skin healing. Will review with IDT, for additional considerations, including possible psych evaluation. Will continue to monitor and encourage meal intake, monitor weight pattern and hydration status, monitor for wound assessments. Goal for nutrition intake to remain adequate in preventing significant weight loss, improving skin status, improved or stable labs and hydration status. Surveyor reviewed R25's MD orders and did not locate evidence that a trial of Prostat was ordered to start on 3/21/25. Surveyor reviewed R25's medical record and did not locate documentation of an IDT note indicating that R25 nutrition status was discussed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R25's medical record and did not locate documentation that R25's primary care provider was notified of R25's weight loss and refusals to eat. On 3/20/25, a new intervention was added to R25's care plan: Nutrition status adequate to promote stable or improved skin status. Surveyor noted R25's 15.7% weight loss and R25's multiple refusals of meals. Surveyor noted that an intervention or MD order for accurate Intake and Output with parameters was not added to R25's plan of care. On 3/21/25 at 7:01 AM, a dietary note documents: [R25] was given Ensure by PM nurse per dietitian recommendation . Nurse removed cup of ensure at [4 AM] from room since it had been in there too long. Cup still full, [R25] stated it was too sweet. Surveyor noted a trial of Ensure was given, not Prostat as was documented to be trialed in Dietician note on 3/20/25. On 4/14/25 at 9:34 AM, DON-B gave Surveyor a copy of an email sent by Dietician-C dated 3/20/25 which documents, in part: R25 continues to refuse to talk to [Dietician-C] . [Dietician-C] spoke to the nurse, [name of nurse], this evening, [name of nurse] is going to try Prostat with [R25] to see if [R25] will take it. [R25] is not eating well. [R25] has snacks in [R25's] room brought from family, not eating these either. [Dietician-C] put [R25] on our [Nutritionally at Risk] NAR list for tomorrow and [name of nurse] said that [nurse] would document if [R25] was accepting of the Prostat or anything else that [nurse] offered tonight. On 4/14/25, DON-B also provided a summary of the facility NAR meeting conducted on 3/21/25. The summary documents in part: R25's significant weight loss and refusal of meals and wound care were highlighted. They considered using yogurt and Prostat to improve [R25's] nutrition . Surveyor did not locate an MD order or documentation that Prostat or yogurt was trialed or implemented on 3/20/25 or 3/21/25. On 4/10/25 at 12:06 PM, Surveyor interviewed Dietician-C about R25's significant weight loss. Dietician-C stated Dietician-C used a weight that was documented in R25's hospital record before R25's admission to the facility to calculate the weight loss. Dietician-C indicated R25's weight is something that Dietician-C was going to keep an eye on and trend what was happening. Dietician-C stated at first, anesthesia from R25's leg surgery could influence R25's meal intake at admission. Dietician-C indicated Dietician-C was going to let things settle at first. Dietician-C stated staff stated it is difficult to convince R25 to eat. Dietician-C stated R25 would refuse interviews with Dietician-C. Dietician-C stated family members would bring in some of R25's favorite foods and R25 would still refuse. Dietician-C stated R25 likes juice and was drinking appropriately. Surveyor asked if Dietician-C notified R25's primary care provider about the weight loss. Dietician-C stated Dietician-C does not communicate with the provider. Dietician-C stated Dietician-C would assume the nurses would let the provider know. Surveyor asked why the Prostat or other supplements were not ordered when the weight loss and new wound was discovered. Dietician-C stated Dietician-C spoke to the evening nurse who was going to trial Prostat and let the team know how R25 did with the trial. Dietician-C stated Dietician-C currently has R25 on supplements. Dietician-C stated R25 was refusing psych services but stated that there are medications that could help both psych symptoms and appetite. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/21/25 at 6:03 PM, R25's eMAR behavior note documents: crying, repeats verbalization, yells when [R25] wants a pain pill, rejection of care noted even after reviewed step by step what we will do. On 3/24/25 at 12:30 AM, R25's eMAR behavior note documents: crying or moaning often during the shift, might even be in her sleep. Surveyor reviewed R25's Meal intake task and noted R25 continued to refuse at least one meal a day and documented 0-25% consumed on any other meal eaten from 3/22 through 3/25/25. R25 refused all meals on 3/26/25. Surveyor reviewed R25's Medication Administration Record (MAR) from admission through 3/26/25. R25 was consistently taking 2 to 3 doses of Oxycodone narcotic pain medication a day. Surveyor reviewed R25's urine elimination task and noted from admission through 3/26/25, R25 had between 2 and 5 urine output occurrences per day. On 3/27/25, R25 had 0-25% of breakfast and lunch, and there is no documentation of meal consumption at dinner. R25 had a documented 400 mls of fluid intake. R25 had one urine output occurrence. R25 received one dose of Oxycodone. Surveyor noted R25's meal intake continued to be poor, R25's fluid intake is well below the recommended 2220 mls per day which resulted in only one urine output, and R25's use of pain medication is decreased from R25's typical pattern. On 3/28/25, R25 refused all meals. R25 had a documented 480 mls of fluid intake. R25 had one urine output occurrence. R25 received one dose of Oxycodone. Surveyor noted R25's food and fluid intake are well below the recommendations per day which resulted in only one urine output. Surveyor reviewed R25's medical record and did not find documentation that R25's primary care provider was notified of R25's concerning low fluid intake and low urine output on 3/27 and 3/28/25. On 4/9/25 at 2:56 PM, Surveyor interviewed DON-B. Surveyor asked if a resident has less than 500 mls of fluid intake for 2 days in a row, would DON-B expect the nurse to notify the primary provider. DON-B stated yes. DON-B stated the nurse would only know if the CNA told the nurse though so it would depend on communication. Surveyor asked if a resident had only one urine output in a 24-hour period, would DON-B be concerned. DON-B stated absolutely. Surveyor asked if a nurse should notify the primary provider of the low urine output. DON-B indicated yes. On 3/28/25 at 11:18 AM, R25's eMAR behavior note documents: Frequent crying, repeats verbalization, yelling, rejection of cares such as repositioning and wash ups only allows staff to wash her peri area . Resident declined diversional activities such as group activity, TV, movie, magazine, book, etc. Resident likes to just lay in [R25's] bed, multiple attempts made to offer. On 3/28/25 at 2:27 PM, R25's eMAR behavior note documents: Crying, social isolation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted R25 had documented continued behaviors of depression including refusals and no new interventions were placed by facility staff to address these behaviors. On 3/29/25 at 2:52 PM, R25's progress note documents: Resident refused to eat breakfast and lunch today. Writer encouraged resident to eat x3; resident refused. Fluids encouraged. On 3/29/25, facility staff documented that R25 had 3 soft, formed stools. R25 had 1080 mls of fluid intake and 4 urine output occurrences. R25 had one dose of Oxycodone. On 3/30/25, R25 refused breakfast and dinner and had 0-25% of lunch. R25 had 3 soft, formed stools. R25 had 1700 mls of fluid intake and 6 urine output occurrences. R25 did not receive Oxycodone. On 3/31/25, R25 had 0-25% of breakfast and lunch, and there is no documentation of meal consumption at dinner. R25 had a documented 500 mls of fluid intake. R25 had one soft, formed stool and 2 urine output occurrences. R25 had one dose of Oxycodone. Surveyor noted R25's meal intake continued to be poor, and R25's fluid intake is well below the recommended 2220 mls per day. Surveyor reviewed R25's medical record and did not find documentation that R25's primary care provider was notified of R25's concerning low fluid intake on 3/31/25. On 3/31/25 at 2:48 PM, R25's eMAR behavior note documents: Social isolation noted does not want to get out of bed. R25's MD orders entered on 3/31/25 documents: -House Supplement two times a day for poor appetite and meal intake. Provide 206 juice with breakfast and lunch daily. -Prostat two times a day for wound healing. Surveyor noted Prostat was added to R25's orders 11 days after Dietician-C documented a trial of this in Dietician-C's note. On 4/1/25, R25 did not have any recorded fluid intake. R25 refused 2 meals. R25 had 2 urine output occurrences. R25 did not receive Oxycodone. R25's Change of condition note entered on 4/1/25 at 9:31 AM documents, in part: . Seems different than usual . [blood pressure] 135/98. Pulse 97. [Respiratory Rate] 18. [Temperature] 97.6. Pulse Oximetry 93% . Mental Status evaluation: other symptoms or signs of delirium . Functional Status Evaluation: General weakness . Resident has been noted to have decreased eating the last couple of days. [R25] has been drinking water and [R25's] 7 up without any problems. Today [R25] was very dry and coughing. [Nurse Practitioner] in house and assessed [R25], requested labs afterwards. Peri area was assessed as well as [R25's] vitals and lungs and abdomen. After lab results returned, [Nurse Practitioner] requested that [R25] be sent out to ER for IV [potassium] [due to] [R25's] [potassium] being 2.2 . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NP-H's visit note dated 4/1/25 documents, in part: The patient appears to be in distress with increased respirations and is reporting discomfort, though unwilling to elaborate on the specifics. The patient has been refusing to eat and has declined Prostat supplements . Nutritional status: Patient has been refusing to eat and declining Prostat supplements, raising concerns about nutritional status and potential electrolyte imbalances. Ordered stat [Complete blood count (CBC) and Basic metabolic panel (BMP)] . R25's MD order dated 4/1/25 documents: BMP and CBC today. One time only for labs-screening. Surveyor noted R25's labs were not ordered as STAT as documented in NP-H's visit note. Surveyor reviewed R25's Laboratory result dated 4/1/25 which documents in part: Specimen collected: 4/1/2025 10:27. Specimen Received 4/1/2025 [2:56] PM. Final Reported: 4/1/2025 [6:14] PM. Potassium 2.2 [Critical low]. Reference [NORMAL] Range 3.5-5.1. Surveyor noted 4-hour and 29-minute difference between the collection time and the time the specimen was received by the laboratory. Surveyor noted it took an additional 3 hours and 18 minutes to run the labs and get results. Surveyor noted it took a total of 7 hours and 47 minutes to complete the lab tests. On 4/10/25 at 8:56 AM, Surveyor interviewed NP-H regarding R25's change of condition. NP-H stated R25 was the first resident that NP-H visited on 4/1/25. NP-H stated NP-H evaluated R25 between 8 and 9 am. NP-H stated R25 seemed off but R25 was not good at vocalizing what was wrong. R25 just kept repeating that R25 did not feel good. R25 was also pointing at R25's peri-area. NP-H and DON-B assessed R25's peri-area and noted there was no redness or concerns. NP-H stated R25 kept saying that R25 was thirsty, and staff were giving R25 water. NP-H indicated R25's vitals were fine. NP-H stated NP-H ordered STAT labs, and the lab results came back between 6 and 7 PM that night. NP-H stated R25's potassium was 2.2 and NP-H ordered R25 be sent to the hospital. Surveyor asked what a reasonable amount of time would be for STAT labs to be resulted. NP-H stated, for NP-H, a STAT lab would be completed within a couple hours. Surveyor asked if NP-H was aware R25 had refused eating and had low food intake since admission. NP-H stated NP-H was told on 4/1/25 that R25 was not eating or drinking that much. NP-H stated NP-H found out that morning and was not notified prior of any refusals to eat. Surveyor asked if NP-H was aware of a 30. 4-pound weight loss that occurred 15 days after R25 was admitted to the facility. NP-H stated NP-H was not aware of R25's weight loss. Surveyor asked if knowing about R25's weight loss and meal refusals would have changed how NP-H assessed and cared for R25. NP-H stated NP-H would have inquired more and would have gotten labs sooner. Specifically, NP-H would order a Complete Metabolic Panel and look at R25's albumin level. Surveyor asked if NP-H was made aware of R25's less than 500 mls of fluid intake that occurred on 3/27/25, 3/28/25, and 3/31/25. NP-H stated from what NP-H can recall, NP-H was only told of low food and fluid intake on 4/1/25. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/10/25 at 10:14 AM, Surveyor interviewed DON-B who entered R25's change of condition note on 4/1/25. DON-B stated on that morning, R25 was acting really goofy. R25 was calling out and wanted R25's peri area washed. DON-B stated DON-B and NP-H assessed R25's peri area and had no concerns. DON-B stated NP-H was going to order a urinalysis but R25 did not have an ounce of pee all day. DON-B stated R25 was also bringing R25's bedding to R25's mouth and rubbing it on R25's tongue. DON-B stated because of that NP-H and DON-B thought maybe R25 had thrush and R25 was tested for that. Surveyor asked why the STAT labs were not ordered and completed as STAT. DON-B stated the facility utilizes a Laboratory that is in a different state. DON-B stated for any lab, it takes at least four hours to get results. DON-B stated there is a local hospital with a lab close to the facility and DON-B does not understand why the facility has to use a Laboratory that is so far away. Surveyor asked if DON-B was aware of R25's significant weight loss. DON-B stated DON-B was aware. DON-B stated DON-B spoke to R25's family member who stated they did not believe R25 was ever 193 pounds. The family member told DON-B they did not believe that R25 has ever weighed over 180 pounds. DON-B continued and stated DON-B was not sure how involved the family member was because the family member was incarcerated for years. Surveyor asked if IDT reviewed R25's weight loss and nutrition. DON-B stated yes. Surveyor asked for documentation completed by IDT regarding R25's weight loss and nutrition. DON-B indicated DON-B would get back to Surveyor. Surveyor asked what was being done for R25's depression and the results of R25's behavior monitoring. DON-B stated the facility conducts behavior meetings regularly. Surveyor asked when the last behavioral meeting was. DON-B stated it was on the 18th of March. Surveyor asked if R25's behaviors were discussed. DON-B stated no because R25 had refused psych services multiple times. Surveyor asked if behaviors are discussed in the behavioral meetings even to identify non-pharmacological interventions that could be used. DON-B stated R25 was not discussed at all for non-pharmacological interventions because R25 refused psych services multiple times. DON-B indicated R25 would [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure 2 of 3 residents (R10 and R25) reviewed with pressure injuries had the necessary care and treatment to prevent and heal the pressure injuries. *On 3/11/25, R10 developed a Deep Tissue Injury (DTI) to the right heel. R10 was assessed to be at risk for pressure injuries. R10's Treatment Administration Record (TAR) documents an order dated 2/19/25, to float R10's heels when in bed as needed (PRN) with no documentation noted in February or March 2025, indicating R10's heels were floated. R10's care plan was updated on 4/8/25, to include bed extenders which is 48 days from when R10 was noted to have an open wound on the right foot on 2/20/25 that developed into a DTI on 3/11/25. *R25 was admitted on [DATE] without any pressure injuries and was assessed by facility staff to be at moderate risk for developing pressure injuries. On 3/10/25, R25 was assessed by facility staff to be at a very high-risk for developing pressure injuries. Facility staff did not initiate any new care plan interventions to prevent pressure injuries. R25 had an active physician order since admission to float heels when in bed as needed. From 3/3/25 through 3/14/25, facility staff did not document that this was being completed. On 3/14/25, 11 days after admission, R25 developed a Stage 1 pressure injury to R25's left heel. When the facility wound nurse assessed R25 on 3/17/25, the pressure injury had developed into a Deep Tissue injury (DTI). On 3/20/25, the facility dietician documented that facility staff would trial Prostat (a liquid designed for individuals who require extra protein, especially those with conditions like pressure ulcers) for weight stability and wound healing. The facility did not provide documentation that Prostat was trialed, and an active physician order was not started until 4/1/25. Findings include: The facility's policy titled, Pressure Injury Prevention Guidelines, with no date, documents: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Explanation and compliance guidelines: 1 Individualized interventions will address specific factors identified in the residence risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 2 The goal and preferences of the resident and/or authorized representative will be included in the plan of care. 3 Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	4 In the absence of prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care and will notify physician to obtain orders. 5 Prevention devices will be utilized in accordance with manufacturer's recommendations (e.g., heel flotation devices, cushions, mattresses). 6 Guidelines for prevention may be utilized in obtaining physician orders. a The guidelines are to be used to assist in treatment decision making. b Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. c When physician orders are present, the facility will follow specific physician orders. 7 Interventions will be documented in the care plan and communicated to all relevant staff. 8 Compliance with interventions will be documented in the medical record. a For at-risk-residents: treatments or medication administration records. b For residents who have a pressure injury present: treatment or medication administration records; Weekly wound summary charting. 9 The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: a Development of a new pressure injury. b Lack of progression towards healing or changes in wound characteristics. c Changes in the resident's goals and preferences, such as at end of life or in accordance with his/her rights. Preventative skin care: 1 Inspect skin while providing care, paying close attention to bony prominences. 2 Inspect skin underneath medical devices at least twice weekly. Keep skin clean and dry underneath. Adjust devices as needed for proper fit. 3 Avoid positioning the resident on an area of redness whenever possible. 4 Keep the skin clean and dry. a Manage incontinence and absorptive products. Check every two hours and provide perineal care as needed after incontinent episodes. Diaper usage in bed is not recommended. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b Protect skin from exposure to excessive moisture with barrier products. 5 Moisturize dry skin. 6 Use positioning devices or folded linens to keep body surfaces from rubbing against one another period 7 Consider use of prophylactic dressings for prevention of sacral and heel pressure injuries. 8 Avoid vigorous massage over bony prominences. Nutrition/Hydration: 1 Consult dietitian for nutritional screen for each resident who is at risk for a pressure injury or has a pressure injury present. 2 Develop an individualized nutrition care plan for each resident with or at risk for a pressure injury, considering the recommendations made by the dietician. 3 Monitor weight and intake according to facility policy. 4 Provide and encourage adequate daily fluid intake. Repositioning: 1 Reposition all residents at risk of, or with existing pressure injuries, unless contraindicated due to medical condition. Utilize small shifts in repositioning, if otherwise contraindicated. 2 Routine repositioning schedule every two hours, using both side-lying and back positions. Reposition when in bed, and out of bed. 3 Considerations for alternative repositioning schedule: a General Medical condition b Tissue tolerance c Overall treatment goal/resident's goals and preferences d Skin condition e Comfort 4 Teach residents to do pressure relief lifts or other pressure relieving maneuvers as appropriate. 5 Repositioning techniques: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	a Avoid positioning the resident on bony prominences/turning surfaces with existing pressure injuries, including stage one. b Utilize lift sheets or pads to reduce shear force. Avoid dragging the resident when repositioning. c Limit head of bed to 30 degrees, if not contraindicated. [NAME] the knees when head of bed is elevated to reduce shearing. d Avoid positioning the resident directly onto medical devices (i.e., tubes, drainage systems). e When turning to side lying position, do not tilt more than 30 degrees. f Ensure that heels are floated off the surface of the bed, using pillows or devices that elevate and offload the heel in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon. g When in chair, provide adequate seat tilt to prevent sliding forward. Ensure the feet are properly supported. h Position bariatric residents with a large abdominal [NAME] on his/her side and use a pillow or other device to lift the pannus away from the underlying skin surface. 6 Minimize seating time/out of bed time to promote ischial and sacral wound healing. Pressure relieving devices: 1 Support surfaces do not eliminate the need for turning and repositioning. 2 Pillows and wedges may be utilized to maintain proper positioning. 3 Apply heel suspension devices according to the manufacturer's instructions. 4 The standard mattress for all facility beds are pressure redistribution mattresses. 5 The standard seat cushion for wheelchairs are pressure redistribution seat cushions. 6 Provide alternative support services as needed. Considerations for utilizing specialized support services: a Medical condition and weight. b Cannot be positioned off existing pressure injury. c Has pressure injuries on two or more turning surfaces that limit turning options. d Failure to heal or deterioration in wound status despite appropriate comprehensive care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	e Stage 3, 4, unstageable, or deep tissue injury on trunk. f Bottoms out on the existing support surface. g Need for microclimate (i.e. moisture) control. 7 Do not use ring or doughnut shaped devices, synthetic sheepskin pads or mattresses, or egg crate type mattresses for residents with or at risk for pressure injuries. 1.) R10 was admitted to the facility on [DATE]. R10 was hospitalized from [DATE] to 2/19/25 and readmitted to the facility on [DATE]. R10's diagnoses include Type 2 Diabetes Mellitus (DM) with Diabetic Peripheral Angiopathy without gangrene, osteomyelitis, chronic embolism and thrombosis of right femoral vein, history of pulmonary embolism, End Stage Renal Disease (ESRD), Congestive Heart Failure (CHF), and unsteadiness on feet. R10's Significant Change Minimum Data Set (MDS) completed on 2/26/25, documents that R10 has lower extremity impairment on once side, uses a walker and wheelchair, requires partial/moderate assistance with toileting hygiene and rolling left to right. R10 requires substantial/maximal assistance when transferring. R10's 2/26/25 MDS documents no unhealed pressure injuries, no venous and arterial ulcers, and is at risk for pressure injuries. R10 is documented as having a diabetic foot ulcer. R10 was documented as having a Brief Interview for Mental Status (BIMS) score of 14, indicating that R10 is cognitively intact. R10's Care Area Assessment (CAA) for Pressure Injury documents R10 is at risk for pressure injuries with Care Plan considerations documented, to minimize risks for R10. Surveyor noted there is no further documentation on R10's Pressure Injury CAA. R10's care plan, dated 2/20/25, documents: R10 has a physical functioning deficit related to mobility impairment (date initiated 2/24/25) Interventions include: Assistive devices - Walker, quad cane, wheelchair, power wheelchair (date initiated 2/24/25). Bed mobility with assistance of one (date initiated 2/24/25). Dressing with assistance of one (date initiated 2/24/25). Toileting with assistance of one. R10 is incontinent. (date initiated 2/24/25). Transfer assistance with two staff. Mechanical lift required (date initiated 2/24/25). R10 sometimes has behaviors which include refusing therapy and medications (date initiated 3/18/25). Interventions include: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Notify R10's physician if behaviors are interfering with my daily living related to refusals (date initiated 3/18/25). R10 is at risk for pressure ulcer and altered skin integrity due to DM, osteomyelitis, ESRD, CHF, gout, contracted left hand, Hypertension, Peripheral Vascular Disease (PVD), needs assistance with bed mobility, and incontinent (date initiated 3/18/25). Interventions include: Air mattress (date initiated 3/21/25). Bed extender to keep feet from pushing up against footboard of bed (date initiated 4/8/25). Conduct weekly skin inspection (date initiated 3/18/25). Diabetic foot monitoring (date initiated 3/21/25). Encourage heel boots to left and right foot when in bed (date initiated 3/18/25). Encourage to float heels when in bed (date initiated 3/18/25). Encourage turning and repositioning (date initiated 3/21/25). Treatments as ordered (date initiated 3/18/25). Wound Management (date initiated 2/21/25). Interventions include: Encourage R10 to elevate legs (date initiated 2/21/25). Evaluate ulcer characteristics (date initiated 2/21/25). Measure ulcer at regular intervals (date initiated 2/21/25). Monitor ulcer for signs of infection (date initiated 2/21/25). Monitor ulcer for signs of progression or declination (date initiated 2/21/25). Notify provider if no signs of improvement on current wound regimen (date initiated 2/21/25). Provide wound care per treatment order (date initiated 2/21/25). R10's Skin Check dated 2/19/25, after returning from the hospitalization on 2/10/25 - 2/19/25, documents no skin issues on R10's right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R10's TAR (Treatment Administration Record) documents a physician order placed on 2/19/25 that indicated that R10 was to have R10's heels floated when in bed as needed (PRN) for precautionary measures. Surveyor noted there are no entries documented in February or March 2025 TAR documenting that R10's heels were floated. R10's shower sheet dated 2/20/25, documents no skin abnormalities to R10's right heel. R10's Advanced Wound Care noted dated 2/25/25, documents an open wound to R10's right foot with heavy amount of serosanguinous exudate with exposed subcutaneous tissue and macerated periwound. Surveyor noted there are no measurements and no wound descriptions that include where the open wound is on R10's right foot. Treatment orders include cleanse the area with Vashe Wound Solution and the periwound area followed by Hydrofera Blue Ready dressing, followed by Abdominal Pad (ABD), cotton roll, and ace wrap daily. Wound is to be offloaded using Prevalon boots. Surveyor noted, R10's TAR did not change to document that R10's heels were to be offloaded using Prevalon boots. R10's facility Skin Check dated 2/27/25, documents no skin abnormalities to R10's right heel. Surveyor noted there is no documentation of R10's right foot wound documented on 2/25/25. R10's Wound Care noted dated 3/5/25, documents R10 refused wound care visit due to nausea. Wound care recommendations were to continue previous wound care orders and follow up next week. R10 refused shower on 3/6/25. R10's weekly facility skin evaluation dated 3/11/25, documents a right heel DTI measuring 4 x 10 x <0.1 with no drainage and dry visible wound tissue. Current treatment noted to be area is off loaded with ABD pad and wrapped with kerlix every other day. R10's physician was notified. Surveyor noted there were no addditional wound descriptions. R10's wound care noted dated 3/12/25, document a right plantar foot blister intact with orders to paint with betadine, cover with foam or ABDs, kerlex, and tubigrips three times weekly. Surveyor noted a handwritten note indicating cancelled appointment and R10 to follow with wound care at the facility on 3/18/25. Surveyor also noted there are no measurements or wound descriptors for R10's right plantar foot blister. R10's Advanced Wound Care noted dated 3/18/25, documents a right heel/foot pressure ulcer first noted on 3/18/25 measuring 27 x 9 x 0 with no exudate and intact skin. Treatment orders include betadine to periwound followed by foam border dressing three times a week. Surveyor noted there are no further wound descriptors for the wound bed. R10's TAR documents an order placed on 3/18/25, for heel boots when R10 is in bed. Float heels if R10 refuses heel boots every shift. R10's wound care noted dated 4/1/25, documents right heel/foot DTI measuring 21.5 x 7.5 x 0 with no exudate and intact skin. Orders include betadine to periwound followed by ABD, followed by roll gauze three times a week and PRN. Recommendations to float heels when in bed and non-weight bearing. Surveyor noted there are no additional wound descriptions for R10's wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R10's wound care noted dated 4/8/25, documents right heel/foot DTI measuring 18.5 x 6.5 x 0 with no exudate and intact skin. Orders include betadine to periwound followed by Abdominal Pads (ABD) followed by roll gauze three times a week and PRN. Recommendations to float heels in bed and non-weight bearing. Surveyor noted there are no additional wound descriptions for R10's wounds. On 4/7/25, at 11:00 AM, Surveyor interviewed R10 who reported R10 has had multiple wounds for a long time and was recently hospitalized . Surveyor noted wound care dressings to R10's feet and a pillow under the left foot with the right foot directly on the bed. R10 stated the wounds are pretty good. R10's bed is pushed up against the wall on the right side. R10 is laying on the right side with a pillow by R10's head against the wall and another pillow behind R10's head. Surveyor noted R10 being tall and bed extenders level with the mattress to prevent R10's feet from hitting the end of the bed. On 4/8/25, at 3:20 PM, Surveyor interviewed R10 and noted R10 to be wearing Prevalon boots. R10 stated they use to put my boots on, then they took them off, and now they are back on. R10 stated the physician recommended amputation of R10's foot and R10 refused. Surveyor asked R10 why the wounds got so bad, and R10 stated it's probably because R10 was getting up and doing things when R10 was not supposed to. On 4/9/25, at 10:50 AM, Surveyor interviewed R10 who denied any additional concerns. Surveyor noted R10 having Prevalon boots on and bed extenders on the bed. On 4/9/25, at 12:44 PM, Surveyor interviewed Wound Care Registered Nurse (WC RN)- E who stated she has followed R10's wound care since 3/17/25. WC RN- E indicated she rounds with Wound Care Physician Assistant (WC PA)- G weekly during wound care rounds. WC RN- E stated R10 was previously being seen by an Advanced Wound Care facility outside the facility. WC RN-E stated that R10 was declining leaving the facility for Advanced Wound Care and was requesting to be seen by the wound care team within the facility. WC RN- E stated R10 was noted to have a large blister to the entire plantar foot on 3/12/25 by the Advanced Wound Care team. WC RN- E stated R10 was then seen by WC PA- G on 3/18/25. WC RN- E stated R10 did not have a right foot/heel blister on 3/18/25 and R10 had a pressure injury to the right foot/heel. Surveyor asked WC RN- E how she thought R10's right DTI formed. WC RN- E stated it was due to his foot being up against the foot board. WC RN- E stated the facility put foot bed extenders on R10's bed on 3/18/25. WC RN- E then stated she talked with WC PA- G who thinks R10's right heel/foot DTI was caused by calciphylaxis (a condition where calcium builds up in the blood vessels and skin that can result in skin ulcers and life-threatening infections). WC RN- E stated R10's right heel/foot DTI is smaller and improving. WC RN- E stated R10's right heel/foot DTI may be improving by applying Prevalon boots and elevating R10's legs. WC RN- E also noted orders were placed on 4/1/25 for R10 to be non-weight bearing. On 4/9/25, at 1:44 PM, Surveyor observed R10's wound care with WC RN- E performing R10's wound care to the right heel/foot DTI. WC RN- E gathered supplies outside R10's room and donned gown and gloves prior to entering R10's room. WC RN- E removed R10's right heel/foot dressing dated 4/8/25, that was noted to be around R10's right foot up to mid-calf with toes exposed. Surveyor noted eschar present throughout approximately 75% of R10's bottom of the foot. Boggy skin was noted throughout R10's mid foot and up to R10's mid-calf. Redness and stasis changes were noted throughout R10's foot up to mid-calf. Eschar was present but limited on R10's right heel with eschar mainly noted on R10's bottom of the foot. Hand hygiene was performed appropriately throughout wound care treatment and WC RN- E applied betadine, followed by ABD pad, and roll gauze appropriately per wound care orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor interviewed WC RN- E immediately after wound care observation. WC RN- E stated R10's wound looks the same from yesterday on 4/8/25, but noted wound has improved since 4/1/25. WC RN- E stated eschar has improved on R10's heel indicating eschar is mainly on the bottom of R10's right foot with very limited eschar on R10's right heel. On 4/10/25, at 10:54 AM, Surveyor interviewed WC PA- G who stated she first saw R10 on 2/4/25, and R10 was off dialysis at that time. R10 was experiencing very painful DM neuropathy on 2/4/25, which WC PA- G stated is not normal. WC PA- G stated R10's wounds were very suspicious of calciphylaxis and advised R10 go to the emergency room (ER) for wound care management and further evaluation of ESRD with suspicion of R10 needing to go back on dialysis. R10 declined going to the ER at that time and later agreed to go to the ER on [DATE] and was hospitalized [DATE] - 2/19/25. WC PA- G stated R10 chose to see an outside wound clinic instead of following with vascular care. WC PA- G stated she was prepared to bring in the ultrasound machine on 3/4/25 for further vascular evaluation and R10 declined wound care at that time on 3/4/25. WC PA- G stated R10 went out of the facility on 3/5/25, for wound care treatment but was not seen due to R10 refusing the wound care visit. WC PA- G stated the outside wound care clinic noted a blood-filled blister on 3/12/25, on R10's right foot/heel and ordered wrapped compression for treatment orders. WC PA- G stated she was provided a photo from the outside wound clinic of R10's right foot/heel blister found on 3/12/25. WC PA- G stated R10's right heel/foot wound then changed to eschar on 3/18/25 due to the outside wound care clinic ordering compression treatment. WC PA- G stated R10 just restarted dialysis, and she would not recommend compression treatment due to R10's vascular status. WC PA- G stated compression over a blood-filled blister will cause a pressure injury and WC PA- G stated she would not have put compression on an ESRD resident but that is what the outside wound clinic chose to do for treatment. WC PA- G stated R10 barely got through the dressing changes on 3/12/25, due to pain and noted R10 was readmitted to the hospital on [DATE], due to ESRD and treatment. WC PA- G stated R10's blood-filled blister, is due to calciphylaxis which is due to kidney failure and the ESRD can cause wound concerns. WC PA- G stated R10 is not compliant with dialysis and did not want to go back on dialysis. WC PA- G stated it's hard to treat R10 because of R10 going to multiple clinics. WC PA- G stated she would have thought R10 would have both legs amputated by now due to ESRD and calciphylaxis. WC PA- G stated each time she sees R10, there is a new abrasion or wound which is expected due to R10's ESRD and calciphylaxis. On 4/14/25, at 10:45 AM, Surveyor interviewed Director of Nursing (DON)- B who stated R10 doesn't like to move a lot and was adamant about always wearing the surgical shoes even when in bed. DON- B stated R10's surgical shoes were only supposed to be used when walking and then stated it's not documented that R10 refused to take off the surgical shoes. Surveyor noted to DON- B that R10 had left leg and foot hanging over the side of the bed during the interview on 4/14/25, at 9:24 AM. DON- B stated R10 likes to hang left foot over the bed, indicating R10's left leg feels better when hanging low. DON- B indicated R19 use to spend most of the time in the wheelchair but now prefers to be in bed as of recently. DON- B then stated, R10 is R10's own worst enemy. On 4/9/25, at 3:20 PM, Surveyor notified Nursing Home Administrator (NHA)- A and Director of Nursing (DON)- B of concerns with R10 developing a right heel DTI while residing at the facility along with concerns listed above. NHA- A and DON- B acknowledged concerns. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R25's Braden scale assessment dated [DATE] documents a score of 9. According to facility documentation a score of 9 indicated R25 is at very high risk for developing pressure injuries. Surveyor reviewed R25's At risk for pressure injury care plan and noted that no new interventions were placed after R25 was assessed at very high risk. R25's Skin Check Evaluation dated 3/12/25 documents, in part: No skin issues. Foot evaluation completed. Surveyor reviewed R25's Treatment Administration Record (TAR) and noted that facility staff did not document that R25's heels were being floated at any time from 3/3/25 through 3/14/25. R25's progress note dated 3/14/25 at 5:40 AM documents: Called to resident's room by [Certified Nursing Assistant (CNA)]. Resident has a pressures injury on the bottom of [R25's] left heel approximately 1.5 oval shape. Red and pink in color not open. Denies pain to the area. Placed [R25's] foot on a pillow and applied a boot. Notified [Nurse Practitioner], [Director of Nursing] and [Family member]. R25's Skin assessment dated [DATE] documents: Left heel pressure ulcer/injury measuring 4 x 1. Stage 1. Non-blanchable erythema of intact skin. R25's progress note dated 3/14/25 at 10:45 AM documents: 24 Hour [Interdisciplinary Team] Note: Resident was assessed this morning and added to wound team for next week for assessment of area. Resident has been difficult to convince to follow plan of care. All staff continue to attempt and encourage [R25] to partake in therapy and [activities of daily living]. [R25] has had [R25's] left leg on a pillow since admission per [R25's] choice. [R25] has a boot in place as of this am to bilateral feet. Surveyor noted that documentation reads that R25 has boot in place as of this am, the day that the pressure injury was found. R25's physician order with a start date of 3/14/25 documents: Betadine Swab sticks External Swab 10 % (Povidone-Iodine). Apply to Left Heel topically every day and evening shift for open area . Apply topically [two times a day] until evaluated by wound care team. R25's actual pressure injury care plan initiated on 3/14/25 documents: DTI pressure ulcer actual to left heel. Interventions include: Evaluate need for pain reliever prior to cleansing or dressing changes. Float heel on pillows when in bed. Heel boot on as resident will allow. Notify practitioner if symptoms worsen or do not resolve. Treatments as ordered. On 4/9/25 at 8:11 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-U. Surveyor asked what interventions are currently in place for R25's pressure injury. CNA-U stated that R25's heels are floated, R25 has heel boots on, R25 has an air mattress, and staff will try to reposition R25 but R25 refuses. Surveyor asked when the air mattress was put in place. CNA-U stated that CNA-U was not sure. Surveyor asked when R25's heel boots were in place. CNA-U stated they started at least 2 weeks ago. Surveyor noted that CNA-U did not say that heel boots were in place since admission. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/9/25 at 12:33 PM, Surveyor interviewed Medication Technician (MT)-L. Surveyor asked what interventions are in place for R25's pressure injury. MT-L stated that R25's heels are floated, and heel boots are on. MT-L stated that MT-L was the staff member who found R25's pressure injury on 3/14/25 and MT-L informed the nurse. MT-L stated MT-L noted the dark spot on R25's heel. R25 was not wearing heels boots at the time. Surveyor asked if heel boots were in place before the pressure area was found. MT-L stated prior to the development of the heel pressure injury R25 was not using heel boots. Surveyor noted MT-L stated that heel boots were not in place prior to the development of the left heel pressure injury. On 4/9/25 at 12:05 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-V. LPN-V stated that LPN-V was alerted by the CNA that R25 had developed a pressure injury. LPN-V stated that LPN-V let the provider know and a treatment was put in place. LPN-V did not indicate if heel boots were on prior to the development of the wound but did state that R25 had an air mattress on. R25's Weekly skin impairment and wound evaluation dated 3/17/25 documents, in part: DTI to left heel . In-house acquired. Date wound identified-3/14/25 . Skin impairment type-pressure ulcer . Comments-deep purple. Wound measurements: 3 [centimeters (cm)] x 3.4 cm . Current treatment plan- Betadine [two times a day] . [Nurse Practitioner (NP)-H] updated. R25's Wound NP note dated 3/18/25 documents: Attempted to see patient, but patient refused. Will attempt to see patient at next visit. Discussed with [Name of facility wound nurse], Facility RN and [Name of facility wound nurse] is managing wound appropriately. On 3/18/25 at 11:22 AM, facility staff documented a weight of 163 pounds. On 3/20/25 at 9:42 PM, Dietician-C completes a dietary note which documents, in part: . [R25] is noted to have new pressure injury to [left] heel . Meal intake has been variable, [R25] has been refusing most meals over the past 2 days . Weight: (3/18/25): 163 [pounds] . Compared to documented dosing weight per hospital records, current weight reflects significant loss of 30.4 [pounds]/15.7% . Estimated Needs: . Calories: 1850-2220 kcal . Fluid:2220 ml . [R25] continues to refuse conversation with writer regarding nutrition preferences and needs . [R25] has been refusing meals over the past couple of days and intake prior to that was variable ranging from 25% to 75% . Current weight refle

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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** 3.) R24 was originally admitted to the facility on [DATE] with diagnosis that included unspecified convulsions, Schizophrenia, Depressive Episodes, Anxiety Disorder, Cognitive Communication Deficit and Chronic Artial Fibrillation. A review of the most recent quarterly MDS (Minimum Data Set), dated 3/21/25 documents that R24 has a BIMS (brief interview for mental status) score of zero (severe cognitive impairment). R24 has also had a fall at the facility without injury and is frequently incontinent of urine and always incontinent of bowel. R24's individual plan of care documents that he is at risk for falls related to history of falls, use of medication, diagnosis history that includes HTN, CVA, seizure, schizophrenia, a-fib and insomnia. Use of Psychotropic medications. Require staff assist with ADLS/mobility, incontinence cares. Impaired range of motion. This plan of care was initiated on 6/30/23. Interventions included pillows for positioning while in bed. R24 to wear helmet at all times. Off during cares and showers. Room rearranged for safety. Staff to ensure that when R24 gets up out of bed that his call light is attached to the edge of bed, easily accessible for him. Standard cushion to wheelchair. The Visual Bedside Kardex Report, dated 4/14/25 (for use by Certified Nursing Assistants) documents under safety that R24 should be offered to lay down after meals, anti-tip bars added to wheelchair, bed in lowest position, footwear to prevent slipping, keep bed locked, check bed positioning on rounds at night to ensure not on edge of bed, mat beside bed, perimeter mattress to assist with identifying edge of bed, call light and personal items available and in easy reach. Nursing note dated 2/28/2025 at 01:30 AM ;General Note Text: (R24) Found on floor parallel to bed but feet were by the head. Gown on, had taken the brief off, no shoes or socks. Bed was in the lowest position. Mat on floor was partially on it. Floor was wet as were his blankets. When I walked into his room, he said I'm wet. Used the mechanical lift and sling to lift him back into bed. Vitals taken for neurological checks notified DON (Director of Nursing), NP (Nurse Practitioner) . Nursing note dated 2/28/2025 at 03:00 AM; R24 Sent to Fort Hospital ER. for evaluation and treatment from being found on floor and NP orders. Guardian aware and was in agreement to it. Nursing note dated 2/28/2025 at 06:23 AM; R24 returned to facility per stretcher transport. Transferred to his bed. Neurochecks WNL (within normal limits) . Nursing note dated 2/28/2025 at 11:25 AM; Late Entry: Note Text: 24 Hour IDT Note: R24 without any c/o pain when asked. Up in w/c per his norm. No injuries noted. Continues with neurological checks. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The electronic medical record contained the Post Fall Evaluation Fall Details : Date / Time of Fall: 02/28/2025 at 1:30 AM. Fall was not witnessed. Fall occurred in the Resident's(R24) room. Activity at the time of fall: brief was off and was soiled the reason for the fall was not evident. Did an injury occur because of the fall: No. Did fall result in an ER visit/hospitalization: Yes. ER Visit/Hospitalization Details: sent to ER per NP because we don't know if he hit his head, and he is on Coumadin. Provider: NP Time notified: 02/28/2025 Notified of fall no injuries. New orders received; See Provider order sheet. Fall Details Note: found (R24) on floor parallel to bed but feet were by the head. Gown on, had taken the brief off, no shoes or socks. Bed was in the lowest position. Mat on floor was partially on it. floor was wet as were his blankets. When I walked into his room, he said I'm wet. Used the mechanical lift and sling to lift him back into bed. Vitals taken for neurological checks notified DON, NP. Guardian, Case worker. Contributing Factors: Recent change in environment: Yes. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: Yes. Poor lighting in the area: Yes. Bed was at an improper height: No. Other furniture involved: No. Wheelchair was not involved in fall. Wearing glasses at the time of the fall: No. Footwear at time of fall: Bare feet. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall. Resident was using incontinence supplies at the time of the fall. Incontinent at time of fall: Yes. Bedside call light on when Resident was found: No. Bathroom call light on when Resident was found: No. Personal alarm sounding when Resident found: No. Other Residents were not involved in fall. On 04/09/25 at 11:15 AM, Surveyor conducted a review of facility's falls investigation dated 2/28/25 at 1:30 a. m. The investigation stated that R24 was found on floor parallel to bed, but feet were by the head. Gown on had taken the brief off, no shoes or socks. Bed was in lowest position. Mat on floor was partially on it. Floor was wet as were his blankets. When I walked into his room, he said I'm wet. R24 was found on the floor during rounds with a wet depend/ brief that he took off and wet blankets. Intervention: Staff to reposition, check and change resident every 2-3 hours to ensure that he is clean and dry. Further review of R24's individual plan of care documented that R24 has an alteration in elimination of bowel and bladder. R24 is always incontinent of bowel and bladder, requires staff assist with incontinent cares. Date Initiated: 01/09/2024. Interventions included : Use of briefs/pads for incontinence protection. Date Initiated: 01/09/2024. The facility's investigation did not include statements from staff that would indicate the last time R24 was cared for on 2/28/25. R24 is incontinent of bowel and bladder and would need the assistance of staff for all toileting needs, including checking and changing the incontinence brief. The investigation also did not address if all of the fall's interventions were in place at the time of the fall. The facility added the intervention for staff to reposition, check and change R24 every 2-3 hours to ensure that he is clean and dry. Date Initiated: 02/28/2025. This intervention should have already been apart of R24's plan of care as he is dependent on staff for all activities of daily living. In addition, the facility did not determine a possible root cause of this unwitnessed fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/23/2025 at 06:29 AM, the facility staff completed the Post Fall Evaluation Fall Details for a fall that happened on 03/22/2025 at 10:29 AM. The fall was not witnessed. Fall occurred in the Resident's (R24) room. R24 was reaching for item(s) at time of the fall. Reason for the fall was evident. Reason for fall: R24 stated he was reaching for his call light. Did an injury occur as a result of the fall: No. Did fall result in an ER visit/hospitalization: No. Provider: NP Time notified: 03/22/2025 Notified of: R24 on his bedroom floor . Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: No. Poor lighting in the area: No. Bed was at an improper height: No. Other furniture involved: Yes. Wheelchair was involved in fall. Wheelchair was unlocked at time of fall. Wheelchair footrest(s) were in the way at the time of fall. Wearing glasses at the time of the fall: Yes. Footwear at time of fall: Shoes. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall. Resident was using incontinence supplies at the time of the fall. Incontinent at time of fall: Yes. Bedside call light on when R24 was found: No. Bathroom call light on when Resident was found: No. Personal alarm sounding when Resident found: No. Other Residents were not involved in fall. Contributing factors note: R24 stated he needed to use the restroom was trying to reach the wall button that turns it off his soft touch was on his bed as per usual there was a recliner in front of R24. R24 was sitting in an upright position on the floor leaning against the recliner. On 4/9/25 at 11:40 AM, Surveyor conducted a review of the facility's falls investigation for the fall that occurred on 3/22/25. The investigation stated that R24 had an unwitnessed fall and was found on floor next to recliner in his room sitting upright leaning on recliner. R24 stated he was trying to get to his call light. 2 assist with hoyer to assist R24 off the floor into his bed. R24 without any injuries noted. Denies pain when asked. VSS, Skin assessment completed without any findings. No injuries observed at time of incident. No statements found. 3/22/25 Notes: R24 was reaching for call light that was on his bed, but he went between the two beds, rather than from the edge of bed. Intervention: Staff to ensure that when resident gets up out of bed that his call light is attached to the edge of the bed, easily accessible for him. The falls investigation did not include statements from staff that would help determine the last time R24 was provided cares. In addition , it is not clear if all the falls' interventions were in place at the time of the fall and if a root cause for the fall was determined. On 04/14/25 at 10:49 AM, Surveyor conducted an interview with DON- B regarding R24's falls on 2/28/25 and 3/22/25. Surveyor asked if the falls investigation had information about when the last time R24 was provided cares on 2/28/25. At the time R24 was found he was soaked in urine, had taken his brief off. DON-B stated that staff did rounds, he would have been toileted then and I'm guessing that would have been around 10:30 PM. Surveyor asked DON- B how she was able to confirm this without any statements from the staff working that evening. DON- B stated that she was just guessing and as far as she knew it was done. Surveyor asked if all interventions were in place at the time of the fall on 2/28/25 and 3/22/25. DON- B stated that if she checked the boxed on the report, then they were in place. DON- B was not able to provide evidence that staff were interviewed to confirm this for the fall on 2/28/25 or 3/22/25. DON- B was not able to provide evidence that the facility had determined the root cause of the unwitnessed falls on 2/28/25 and 3/22/25. 2.) R10 is a [AGE] year-old-resident who was admitted to the facility on [DATE]. R10 was hospitalized from [DATE] to 2/19/25 and readmitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus (DM) with , osteomyelitis, chronic embolism and thrombosis of right femoral vein, history of pulmonary embolism, End Stage Renal Disease (ESRD) and unsteadiness on feet. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R10's Significant Change Minimum Data Set (MDS) completed on 2/26/25, documents that R10 has lower extremity impairment on once side, uses a walker and wheelchair, requires partial/moderate assistance with toileting hygiene and rolling left to right. R10 requires substantial/maximal assistance with transfers. R10 is always continent of bowel and bladder and has no falls since admission. R10's Care Area Assessment (CAA) for Functional Abilities (Self-Care and Mobility) documents R10's Care Plan considerations, to improve and avoid complications. Surveyor notes there is no further documentation on R10's Functional Abilities CAA. Surveyor also notes there is no Falls CAA documented for R10. R10's care plan, dated 2/20/25, documents: R10 has a physical functioning deficit related to mobility impairment (date initiated 2/24/25) Interventions include: Assistive devices - Walker, quad cane, wheelchair, power wheelchair (date initiated 2/24/25). Bed mobility with assistance of one (date initiated 2/24/25). Dressing with assistance of one (date initiated 2/24/25). Toileting with assistance of one. R10 is incontinent. (date initiated 2/24/25). Transfer assistance with two staff. Mechanical lift required (date initiated 2/24/25). R10 is at risk for falls related to weakness, physical limitations, and need for staff assistance (date initiated 2/24/25). Interventions include: Assess that wheelchair is of appropriate size; assess need for footrests; assess for need to have wheelchair locked/unlocked for safety, anti-tippers (date initiated 2/24/25). Encourage fluids (date initiated 2/24/25). Encourage participation in activities to improve strength or balance (date initiated 2/24/25). Encourage rest periods if feeling fatigued (date initiated 2/24/25). Encourage use of a chair with armrests (date initiated 2/24/25). Ensure proper placement of R10's feet on foot pedals to reduce the risk of R10 sliding out of the wheelchair (date initiated 4/5/25). Footwear to prevent slipping (date initiated 2/24/25). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Gait belt with transfers (date initiated 2/24/25). Keep bed locked (date initiated 2/24/25). Keep environment well lit and free of clutter (date initiated 2/24/25). Keep personal items within reach (date initiated 2/24/25). Nonskid socks/slippers (date initiated 2/24/25). Surveyor reviewed the facility fall investigation dated 4/5/25, which states on 4/5/25, at 11:00 AM, R10 was heard yelling for help. Staff noted R10 to be lying on back, on the floor, in front of the wheelchair with both legs extended in front. R10 was noted to have surgical shoes on. Assessment was completed and R10 denied hitting head. Neurological checks were completed. Surveyor notes the 4/6/25, AM documentation is blank with no entry. R10 was assisted off the floor using the Hoyer lift and assistance of 3 staff members. Skin check was completed with no new concerns noted. Provider, family, and Director of Nursing (DON)- B were updated on 4/5/25. R10's statement indicates R10 was taking feet of wheelchair pedals and just slipped out of the wheelchair. Care plan was updated on 4/5/25, to ensure proper placement of R10's feet on wheelchair foot pedals to reduce the risk of R10 sliding out of the wheelchair. Therapy Screen Form dated 4/7/25, documents R10 with a fall on 4/5/25, and R10 refusing to participate in therapy. Therapy recommends, facility staff ensure proper placement of feet on foot pedals. Surveyor notes the fall investigation form does not include the following documentation being filled out: Mental Status Predisposing factors (Environmental, Physiological, Situation) Statements from staff Risk for falls (including diagnosis of risk for falls, goals and interventions) Surveyor notes R10's gait/balance was documented as not able to perform function on the fall investigation form, however, the check box indicating requires use of assistive devices (i.e. cane, wheelchair, walker, furniture) was not marked. Surveyor notes R10 was noted to have a fall from the wheelchair. Surveyor reviewed R10's medical record which documents on 4/6/25, the Interdisciplinary Team (IDT) notes R10 without any pain or adverse effects and R10 is up per R10's normal with neurological checks being within normal limits. Surveyor reviewed R10's medical record which documents on 4/8/25, the IDT notes R10 continues therapy case load with little participation. R10 has been dependent on staff to provide cares and needs reminders to call for assistance with transfer needs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor notes R10's care plan does not include the need for increased monitoring or checks after R10 is noted as needing reminders to call for assistance with transferring. On 4/7/25, at 11:00 AM, Surveyor interviewed R10 who reports R10 has had multiple wounds for a long time and was recently hospitalized . Surveyor notes wound care dressings to R10's feet and a pillow under the left foot with the right foot directly on the bed. R10's bed is pushed up against the wall on the right side. R10 is laying on the right side with a pillow by R10's head against the wall and another pillow behind R10's head. Surveyor notes R10 being tall and bed extenders level with the mattress to prevent R10's feet from hitting the end of the bed. R10 states dialysis occurs 3 times weekly and is transported via wheelchair to dialysis. Surveyor notes a low bed and bed extenders level with the mattress. On 4/8/25, at 3:20 PM, Surveyor interviewed R10 and noted R10 to be wearing Prevalon boots. R10 states they use to put my boots on, then they took them off, and now they are back on. R10 states the physician recommended amputation of R10's foot and R10 refused. Surveyor asked R10 why the wounds got so bad, and R10 states it's probably because R10 was getting up and doing things when R10 was not supposed to. On 4/14/25, at 9:24 AM, Surveyor interviewed R10 who was noted to be laying supine in bed with head of bed approximately 60 degrees. R10 was noted to have Prevalon boots on both feet and R10's left foot and leg was hanging over the side of the bed. R10 states he was looking for a spoon to eat his cereal. Surveyor suggested he press his call light and staff entered R10's room within 1-2 minutes to assist R10. On 4/14/25, at 10:45 AM, Surveyor interviewed DON- B who states R10 had just got back from dialysis on 4/5/25 when R10 had a fall. DON- B states R10's care plan was updated to include an intervention to put R10 to bed upon return from dialysis per R10's request. Surveyor noted there is no documentation on R10's care plan to put R10 to bed upon return from dialysis. DON- B stated R10 hasn't been tolerating being up in the chair on dialysis days. DON- B indicated that R10 will take feet off the wheelchair foot pedals and R10 hasn't been using the electric wheelchair due to it not fitting in the van when being transported to dialysis. DON- B states she has asked therapy to get a chair that works better for R10 and therapy is working on this. DON- B states it depends on which vehicle comes to transport R10 to dialysis, because one wheelchair is not long enough and R10 will kick feet forward. Surveyor noted to DON- B there is no documentation on R10's 4/5/25 fall investigation, indicating when and where R10 was last seen prior to R10's fall on 4/5/25, at 11:00 AM. DON- B states R10 gets back from dialysis at 10:45 AM. DON- B then states she wouldn't doubt it, if R10 was trying to get back into bed but the facility is unable to determine this as R10 is not a good historian. Surveyor noted to DON- B that R10 had left leg and foot hanging over the side of the bed during the interview on 4/14/25, at 9:24 AM. DON- B states R10 likes to hang left foot over the bed, indicating R10's left leg feels better when hanging low. DON- B indicates R19 use to spend most of the time in the wheelchair but now prefers to be in bed as of recently. DON- B then stated, R10 is R10's own worst enemy. Surveyor notified DON- B on concerns with R10's 4/5/25 fall investigation, not identifying a thorough root cause, no staff statements, and no documentation to identify when and where R10 was last seen prior to the fall. Surveyor requested additional information if available. DON- B acknowledged concerns. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/14/25, at 12:30 PM, Wound Care Registered Nurse (WC RN)- E provided a copy of a progress note that was entered in R10's medical record, with a created date of 4/14/25, at 12:19 PM, and an effective date of 4/5/25, at 11:07 AM. Surveyor notes the progress note indicates WC RN- E heard R10 calling out for help. WC RN- E entered R10's room and noted R10 sitting on buttocks with legs in front. R10 stated R10 just slid out of the wheelchair. R10 had just returned from dialysis. Surveyor notes R10's fall investigation identifies the manager on duty responded to R10 on 4/5/25 after hearing R10 yelling for help. Surveyor notes Assistant Director of Nursing (ADON)- F completed the fall investigation and did not mention WC RN- E responding to R10's fall on 4/5/25. Based on interview and record review, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 3 (R19, R10, and R24) of 3 residents reviewed for falls. *On 7/21/24, R19 was receiving cares from two aides. During cares, R19 fell from R19's bed. R19 complained of immediate pain and was sent to the Emergency Room. R19 was diagnosed with a closed head injury. The facility did not thoroughly investigate the fall. *R10 fell on 4/5/25 and the fall was not thoroughly investigated. *R24 fell on 2/28/25 and 3/23/25. These falls were not thoroughly investigated. Findings include: The facility's undated policy titled, Fall Risk Assessment, documents, in part: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls . Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk . Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. When any resident experiences a fall, the facility will: Assess the resident. Complete an event documentation report. Complete a fall risk assessment. Notify physician and family. Review the resident's care plan and update as indicated. Document all assessments and actions. If a fall is witnessed, obtain witness statement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The undated facility policy titled, Falls Management Process documents, in part: In the event a resident has fallen and/or is found on the ground, a complete head-to-toe assessment must be performed prior to moving the resident unless life-threatening safety concerns are present . Resident is not to be moved until assessed for injury by a nurse . If able, ask the resident to explain what happened and what they were attempting to do at the time of the fall (helpful for root cause analysis later) . Obtain vital signs: blood pressure, pulse, pulse oximetry, and respirations. Obtain neurological checks per policy for any unwitnessed fall or any fall with evidence of injury to head . The nurse will complete an event documentation report, fall risk assessment, pain assessment, and obtain witness statements. The nursing supervisor will determine the most appropriate intervention, implement, and update care plan . Resident fall will be noted on 24 hour Report for three days for post fall monitoring, assessing for injury, full vital signs every 8 hours, and pain assessment . Post fall: Director of Nursing/Designee will assess the resident and review fall documentation, including witness statements, resident interview, environment review of area where fall occurred, and equipment inspection. The event will be discussed, and event documentation reviewed for completion in [Interdisciplinary Team] meeting. Compare data from previous assessments. Discuss identified trends. Therapy referral and Medication Review initiated . Review fall risk assessment for any potential new risk factors. Review plan of care/interventions to ensure all prior interventions are in place and still appropriate. Adjust/add interventions on the Plan of Care. Update and communicate interventions. Provide appropriate training for caregivers if appropriate . 1.) R19 was admitted to the facility on [DATE] with diagnoses that included stroke, Type 2 Diabetes, muscle weakness, and acquired absence of right and left leg above the knee. R19's Annual Minimum Data Set (MDS) assessment dated [DATE] documents R19 is severely cognitively impaired. R19 is independent for rolling left and right. R19 is dependent for toileting, bathing and transfers. R19's Falls Care Area assessment dated [DATE] documents, in part: Resident is at risk for falls. Resident has bilateral amputation to legs. Resident uses Hoyer for transfers. Resident receives antidepressant, antianxiety, anticoagulant, opioids and antiplatelet medications. Staff to monitor for side effects of medication. On 4/7/25 at 10:33 AM, Surveyor interviewed R19. Surveyor asked if R19 had experienced any recent falls. R19 stated that R19 did have a fall from R19's bed and R19 had to go to the hospital. R19 stated that R19 suffered a head and knee injury as a result of the fall. Surveyor asked for more details regarding the fall and R19 stated that R19 could not remember much more than rolling out of bed. R19's Fall risk care plan initiated on 12/21/2021, documents the following pertinent interventions: Bed in low position, fall mat next to bed, and health teaching regarding changing positions slowly. R19's Fall Risk Evaluation dated 12/28/23, documents R19 is at risk for falls. R19's Annual MDS assessment dated [DATE], documents that R19 is cognitively intact. R19 is dependent for toileting, bathing and transfers. R19 has not had any falls since admission/entry or reentry or the prior assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R19's Falls Care Area assessment dated [DATE] documents, in part: [R19] is at risk for falls related to medication use including opioid and psychotropics. [Diagnosis history] including [stroke], [both side lower extremity] amputation, obesity, [chronic obstructive pulmonary disease], [Osteoarthritis]. R19's progress note dated 7/21/24 at 9:42 PM documents: Writer called to room around [2:58 PM]. alerted by [Certified Nursing Assistant (CNA)] that patient had rolled out of bed. Writer called to room, upon walking in room, patient on floor with aide bed was in a high position, writer asked patient what happen, patient stated I was lying on side and rolled to floor, I am in a lot of pain. Writer assessed patient vitals T98.9, R22, B/P 144/80, P77. Writer called [Doctor]on call and was given ok to send patient to ER for evaluation and treatment. Writer called [Director of Nursing (DON)] and updated DON as well. Surveyor noted that facility staff documented that the bed was in a high position and not low according to R19's plan of care. Surveyor reviewed R19's Risk Management Fall investigation dated 7/21/24 which documents, in part: Writer called to resident's room. Patient on floor on side. Writer was told by CNA that cares was being performed and patient rolled to the floor. Resident description, I was lying on my side while they performed cares and just rolled to floor. I don't know what happened. Was this incident witnessed. Yes . Statements: [CNA-X, CNA-Y and R19] . Root cause: [R19] is bilateral amputee, [R19's] left stump was crossed over to give proper hygiene of peri cares. It is possible that crossing [R19's] stump may have made her roll toward the door. 5 Whys: Why 1-rolled out of bed. Why 2- did not want bolsters inflated. Why 3- didn't feel [R19] needed them. Why 4- feels safe in bed. Why 5- bilateral amputee and needs assist with rolling from staff and uses enabler bar. Intervention: [R19] has agreed to inflate bolsters to enhance bed boundaries when in bed . Surveyor noted that witness statements were not included in the fall investigation documentation. Surveyor noted that the investigation did not include that the bed was at a high height. Surveyor noted that there is no further documentation of where the aide/aides were located when R19 fell. Surveyor noted that the fall was not thoroughly investigated in order to come up with an accurate root cause. R19's Post Fall evaluation dated 7/30/24 documents, in part: Who witnessed fall? [CNA-X and CNA-Y]. Location of fall? Resident's room. Activity at the time of fall? On [R19] side to get cleaned up. Was the reason for the fall evident? No . Did ER visit/hospitalization occur as a result of the fall? Yes . Floor mat on floor? No. Surveyor noted that facility staff documented that a fall mat was not in place at the time of R19's fall according to R19's plan of care. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/14/25 at 11:14 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-W. LPN-W was the nurse who was called into R19's room after R19's fall. LPN-W stated that 2 aides were completing cares. LPN-W stated that an aide told LPN-W that the aides turned R19 on R19's side and R19 tried to grab one of the CNAs that R19 was leaning on. R19 slipped out of bed. LPN-W stated that LPN-W assessed R19 on the floor. LPN-W took vitals, did not move R19 because R19 was complaining of pain. LPN-W let the Director of Nursing know what happened and informed R19's provider who ordered that R19 be to the hospital. LPN-W stated that LPN-W put a pillow under R19's head and waited for paramedics to arrive. Surveyor asked if neurological-checks were completed. LPN-W did not remember doing neurological-checks. Surveyor asked where R19's pain was. LPN-W stated that R19 was complaining of pain everywhere. Surveyor asked if a fall mat was on the floor. LPN-W stated I don't think so. Surveyor asked what height the bed was at. LPN-W stated, It wasn't low, I know that. Surveyor asked if R19 had bolsters on R19's bed prior to this fall. LPN-W stated I don't think so. LPN-W continued and stated that R19's bed was weird, and LPN-W stated that LPN-W did not feel like it was safe. LPN-W told management about the concerns but R19 liked the bed how R19 had it, so nothing was changed. Surveyor asked if any education was completed with staff after this fall. LPN-W stated LPN-W can't remember and didn't know. Surveyor noted that both aides, CNA-X and CNA-Y, that witnessed R19's fall are no longer employed by the facility. Surveyor attempted to reach both CNA-X and CNA-Y by telephone but was unsuccessful. In addition, Surveyor attempted to reach any other staff member that was on the PM shift on the day the fall occurred. On 4/14/25 at 11:42, Surveyor spoke to CNA-O who did not have any information on R19's fall. CNA-O stated that CNA-O did not hear anything about R19 having a fall that occurred with CNAs as witnesses. R19's ED physician note dated 7/21/25 documents, in part: . [R19] presenting to the ED for evaluation after a fall. [R19] notes an aide was doing cares on [R19] and the other aide left the room to get more supplies. [R19] is unsure if the aide in the room touched [R19] wrong, but [R19] slid out of [R19's] bed, noting that this has happened before when laying on [R19's] right side. Since [R19's] fall, [R19] feels like where her knees and toes would be are in pain and burning. [R19] also notes the back of [R19's] head and hips are in pain. [R19] denies being in pain before falling . CT of head without evidence of bleed . There are no acute traumatic injuries found on secondary survey or imaging . Diagnosis: Closed head injury . Surveyor noted the ED note documented that R19 informed the ED physician that 2 aides were in the room, but one aide left to get supplies and that is when R19 fell. Surveyor noted that this was not included in the facility investigation. Surveyor noted that R19 complained of head pain. R19's Emergency Department (ED) Patient Summary dated 7/21/24 documents, in part: Diagnosis from today's visit: Closed head injury . Fall . You have a head injury. It doesn't appear serious at this time. But symptoms of a more serious problem, such as a mild brain injury (concussion) or bruising or bleeding pin the brain, may appear later . R19's progress note dated 7/22/25 at 9:50 AM documents: resident returned from ER with noted head injury but stated it doesn't appear serious at this time. writer will update [Doctor]. R19's Family Practice outpatient clinic note dated 7/24/24 documents, in part: ED follow up . Chief complaint-fall from bed at skilled nursing facility. Reporting phantom pain to bilateral knees and toes, posterior head and bilateral hips . Diagnosis- closed head injury . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted multiple documents that indicate that R19 suffered a closed head injury as a result of R19's fall. Surveyor reviewed R19 electronic medical record for documentation of completed Neurological checks after R19's fall and diagnosis of a closed head injury. No neurological check documentation was found. Surveyor reviewed R19's vital signs tab within R19's medical record and noted that BP, pulse, and oxygen saturation are not documented as being completed from 7/18/24 through 7/30/24. These vital signs are typically completed with Neurological checks. Cross reference F684 citation. Surveyor reviewed R19's electronic medical record for IDT note documentation regarding R19's fall. No IDT [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility did not ensure sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility had low staffing on the evening (PM) shift on 4/2/25, while having a census of 30 residents. 2 Certified Nursing Assistants (CNA)s called in on the PM shift on 4/2/25 which left 1 Licensed Practical Nurse (LPN) alone for a census of 30 residents. The facility has made recent staffing changes at the end of March 2025, that allow one dietary staff member on the PM shift, 2.5 Certified Nursing Assistants (CNA)s on the days shift, and 1.5 CNAs on the night shift. This change in staffing puts 1 CNA from 10:00 PM until 2:00 AM with a census of 30 residents. The facility has 12 residents that require a Hoyer lift and 6 residents that require two staff members for assistance. Findings include: Surveyor reviewed the Facility Assessment, last reviewed by the facility on 4/3/25, and 1/13/25, which documents the following General Staffing Plan: Dietary Cooks 1-2 Dietary Aides 2-4 Hands on Registered Nurse (RN) 1-3 Hands on LPN 1-3 Hands on CNA 6-7 Surveyor reviewed facility staff schedules, dated 3/1/25 - 4/14/25. Surveyor notes the following concerns: *3/13/25 - No RN on the schedule with 1 med tech working the day shift *3/28/25 - No RN on the schedule with 1 med tech working the PM shift *4/2/25 - 2 CNAs called in on the PM shift which left 1 LPN alone for 30 residents *Surveyor notes DON- B and/or Assistant Director of Nursing (ADON)- F working as a floor nurse. This occurred 25 out of 41 days reviewed. Surveyor reviewed a facility summary of a list of residents and the level of acuity which includes bed mobility, transfer requirements, assistive devices requirements, toileting needs, safety precautions, diet/fluid orders, and special instructions. Surveyor notes the following requirements for residents: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Transferring: 12 residents require a Hoyer lift 6 residents require 2 person assistance 4 residents require 1 person assistance 8 residents are independent *Dietary Orders/Needs: 2 residents require a pureed diet 6 residents require a mechanical soft diet 2 residents require a staff member to feed them 2 residents require a staff member to cue them to eat 1 resident requires a staff member to set up their meal tray and cut/prepare food for eating. *Code Status: 22 residents have elected a full code status which requires at least 2 staff members to administer Basic Life Support (BLS) *Safety/Special Precautions: 3 residents are at risk for elopement 10 residents are at risk for falling 14 residents are incontinent of urine and/or bowels 4 residents require a bed pan for assistance with toileting (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/3/25, at 8:34 AM, Surveyor interviewed Scheduler- Q who states she was notified by facility management to make staffing changes at the end of March. Scheduler- Q states the facility was previously staffing 2-3 CNAs on the night shift prior to the staffing changes and now she is to schedule 1 CNA on the night shift. Scheduler- Q states a CNA is scheduled a split shift (2:00 AM - 10:00AM) to help the CNA on the night shift and assist with getting residents out of bed in the morning on day shift. Surveyor asked Scheduler- Q how many CNAs work on night shift and Scheduler- Q responded 1.5 CNAs. Scheduler- Q then states there is only 1 CNA from 10:00 PM until 2:00 AM. Scheduler- Q was unable to provide the exact date she was instructed to make staffing changes, however Surveyor notes staffing changes are reflected on the 3/25/25 schedule. Scheduler- Q states she was notified to make these schedule changes due to overstaffing and the facility having a census of 30 residents. Surveyor asked how the facility handles staff call ins. Scheduler- Q states staff have been picking up shifts or staying late. Scheduler- Q states she has not had any staff call in on the night shift since the scheduling changes has happened and then knocked on the table. Scheduler- Q indicates staff are unhappy about the scheduling changes and she has brought their concerns to management. Scheduler- Q states the facility does not use agency staff. On 4/3/25, at 8:59 AM, Surveyor observed the Director of Nursing (DON)- B passing morning medications and working as a floor nurse. On 4/3/25, at 9:40 AM, Surveyor interviewed Dietary Director- R who states she was instructed by facility management to make staffing changes. Dietary Director- R states she would staff 1 cook and 2 dietary aides for day shift and PM shift prior to the scheduling changes. Dietary Director- R states she was notified to make scheduling changes and only schedule 1 cook and 1 dietary aide on day shift, and 1 cook and 0 dietary aides on PM shift. Dietary Director- R states it's not working out well since the new scheduling changes and she has been working as the cook and the cook has been working as the dietary aide. Dietary Director- R indicates eating times have been pushed back due to staffing changes. Dietary Director- R states breakfast was served 20 minutes late today on 4/3/25 due to staffing changes. Dietary Director- R states she has reported staffing concerns to facility management. Dietary Director- R states she was notified to make staffing changes due to having a census of 30 residents and the facility not accepting new residents. Cook- S entered the conversation and states she has been working as a dietary aide which is all new to her. Dietary Director- R indicates staff will come in early and work off the clock to help prepare for their shift. On 4/3/25, at 11:42 AM, Surveyor interviewed Scheduler- Q who states she remembers the staffing changes happened last week, but the staffing changes have been brewing for the last couple of weeks. Surveyor asked Scheduler- Q about the schedule on 4/2/25. Scheduler- Q states the 2 CNAs scheduled on the PM shift called in, which left 1 nurse by themselves in the facility for about 2 hours, with a census of 30 residents. Scheduler- Q states the 2 CNAs planned on calling in due to being upset about the recent staffing changes and were notifying other staff members that they were going to call in. Scheduler- Q states it will happen again, and they are putting residents at risk by doing this. On 4/3/25, at 1:22 PM, Surveyor interviewed Ombudsman- T who states she makes frequent visits to the facility and recently attended Resident Council in March 2025. Ombudsman- T states she also plans to attend Resident Council in April 2025. Ombudsman- T states a staff member had approached her with staffing concerns and Ombudsman- T had directed that staff member to contact the State Agency. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/3/25, at 2:23 PM, Surveyor interviewed Nursing Home Administrator (NHA)- A and DON- B who indicate nursing staff are required to hold a current BLS certification and CNAs are not required. Surveyor expressed concerns with the facility staffing one nurse at times, and not having a second nurse or staff member who is BLS certified to perform BLS appropriately if a resident is noted to be unresponsive and has elected a full code status. On 4/3/25, at 4:04 PM, Surveyor notified NHA- A and DON- B of staffing concerns listed above. NHA- A and DON- B acknowledged these concerns. On 4/9/25, at 12:33 PM, Surveyor interviewed Medication Technician (MT)- L. MT- L stated the facility is short staffed, and staff are stretched to the max. MT- L indicated staff have to rush through assessments and cares because there is not enough time to do everything. MT- L stated MT- L believes things are missed because of low staffing levels. MT- L stated MT- L has expressed concerns to management, but the staffing has only gotten worse the last month and a half. MT- L stated they can not care for the elderly the way they deserve because they do not have the time to do it. On 4/10/25, at 10:14 AM, Surveyor interviewed DON- B. DON- B informed Surveyor that Surveyor is not getting a full picture of what is going on with a resident because of lack of documentation. DON- B indicated CNAs are not charting as they should. DON- B showed Surveyor DON- B's computer screen with a dashboard. DON-B pointed to an area on the screen that indicates how much of the CNA charting is being completed. Surveyor noted CNAs are not fully completing their charting within the medical record. DON-B stated CNAs are not charting because it is their way of rebelling against a recent change in staffing numbers. CNAs are upset staffing numbers are lower and are not charting because of it. On 4/14/25 at 1:04 PM, Surveyor interviewed CNA- O. CNA- O stated CNA- O has concerns with staffing. CNA- O stated the facility has decreased staffing to a skeleton crew. CNA- O stated there is a resident that requires cares in pairs. CNA- O indicated at times it is impossible to follow this resident's care plan because there is not enough staff. CNA- O indicated the staffing levels are not safe for proper resident care. On 4/10/25, at 1:24 PM, Surveyor interviewed DON- B and ADON- F who state they never use to work the floor and now they are scheduled to work the floor all the time since the recent scheduling changes. DON- B indicate the facility has enough staff and staff use to pick up shifts to cover scheduling needs. DON- B and ADON- F state staff are no longer picking up shifts to cover scheduling needs which is why DON- B and ADON- F are now being added to the schedule to work the floor to cover shifts. DON- B states staff are not picking up shifts because they are upset with the recent scheduling changes. Surveyor expressed staffing concerns as listed above. DON- B and ADON- F both acknowledged staffing concerns.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure adequate monitoring for adverse reactions of high-risk medications for 3 (R4, R19, & R27) of 6 residents reviewed for unnecessary medications. *R4 has a physician's order for Eliquis (an anticoagulant) for chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity. The facility did not implement medication monitoring for any adverse side effects that could result from taking an anticoagulant. *R19 has a physician's order for Eliquis (an anticoagulant) for cerebral infarction. The facility did not implement medication monitoring for any adverse side effects that could result from taking an anticoagulant. *R27 has a physician's order for Eliquis (an anticoagulant) for cerebral infarction. implement medication monitoring for any adverse side effects that could result from taking an anticoagulant. Findings include: 1.) R4 was admitted to the facility on [DATE] with diagnoses including hemiparesis (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles.) acute embolism (A sudden blockage in a blood vessel caused by a foreign substance, often a blood clot.) and congestive heart failure (A sudden condition in which the heart doesn't pump blood as well as it should). R4's Quarterly MDS (Minimum Data Set) Assessment with an assessment reference date of 1/2/2025 indicates R4 received an Anticoagulant medication during the assessment period. Surveyor reviewed R4's electronic medical record and could not locate a person-centered care plan addressing the need to monitor for adverse side effects related to the use of an anticoagulant. R4's medical record was reviewed including physician orders, MARs (Medication Administration Records) TARs (Treatment Administration Records) and comprehensive care plans. R4's physicians orders document the following: . 6/14/22 .Eliquis Tablet (Apixaban), Give 2.5 mg (milligrams) by mouth two times a day related to ACUTE EMBOLISM . Surveyor noted R4 has been receiving Eliquis (an anticoagulant medication) on a scheduled basis since June 2017. Surveyor reviewed R4's comprehensive care plan. R4's comprehensive care plan with an initiation date of 6/5/17 documents the following: At risk for complications related to anticoagulant or antiplatelet medication due to: Risk or Actual Deep Vein Thrombosis. On Eliquis d/t (due to) hx (history) of DVT (Deep Vein Thrombosis). R4's care plan interventions include the following: . Monitor medication regimen for medications which increase effects, Observe for adverse reaction: fever, skin lesions, anorexia, nausea, vomiting, cramps, diarrhea, hemorrhage, hemoptysis .Observe for S/S (signs/symptoms) of bleeding i.e. tarry stools, blood in urine, bruising, petechiae . Surveyor reviewed R4's MARs and TARs for November 2024-April 2025. Surveyor was unable to located any medication monitoring related to R4's use of the anticoagulant medication Eliquis. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	430 Wilcox St Fort Atkinson, WI 53538

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25, at 10:10 AM, Surveyor conducted interview with Director of Nursing (DON)-B. Surveyor asked DON-B how often a resident receiving anticoagulant therapy such as Eliquis, should be monitored for medication side effects or adverse reactions. DON-B responded residents receiving anticoagulants should be monitored for side effects every shift by nursing staff. On 4/14/25, at 11:15 AM, Surveyor informed Nursing Home Administrator-A and DON-B that Surveyor was unable to locate any medication monitoring for R4's use of Eliquis, an anticoagulant medication, in their medical record. No additional information was provided by facility at this time. 2.) R19 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (A type of stroke caused by a blockage in the brain's blood vessels, leading to a lack of blood flow and oxygen to the brain tissue.), Peripheral Vascular Disease (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs.) and history of DVT (Deep Vein Thrombosis)(A condition where a blood clot forms in a deep vein, usually in the leg but sometimes in the arm.) R19's Quarterly MDS (Minimum Data Set) Assessment with an assessment reference date of 12/23/2024 indicates that R19 received an Anticoagulant medication during the assessment period. R19's medical record was reviewed including physician orders, MARs (Medication Administration Record), TARs (Treatment Administration Record) and comprehensive care plans. R19's physicians orders document the following: . 3/17/23 .Eliquis Tablet (Apixaban), Give 5 mg (milligrams) by mouth two times a day related to history of CVA (Cerebrovascular accident) . Surveyor noted R19 has been receiving Eliquis on a scheduled basis since March 2023. Surveyor reviewed R19's comprehensive care plan. R19's comprehensive care plan with an initiation date of 1/21/22 documents the following: At risk for complications related to anticoagulant or antiplatelet medication due to: History of CVA . R19's care plan interventions include the following: . Monitor medication regimen for medications which increase effects, Observe for adverse reaction: fever, skin lesions, anorexia, nausea, vomiting, cramps, diarrhea, hemorrhage, hemoptysis .Observe for S/S (signs/symptoms) of bleeding i.e. tarry stools, blood in urine, bruising, petechiae . Surveyor reviewed R19's MARs and TARs for November 2024-April 2025. Surveyor was unable to locate any medication monitoring related to R4's use of the anticoagulant medication Eliquis. On 4/14/25, at 10:10 AM, Surveyor conducted interview with Director of Nursing (DON)-B. Surveyor asked DON-B how often a resident receiving anticoagulant therapy such as Eliquis, should be monitored for medication side effects or adverse reactions. DON-B responded that residents receiving anticoagulants should be monitored for side effects every shift by nursing staff. On 4/14/25, at 11:15 AM, Surveyor informed Nursing Home Administrator-A and DON-B that Surveyor was unable to locate any medication monitoring for R19's use of Eliquis, an anticoagulant medication, in their medical record. No additional information was provided by facility at this time. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) R27 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (A sudden condition in which the heart doesn't pump blood as well as it should). R27's Annual MDS (Minimum Data Set) Assessment with an assessment reference date of 2/14/2025 indicates R9 received an Anticoagulant medication during the assessment period. R27's medical record was reviewed including physician orders, MARs (Medication Administration Records) TARs (Treatment Administration Records) and comprehensive care plans. R27's physicians orders document the following: . 6/26/24 .Eliquis Tablet (Apixaban), Give 2.5 mg (milligrams) by mouth two times a day related to heart failure . Surveyor noted R27 has been receiving Eliquis (an anticoagulant medication) on a scheduled basis since June 2024. Surveyor reviewed R27's comprehensive care plan. R4's comprehensive care plan with an initiation date of 6/5/2017 and a revision date of 6/4/2024 documents the following: At risk for complications related to anticoagulant or antiplatelet medication due to: heart failure R27's care plan interventions include the following: . Monitor medication regimen for medications which increase effects, Observe for adverse reaction: fever, skin lesions, anorexia, nausea, vomiting, cramps, diarrhea, hemorrhage, hemoptysis . Observe for S/S (signs/symptoms) of bleeding i.e. tarry stools, blood in urine, bruising, petechiae . Surveyor reviewed R27's MARs and TARs for November 2024-April 2025. Surveyor was unable to located any medication monitoring related to R27's use of the anticoagulant medication Eliquis. On 4/14/25, at 10:10 AM, Surveyor conducted interview with Director of Nursing (DON)-B. Surveyor asked DON-B how often a resident receiving anticoagulant therapy such as Eliquis, should be monitored for medication side effects or adverse reactions. DON-B responded that residents receiving anticoagulants should be monitored for side effects every shift by nursing staff. On 4/14/25, at 11:15 AM, Surveyor informed Nursing Home Administrator-A and DON-B that Surveyor was unable to locate any medication monitoring for R27's use of Eliquis, an anticoagulant medication, in their medical record. No additional information was provided by facility at this time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R25) of 6 residents reviewed for medications were free from unnecessary psychotropic medications. *R25 was admitted to the facility with a diagnosis of Major Depressive Disorder and was actively taking psychotropic medication, Fluoxetine, as treatment. R25 did not have a care plan addressing R25's depression or psychotropic medication use. R25 did not have side effect monitoring for Fluoxetine in place. Findings include: The facility policy, dated 10/1/2022, titled, Behavioral Health Services documents, in part: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the residents dignity, autonomy, privacy, socialization, independence, choice, and safety. the facility utilizes the comprehensive assessment process for identifying and assessing a residence mental and psychosocial status and providing person centered care period this process includes, but is not limited to: . Ongoing monitoring of mood and behavior. Care plan development and implementation. Evaluation .The resident, and as appropriate the resident's family, are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall: Have interventions that are person-centered, evidence based, culturally competent, trauma-informed, and in accordance with professional standards of practice. Provide for meaningful activities which promote engagement and positive, meaningful relationships . Reflect the resident's goals for care. Account for the resident's experiences and preferences . Use pharmacological interventions only when non-pharmacological interventions are ineffective or when clinically indicated. Be reviewed and revised as needed, such as when interventions are not effective or when the resident experiences a change in condition . examples of individualized, non-pharmacological interventions to help meet behavioral health needs of all ages may include, but are not limited to: ensuring adequate hydration and nutrition (e.g., enhance taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite); . Pain relief . Assisting residents with access to therapies such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem solving therapy . The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologist. R25 was admitted to the facility on [DATE] with diagnosis that include: Major Depressive Disorder (A mental disorder characterized by persistent feelings of sadness, loss of interest or pleasure in activities, and other symptoms that significantly impair daily functioning). R25's admission Minimum Data Set (MDS) assessment dated [DATE] documents R25 is cognitively intact. R25 displays verbal behavioral symptoms directed toward others 4-6 days in a 7-day period. R25 demonstrates rejections care 1 to 3 days in a 7-day period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's physician order, with a start date of 3/4/25, documents: Fluoxetine HCl Oral Tablet 10 [Milligram (MG)]. Give 1 tablet by mouth one time a day for depression related to Major Depressive Disorder. Surveyor reviewed R25's medical record for a care plan regarding R25's psychotropic medication use and depression. A care plan was not located. Surveyor reviewed R25's medical record for documentation indicating facility staff are monitoring for side effects that are common with taking psychotropic medication. Documentation regarding side effect monitoring was not located. On 4/9/25, at 9:13 AM, Surveyor interviewed Registered Nurse (RN)-P. Surveyor asked if a resident who has a diagnosis of depression and is prescribed medication to treat their depression should have a psychotropic medication care plan. RN-P indicated RN-P would presume the resident would have a care plan. Surveyor asked how side effects of psychotropic medications are monitored. RN-P stated they are monitored on the Treatment Administration Record. RN-P stated if a resident has depression, RN-P would look for an increase in behaviors or increased isolation. On 4/9/25, at 12:05 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-V. Surveyor asked if a resident who has a diagnosis of depression should have an Antipsychotic medication care plan. LPN-V stated yes. LPN-V stated that nurses have to chart on the side effects of a medication like that as well. LPN-V stated that if a resident who has depression has a noted change, LPN-V would document that and let the provider know. On 4/10/25, at 9:30 AM, Surveyor interviewed Social Worker (SW)-D. Surveyor asked who is supposed to put a care plan in place for residents who are prescribed psychotropic medication to treat depression. SW-D stated the previous MDS coordinator would typically, but they no longer work for the facility. SW-D stated the nurse would enter the care plan. Surveyor asked if SW-D should be entering a depression care plan. SW-D stated SW-D has not played a part in that since being in the Social Work role. Surveyor asked if R25 should have a care plan addressing her depression and psychotropic medication use. SW-D stated yes. On 4/10/25, at 10:14 AM, Surveyor interviewed DON-B. Surveyor asked who is supposed to put a care plan in place for residents who are receiving psychotropic medication to treat depression. DON-B stated Social Services. Surveyor asked if R25 should have a care plan for R25's diagnosed depression. DON-B stated yes. Surveyor asked if DON-B could locate a depression care plan for R25. DON-B stated DON-B thought R25 had one but did not locate one within the medical record. Surveyor asked if R25 had documentation within the medical record that indicated staff were monitoring side effects of R25's psychotropic medication. DON-B looked and was unable to locate side effect monitoring. Surveyor noted the discrepancy between SW-D and DON-B's understanding of who is supposed to place a care plan addressing the use of psychotropic medication and depression symptoms. On 4/14/25, at 1:04 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern R25 had a diagnosis of Major Depressive Disorder and facility staff did not implement a care plan to address R25's use of psychotropic medication. R25 did not have documentation that side effect monitoring was being completed by facility staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not implement an effective Infection Prevention and Control Program (IPCP). This has the potential to effect all 30 residents in the facility. The facility did not ensure medication was administered in a sanitary manner. This was observed with 1 (R29) of 1 resident receiving eye medication. * The IPCP did not have documentation of an effective water management program (WMP) to prevent the spread of Legionella. * The facility did not have documentation of identifying infections and completing corrective actions to prevent their spread. * The facility did not utilize preventative potential infection measures when administering eye medications to R29. Findings include: The facility's policy and procedure titled, Infection Prevention and Control Program, dated 10/2/22, was reviewed. The Policy documents: This facility has established and maintains an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Expectations and Compliance Guidelines: 1. The designated Infection Preventionist (IP) is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2. All staff are responsible for following all policies and procedures related to the program. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The IP serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.; . 16. Water Management: a. A water management program has been established as part of the overall infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The Maintenance Director serves as the leader of the water management program. The facility's policy and procedures titled, Water Management Program, dated 10/1/22, was reviewed. The policy documents: It is the policy of this facility to establish water management plans for reducing the risk of Legionella and other opportunistic pathogens . in the facility's water systems based on nationally accepted standards.; Policy Explanation and Compliance Guidelines: 1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. 2. The Maintenance Director maintains documentation that describes the facility's water system. 8. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible. 13. In the event of an update to the water management program, the water management team shall: a. Update the water system schematic/description, associated control points, control limits, and any pre-determined corrective actions. b. Train those responsible for implementing and monitoring the updated program. 14. Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of 3 years. Findings include: 1. On 4/08/25, at 8:22 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated the Director of Nurses (DON)-B is the current Infection Preventionist (IP) for the facility. Surveyor requested Infection Prevention and Control Program (IPCP) documents to review. This included the facility water management plan (WMP). The Facility Assessment was reviewed. This has a revision date of 1/13/25. The IP position is not listed for involvement in the facility assessment. The assessment documents the IPCP is maintained by the Director of Nurses or designee. Surveyor reviewed the facility WMP. The WMP is dated 8/14/24. The WMP team identifies a previous Maintenance Director and a previous Nursing Home Administrator as part of the team. These previous staff are listed as contacts. The WMP team does not include an Infection Preventionist. The WMP was not updated to identify current responsible team members. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The WMP includes a risk assessment with control measures. The control measures document they were verified by a previous Maintenance Director and Nursing Home Administrator. The verification section documents: as digitally signed, and verified, by previous members. The WMP does not contain documentation, of verified control measures, with current staff. On 4/9/25, at 10:25 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A started at the facility on 2/25/25. DON-B started on 1/14/25 and has been in the IP role as well. NHA-A was not aware the documentation in the WMP, and the facility assessment, does not include an IP. On 4/09/25, at 11:04 AM, Surveyor interviewed DON-B and Assistant Director of Nurses (ADON)-F. DON-B stated she has not had time to complete infection control training. DON-B stated this has been due to working on the Statement of Deficiencies from January, and State being in the facility all the time. ADON-F is still in training for the IP position. DON-B stated they discuss water in the Quality Assurance (QA) meetings and they have not been involved in the WMP assessment. On 4/10/25, at 10:13 AM, Surveyor interviewed Director of Maintenance (DOM)-N and NHA-A. DOM-N has been in this position for 9-10 months. DOM-N stated they share results with the current NHA-A. DOM-N stated they do weekly water testing per a wing. Each week is a different wing. They run the faucets, flush toilets and run shower heads. The water is run every 4 days for at least 5-6 minutes. They oil the ice machine coils and change the filters every 3 months. They test the chlorine in the water every week. They take temperatures at the water heaters and flow areas. DOM-N stated they do not retain documentation of the chlorine testing and water temperatures. SURVEILLANCE The facility's October 2024 Infection Surveillance Monthly Report documents: - 3 skin conditions, with 1 antifungal and 2 with antibiotics. - 4 unitary tract infections with no organism. - 4 other infection with no identification, or type or organism, documented. Surveyor notes the document does not include the definitions for treating infections. There is not an infectious organism identified. There is no corrective actions documented related to identified infections in the facility. The November 2024 Infection Surveillance Monthly Report documents: - 7 urinary tract infections with no organism. - 2 pneumonia listed. - 3 skin conditions, with 2 antifungal and 1 antibiotic. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor note the document does not include the definitions for treating infections. There is not an infectious organism identified. There is no corrective actions documented related to identified infections in the facility. The December 2024 Infection Surveillance Monthly Report documents: - 2 eye infections. - 6 skin conditions, with 5 antifungal and 1 antibiotic. - 6 urinary tract infections with 1 cystitis and no organisms. - 1 other, with no identification and organism. Surveyor note the document does not include the definitions for treating infections. There is not an infectious organism identified. There is no corrective actions documented related to identified infections in the facility. On 4/10/25, at 11:26 AM, Surveyor interviewed [NAME] President of Clinical Services (VPCS) - J and DON-B. DON-B is currently covering the IP role. DON-B started in the facility January 2025. VPCS-J reviewed the October 2024, November 2024 and December 2024 surveillance Monthly Reports with Surveyor. VPCS-J stated the December other was for training purposes and not real. VPCS-J stated there is a infection screener form that is not attached to the logs. VPCS-J did not know what the October other infections were. VPCS-J stated they will look for supporting criteria and education for corrective actions. VPCS-J stated the facility uses McGeer's for definitions of infections. On 4/14/25, at 3:00 PM, during the exit meeting with NHA-A and DON-B, Surveyor shared concerns the facility IPCP. The facility did not have an accurate and comprehensive water management plan. The facility did not implement an effective surveillance program to prevent, and identify, infections in the facility. *On 4/10/2025, at 8:15 AM, Surveyor observed Director of Nursing (DON)-B conducting morning medication pass. On 4/10/2025 Surveyor observed DON-B administer R29's morning medications. Surveyor observed DON-B performing hand hygiene with an alcohol based hand sanitizer and administer R29's scheduled artificial tear eye drops. Surveyor did not observe DON-B donning gloves prior to administering R29's artificial tear eye drops. On 4/14/2025, at 10:10 AM, Surveyor conducted interview with DON-B. Surveyor asked DON-B what the proper protocol would be for administering a resident's eye drops. DON-B told Surveyor nurses should perform hand hygiene, don gloves, administer eye drops per physician order then perform hand hygiene again. On 4/14/2025, at 11:15 AM, Surveyor shared concern with Nursing Home Administrator (NHA)-A that on 4/10/2025, Surveyor observed DON-B administering R29's scheduled eye drops without donning gloves. No additional information was provided at this time.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on record review and interview, the facility not have a designated, and qualified Infection Preventionist (IP), responsible for the facility's Infection Prevention and Control Program (IPCP). This has the potential to affect all 30 residents in the facility. The Facility Assessment does not include the role of the Infection Preventionist. The Director of Nurses (DON)-B has not completed training in infection prevention and control. The facility's policy and procedure titled, Infection Preventionist, dated 10/1/22, was reviewed. The policy documents: The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.; Policy Explanation and Compliance Guidelines: 2. The facility will ensure the IP is qualified by education, training, experience or certification. 4. The IP will have the knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities. 6. The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for it's IPCP (Infection Prevention and Control Program). Designated IP hours per week may vary based on the facility and it's resident population. 7. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as Quality Assessment and Assurance (QAA) 8. The IP will physically work onsite in the facility. 9. The IP must be sufficiently trained in infection prevention and control. 10. The IP must have obtained specialized infection prevention and control (IPC) training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation. 11. The IP reports to the Director of Nursing. Findings include: 1. On 4/08/25, at 8:22 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated the Director of Nurses (DON)-B is the current IP for the facility. Surveyor requested IPCP documents to review. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility Assessment was reviewed. The Facility Assessment has a revision date of 1/13/25. The IP position is not listed for involvement in the facility assessment. The assessment documents the IPCP is maintained by the Director of Nurses or designee. It does not identify the role for a Infection Preventionist (IP). The IP role is not included in the facility staffing hours. On 4/09/25, at 10:42 AM, Surveyor interviewed NHA-A. NHA-A started at the facility 2/25/25 and the DON-B started 1/14/25. NHA-A stated DON-B, and Assistant Director of Nursing (ADON)-F, are working on their infection control certification. NHA-A did not know why the IP was not included in the facility assessment, including hours and the position. On 4/09/25, at 11:04 AM, Surveyor interviewed DON-B and ADON-F. DON-B stated she has not had time to complete infection control training. DON-B stated this has been due to working on the Statement of Deficiencies from January, and State being in the facility all the time. ADON-F is still in training for the IP position. Surveyor notes DON-B and ADON-F, do not have specialized infection control training. The facility does not have a designated, and qualified, IP for the IPCP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525262	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Atkinson Care Center	430 Wilcox St Fort Atkinson, WI 53538

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents immunizations were offered, or refused, as eligible. This was observed with 2 (R32 and R9) of 5 residents immunization record reviewed. * R32 did not have documentation of any pneumococcal vaccines. * R9 did not have documentation of the influenza vaccine 2024-2025 timeframe. Findings include: The facility's policy and procedure titled, Vaccine Information Statements, dated 3/1/2019 was reviewed. The policy documents: Prior to the administration of any vaccine, a copy of the most current, relevant Center for Disease Control (CDC) Vaccine Information Statement (VIS) will be provided to any child or adult receiving the vaccine or such information will be provided to the legal representative who has the authority to consent to the immunization of a minor child or incompetent adult.; Policy Explanation and Compliance Guidelines: 3. A notation will be made in each resident's medical record at the time vaccine information materials are provided indicating: 3.a. The edition date of the VIS provided, and; 3.b. The date the VIS was provided. The facility's policy and procedure titled, Influenza Vaccination, dated 3/1/2019, was reviewed. The policy documents: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza.; Policy Explanation and Compliance Guidelines: 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. 9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. The facility's policy and procedures titled, Pneumococcal Vaccine (Series), dated 3/1/2029, was reviewed. The policy documents: It is our policy to offer residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations.; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. 1. R32 was admitted [DATE] with diagnoses, including, type 2 diabetes mellitus (A condition in which the body has trouble controlling blood sugar and using it for energy), acute and subacute respiratory conditions (An illness affecting the airways and lungs.) due to chemicals, gases, fumes and vapors. R32 is under [AGE] year. There is no documentation of any pneumococcal vaccines. The Wisconsin Immunization Registry (WIR) does not have any pneumococcal vaccine administration on record. R32 would be eligible for the PCV15 (Pneumococcal Conjugate Vaccine), PCV20, or PCV21. If PCV15 was administered, they would be eligible after a year for the PCV23. On 4/08/25, at 8:22 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A. NHA-A stated Director of Nurses (DON)-B is performing the Infection Preventionist (IP) role at this time. Surveyor requested any information related to R32's vaccine administrations. On 4/08/25, at 12:44 PM Surveyor interviewed DON-B. DON-B stated they were not in the facility during this time and is still looking for things. Surveyor notes there was no documentation of R32 being offered pneumococcal vaccines in the facility. 2. R9 was admitted to the facility on [DATE] with diagnoses, including, severe morbid obesity, pneumonia (An infection that inflames the air sacs in one or both lungs). R9 is over [AGE] year. There is no documentation R9 was offered or administered the influenza vaccine for the 2024-2025 timeframe. There is no documentation of contraindications for administration in the medical record. On 4/08/25, at 8:22 AM, Surveyor interviewed the Nursing Home Administrator (NHA) -A. NHA-A stated Director of Nurses (DON)-B is performing the Infection Preventionist (IP) role at this time. Surveyor requested any information related to R9's vaccines administrations. On 4/08/25, at 12:44 PM Surveyor interviewed DON-B. DON-B stated they were not in the facility during this time and is still looking for things. There was no documentation of R9 being offered the influenza vaccine for the 2024-2025 timeframe.

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on observation, interview, and record review, the facility did not ensure a safe, and protected, area for smoking. This has the potential to effect all 5 (R30, R27, R29, R31 and R33) residents that smoke at the facility. The facility's designated smoking area is not protected from weather events. The area is adjacent to the facility parking lot, and a facility circle driveway that leads to the front entrance. Findings include: The facility's policy and procedure titled, Resident Smoking-Smoke Free Facility, dated 10/11/2022, was reviewed. The policy documents: It is the policy of this facility to provide a safe and healthy environment for residents, visitors and employees. A facility-wide Smoke Free Facility Policy was initiated on (unknown). This change did not affect facility residents who were smokers as of that date. Therefore, it is the policy of this facility to promote smoking cessation efforts while ensuring resident safety as related to residents who smoke. The Policy Explanation and Compliance Guidelines: 3. Safety measures for the designated smoking area will include, but not limited to: a. Protection from weather (i.e. covered). 1.) Surveyor reviewed the Resident Council Meeting minutes. The March 11, 2025 meeting was attended by 7 residents. The Resident Council Meeting minutes document residents were reminded to use the designated smoking area. The February 10, 2025 meeting was attended by 9 residents. The meeting minutes document the residents were reminded to use the designated smoking area. The January 6, 2025 meeting was attended by 9 residents. The meeting minutes document residents were reminded to use the designated smoking area. On 4/09/25, at 11:38 AM, Surveyor conducted a Resident Group meeting with R15, R11, R30, R18 and R27. These residents stated they attend Resident Council regularly. Surveyor queried the concern related to the designated smoking area. The residents stated the smoking residents will smoke under the entrance overhang instead of the designated smoking area. This due to the designated smoking area being uncovered and farther away. Surveyor noted R27 uses a wheelchair for mobility and smokes. R27 stated they can not go out to smoke when its raining. R30 and R18, stated residents will smoke in front of the entrance instead of the designated smoking area. On 4/10/25, at 8:06 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A stated he is not aware of the smoking area weather protection aspect for smoking on the premises. NHA-A stated they started working at the facility in February 2025. NHA-a was unable to provide additional information about the designated smoking area and why it isn't protected from the weather.