STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 21855 Based on observation and interview, the facility did not ensure the required posted information was displayed. This was observed in main areas and all 6 units, This had the potential to effect all 117 residents in the facility. The facility did not display the following information: -A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives. Findings include: 1.) On 03/14/24 at 11:34 AM Surveyor observed the main entrance and lobby area. There was no display of the required posting information. On 03/14/24 at 11:35 AM Surveyor observed the 200 unit. There was no display of the required posting information. On 3/14/24 at 11:37 AM Surveyor observed the 300 unit. There was no display of the required posting information. On 3/14/24 at 11:38 AM Surveyor observed the 400 unit. There was no display of the required posting information. On 03/14/24 at 11:41 AM Surveyor observed the 500 unit. There was no display of the required posting information. (continued on next page)

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

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

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	On 03/14/24 at 11:42 AM Surveyor observed the 600 unit. There was no display of the required posting information. On 03/14/24 at 11:43 AM Surveyor observed the 700 unit. There was no display of the required posting information. On 3/14/24 at 11:47 AM, Surveyor spoke with ANHA-C (Assistant Nursing Home Administrator), and Administrator-A, they were not aware postings of information were not displayed. They indicated the Ombudsman just dropped off posters, however the Ombudsman for the facility was not listed on the posters. The (Director of Nurses) DON-B came into the interview, and thought the postings were not up anywhere due to remodeling. Surveyor shared there are no postings in the facility lobby, or on all 6 units. The F-tag posting requirements were reviewed and Nursing Home Administrator-A indicated they will take care of it. Nursing HomeAdministrator-A is newer to the facility and thought the postings were displayed. On 3/14/24 at 12:27 PM, Nursing Home Administrator-A provided Surveyor with a sheet of paper for the required postings. The State Survey Agency information was not correct, there was no statement related to complaints, abuse, advanced directives, nor the right State Agency office listed. Nursing Home Administrator-A indicated they are working on it.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure that staff promptly consulted with a physician when 1 of 1 resident (R414) experienced a significant change in condition. R414 had unwitnessed falls on 10/27/23 and 10/29/23. After each fall, R414 experienced a significant change in condition with signs that are consistent with a head injury. Despite these changes, the Hospice nurse assigned to R414's case declined to send R414 to the emergency room for evaluation. The facility did not consult with the Hospice provider, R414's primary physician, or the Medical Director regarding R414's continued decline. R414 subsequently passed away. The facility's failure to promptly consult with the MD regarding R414's significant change in condition and for failing to get direction from the MD as to whether the resident should be sent out for further evaluation created a finding of immediate jeopardy that began on 10/27/23. Surveyor notified the Director of Nursing (DON)-B of the Immediate Jeopardy on 3/18/24 at 10:09 am. The immediate jeopardy was removed on 3/19/24. The deficient practice continues at a scope and severity of an E (potential for harm/pattern) as the facility continues to implement their action plan. Findings include: The facility's policy titled Change in Condition (Resident) dated 9/2020 states: Purpose: to ensure that the resident's physician/physician on call/Nurse Practitioner (NP) and responsible party is kept informed regarding the resident's change in condition. Policy: The attending physician or physician on call/NP and responsible party will be notified with changes in a resident's condition. Procedure: 1. Attending physicians or physicians on call/NP and responsible party will be notified of all changes in condition. 2. Follow framework for reporting changes in vital signs or laboratory values based on AMDA Guidelines. 3. Follow suggested guidelines for reporting clinical problems based on AMDA guidelines. 4. Document time of call, physician or NP or other person spoken to; reason for call and result or orders received. 5. Place call to responsible party to notify them of the resident's change in condition. R414 was admitted to the facility on [DATE] with diagnosis of dementia, depression, panic disorder, anxiety, a-fib, obstructive uropathy, urine retention, [NAME] syndrome, and failure to thrive. R414 was his own person at the time of admission. R414's Admission Minimum Data Set (MDS) assessment completed on 8/24/23 indicates a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R414 requires extensive assistance with one person and physical assistance with bed mobility, transferring, dressing, and toileting. R414 is not steady and is only able to stabilize himself with staff assistance while moving on and off the toilet. R414 has an indwelling urine catheter and is always continent of his bowels. R414's care plan indicates he is at high risk for falls related to limited mobility and impaired balance, dated 8/17/23. R414's Care Plan indicates R414 is at high risk for falls related to limited mobility and impaired balance dated 8/17/23. R414 was admitted to hospice due to Monoclonal Gammopathy (condition in which abnormal proteins are found in the blood.). R414's medical record indicates R414 had a prescreening for a possible discharge from hospice due to ineligibility on 10/17/23 as R414's health status was stable. On 3/18 /24 at 9:17 am, Surveyor interviewed Hospice Director of Social Work (SW)-P who indicated there was a pre-discussion of possible ineligibility for R414 due to showing improvement. The Hospice Director of Social Work-P stated a pre-discussion of hospice care takes place when recertification time is approaching. The Hospice Director of SW-P indicated once a resident is deemed ineligible for hospice, the hospice staff have 2 days to develop a plan of care for discharge. Hospice Director of SW-P indicated R414 had continued hospice care due to the change in condition after the unwitnessed falls. On 10/27/23 at 1730 (5:30 pm), the facility documentation indicates the CNA found R414 on the bathroom floor. R414 had an elevated blood pressure (BP) and was noted to have altered mentation; R414 was unable to convey where he was, day of the week, nor the month. R414's baseline orientation is fully oriented to person, place, time, and event. The facility charge nurse and Hospice were notified of the unwitnessed fall. R414 had an improvement with his vital signs and mentation after Hospice arrived at the facility at 6:45 pm. On 10/27/23 at 5:34 pm, the facility documentation indicates R414 was found lying on his back flat on the bathroom floor and R414 had hit his head. R414 had complaints of pain in his upper back between his shoulder blades, altered mentation, and high blood pressures and low pulse rates. R414 had a brown emesis while being transferred with a Hoyer lift back to his bed. Documentation states hospice was updated. Hospice instructed the facility to administer Zofran for vomiting. There is no evidence the facility and/or hospice staff identified vomiting as a sign/symptom of a head injury. The facility documentation indicates family was informed of R414 having a change in condition by the hospice staff. Facility documentation states the resident hit his head. There is no evidence this was relayed to the hospice staff or MD at the time of the change in condition and it is unclear if family was updated on R414 hitting his head along with symptoms of altered mentation. It is unclear if the power of attorney was given the option for R414 to seek evaluation for the significant change in condition that is unrelated to R414's hospice diagnosis. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed the hospice visit note from the hospice RN dated 10/27/23 at 6:45 pm. Documentation indicates R414 is fully oriented with pupils being equal and reactive to light. Documentation reports R414 denies hitting his head. R414 was provided Tylenol and reports his last bowel movement being 3 days ago. Hospice changed R414's MiraLAX from every other day to every day during this visit. Documentation indicates the MD on call and POA were notified of updates however, Surveyor notes there is no documentation indicating what was discussed with the MD at the time of the update from hospice staff. Surveyor notes R414 denying hitting his head however, R414 was noted to have altered mentation at the time of his fall and was unable to recall place and time while being evaluated. There is no evidence the facility increased monitoring of R414's bowel pattern or need for assistance with toileting. Neuro check documentation dated 10/28/23 at 3:47 am indicates R414 was having rambling speech with a weak right-hand grasp. This is not R414's baseline. There is no evidence that hospice or the MD were notified or consulted with regarding this significant change in condition with R414 having weak right-hand grasps and rambling speech. Facility documentation dated 10/28/23 at 9:58 am indicates the facility nurse notified hospice with a significant change in condition. R414 was feeling off, hands were shaky, he was lethargic, and he needed assistance with eating breakfast. R414 did not previously require assistance with eating. Documentation indicates R414 indicated to the nursing staff he hit his head and acknowledged he notified hospice on 10/27/23 that he did not hit his head. This was relayed to the hospice staff by the facility staff via phone call. Surveyor notes the MD was not consulted after R414 notified staff he hit his head and his having a significant change in condition. On 10/28/23 at 10:28 am, hospice was contacted again when R414 was hunched over in his wheelchair with increased fatigue. The facility staff requested hospice evaluation. There is no evidence the facility staff or hospice staff consulted with R414's MD to discuss R414's continued decline and changes in condition after the fall. On 10/28/23 at 2:19 pm, the documentation from hospice indicates R414 was having poor coordination, increased sleep, lethargy, and Foley draining concentrated clear urine. There is no evidence the MD was notified of the significant change in condition and no evidence new interventions were placed after hospice was notified of R414 hitting his head. Surveyor reviewed the Neuro check performed on 10/28/23 at 4:00 pm which indicates R414 had a change in condition with having slurred speech. R414 has a strong right-hand grasp, and the left hand was not documented as assessed. There is no evidence facility staff consulted with the MD about the ongoing decline in R414's condition. Surveyor reviewed the post fall documentation on 10/28/23 at 8:00 pm which indicates R414 is alert with confusion and fatigue is noted. R414 can answer questions appropriately but did mumble stories about siblings that were nonsensical. Documentation reports R414 hit his head on 10/27/23 and Surveyor notes there is no evidence the MD was consulted with regarding this change in condition at the time of the post fall documentation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Documentation from 10/29/23 at 9:10 pm indicates R414 was found on the floor lying on the left side of the bed with the call light and nightstand base under him. R414 was moaning in pain with c/o (complaints of) pain in his back, left arm and left shoulder. R414 had a head injury with blood present on the floor. R414 was noted to have cognitive impairment, intermittent nonsensical verbalization, pinpoint eyes, eyes wrenching, a left forehead hematoma measuring 4 cm x 3 cm with a 2 cm laceration to the middle of the hematoma, and no urine output in the urine Foley bag. The charge nurse and hospice were notified. Hospice instructed the facility staff to not send R414 out for evaluation prior to hospice doing an evaluation. The facility nurse applied pressure to R414's head injury site and remained with R414 in the fall position until hospice arrived for evaluation. There is no evidence the MD was consulted regarding the significant change in condition. Documentation from Hospice Progress notes dated 10/29/23 at 9:34 pm indicates R414 had an unwitnessed fall and sustained a head injury. R414 denied pain but was observed to be wincing with movement. Notes indicate an as needed (PRN) pain medication was given due to R414 likely being sore and probably having a headache. R414 was observed to be alert and oriented and tolerating changing his shirt without the facility staff in R414's room. Hospice reports facility staff chose to leave R414 on the floor with a pillow under his head until hospice arrived for evaluation. R414 was assisted back to bed using a Hoyer lift. Hospice attempted to contact R414's POA who was unavailable and a message was left. The hospice nurse applied steri strips to R414's head wound and a new Foley catheter was inserted with 2400 cc of dark amber urine and large amounts of thick fibrous tan drainage was noted. There is no evidence the MD was consulted related to R414's significant change in condition with R414's fall and his retaining large amounts of urine or the discrepancies in the facility and the hospice notes and recommendations. Surveyor interviewed Licensed Practical Nurse (LPN)-S on 3/14/23 at 11:00 am. LPN-S indicated R414 was typically alert and oriented and able to make his needs known. LPN-S reported R414 was weak and requires assistance of one with ambulation, toileting, and transferring. LPN-S stated the facility staff had to frequently remind R414 to contact staff when needing to transfer as R414 frequently ambulated independently without calling for assistance. LPN-S indicated she could clearly tell R414 had a head injury on 10/29/23 at 9:10 pm after R414 had a second unwitnessed fall from his bed while reaching for the call light that was out of reach. LPN-S indicated she applied pressure to R414's head to help control bleeding and stayed with R414 for approximately 30-40 minutes in the fall position while she waited for hospice to come and evaluate R414. LPN-S stated she thought residents had the option to be sent out for evaluation with a significant change in condition even though they are receiving hospice care. LPN-S indicated R414's change in condition was not related to his hospice diagnosis but she was told by hospice to not send R414 out for evaluation. LPN-S stated she did not feel comfortable with this decision as she knew R414 clearly had a brain injury with R414's eyes being dilated and changed. LPN-S was unsure if R414's POA was contacted to discuss the significant change in condition and whether the POA was given the option to send R414 out for evaluation. LPN-S indicated she was fearful of the head and neck injury R414 sustained. LPN-S indicated she noticed no urine output in R414's urine Foley catheter bag while holding pressure on R414's head injury and notified hospice upon arrival. LPN-S indicated she does not recall if the MD was notified by the hospice nurse. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor interviewed DON-B on 3/18/24 at 10:09 am. DON_B indicated facility staff are to contact hospice regarding any residents receiving hospice care and experiencing a change in condition. Surveyor reviewed with DON-B that facility staff were interviewed and reported not feeling comfortable with coordination and care being provided to R414 by hospice staff on 10/29/23 at the time of R414 having a second unwitnessed fall. DON-B indicated staff are to contact clinical leadership if they do not feel comfortable with orders given by the hospice staff. DON-B indicates she was not aware of the facility staff not feeling comfortable with orders being provided by hospice indicating R414 is to not be evaluated due to being on hospice. DON-B indicated clinical leadership should have been notified with this significant change on 10/29/23 and the facility staff not feeling comfortable with hospice recommendations to not send resident out for evaluation. Surveyor reviewed the facility fall investigation dated 10/29/23 at 9:10 pm. The investigation indicated R414 sustained a hematoma and laceration to the face along with a skin tear to the left hand. R414 is oriented to person, the facility NP was notified on 10/30/23 at 3:53 pm, and POA was notified on 10/30/23 at 3:29 pm. This is over 18 hours after the fall occurred. There is no documentation as to what information was shared with the NP and the POA. There is no evidence the MD was consulted after the fall with a significant change in condition. On 3/18/24 at 8:57 am, Surveyor spoke with Medical Director (MD)-O of the facility. Surveyor reviewed the change in condition with R414 that occurred on 10/29/23. MD-O indicated he does not recall being notified of the change in condition with R414 on 10/29/23. MD-O stated, if the facility does not agree with hospice recommendations, the facility is to reach out to the MD to discuss the change in condition with the resident. MD-O indicated the resident has the option to go to the emergency room for further evaluation while receiving hospice services. Surveyor reviewed the facility neuro check documentation on 10/30/23 at 1:00 am which indicates R414's pupils not being equal in size, with the right pupil being fixed, left pupil being sluggish, and R414 being unable to grasp hands. There is no evidence of MD consultation regarding this change in condition. Surveyor reviewed the facility neuro check documentation on 10/30/23 at 2:00 am which indicates R414 is aphasic (a person who is unable to communicate), right pupil is fixed, left pupil is sluggish, and unable to grasp hands. There is no evidence of MD consultation regarding this change in condition. Facility progress note dated 10/30/23 at 2:59 am indicates the facility placed a call to hospice with an update on R414's neuro checks and R414 being unresponsive. Hospice advised the facility to continue with keeping R414 comfortable and provided no additional interventions. There is no indication clinical leadership and the MD were notified of these changes. Facility progress note dated 10/30/23 at 3:04 am indicates the facility contacted R414's POA with an update. There is no documentation as to what was discussed with R414's POA and if options to send R414 out for evaluation were provided. There is no evidence clinical staff and the MD were updated of the significant changes in condition with R414. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed facility progress note dated 10/30/23 at 3:13 am which indicated the facility contacted hospice with updates on neuro checks and R414 being non-responsive. Hospice stated if R414 had a brain bleed that there is nothing that can be done for his condition. There is no evidence MD and clinical leadership were updated at this time. Surveyor reviewed hospice progress note dated 10/30/23 at 9:15 am which indicated R414 requires meals set up, has decreased appetite, increased dysphagia, choking and coughing with thinned liquids, increased pain, total dependence with bathing, and is bedbound with assistance of a Hoyer lift after two unwitnessed falls on 10/27/23 and 10/29/23. R414 is requiring head support with a rolled towel to prevent neck pain and is unable to move his own head/neck. Urine is noted to be dark concentrated with sediment in Foley catheter tubing. Surveyor reviewed the Interdisciplinary Team (IDT) note dated 10/30/23 at 11:42 am which indicated the 10/27/23 fall for R414 was reviewed for safety and a new intervention was placed. Surveyor notes the 2nd fall from 10/29/23 was not reviewed, the MD was not consulted with regarding the significant changes in condition, and there was one change to the care plan to include medication adjustments per hospice for R414 being a high risk of falls. Surveyor also notes it is unclear if clinical leadership was present for the IDT meeting. Surveyor reviewed the Hospice Comprehensive Review Assessment note dated 10/30/23 at 11:21 pm which indicates hospice sent an email to the POA and DON-B regarding R414 having an increase in lethargy, rambling speech, reduced appetite, and trouble swallowing post falls. Facility progress note dated 10/31/23 at 12:30 am indicates the facility contacted hospice with concerns of R414 having a low-grade fever, elevated BP and R414 complaints of neck pain. Hospice instructed the facility to administer Morphine for pain and apply a cool cloth to reduce the fever. There is no indication the MD was notified of this change. Surveyor reviewed the facility progress note dated 10/31/23 at 2:05 pm which documented the POA was visiting with R414 and expressed concerns with hearing cracks in R414's neck when he moves. The facility progress note indicates Morphine was administered to R414 for neck pain and the charge nurse and hospice were contacted with an update. There is no indication the MD was consulted regarding this significant change. Hospice Progress note dated 10/31/23 at 3:30 pm indicates R414 is in pain, increased sleeping, withdrawn, minimal responsiveness, barely opening his eyes, abdominal respirations, slow capillary refill in his nail beds, pallor, crackles in his lungs (fluid building up in the lungs), skin cool to touch, skin mottled in areas (lack of blood flow to the skin), and unable to respond to tell staff how he feels. Surveyor reviewed the Hospice Progress Note dated 11/1/23 at 10:00 am which document R414 is unresponsive, having irregular heart rates, breathing through his mouth, eyelids barely opening, shallow respirations, crackles to his lungs, coughing to clear his airway, unresponsive to touch or voice however, R414 jerks and gasps when the hospice nurse swabs R414's lips. Documentation indicates the hospice nurse noted no PRN medications (Lorazepam and Morphine) given since last visit on 10/31/23 at 3:30 pm. Hospice updated the POA however, Surveyor notes documentation does not indicate what was discussed with POA. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor notes the facility documentation on 11/2/23 at 2:48 am indicates R414's POA contacted the Nursing Home Administrator (NHA)-A regarding R414's current condition. The POA expressed concerns with R414 needing to eat more. NHA-A educated the POA on the risk of intake when R414 is not alert and oriented. The NHA-A suggested the POA reach out to hospice for additional support. Surveyor notes the POA is not comprehending the severity of R414's current prognosis and significant change in condition and the NHA-A advised POA to contact hospice. Hospice Progress Note dated 11/2/23 at 11:00 am notes R414 to have an elevated pulse, rapid respiratory rate (RR) of 36 (normal RR is 16), gasping for air, abdominal respirations, using accessory muscles with breathing, coughing, short of breath, and moderate discomfort with breathing. Documentation indicates hospice updated the POA and administered 1 dose of Morphine for shortness of breath. Facility progress note dated 11/2/23 at 10:50 pm states a CNA called the nurse into R414's room. R414 was pulseless and not breathing. Hospice and the facility charge nurse were notified by the facility staff. On 3/18/24, at 10:09 AM Surveyor notified Nursing Home Administrator-A and Director of Nursing-B of the above concerns. The immediate jeopardy was removed on 3/19/24 when the Facility complete the following -All Residents were reviewed for changes in condition, falls, and hospice services and the care plan were updated as indicated. -The Nurse Consultant educated the Director of Nursing when to notify the physician when a change of condition occurs with a resident, notifying the resident's representative when a change in condition occurs, proper care coordination with the hospice provider regarding when it would be appropriate to discuss a change in the treatment/care plan of the residents based on residents's needs, properly assessing the patient, including hospice patients, and when a patient should be transferred out to the hospital. - All nursing staff and clinical managers were reeducated by the Director of Nursing or designee when to notify the physician when a change of condition occurs with a resident, notifying the resident's representative when a change in condition occurs, proper care coordination with the hospice provider regarding when it would be appropriate to discuss a change in the treatment/care plan of the residents based on residents's needs, properly assessing the patient, including hospice patients, and when a patient should be transferred out to the hospital. -All professional nursing staff were competency tested by the Director of Nursing or designee on hospice coordination of care and notification requirements. -The Facility Director of Nursing, Nursing Home Administrator, Nurse Consultants and Medical Director reviewed policies and procedures on the change in condition and comprehensive care plan. -Audits for compliance related to notification to the physician and resident representative were conducted. The audits will be conducted 4 times a week for 4 weeks, 3 times a week for 4 weeks and monthly for three months. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Results of the audits will be reviewed monthly by the Facility Interdisciplinary Team and QAPI (Quality Assurance and Performance Improvement) team to determine any necessary changes. -An emergency QA (Quality Assurance) meeting was held 3/18/24 by the Nursing Home Administrator with the Interdisciplinary Team and Medical Director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525271	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not ensure 1 out of 1 allegations of an injury of unknown source (R38) were reported immediately, but not later than 2 hours after the allegation is made to the State Survey Agency. In addition, the facility did not ensure they reported the results of the investigation, within 5 working days to the State Survey Agency for 1 out of 1 allegations of an injury of unknown source (R38). R38 experienced pain in the left knee although no injury had been reported. An X-ray was obtained and it was noted R38 had suffered a left distal femur fracture and was admitted to the hospital and underwent surgical repair. The facility did not report the injury within 2 hours of being aware of the femur fracture, to the State Survey Agency, when they were not able to determine the cause of the fracture. In addition, the facility did not report, within 5 working days, the outcome of their investigation of the injury of unknown source for R38 following the diagnosis of the left femur fracture. This is evidenced by: Policy Review: Abuse Policy (for Wisconsin facilities) dated 09/2020 documents, Serious Bodily Injury is an injury involving extreme physical pain, involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization , or physical rehabilitation. 7.) Reporting-Initial reporting of allegations are reported immediately. CMS (Centers for Medicare and Medicaid Services) defines immediately as not later than 2 hours after forming the suspicion of abuse which results in serious body injury or not later than 24 hours if no serious bodily injury. A written report shall be sent to the Wisconsin Division Of Assurance (DQA). (Please see policy regarding contacting local law enforcement). c.) Five-day final Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation will be sent to the Wisconsin Division of Quality Assurance. R38 was originally admitted to the facility on [DATE] and the last readmission to the facility was on 11/10/23. R38 has diagnoses that include: epilepsy, muscle weakness, anxiety disorder, dysphagia, history of falling and hemiplegia. Surveyor conducted a review of R38's individual plan of care which indicated R38 is at risk for abuse related to: psychosis, impaired cognition. Date Initiated: 09/20/2021. Interventions included: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R38 will remain safe, calm and free from abuse through next review. Date Initiated: 09/20/2021 - Check and assure physical comfort. Date Initiated: 09/20/2021 - Consider past patterns, personal and medical/psych history, interests, family/friends accounts to past incidents. Date Initiated: 09/20/2021. - Consider possible antecedents: fear, fatigue, loss of control over a situation. Date Initiated: 09/20/2021. R38 was seen by the Nurse Practitioner on 11/6/23 for routine maintenance. The progress note indicates R38 has been complaining of left knee pain, no reported injury. X-ray ordered. No other concerns reported by R38 or nursing staff. Nursing note dated 11/7/2023 at 7:09 p.m., R38 c/o (complaint of) left knee pain new order to x-ray left knee and pelvis. X-Ray tech arrived approx. 1900 (7:00 p.m.) awaiting results. Nursing note dated 11/7/2023 at 10:53 p.m.: Xray results came back that R38 has fx (fracture) to distal femoral rod. Call placed to 3rd eye Dr (doctor) and orders received to send R38 out to hospital. Call also placed to POA (Power of Attorney) message left to call us back, call placed to 2nd emergency contact person, and he was updated on info. Ok with the transfer. Ambulance called at 10:58 p.m., report called to triage nurse at ER (emergency room) . Surveyor conducted a review of the emergency room preliminary reported, dated 11/7/23 at 11:40 p.m. The report indicates R38 is presenting from [facility name] with reported left leg pain and was found to have a left distal femur fracture based on their x-ray. There is no reported fall or illness . Surveyor conducted a review of the history and physical- final report dated 11/8/23 from the hospital. The report states that the chief complaint was R38 arrived with EMS from [facility name]. Left distal femur fracture around rod. Unknown cause of injury. R38 poor historian. Facility staff stated that she started to complain of pain yesterday (11/7/23). Nursing note dated 11/10/2023 at 3:43 p.m., ;72 Hour Admission Note #1. R38 returned from hospital today. R38 was hospitalized post fall with L (left) femur/knee fracture. R38 underwent surgery to repair fracture. R38 is here for LTC (Long Term Care) with dx (diagnoses): hemiplegia, hemiparesis, epilepsy, hx falls, glaucoma, cognitive deficit, and weakness and LLE (Left Lower Extremity) Fracture. R38 is awake, alert and oriented x 3. Able to make needs known. Generally pleasant and cooperative. Does have periods of acute anger with outbursts as well as periods of tearfulness. On 3/13/24 at 7:40 a.m., Surveyor interviewed Director of Nursing (DON)- B regarding the investigation into R38's injury of unknown source. DON- B stated she did obtain staff statements but is unable to locate at this time. Surveyor asked if the facility submitted a self-report investigation regarding the injury of unknown source. DON- B stated that they did not because the fracture was pathological, so it was not necessary. Surveyor conducted further review of R38's medical record and hospital record and there was no documentation that the fracture was pathological in nature. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 01:31 p.m., Surveyor interviewed DON- B regarding R38. DON- B stated the Nurse Practitioner saw R38 on 11/6/24 and R38 reported she was having some pain and she was given Tylenol. R38 was having more pain the next day. DON- B stated she spoke with R38 on 11/7/23 and R38 reported it had been hurting since she put herself on the toilet. DON- B reminded her not to transfer herself. Surveyor discussed the medical record review that was conducted and the lack of evidence supporting the fracture was pathological. DON- B stated that she also couldn't find anything about pathological fracture either, but she was sure she was told that it was. DON- B stated the only thing she could find was R38 has Osteoporosis. Surveyor reviewed the nursing note that indicated R38 was hospitalized post fall. DON- B stated that there was no fall and she started questioning staff because R38 said it was from transfer herself. DON- B stated she had staff report that R38 bumped her knee in the dining room. Surveyor stated to DON- B there is no documentation of either situation in the medical record. Surveyor asked DON- B if she was able to state how the injury occurred to R38. DON- B was unable to provide any additional information that the injury was thoroughly investigated and then reported to the state survey agency.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure resident's received the required written notice information related to their transfers out of the facility. This was observed with 7 (R108, R38, R25, R77, R54, R85 and R65) of 7 resident reviewed transfers. *R108, R38, R25, R77, R54, R85 and R65 were transferred to the hospital from the facility. A transfer notice including the following information was not provided: -A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; . (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. Findings include: On 3/13/24 at 11:11 AM, Surveyor spoke with ANHA-D (Assistant Nursing Home Administrator) regarding resident transfer notices. ANHA-D indicated nursing staff will open the Interact tool in the electronic medical record (EMR). The bed-hold form that should be used is dated 12/22. ANHA-D stated there were old transfer summary forms in the nurses stations and the facility replaced all the forms yesterday. The bed-hold form is not updated to include any other information. ANHA-D was not aware of any other notice information requirements besides bed-hold. ANHA-D indicated the Corporation is in the process of developing the notice requirements. The facility does not have a policy and procedure related to transfer notice requirement. 1.) R108 medical record was reviewed by Surveyor. R108 had a fall in the facility and was sent out to the hospital on 12/31/23 for further evaluation. A Progress Note dated 1/4/24 indicates R108 went from the hospital to their home. R108 did not return back to the facility per their choice. R108's medical record did not contain evidence R108 received the required written notice information with their transfer to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/24 at 3:12 PM, at the Facility exit meeting Surveyor shared with Nursing Home Administrator-A and Director of Nursing-B the concern R108 did not receive a transfer notice when transferred to the hospital. No additional information was provided. 16584 2) Surveyor reviewed R38's medical record. It was noted on 9/2/23, R38 was transferred to the hospital due to hypoxic and very large bleeding external hemorrhoid. The facility eINTERACT transfer form and Bed Hold information was provided, except information on how to appeal a transfer and Ombudsman contact information was not included. The medical record did not contain all the required information at the time of transfer. On 11/7/23, R38 was transferred to the hospital due to a change of condition. The facility eINTERACT transfer form and Bed Hold information was provided, except information on how to appeal the transfer and Ombudsman contact information was not included. The medical record did not contain all the required information at the time of transfer On 3/13/24 at 11:11 AM, Surveyor spoke with ANHA-D (Assistant Nursing Home Administrator) regarding resident transfer notices. ANHA-D indicated nursing staff will open the Interact tool in the electronic medical record (EMR). The bed-hold form that should be used is dated 12/22. ANHA-D stated there were old transfer summary forms in the nurses stations and the facility replaced all the forms yesterday. The bed-hold form is not updated to include any other information. ANHA-D was not aware of any other notice information requirements besides bed-hold. ANHA-D indicated the Corporation is in the process of developing the notice requirements. The facility does not have a policy and procedure related to transfer notice requirement. 38146 3) R25 admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following Cerebral Infarction, Dysarthria, Dysphagia, Spondylosis lumbar region, Adult Failure to Thrive, Hypertension, Anemia, Polyosteoarthritis and Depression. Facility progress notes document: On 2/11/24 at 9:12 AM, Nurses Note Text: Resident c/o (complained of) not feeling well earlier this morning, light cough noted, while up in wc (wheelchair) he became somewhat diaphoretic with slow reaction with verbal and tactile stim (stimulation), cold compresses applied, and vitals obtained. Resident is a dnr (do not resuscitate) status, when I asked him if he wanted to go to the hospital or stay here, he said stay here. Call placed to son and poa (power of attorney), updated him on all the above. Son requested for him to stay and have labs done here at (facility). Update to NP (Nurse Practitioner) with all the above and orders received. Resident is resting back in bed and labs obtained left forearm. He seems more alert now. No cough. Rapid for Covid negative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/24 at 1:49 PM, Nurses Note Text: Return labs note high liver enzymes. Call placed to NP and to pt's (patient) POA. POA aware of options for comfort cares, Hospice cares or hospitalization for further eval (evaluation). Family to consult with each other and get back to staff. Res has been comfortable in bed at this time with no intake this shift. On 2/11/24 at 2:30 PM, Nurses Note Text: Family returned call and want resident send to the hospital for further eval. NP notified. Surveyor noted R25 was admitted to the hospital. Surveyor was unable to locate evidence a transfer notice with the required information was provided to R25 or his POA. The facility was unable to provide evidence the transfer notice was provided. No additional information was provided. 4) R77 admitted to the facility on [DATE] and has diagnoses that include Acute Kidney Failure, Hydronephrosis, Chronic Kidney Disease stage 3, Obstructive and Reflux Uropathy, Alcohol-Induced Chronic Pancreatitis, Epilepsy, Anemia, Benign Prostatis Hyperplasia, Hypertension, Cholelithiasis and Depression. Facility progress notes document: On 7/1/23 at 11:33 AM, Nurses Note Text: Resident states he hasn't felt good since yesterday and that it burns when i pee update to NP with orders for labs, drawn and sent. Resident is afebrile and vitals are stable. On 7/2/23 at 1:44 PM, Nurses Note Text: Resident continues to state he's not feeling well, call to (hospital) for labs which returned critical. Consulted with NP and with resident, he is full code and will be sent to (hospital) for evaluation. 911 called and update to (hospital) ER (emergency room). Surveyor noted R77 was admitted to the hospital. Surveyor was unable to locate evidence a transfer notice with the required information was provided to R77 or his POA. The facility was unable to provide evidence the transfer notice was provided. No additional information was provided. On 3/13/24 at 3:11 PM during the daily exit meeting, the facility was notified of concern regarding transfer notice not provided. 46214 5) R54 was admitted the facility on 2/26/2020 with diagnoses that include, acute and chronic respiratory failure, chronic obstructive pulmonary disease, cerebral infarction, and bipolar. R54 signed onto hospice on 2/21/2024. On 1/21/2024, at 11:15 AM, in the nursing progress notes nursing documented, went into R54's room resident was not responsive. R54 sent to ER (emergency room) for evaluation and treatment. On 2/6/24, at 02:28 AM, in the progress notes, nursing documented staff spoke with hospital staff and R54 is being admitted to the ICU (intensive care unit). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/24, at 03:30 AM, in the progress notes, nursing documented staff spoke with ER (emergency room) nurse who stated that R54 would be admitted with a diagnosis of hypercapnia. Surveyor requested evidence of a bed hold and transfer notice for transfers that occurred on 1/21/24, 2/5/24 and 2/19/24. The facility provided a copy of the Bed Hold Notice and eINTERACT Transfer Form dated 1/21/24, 2/5/24 and 2/19/24. Surveyor noted the documents do not contain any information about appeal rights to the State Agency. On 03/13/24, at 03:28 PM, during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Assistant Nursing Home Administrator (ANHA)-C, Surveyor shared concerns regarding the transfer notice not including required information including the appeal to the State Agency for R54's three transfers. No additional information was provided. 6) R85 was admitted to the facility on [DATE] with diagnoses that include acute and chronic respiratory failure, congestive heart failure, encephalopathy, narcolepsy and type 2 diabetes. On 1/12/2024, at 15:36 (3:36 PM), in the progress notes, nurse documented, resident in respiratory distress, orders to send to ER (emergency room) for evaluation and treatment. On 2/3/2024, at 21:50 (9:50 PM), in the progress notes, nurse documented resident had an unwitnessed fall with no injury. Resident weak due to COVID, will send to ER for IV (Interavenous) treatment. Surveyor requested evidence of a bed hold and transfer notice for R85's transfers that occurred on 1/12/24 and 2/3/24. The facility provided a copy of the Bed Hold Notice and eINTERACT Transfer Form dated 1/12/24 and 2/3/24. Surveyor notes the documents do not contain any information about appeal information to the State Agency. On 03/13/24, at 03:28 PM, during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Assistant Nursing Home Administrator (ANHA)-C, Surveyor shared concerns regarding the transfer notice not including required information including the appeal to the State Agency for the two transfers. No additional information was provided. 49011 7) R65 was admitted to the facility on [DATE]. R65 is responsible for self. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/13/24 at 01:34 PM, the Surveyor reviewed R65's electronic medical record which indicated R65 was transferred to the hospital on 12/22/2023 and admitted to the hospital for severe sepsis, catheter associated urinary tract infection. R65 returned to same room in the facility on 12/26/2023. On 1/19/2024, R65 was admitted transferred to the hospital due to neck swelling and dental pain, R65 returned to the same room at the facility on 1/19/2024. Surveyor requested evidence from the facility that notice of bed hold and transfer was provided to R65 and to R65's responsible party when R65 was hospitalized on [DATE] and 1/19/2024. The facility provided copies of the Facility Bed Hold and Re-admission Policy Notice paperwork dated 12/22/2023 and 1/19/2024. Surveyor noted the information on the forms did not have contact information, including address, phone number and email address for the State Agency, Ombudsman, or Disability Rights agency. On 03/13/24 at 11:11 AM, Surveyor interviewed ANHA (Assistant Nursing Home Administrator)-D regarding the process of paperwork for transfer notice. ANHA-D reports the Ombudsman is notified by the facility monthly of all hospitalization s through an e-mail. ANHA-D stated yesterday they found Facility Bed hold and Re-admission Policy Notice paperwork on the units that was old and replaced it with paperwork that includes the current ombudsman contact information. When Surveyor asked if the information for the state agency to appeal to was included ANHA-D stated the facility put in a request with corporate staff yesterday for an updated form with appeal information included on the form. On 03/13/24 at 03:11 PM, during the end of day meeting the concern about R65's transfer notice not being given on 12/22/2023 and 1/19/2024 was shared. Additional information was requested if available. None was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46214 Based on observations, record review and interviews, the facility did not ensure residents had an individualized comprehensive plan of care. This was observed with 2 (R85 and R81) of 23 resident comprehensive care plan reviews. 1. R85 was admitted to the facility with an indwelling catheter after a short stay in the hospital and there was no comprehensive plan of care with individualized interventions to address catheter care. 2. R81 was admitted to the facility on anticoagulant medication and there was no comprehensive plan of care with individualized interventions to address monitoring of the anticoagulant. Findings include: The facility policy entitled, Comprehensive Care Plans, dated 11/2017 states: An individualized, person-centered comprehensive care plan, including measurable objectives with timetables to meet Resident physical, psychosocial and functional needs, is developed and implemented for each Resident. #4. Care plan interventions are initiated based on an analysis of information collected throughout the comprehensive assessment process. #8. Assessment of the Resident is ongoing and care plans are revised based on the Resident condition, preferences, treatments and goals change. 1.) R85 was admitted to the facility on [DATE] with diagnoses that include acute and chronic respiratory failure, congestive heart failure, encephalopathy, narcolepsy and type 2 diabetes. R85's Quarterly MDS (Minimum Data Set) assessment completed on 2/13/24 indicates R85 is cognitively intact and has an indwelling catheter and is always continent of bowel. R85's physician orders document to change catheter every 30 days, active date of 2/28/24 and may use indwelling urinary catheter Foley, 18F size 10 cc (cubic centimeters) balloon size due to urinary retention, active date 1/15/24. R85's electronic, and paper medical record, did not contain a comprehensive plan of care with individualized interventions for bowel and bladder or an indwelling catheter care and treatment. On 03/13/24, at 10:34 AM, Surveyor interviewed Registered Nurse (RN)-J who stated when a resident is admitted to the facility the admitting nurse will complete a baseline care plan and then the Resident Care Coordinator will complete the comprehensive care plan. Should the care plan require any updates, anyone can update it like the floor nurse or Resident Care Coordinator. RN-J confirmed that should a resident return from a stay in the hospital with an indwelling catheter that should be identified in the hospital discharge paperwork and added to the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24, at 10:55 AM, Surveyor interviewed Resident Care Coordinator-T who confirmed that floor nurses are responsible to complete baseline care plans for new admissions, and she is responsible for completing the comprehensive care plan. Resident Care Coordinator-T explained it is all staffs' responsibility to update the care plan as needed. She also confirmed that if a resident has an indwelling catheter that should be reflected in their care plan. On 03/14/24, at 08:23 AM, Surveyor interviewed Director of Nursing (DON)-B who informed Surveyor that if a resident has an indwelling catheter, then that should be part of their care plan. Surveyor informed DON-B that R85 returned from a hospital stay on 1/15/24 with an indwelling catheter and no bowel and bladder care plan could be located in R85's care plan as well as no indwelling catheter care plan. DON-B stated that typically when a resident returns from the hospital their discharge paperwork is reviewed by a nurse in admissions to check for any new physician orders. DON-B stated that this must have been an oversight. On 03/14/24, at 03:28 PM, during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Assistant Nursing Home Administrator (ANHA)-C, Surveyor shared concerns regarding the lack of a bladder and bowel care plan for R85 including interventions for an indwelling catheter. No additional information was provided. 48391 2.) R81 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes, generalized anxiety disorder, post-traumatic stress disorder (PTSD), cognitive communication deficit, essential tremor and absence of right leg above knee. R81's quarterly MDS (minimum data set) dated 2/20/24 indicates a BIMS (brief interview for mental status) score of 15, which indicates cognitively intact. R81's MDS indicates he is taking an antidepressant, opioids, and anticoagulant. No antipsychotics were received. Active diagnosis include amputation, type 2 diabetes, hyperlipidemia, anxiety disorder, and PTSD. R81 uses a wheelchair for ambulating, is independent with eating and toileting, and requires partial to moderate assistance with bathing. R81's November 2023 Medication Administration Record (MAR) documents: Eliquis 5 mg (milligrams) - Give one tablet by mouth two times a day, ordered on 11/27/23. R81's comprehensive care plan contains the following significant focused problems, initiated on 12/16/22 and resolved on 12/16/22: R81 has the potential for hemorrhage/bruising due to use of anticoagulant; initiated 12/16/22, resolved 12/16/22. Surveyor notes this care plan was initiated and resolved on the same day dated 12/16/22. R81 will show no complications related to anticoagulant use; initiated 12/16/22, resolved 12/16/22 Interventions include: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Encourage R81 to get out of bed and move about per plan of care to help prevent blood clots, monitor labs if ordered, -Monitor R81 for and encourage to report any side effects of anticoagulant use such as pain, swelling, hot/cold sensations, skin changes, or discolorations on the body, sudden and severe leg or foot pain, foot ulcers, circulation issues, sudden headache, dizziness or weakness, unusual bleeding, pain in stomach, back or side, urinating less than usual or not at all, flu-like symptoms; initiated 12/16/22, resolved 12/16/22. Surveyor notes there is not an active care plan to monitor the use of or side effects of Eliquis (anticoagulation therapy) for R81. Surveyor interviewed Resident Care Coordinator-T on 3/14/24 at 8:01 am who indicated the nurses on the floor will get a new admit and complete an admission baseline care plan. Resident Care Coordinator-T indicated the facility then has 21 days to complete a comprehensive care plan. Resident Care Coordinator-T indicates residents are to have a care plan while taking anticoagulation therapy. Resident Care Coordinator-T reviewed R81's medical records and noted there was no care plan for anticoagulation therapy and notes there should be one included in R81's chart. Resident Care Coordinator-T indicates she has a new partner who is working with her and currently training. Resident Care Coordinator-T reports her previous partner was the individual responsible for including the anticoagulation therapy care plan for R81. Resident Care Coordinator-T indicated, had he been her resident, she would have included an anticoagulation therapy care plan for R81 On 3/14/24 at 8:36 am, Surveyor notified Director of Nursing (DON)-B of concerns with R81 taking anticoagulation and not having a current care plan. Surveyor requested additional information if available. None was provided.

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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** 16584 Based on interview and record review, the facility did not ensure they provided the necessary care, consistent with professional standards of practice, to prevent the development of pressure ulcers for 1 out of 5 residents (R38) reviewed who were at high risk. R38 returned to the facility following surgical repair to the left knee. R38 was to wear an immobilizer to the left lower extremity for 6 weeks after the surgery. The facility did not provide monitoring of R38's skin under the immobilizer and R38 developed a stage 4 pressure ulcer to the back of her left lower leg. This is evidenced by: R38 was readmitted to the facility on [DATE] following an acute left distal femoral fracture with surgical repair. Hospital discharge instructions included, wound/skin care: may reinforce left knee dressing; otherwise leave in place until ortho follow-up. Stage #3 coccyx pressure injury - silicone boarded foam change 3 times a week, offload from pressure. Surveyor conducted a review of the physician orders for November 2023. R38 had an order that stated, may reinforce left knee dressing; otherwise leave in place until ortho follow-up. As needed for wound healing. Start date 11/10/23. (d/c date 12/27/23). A review of the plan of care for R38 indicates: R38 Requires an immobilize to LLE (Left Lower extremity) secondary to Limitation in ROM (Range of Motion) from recent surgery. Date Initiated: 11/17/2023. Interventions include: o Will tolerate splint use through next review. Date Initiated: 11/17/2023 o Apply splint/brace per MD (Medical Doctor) order to affected area. Date Initiated: 11/17/2023 o Monitor splint for cleanliness, need for refitting, repair, or fit as needed. Date Initiated: 11/17/2023 o Report any changes in ability to use the affected area. Date Initiated: 11/17/2023 R38 has alteration in skin integrity r/t (related to) non-removable medical device stg (stage) 4 to LLE, Left thigh/knee wound near surgical incision, decreased mobility, need for staff assistance for ADLs (Activities of Daily Living) and transfers, diagnosis of lymphedema, hemiplegia and hemiparesis, epilepsy, anemia, hx of falls, poly osteoarthritis. Recurrent shingles/zoster, rashes, dx (diagnosis) atopic neurodermatitis. Non-compliance with repositioning/chair time. Date Initiated: 09/05/2023 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interventions include: o Skin will show s/s (signs/symptoms) of healing thru next review Date Initiated: 09/05/2023 o Absorbent to wick up moisture. Date Initiated: 06/25/2023 o Barrier cream to areas exposed to moisture/incontinence. Date Initiated: 09/26/2021 o Bathe with mild soap. Date Initiated: 09/18/2021 o Inspect skin daily with care Date Initiated: 09/05/2023 o LAL (Low Air Loss) mattress to bed. Date Initiated: 11/10/2023 o Moisturize dry skin Date Initiated: 09/26/2021 o Monitor nutritional status Date Initiated: 09/26/2021 o Monitor wound related pain and administer pain medications as appropriate. Date Initiated: 06/25/2023 o Position body with pillows/support devices Date Initiated: 09/26/2021 o Pressure reduction support on wheelchair with LLE calf support in W/C (wheelchair) Date Initiated: 09/26/2023 o Remind of importance of frequent position changes. Explain risks of prolonged sitting in her w/c. Date Initiated: 11/27/2023 o Treatment as ordered Date Initiated: 09/18/2021 R38 had a follow up Orthopedic consult on 11/22/23. The progress note indicates there is a slow stable fracture alignment. Staples removed today. May allow running water over incision. No soaking under water. Steri strips may be removed after 1 week. Continue non-weight bearing on left lower extremity. No rx (prescription) changes. The facility conducted a comprehensive assessment on 12/19/23 for R38's development of a pressure ulcer to the left lower leg (rear). Pressure Ulcer is unstageable. 5.0 centimeters in length by 2.0 centimeters in width and depth is less than 0.1 centimeters. Area described as superficial. 25% granulation, 75% slough, and 0 eschar. Margins are irregular, peri-wound is intact. Comments: Unstageable pressure ulcer noted to left lower extremity. New orders received. Low air loss mattress in place. Education on importance of repositioning with R38, who verbalized understanding. On 12/18/2023 at 6:01p.m., Physician progress note: DATE OF SERVICE: 12/19/2023 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	CHIEF COMPLAINT: Mobility and ADL dysfunction secondary to h/o (history of) of CVA (Cerebral Vascular Accident) with left ORIF (Open Reduction and Internal Fixation) distal femur with removal of hardware. REASON FOR RE EVALUATION: R38 was discharged on ,d+[DATE] and was re admitted in the facility due patient undergone left ORIF distal femur with removal of hardware. HOSPITAL COURSE: R38 is a [age and sex of R38] who is a LTC (Long Term Care) resident with h/o of CVA with left ORIF distal femur with removal of hardware in the presence of multiple medical comorbidities leading to a functional decline. Patient admitted to the SNF (Skilled Nursing Facility) on 09/16/2021 for skilled nursing and rehab. Patient asked to be seen by primary team to optimize therapy, pain control and discharge planning. Patient's plan and progress was discussed with nursing staff and therapy. HPI (History of Present Illness): R38 seen and examined. R38 is going out for an appointment today. Unfortunately, R38 has a pressure injury from rubbing from knee immobilize brace which she has had at all times located on that left LE (left extremity). She does not feel a lot of pain there which she states she has not report it to nursing. She does have PRN (as needed) pain medication available. Spoke with nursing and will follow-up with her team today. Hopefully will get the immobilizer switch (sic) out to something that will allow for relief. Pain is a 0/10 today at rest. Pain is well controlled on pain medications. No reported side effects. On 12/19/2023, the facility conducted an Unavoidable Pressure Injury or Condition Review of clinical Manifestations. The progress note states R38 has a non-removable brace to LLE. Does not like to reposition. Chooses not to drink nutritional supplement to aide in healing. Nursing note dated 12/19/2023 at 4:36 p.m.: R38 returned from ortho appointment with orders for NWB (Non Weight Bearing) x (for) 6 more weeks to dc (discontinue) immobilizer, follow up in 6 weeks, to also consult with [name of doctor] for the wound on her left calf and heel noted and carried out. On 12/26/23, the facility conducted a weekly comprehensive assessment of R38's pressure ulcer to the left lower extremity (rear). Stage is assessed to be a stage 4 measuring 5.5 cm in length by 2.5 cm in width by 0. 1 cm in depth. 25% epithelization, 25% granulation, and 50% slough. Margins are irregular. Moderate exedute. This area is offloaded with pillow. R38 complains of pain with washing, subsides when completed. Wound is healing. NP (Nurse Practitioner) updated and continue treatment. On 1/2/24, the facility's weekly skin assessment indicates R38 has a stage 4 pressure ulcer to the left lower extremity-rear measuring 5.6 cm by 2.3 cm by 0.1 cm. This area is offloaded with pillow. Wound bed is 25% epithelization, 50% granulation and 25% slough. No eschar present. Continue treatment. On 1/9/24, the facility's weekly skin assessment indicated R38 had a stage 4 pressure ulcer to the left lower extremity-rear measuring 4.5 cm by 2.0 cm and depth is unable to measure. 10% slough and 90% eschar. Continue treatment. On 1/16/24, the facility's weekly skin assessment indicates R38 has a stage 4 pressure ulcer to the left lower extremity-rear measuring 3.4 cm by 1.0 cm by 0.4 cm. Description - cavity or crater. On 1/23/24, the facility's weekly assessment indicates that R38 has a stage 4 pressure ulcer to the left lower extremity measures 3.5 cm by 1.1 cm by 0.5 cm depth. 100% granulation. This area is offloaded with pillow. NP updated. Continue treatment, improved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Continued weekly assessments were completed by the facility. The pressure ulcer continued to improve towards healing which was indicated by decrease in size of the area. On 3/5/24, the weekly skin assessment indicated that the pressure ulcer to R38's left lower extremity is noted to be healed. On 03/13/24 at 1:31p.m., Surveyor interviewed Director of Nursing (DON) - B regarding R38's acquired pressure ulcer to her left lower extremity-rear. Surveyor asked DON-B if the staff should have been monitoring R38's skin underneath the leg immobilizer. DON-B stated Nursing should have been looking at the skin and typically this would have been conducted each shift. DON-B stated she would need to investigate this further and get back to Surveyor to confirm skin assessments. Surveyor asked DON-B how the pressure ulcer was discovered. DON-B stated that I went to conduct a skin check, I was just doing random skin checks and I found the area. DON-B confirmed that no other staff had reported discovering the pressure ulcer prior to her finding it. DON B stated staff reported looking at the skin under the immobilizer and that CNAs would wash the left lower leg and put lotion on it. Surveyor reviewed with DON-B the facility's assessment that the pressure ulcer development was unavoidable because the brace R38 was wearing was non-removable and how did the facility staff wash and apply lotion if the immobilizer was not to be removed. DON-B was unable to provide additional information at this time and stated she would follow-up. On 03/13/24 at 03:11 p.m., Surveyor shared concerns about the development of the stage 4 pressure ulcer that developed under R38's immobilizer on her left lower extremity-rear. Surveyor shared concerns the facility staff were not checking R38's left lower extremity daily knowing that R38 was at high risk for developing a pressure ulcer. The facility did provide evidence R38's skin was checked weekly, every day shift on Mondays with her shower however, the information did not document if the staff removed the immobilizer during the skin checks. In addition, the facility provided discharge documentation from 11/7/23 stating R38 is non-weightbearing to her left lower extremity for at least the next 6 weeks. Knee immobilizer to remain in place. Surveyor noted the order did not indicate if the skin under the immobilizer should or should not be checked and there is no documentation this was clarified with R38's physician. No additional information has been provided as of the time of exit from the facility.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 48391 Based on interview and record review the facility failed to identify and eliminate all known and foreseeable accident hazards in 1 (R414) of 1 resident reviewed with a significant change in condition. The facility had assessed R414 as being at high risk for falls. On [DATE], R414 had an unwitnessed fall. Facility charting on [DATE] at 5:30 pm indicates the CNA found R414 on the bathroom floor. R414 was noted to have hit his head and was experiencing altered mentation with being only oriented to self. R414's baseline orientation is to person, place, time, and event. The facility did not do a post-fall investigation on this date to determine the circumstances surrounding the fall to analyze what occurred and what could be done to prevent further falls. On [DATE], R414 sustained a second unwitnessed fall while reaching for his call light that was not within reach (contrary to the care plan, which directed staff to keep the call light within reach). R414 was found on the floor lying on his left side next to the bed lying over the call light and nightstand base. R414 sustained a head injury, was moaning in pain, and in and out of cognition with intermittent nonsensical verbalization. The facility did not do a post-fall investigation to analyze what occurred and what could be done to prevent further falls. R414 died on [DATE]. The facility's failure to prevent accidents to the extent possible created a finding of immediate jeopardy that began on [DATE]. Surveyor notified the Director of Nursing (DON)-B of the Immediate Jeopardy on [DATE] at 10:09 am. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of an E as the facility continues to implement their action plan. Findings include: The facility policy titled Management of Falls dated ,d+[DATE] states: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedure: 1. Complete a Fall Risk Assessment upon admission, re-admission, with significant change, post fall, quarterly, and annually. 2. Orient resident to room, call light, unit, and location of the nurse's station upon admission to the facility. 3. Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following; Contributing diagnoses/disorders/disease processes/active infections/other comorbidities, history of fall incidents, incontinence, medications (Narcotics, Antihypertensives, etc.), assistance required with Activities of Daily Living (ADL's), gait/transfer/balance issues, behaviors, and/or cognitive status. 4. Provide assistive devices for mobility, hearing and vision as appropriate for the resident. 5. Assess appropriateness for resident to participate in skilled therapy or restorative programming in order to maintain or improve physical function of resident. 6. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. 7. Monitor for changes in medical condition and notify physician as necessary to manage changes in status of the resident. 8. Conduce care plan meetings with resident, responsible party, and facility interdisciplinary team quarterly and as needed. 9. Review and/or modify the resident's plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury. R414 was admitted to the facility on [DATE] with diagnoses of dementia, depression, panic disorder, anxiety, a-fib, obstructive uropathy, urine retention, [NAME] syndrome, and failure to thrive. R414 is his own person. R414's Admission Minimum Data Set (MDS) assessment completed on [DATE] indicates a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. R414 requires extensive assistance with one-person and physical assistance with bed mobility, transferring, dressing and toileting. R414 is not steady and is only able to stabilize himself with staff assistance while moving on and off the toilet. R414 has an indwelling urine catheter and is always continent of his bowels. R414's Care Plan indicates R414 is at high risk for falls related to limited mobility and impaired balance dated [DATE]. Interventions include; 1. Assist R414 resident get up and out of bed during the night when resident is not feeling sleepy, Date Initiated: [DATE], 2. Encourage R414 to call, don't fall, Date Initiated: [DATE], 3. Complete frequent checks, Date Initiated [DATE], 4. Keep frequently used items within reach in room, Date Initiated [DATE], 5. Monitor for changes in ability to navigate the environment, Date Initiated [DATE], 6. Notify family and MD of any new fall, Date Initiated [DATE], 7. Promote placement of call light within reach, Dated Initiated [DATE]. On [DATE] at 1730 (5:30 PM), the facility documentation indicates the CNA (Certified Nursing Assistant) found R414 on the bathroom floor. R414 had an elevated BP (Blood Pressure) and noted to have altered mentation with being unable to convey where he was, day of the week nor the month. R414's baseline orientation is fully oriented to person, place, time, and event. The facility charge nurse and Hospice were notified of the unwitnessed fall. R414 had an improvement with his vital signs and mentation after Hospice arrived at the facility at 6:45 pm. On [DATE] at 5:34 pm, the facility documentation indicates R414 was found lying on his back flat on the bathroom floor and R414 hit his head. R414 had complaints of pain in his upper back between his should blades, altered mentation, along with high blood pressures and low pulse rates. R414 had a brown emesis while being transferred with a Hoyer lift back to his bed. Hospice instructed the facility to administer Zofran for vomiting. There is no documentation of a post-fall investigation to determine the circumstances that led to R414's fall and to determine what changes might be made to the care plan to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed the facility Neuro check documentation dated [DATE] at 3:47 am indicating R414 having rambling speech with a weak right-hand grasp. Surveyor notes there is no documentation indicating hospice or the MD were notified of this significant change in condition with R414 having weak right-hand grasps and rambling speech. Facility documentation dated [DATE] at 9:58 am indicates the facility nurse notified hospice with a significant change in condition. R414 was feeling off, hands being shaky, lethargic, and needing to be fed for breakfast. R414 did not previously require assistance with eating. Documentation indicates a second call was placed by the facility to hospice on [DATE] at 10:28 am indicating R414 is hunched over in his wheelchair with increased fatigue. Surveyor reviewed the post fall documentation on [DATE] at 8:00 pm which indicates R414 is alert with confusion and fatigue is noted. R414 can answer questions appropriately but did mumble stories about siblings that were nonsensical. Documentation reports R414 hit his head on [DATE] and surveyor notes the MD was not notified of this change in condition at the time of the post fall documentation. Documentation from [DATE] at 9:10 pm indicates R414 was found on the floor lying on his left side of the bed with the call light and nightstand base under him. R414 was moaning in pain with c/o pain in his back, left arm and left shoulder. R414 had a head injury with blood present on the floor. R414 was noted to have cognitive impairment, intermittent nonsensical verbalization, pinpoint eyes, eyes wrenching, a left forehead hematoma measuring 4 cm x 3 cm with a 2 cm laceration to the middle of the hematoma, and no urine output in the urine Foley bag. The charge nurse and hospice were notified. Hospice instructed the facility staff to not send out R414 for evaluation prior to hospice doing an evaluation. The facility nurse applied pressure to R414's head injury site and remained with R414 in the fall position until hospice arrived for evaluation. Documentation from Hospice Progress notes dated [DATE] at 9:34 pm indicate R414 had an unwitnessed fall and sustained a head injury. R414 denied pain but was observed to be wincing with movement. Documentation from Hospice indicates as needed (PRN) pain medication was given due to R414 likely being sore and probably having a headache. R414 was observed to be alert and oriented and tolerating changing his shirt without the facility staff in R414's room. Hospice reports facility staff chose to leave R414 on the floor with a pillow under his head until hospice arrived for evaluation. R414 was assisted back to bed using a Hoyer lift. Hospice attempted to contact R414's POA who was unavailable, and hospice left a message. The hospice nurse applied steri strips to R414's head wound and a new Foley catheter was inserted with 2400 cc of dark amber urine and large amounts of thick fibrous tan drainage was noted. Surveyor interviewed Licensed Practical Nurse (LPN)-S on [DATE] at 11:00 am. LPN-S indicated R414 is typically alert and oriented and able to make his needs known. LPN-S reported R414 being weak and requires assistance of one with ambulation, toileting and transferring. LPN-S stated the facility staff had to frequently remind R414 to contact staff when needing to transfer as R414 frequently ambulated independently without calling for assistance. LPN-S indicated she could clearly tell R414 had a head injury on [DATE] at 9:10 pm after R414 had a second unwitnessed fall from his bed while reaching for the call light that was out of reach. LPN-S applied pressure to R414's head to help control bleeding and stayed with R414 for approximately ,d+[DATE] minutes in the fall position while she waited for hospice to come and evaluate R414. LPN-S stated she knew R414 clearly had a brain injury with R414's eyes being dilated and changed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed the facility fall investigation dated [DATE] at 9:10 pm indicating R414 sustained a hematoma and laceration to the face along with a skin tear to the left hand. R414 is oriented to person, the facility NP was notified on [DATE] at 3:53 pm, and POA was notified on [DATE] at 3:29 pm. Surveyor notes the MD was not notified of the significant change in condition. Surveyor also notes the facility NP and POA were notified the following day approximately 18+ hours after the significant change in condition. Surveyor notes documentation does not state was what discussed with the facility NP and POA at that time of phone call and if it the option for R414 to seek further evaluation was discussed. Surveyor reviewed the facility neuro check documentation on [DATE] at 1:00 am indicating R414's pupils not being equal in size, with the right pupil being fixed, left pupil being sluggish, and R414 being unable to grasp hands. Surveyor reviewed the facility neuro check documentation on [DATE] at 2:00 am indicating R414's is aphasic (a person who is unable to communicate), right pupil is fixed, left pupil is sluggish, and unable to grasp hands. Surveyor reviewed hospice progress note dated [DATE] at 9:15 am indicating R414 requires meals set up, decreased appetite, increased dysphagia, chocking and coughing with thinned liquids, increased pain, total dependence with bathing, and is bedbound with assistance of a Hoyer lift after two unwitnessed falls on [DATE] and [DATE]. R414 is requiring head support with a rolled towel to prevent neck pain and is unable to move his own head/neck. Urine is noted to be dark concentrated with sediment in Foley catheter tubing. Surveyor reviewed the Interdisciplinary Team (IDT) note dated [DATE] at 11:42 am indicating the [DATE] fall for R414 was reviewed for safety and a new intervention was placed. Surveyor notes the 2nd fall from [DATE] was not reviewed, the MD was not notified of the significant changes in condition, and there was one change to the care plan to include medication adjustments per hospice for R414 being a high risk of falls. Hospice Progress note dated [DATE] at 3:30 pm indicates R414 is in pain, increased sleeping, withdrawn, minimal responsiveness, barely opening his eyes, abdominal respirations, slow capillary refill in his nail beds, pallor, crackles in his lungs (fluid building up in the lungs), skin cool to touch, skin mottled in areas (lack of blood flow to the skin), and unable to respond to tell staff how he feels. Surveyor reviewed the Hospice Progress Note dated [DATE] at 10:00 am indicating R414 is unresponsive, having irregular heart rates, breathing through his mouth, eyelids barely opening, shallow respirations, crackles to his lungs, coughing to clear his airway, unresponsive to touch or voice however, R414 jerks and gasps when the hospice nurse swabs R414's lips. Documentation indicates the hospice nurse noted no PRN medications (Lorazepam and Morphine) given since last visit on [DATE] at 3:30 pm. Surveyor reviewed the Hospice Progress Note dated [DATE] at 11:00 am indicating R414 is noted to have an elevated pulse, rapid respiratory rate (RR) of 36 (normal RR is 16), gasping for air, abdominal respirations, using accessory muscles with breathing, coughing, short of breath, and moderate discomfort with breathing. Documentation indicates hospice updated the POA and administered 1 dose of Morphine for shortness of breath. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility progress note dated [DATE] at 10:50 pm indicating the CNA called the nurse into R414's room. R414 was pulseless and not breathing. Hospice and the facility charge nurse were notified by the facility staff. On [DATE], at 10:09 AM, Surveyor notified the Nursing Home Administrator-A and Director of Nursing-B of the concerns with the following: ~ No root cause analysis performed for [DATE] and [DATE] unwitnessed falls to minimize future falls or harm. ~ Lack of determining what may have caused or contributed to the fall, including what R414 was trying to do before he fell . ~ Revising R414's plan of care to reduce the likelihood of another fall. Including no additional monitoring after increasing Miralax on [DATE]. ~ Call light was not within reach on [DATE]. R414 was reaching for his call light and sustained a fall on [DATE]. ~ MD indicated R414 was not to ambulate independently. R414 was noted to be in the bathroom independently on [DATE] at the time of his unwitnessed fall. The facility's failure to keep R414 free from hazards, reduce the risk of all known and foreseeable accident hazards that cannot be eliminated, provide appropriate and sufficient supervision to R414 to prevent an avoidable falls increased a reasonable likelihood for serious harm, thus creating a finding of Immediate Jeopardy. The Immediate Jeopardy was removed on [DATE] when the Facility completed the following: -All residents were reviewed for changes in condition, falls, and hospice services and the care plans were update as indicated. -All nursing staff were educated by the Director of Nursing, Nurse Consultant or designee regarding assessing for changes in condition post fall and notifying the primary care provider of those changes in condition. -All nursing staff were educated by the Director of Nursing, Nurse Consultant, or designee on the facility's fall prevention policy. -All nursing staff were educated by the Director of Nursing, Nurse Consultant, or designee on the facility's change in condition policy. -All nursing staff were educated by the Director of Nursing, Nurse Consultant, or designee on conducting a root cause analysis post fall to further assess resident's needs, addressing risk factors such as the resident's medical condition(s), facility environmental issues and/or staffing issues. (continued on next page)

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	525271	A. Building B. Wing	03/27/2024

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Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- All nursing staff were educated by the Director of Nursing, Nurse Consultant, or designee on ensuring interventions were established to prevent further falls based on the root cause analysis/assessment. -The facility Nursing Home Administrator, DON, and Nurse Consultants reviewed policies and procedures on falls, change in condition, and comprehensive care plan with the Medical Director. -The Nursing Home Administrator and Director of Nursing conducted a review of compliance using a Quality Assurance audit tool for falls, changes in condition post fall, and root cause analysis post fall. Interventions were established and included in the comprehensive plan of care based on the root caused analysis/assessment to prevent further falls. -Audits well be completed three times a week for four weeks, then weekly for four weeks, then monthly for 3 months, then randomly by the Nursing Home Administrator, DON, Assistant Director of Nursing/designee until compliance is maintained. -The results of the audits will be reviewed monthly by the Facility QAPI team to determine any necessary changes. -An emergency QA meeting was held on [DATE] by the Nursing Home Administrator with the Interdisciplinary Team and Medical Director. The meeting included discussion of a fall resulting in a change in condition, root cause analysis post fall, and implementation of a comprehensive care plan with interventions reflective of the root cause analysis.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review, interview and observation, the facility did not ensure a resident with an indwelling catheter received consult services. This was observed with 1(R22) of 4 residents reviewed with an indwelling catheter. * R22 was admitted without an indwelling catheter. R22 went out to the hospital due to a change in condition and an indwelling catheter was placed in the hospital due to urinary retention. There was no follow-up with a Urology to determine long term needs of the catheter. Findings include: The facility's policy and procedure Indwelling Catheter, dated 9/20, was reviewed by Surveyor. The procedure includes under 15: A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible. On 03/11/24 at 1:08 PM, Surveyor observed and spoke with R22. R22 was observed to have an indwelling Foley bag hanging below their wheelchair. R22 did not know why they had an indwelling catheter. R22 was admitted to the facility on [DATE] for rehabilitation services. R22 had a fall at home and fractured their hip. R22's Admission MDS (minimum data set) assessment completed on 12/11/23, indicates: No indwelling catheter and frequently incontinent of urine. Per Progress Note on 12/29/2023 at 11:07 AM, R22 Went out to Ortho (orthopedic) appointment this morning. Message received that she will be admitted to hospital for debridement of left hip. R22 returned to the facility on [DATE] with a indwelling catheter for their bladder. The Hospital Discharge Notes from 1/4/24, indicate R22 was straight cathed x (times) 3 and then a Foley was placed for having over 500 ML (milliliters) of urine in the bladder after voiding. R22 has chronic overflow incontinence symptoms. R22 instructions include: Maintain Foley on rehab discharge; Urology follow-up for voiding trial to be arranged in the coming weeks. R22's Nurse Practitioner progress notes dated 1/22/24, indicates under Assessment #6: Urinary retention with failed voiding trial, Foley replaced. Start Tamsulosin (medication for urinary retention) today. Monitor and consider a second voiding trial in 2 weeks or follow-up outpatient urology. R22's Nurse Practitioner progress notes dated 2/6/24, indicates under Assessment #6: Urinary retention with failed voiding trial, Foley replaced. Start Tamsulosin today. Monitor and consider a second voiding trial in 2 weeks or follow-up outpatient urology. On 3/12/24 at 11:07 AM, Surveyor spoke with ADON-H (Assistant Director of Nurses) regarding the concern R22 is experiencing urinary retention, Foley trial removals have been attempted and failed, and Surveyor was unable to locate documentation the outpatient urology follow up took place. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 2:45 PM, at the facility exit meeting with Nursing Home Administrator-A, Director of Nursing-B Surveyor shared the concerns with R22's Foley use. On 3/13/24 at 11:09 AM, ANHA-D (Assistant Nursing Home Administrator) spoke with Surveyor. ANHA-D indicated R22 was in the hospital and the hospital indicated the Urology referral was canceled due to the hospital stay. The skilled nursing facility will be managing the Foley. R22 had bladder voiding trials and failed to urinate on their own. After the canceled Urology referral, the facility did not request another referral to a Urologist. On 1/4/24, the hospital ordered a Urology referral for urine retention. ANHA-D provided a plain white paper that was dated 3/13/24 at 10:27 AM, indicates a telephone encounter from 1/30/24 states R22 is still in the hospital and catheter to be managed at the care facility. Referral closed. Surveyor notes R22 went out to the hospital on 1/29/24 for a respiratory illness. Prior to this hospital transfer there was no urology consult set up for R22. On 3/13/24 at 3:12 PM at the Facility Exit Meeting Surveyor shared the urology follow-up concerns. DON-B (Director of Nurses) indicated R22 was admitted to the facility with the indwelling catheter. Surveyor provided R22 Admission MDS assessment completed on 12/11/23 that indicates R22 is frequently incontinent of the bladder. R22 was not admitted to the facility with an indwelling catheter for bladder. DON-B did not validate the MDS information. Surveyor requested any additional information. As of 3/18/23 no additional information was provided.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46214 Based on observation, record review and interview, the facility did not ensure 1 Resident (R82) of 1 resident was properly assessed for the use of bed rails and the facility did not have evidence that risks and benefits were discussed with the resident and/or representative. R82's was assessment to not be appropriate for the use of bed rails. R82's bed was observed to have grab bars. Findings include: The facility's policy entitled, Side Rail Assessment, dated 9/2020 states: It is the policy of this facility to properly assess a resident's needs for side rail use. The side rail assessment form will be completed upon admission, readmission, with significant change and annually thereafter. R82 was admitted to the facility on [DATE] for short term rehabilitation with diagnoses that include fracture of unspecified part of neck of left femur, presence of left artificial hip joint, lack of expected normal physiological development in childhood, schizophrenia, moderate intellectual disabilities and history of traumatic brain injury. R82's admission MDS (Minimum Data Set) dated 2/28/24 documents R82 as being severely cognitively impaired. R82 is assessed to have impairment on one side of his upper and lower extremity. R82 requires partial to moderate assistance when rolling left to right and sit to lying position and supervision/touching assistance for bed to chair transfers. On 03/11/24 at 09:31 AM, during the initial tour, Surveyor observed R82 laying in a low bed with regular mattress and black grab bars on both sides of the bed. The grab bars were in a fixed position and did not move up and down. Surveyor reviewed R82's medical record. A side rail assessment for R82 was completed on 2/21/24 which documents that the resident is not able to make decision regarding safety and is not able to get in and out of bed without staff assist. The decision regarding the use of side rails documented in this assessment is no use of side rails. A review of R82's ADL (Activities of Daily Living) Functional Performance Deficit care plan created 2/21/24 documents the intervention, Cue resident to grasp side rail and pull self-up to a sitting position or to the side of bed, Date Initiated: 02/21/2024. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/24, at 09:45 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-I who informed Surveyor that typically the nurse on the floor will complete a side rail assessment. She confirmed that enabler bars are considered side rails and explained that all residents have an assessment completed upon admission and then quarterly if they have a side rail otherwise yearly if they did not. ADON-I was unsure how the results of the side rail assessment are communicated other than just being in the resident medical record. Surveyor and ADON-I walked to R82's room and ADON-I confirmed the black bars attached to R82's bed were enabler bars which are considered side rails. On 03/12/24, at 11:09 AM, Surveyor interviewed Registered Nurse (RN)-J, who stated typically the floor nurse will complete side rail assessments upon admission and at times therapy will complete them as well. On 03/12/24, at 01:26 PM, Surveyor spoke with Therapy Director-K who explained therapy may complete a side rail assessment if they think a resident would benefit from having them. Therapy Director-K confirmed therapy did not make any recommendations for side rails to be used for R82. On 03/12/24, at 01:34 PM, Surveyor observed R82 laying in the bed and observed the black enabler bars were removed from the bed. Surveyor spoke with Certified Nursing Assistant (CNA)-L who confirmed that maintenance came about an hour earlier and removed the bars. CNA-L stated the resident didn't need them anymore. On 03/12/24, at 02:51 PM, at the end of the day meeting with Nursing Home Administrator-A and Director of Nursing (DON)-B, Surveyor explained concerns regarding enabler bars on R82's bed when the side rail assessment assessed R82 to not use side rails. Requested side rail policy and procedures. On 03/12/24, at 03:19 PM, Surveyor spoke with Building Manager-M who confirmed he did remove the enabler bars from R82's today. Building Manager-M stated they do complete bed rail audits yearly as well as when a resident is discharged . Surveyor asked if he recalled a request to put the bed rails onto the bed for R82 and he stated he didn't remember and did not keep a log to check. Building Manager-M stated he also could not verify the enabler bars were removed from the bed prior to R82 being assigned to that bed and room. No additional information provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48391 Based on observation, interview, and record review, the facility did not ensure sufficient nursing staff was available to provide nursing and related services to assure residents attained or maintained the highest practicable physical, mental, and psychosocial well-being as determined by the resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment potentially affecting 115 of 115 residents in the facility. Residents voiced concerns there were not enough staff to care for their needs. The facility was identified as having consistently low weekend staffing on the Staffing Data Report submitted to CMS (Centers for Medicare and Medicaid Services) from 10/1/23 through 12/31/23. Staff indicated there were not enough staff on the unit to assist with residents' cares and needs. Findings include: The Facility Assessment stated the following for Licensed Nurses and Certified Nurse Aides (CNA) staffing coverage: Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident's needs. Total number needed or average or range of staff are 14 Licensed Nurses and 24 CNAs. Staffing may be adjusted based on resident needs. The facility uses a documented algorithm dated 6/18/23 to determine the number of CNAs needed based on total census. The determination of staff based on the census is as follows: 85-90 residents = 22 CNAs 91-96 residents = 23 CNAs 97-102 residents = 24 CNAs 103-108 residents = 25 CNAs 109-114 residents = 26 CNAs 115-120 residents = 27 CNAs The facility's algorithm indicates 14 Licensed Nurses are required throughout the facility with a total of 112 daily hours. Surveyor reviewed the resident council notes from the facility which indicate the following staffing concerns: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/30/23 Resident council notes document - Re-visited staffing concerns on the weekends. Discussed what the facility is doing to bring in new staff, and what the facility is doing to retain the staff they have. Residents expressed they would like to see more staff. -On 11/20/23 Resident council notes document - The facility spoke again to residents about staffing and incentives given when employees take on extra tasks. -On 12/26/23 Resident council notes document - Staffing concerns were addressed. The facility indicated since the last resident council meeting the facility has hired a new Licensed Practical Nurse (LPN) and two new CNAs. In an interview on 3/13/24 at 11:37 am, Scheduling Coordinator-V stated the facility's daily schedule is determined by following the facility's staffing algorithm to determine the number of CNAs and Licensed Nurses based on the number of residents within the facility. The staffing algorithm supports 27 CNAs and 14 Licensed Nurses per day based on a census of 115-120 residents. Scheduling Coordinator-V indicated weekend staffing requires the same number of staff as weekday staffing requirements. Scheduling Coordinator stated the facility has struggled with low weekend staffing and the facility does not always have the 27 CNAs that are required by the facility. Scheduling Coordinator-V reports about half of the weekends in the last month have not been fully staffed with the required 27 CNAs based on a census of 115-120 residents. Scheduling Coordinator-V reports about half of all weekend staffing has not met the staffing requirements in the last 6 months. Scheduling Coordinator-V stated the facility meets every Monday and every Thursday of the week to discuss scheduling concerns and requirements. Scheduling Coordinator-V report Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Assistant Nursing Home Administrator (ANHA)-C and Scheduling Coordinator-V are in attendance for the Monday and Thursday staffing meetings. Scheduling Coordinator-V indicates NHA-A and DON-B are aware of consistently low weekend staffing and this has been discussed in the Monday and Thursday weekly staffing meetings. Surveyor noted the acuity of the residents was not figured in when calculating the staffing needs. On 12/31/23, the Facility census was 114 residents. The daily staffing schedule reports the following staff: Day shift had 6 nurses and 9 CNAs, evening (PM) shift had 6 nurses and 7 CNAs, night (NOC) shift had 2 nurses and 6 CNAs. The facility reports the daily nursing schedule with 17 nurses for the day and a total of 19 CNAs for the day. Surveyor notes the facility is short a total of 7 CNAs for the day. This is determined based on a census of 114 by the facility algorithm used by the facility and requiring 26 CNAs. On 12/30/23, the Facility census was 117 residents. The daily staffing schedule reports the following staff: Day shift had 6 nurses, 2 Med Techs, and 10.5 CNAs, evening (PM) shift had 6 nurses and 8 CNAs, night (NOC) shift had 2 nurses and 6 CNAs. The facility reports the daily nursing schedule with 17 nurses for the day and a total of 16 CNAs for the day. Surveyor notes the facility is short a total of 11 CNAs for the day. This is determined based on a census of 117 by the facility algorithm used by the facility and requiring 27 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/24/23, the Facility census was 112 residents. The daily staffing schedule reports the following staff: Day shift had 6 nurses and 7.5 CNAs, evening (PM) shift had 5 nurses and 7.8 CNAs, night (NOC) shift had 2 nurses and 6 CNAs. The facility reports the daily nursing schedule with 16 nurses for the day and a total of 21 CNAs for the day. Surveyor notes the facility is short a total of 5 CNAs for the day. This is determined based on a census of 112 by the facility algorithm used by the facility and requiring 26 CNAs. On 12/23/23, the Facility census was 112 residents. The daily staffing schedule reports the following staff: Day shift had 6 nurses and 8.5 CNAs, evening (PM) shift had 6 nurses and 9 CNAs, night (NOC) shift had 2 nurses and 6 CNAs. The facility reports the daily nursing schedule with 16 nurses for the day and a total of 23 CNAs for the day. Surveyor notes the facility is short a total of 3 CNAs for the day. This is determined based on a census of 112 by the facility algorithm used by the facility and requiring 26 CNAs. On 12/17/23, the Facility census was 115 residents. The daily staffing schedule reports the following staff: Day shift had 4 nurses and 9 CNAs, evening (PM) shift had 6 nurses and 7 CNAs, night (NOC) shift had 2 nurses and 6 CNAs. The facility reports the daily nursing schedule with 17 nurses for the day and a total of 20 CNAs for the day. Surveyor notes the facility is short a total of 7 CNAs for the day. This is determined based on a census of 115 by the facility algorithm used by the facility and requiring 27 CNAs. On 12/16/23, the Facility census was 112 residents. The daily staffing schedule reports the following staff: Day shift had 6 nurses and 11 CNAs, evening (PM) shift had 5.5 nurses and 8 CNAs, night (NOC) shift had 2 nurses and 6 CNAs. The facility reports the daily nursing schedule with 17 nurses for the day and a total of 24 CNAs for the day. Surveyor notes the facility is short a total of 2 CNAs for the day. This is determined based on a census of 112 by the facility algorithm used by the facility and requiring 26 CNAs. In an interview on 3/13/24 at 1:27 pm, CNA-W stated CNAs are typically assigned 11 residents on their shift. CNA-W indicated the facility is short staffed and estimated about twice a month, she will be assigned to 22 residents which is over the recommended amount of residents assigned to a CNA. CNA-W stated staffing is based on resident needs indicating the facility will consider the number of residents requiring hoyer lifts and requiring more time when determining how many CNAs are on each unit when short staffed. CNA-W gave the example of the facility assigning one CNA to a unit that doesn't have as many hoyer lifts if they are short staffed for that day. CNA-W stated call lights are activated by the resident and can be visible to staff by looking at the call light monitors on the wall. Call light monitors are located on each unit that include when the call light was activated and for how long the call light has been on. On 3/13/24 at 9:57 am, Surveyor observed the call light monitoring system on the wall. Surveyor noted a resident on the 500 unit with an active call light for a total of 15 minutes. Two other call lights were initiated within that 15 minutes and answered within a few minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 3:47 pm, Surveyor shared with NHA-A and DON-B the concerns with consistently low weekend staffing triggering on the Staffing Data Report to CMS, residents expressing concerns with low staffing consistently during resident council, and staff indicating low staffing is consistent and ongoing. The scheduling coordinator did not take acuity of the residents into account when scheduling nurses and CNAs. NHA-A and DON-B notified Surveyor a performance improvement plan (PIP) was started at the Facility 3/5/24 to address the facility's low staffing concerns. Surveyor reviewed the PIP and noted the identified task of rounding education with the leadership team was the only action item with an estimated completion date identified, which was documented as 3/29/24. Surveyor notes 8 other action items did not have a start or completion date documented. Surveyor also noted the action item of a meeting scheduled for 3/12/24 was documented to have been rescheduled to 3/20/24 due to the State Survey team being in the building. No further information was provided at that 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** 38146 Based on comprehensive assessment of a resident, the facility did not ensure that residents were not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; residents who use psychotropic drugs received gradual dose reductions, unless clinically contraindicated; and PRN (as needed) orders for psychotropic drugs were limited to 14 days for 3 of 5 residents (R25, 103, and R81) reviewed for unnecessary medications. R25 did not have required gradual dose reduction for Mirtazepine (antidepressant medicaiton). R103 was prescribed PRN Lorazepam (sedative/antianxiety) without documentation of rationale by the Physician to extend beyond 14 days. R81 was prescribed Primidone (Anticovulsant) without clear indication of use. Findings include: R25 admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following Cerebral Infarction, Dysarthria, Dysphagia, Spondylosis lumbar region, Adult Failure to Thrive, Hypertension, Anemia, Polyosteoarthritis and Depression. R25's Care plan documented: (R25) is receiving Mirtazapine psychotropic medication. Noted to have diagnosis of Depression, unspecified. POA (Power of Attorney) has declined psych (psychiatric) services at this time. R25's Physician's Order included: Mirtazapine Tablet 15 mg (milligrams) give 1 tablet by mouth two times a day related to depression - start date 12/8/22. R25's February 2023 MAR (Medication Administration Record) documented: Mirtazapine Tablet 15 mg Give 1 tablet by mouth two times a day related to Depression, unspecified. Facility progress note dated 3/15/23 at 1:08 PM, documented: Psychotropic Note Text: GDR (Gradual Dose Reduction) meeting: GDR recommended; pharmacist recommends 15 mg once daily at bedtime. R25's March 2023 MAR documented: Mirtazapine Tablet 15 mg Give 1 tablet by mouth at bedtime related to depression - order Date 3/15/23. Facility progress note dated 1/24/24 at 1:14 PM, documented: Type: Psychotropic Note Author: Social Worker (SW)-E Social Services - Behavior management team reviewed psychotropic medication. GDR recommended for Mirtazapine from 15 mg to 7.5. Nursing will follow up with family to obtain consent for GDR. Surveyor noted a copy of this progress note was signed by the NP (Nurse Practitioner) on 1/25/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/24 at 9:42 AM, Surveyor spoke with SW-E who reported the facility has monthly meetings, but reviews GDR's quarterly so as not do the same unit too close together. Surveyor asked why R25's recommended GDR on 1/24/24 was not completed. SW-E reported she would have to check with nursing to see who followed up on it. On 3/13/24 at 11:52 AM, SW-E advised Surveyor that Director of Nursing (DON)-B called R25's son/POA on 1/31/24 and he did not want the GDR. SW-E informed Surveyor DON-B had an emergency that day and left the building, and that she documented the information in the notebook but didn't do a progress note. Surveyor clarified with SW-E: A GDR wasn't done because R25's son didn't want it? SW-E replied: Correct. Surveyor asked if the facility allows residents' families to dictate resident care. SW-E stated: Well, he is the POA and has the right to refuse GDR. Another Surveyor present asked SW-E where she obtained this information. SW-E reported she was not sure and would get more information. Surveyor was provided a copy titled Psychotropic Behavior Management Program last update 2/8/24 by (SW-E)/700 unit reviewed by behavior management meeting 2/21/24. (R25) Mirtazapine 15 mg. GDR recommended on 1/24/23, POA declined GDR 1/31/24. On 3/13/24 at 3:15 PM, during the daily exit meeting the facility was advised of concern regarding the lack of GDR reduction recommended for R25's Mirtazepine. On 3/14/24 Surveyor was provided a copy of an NP note for a visit on 2/1/24 which documented: GDR of Mirtazepine recommended by pharmacy, however, upon discussion with family, they would like to continue his current dose as he has been doing well and they are concerned that a dose reduction would be detrimental to his health. Continue current dose and will continue to monitor, will reassess for potential GDR again at a future date. Surveyor noted the NP progress note provided to Surveyor is not located in R25's medical record. Subsequent NP progress notes are noted in medical record for 2/15/24 and 2/26/24 with no mention of the recommended GDR. On 3/14/24 at 9:15 AM, Surveyor asked DON-B where the NP progress note for 2/1/24 came from, as it is not in R25's medical record. DON-B reported she called the clinic, and the NP sent it over to be scanned in. Surveyor advised concern still exists due to GDR not attempted in 2 separate quarters within the first year. R25 admitted to the facility on [DATE] with the first GDR 3/15/23, and no subsequent GDR attempt until recommendation on 1/24/24 that did not occur. DON-B reported she understood. 2) R103 admitted to the facility on [DATE] and has diagnoses that include Depression, Parkinson's Disease, Epilepsy, Encephalopathy, Orthostatic Hypotension, Dementia and Dysphagia. R103 signed on to Hospice on 2/22/24. R103's care plan documented: He is also receiving Lorazepam as part of a hospice comfort care package for nausea, restlessness, and moderate agitation - date initiated 2/12/24. Visual hallucinations Interventions: 1. Ensure his safety 2. Create calm atmosphere in his room [ROOM NUMBER]. Give him a little space 4. Talk in a slow, calm, soft tone 5. Redirect conversation. Yelling out/restless Symptoms Interventions: 1. Check and make sure he's ok 2. Talk in a calm, soft tone 3. Ask what we may help with (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Offer fluids or food 5. See if he'd like to be repositioned. R103's Physician Orders documented: Lorazepam Tablet 0.5 mg Give 1 tablet by mouth every 2 hours as needed for Nausea may take by mouth or under the tongue for moderate agitation or restlessness or nausea - order date 2/22/24. Surveyor noted there was no stop date for the as needed Lorazepam. Surveyor notes the 14 day end date would be 3/7/24. On 3/13/24 at 3:15 PM, during daily exit meeting, the facility was advised of concern regarding R103's PRN (as needed) Lorazepam order extending beyond 14 days without a stop date. No additional information was provided. On 3/14/24 Surveyor noted a new Physician's order for R103 entered on 3/13/24 for Lorazepam Tablet 0.5 mg give 1 tablet by mouth every 2 hours as needed for Nausea for 14 Days may take by mouth or under the tongue for moderate agitation or restlessness or nausea active 3/13/24, end date 3/27/24. 48391 R81 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes, generalized anxiety disorder, post-traumatic stress disorder (PTSD), cognitive communication deficit, essential tremor and absence of right leg above knee. R81's quarterly MDS (minimum data set) dated 2/20/24 indicates a BIMS (brief interview for mental status) score of 15, which indicates cognitively intact. R81's MDS indicates he is taking an antidepressant, opioids, and anticoagulant. No antipsychotics were received. Active diagnosis on R81's MDS include amputation, type 2 diabetes, hyperlipidemia, anxiety disorder, and PTSD. R81 uses a wheelchair for ambulating, is independent with eating and toileting, and requires partial to moderate assistance with bathing. R81's comprehensive care plan contains the following significant focused problems with interventions: R81 experiences periods of depressive symptoms related to physical disability and inability to return to home independently, initiated 11/16/23. Goal: R81 will have improved mood state through the review date, initiated 11/16/23. Interventions include: Behavioral health consults as needed, encourage R81 to maintain as much independence and control as possible, monitor/record mood to determine if problems seem to be related to external causes, monitor/record/report to Medical Director (MD) as needed acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills; initiated 11/16/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R81 is at risk for abuse related to diagnosis of PTSD (related to traumatic accident and amputation of leg). R81 does not currently report any trauma/traumatic symptoms affecting his daily life, initiated 12/8/23. Goal: R81 will remain safe, calm, and free from abuse through next review, initiated 1/15/24. Interventions include: At onset of behavior, calmly and firmly attempt to redirect to socially acceptable behaviors; check and assure physical comfort; compliment resident for appropriate social interactions; consider past patterns, personal and medical/psych history, interests, family/friends accounts to past incidents; consider possible antecedents: fear, fatigue, loss of control over a situation; determine preferred setting and approach and then offer health care accordingly; encourage R81 to participate in activities; encourage/reassure/redirect/repeat as needed; investigate accusation; maintain a calm soothing approach/environment and smile/pay compliments to promote feelings of belonging and importance with R81; monitor and report signs/symptoms of abuse; and simplify tasks, reduce stimulation, give more time or space if showing signs of feeling too challenged, initiated 1/15/24. Surveyor reviewed R81's Medication Administration Record (MAR) for March 2024 which includes Primidone 150 mg (milligrams) by mouth two times daily for seizures. Surveyor notes R81 does not have a diagnosis of seizures. Surveyor interviewed Assistant Director of Nursing (ADON)-H on 3/13/24 at 10:44 am who indicates seizures is listed as a reason for R81 taking Primidone according to the MAR. ADON-H then acknowledged R81 does not have seizures listed on his diagnoses and states she will be getting clarification on why R81 is receiving Primidone. On 3/13/24 at 1:36 pm, ADON-H notified Surveyor R81 was taking Primidone for essential tremors and not seizures. ADON-H indicated seizures was listed incorrectly on R81's medication order for Primidone. ADON-H provided documentation that R81's Nurse Practitioner (NP) was contacted for clarification on reason for taking Primidone. The NP indicated R81 is taking Primidone for essential tremors which is a current and accurate diagnosis. On 3/14/24 at 8:36 am, Surveyor notified DON-B of concerns with R81 having an order for Primidone to take for seizures and R81 not having a diagnosis of seizures. Surveyor notified DON-B of interview with ADON-H on 3/13/24 who received clarification of R81 taking Primidone for essential tremors and the order for Primidone had been modified after clarification with facility NP. Surveyor requested additional information if available. None was provided.

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility failed to ensure Hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 1 (R414) of 1 resident. The facility did not consistently update the physician or the power of attorney (POA) with changes in R414's condition; in failing to do so, the facility did not ensure collaboration of care between hospice, the facility, the physician, and the power of attorney. R414 had a change in condition with an unwitnessed fall on 10/27/23. R414 was noted to have hit his head, to have altered mentation, vomiting while being transferred to his bed using a Hoyer lift and fluctuating unstable blood pressure (BP) readings (BP 158/84, 80/40 and 200/94) at the time of the fall. On 10/28/23, R414 presented with further changes with confusion, rambling and slurred speech, weak hand grasp, poor coordination, being hunched over in wheelchair, lethargy, hands shaking, and needing assistance with eating. On 10/29/23, R414 sustained a second unwitnessed fall while reaching for his call light. R414 was found on the floor lying on his left side next to the bed lying over the call light and night stand base. R414 sustained a head injury, was moaning in pain, and in and out of cognition with intermittent nonsensical verbalization. R414 was left in this fall position for approximately 30-40 minutes until Hospice Registered Nurse (RN) arrived for evaluation. The facility nurse contacted hospice and was instructed not to send resident out for evaluation. The facility nurse indicated she did not agree with recommendations from hospice. The facility nurse did not contact clinical leadership with for further evaluation and to discuss discrepancies of recommendations between hospice and the facility at this time. Facility failure to coordinate care to the resident provided by the facility staff and hospice staff in collaboration with the MD and resident/family to ensure that the needs of the resident are addressed are met 24 hours per day, created a finding of immediate jeopardy that began on 10/27/23. Surveyor notified the Director of Nursing (DON)-B of the immediate jeopardy on 3/18/24 at 10:09 am. The immediate jeopardy was removed on 3/19/24. The deficient practice continues at a scope and severity of a D potential for harm/isolated as the facility continues to implement their action plan. Findings include: The Nursing Facility Services Agreement between [name of] Hospice Care and [Name of] Facility dated 7/18/2013 states: Definitions: (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Services means those personal care and room and board services provided by facility as specified in the Plan of Care for a hospice patient including, but not limited to; 1. Contacting family/legal representative for purposes unrelated to the terminal condition; 2. Arranging for the provision of medications not related to the management of the terminal illness. Hospice Physician means a duly licensed Doctor of Medicine or osteopathy employed or contracted by hospice who, along with the hospice patient's attending physician (if any) is responsible for the palliation and management of a hospice patient's terminal illness and related conditions. Hospice Services means those services provided to a hospice patient that are reasonable and necessary for the palliation and management of such hospice patient's terminal illness and are specified in a hospice patient's plan of care. Responsibilities of Facility: Facility shall comply with hospice patient's plan of care and shall ensure hospice patients are kept comfortable, clean, well-groomed, and protected from negligent and intentional harm including, but not limited to, accident, injury, and infection. Facility's primary responsibility is to provide facility services. It is facility's responsibility to provide facility services that meet the personal care and nursing needs that would have been provided by a hospice patient's primary caregiver at home, and facility shall perform facility services at the same level of care provided to each hospice patient before hospice care was elected. Coordination of Care: Facility shall immediately inform hospice of any change in the condition of a hospice patient. This includes, without limitation, a significant change in a hospice patient's physical, mental, social, or emotional status, clinical complications that suggest a need to alter the plan of care, a need to transfer the hospice patient to another facility, or death of a hospice patient. Term and Termination: Notwithstanding the above, either party may immediately terminate this agreement if a party fails to perform its duties under this agreement and the other party determines in its full discretion that such failure threatens the health, safety, or welfare of any patient. R414 was admitted to the facility on [DATE] with diagnoses of dementia, depression, panic disorder, anxiety, a-fib, obstructive uropathy, urine retention, [NAME] syndrome, and failure to thrive. R414 is his own person. R414's Admission Minimum Data Set (MDS) assessment completed on 8/24/23 indicates a Brief Interview for Mental Status (BIMS) of 9 indicating moderate cognitive impairment. R414 requires extensive assistance with one-person and physical assistance with bed mobility, transferring, dressing and toileting. R414 is not steady and is only able to stabilize himself with staff assistance while moving on and off the toilet. R414 has an indwelling urine catheter and is always continent of his bowels. R414's Care Plan indicates R414 is at high risk for falls related to limited mobility and impaired balance dated 8/17/23. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R414's medical records which indicate, Hospice performed a prescreening of possible discharge from hospice due to ineligibility on 10/17/23. Hospice social work will continue to support R414 and be evaluated 1-2 times per month and on an as needed basis. On 3/18/24 at 9:17 am Surveyor interviewed Hospice Director of Social Work (SW)-P who indicated there was a pre-discussion of possible ineligibility for R414 due to showing improvement. Pre-discussion of hospice care starts to take place when recertification time is approaching. The Hospice Director of SW-P indicated once a resident is deemed in eligible for hospice, the hospice staff have 2 days to develop a plan of care for discharge. Hospice Director of SW-P indicated R414 had continued hospice care due to the change in condition. On 10/27/23 at 1730 (5:30 pm), the facility documentation indicates the CNA found R414 on the bathroom floor. R414 had an elevated BP and was noted to have altered mentation with being unable to convey where he was, day of the week nor the month. R414's baseline orientation is fully oriented to person, place, time, and event. The facility charge nurse and Rainbow Hospice were notified of the unwitnessed fall. R414 had an improvement with his vital signs and mentation after Hospice arrived at the facility at 6:45 pm. On 10/27/23 at 5:34 pm, the facility documentation indicates R414 was found lying on his back flat on the bathroom floor and R414 hit his head. R414 had complaints of pain in his upper back between his should blades, altered mentation, along with high blood pressures and low pulse rates. R414 had a brown emesis while being transferred with a Hoyer lift back to his bed. Documentation states hospice was updated however, it is unclear as to whether hospice was updated on R414 hitting his head. Hospice instructed the facility to administer Zofran for vomiting. The facility documentation indicates family was informed of R414 having a change in condition by the hospice staff. Surveyor notes the resident hit his head and it is uncertain if this was relayed to the hospice staff or MD at the time of the change in condition and it is unclear if family was updated on R414 hitting his head along with symptoms of altered mentation. It is unclear if the power of attorney (POA) was given the option for R414 to seek evaluation for the significant change in condition that is unrelated to R414's hospice diagnosis. The hospice visit note from the hospice RN dated 10/27/23 at 6:45 pm. indicates R414 is fully oriented with pupils being equal and reactive to light. Documentation reports R414 denies hitting his head. R414 was provided Tylenol and reports his last bowel movement being 3 days ago. Hospice changed R414's Miralax from every other day to every day during this visit. Documentation indicates the MD on call and POA was notified of updates however, Surveyor notes there is no documentation indicating what was discussed with the MD at the time of the update from hospice staff. Surveyor notes R414 denying hitting his head however, R414 was noted to having altered mentation at the time of his fall and was unable to recall place and time while being evaluated. Facility Neuro check documentation dated 10/28/23 at 3:47 am indicates R414 had rambling speech with a weak right-hand grasp. Surveyor notes there is no documentation indicating hospice or the MD were notified of this significant change in condition with R414 having weak right-hand grasps and rambling speech. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility documentation dated 10/28/23 at 9:58 am indicates the facility nurse notified hospice with a significant change in condition. R414 was feeling off, hands being shaky, lethargic, and needing to be fed for breakfast. R414 did not previously require assistance with eating. Documentation indicates R414 indicated to the nursing staff he hit his head and acknowledged he notified hospice on 10/27/23 that he did not hit his head. This was relayed to the hospice staff by the facility staff at the time of phone call to hospice. Surveyor notes the MD was not notified of R414 notifying staff he hit his head and having significant change in condition. Documentation indicates a second call was placed by the facility to hospice on 10/28/23 at 10:28 am indicating R414 is hunched over in his wheelchair with increased fatigue. The facility staff requested hospice evaluation. On 10/28/23 at 2:19 pm the documentation from hospice indicates R414 having poor coordination, increased sleep, lethargy, and urine Foley draining concentrated clear urine. Surveyor notes there is no documentation that the MD was notified of the significant change in condition and no new interventions were placed after hospice was notified of R414 hitting his head. There is no collaboration between the facility, hospice, MD, and family to discuss treatment options. Surveyor reviewed the Neuro check performed on 10/28/23 at 4:00 pm which indicates R414 with a change in condition with having slurred speech. R414 has a strong right-hand grasp, and the left hand was not documented as assessed. Surveyor notes the MD was not notified of the significant change in slurred speech. Surveyor reviewed the post fall documentation on 10/28/23 at 8:00 pm which indicates R414 is alert with confusion and fatigue is noted. R414 can answer questions appropriately but did mumble stories about siblings that were nonsensical. Documentation reports R414 hit his head on 10/27/23 and surveyor notes the MD was not notified of this change in condition at the time of the post fall documentation. Documentation from 10/29/23 at 9:10 pm indicates R414 was found on the floor lying on his left side of the bed with the call light and nightstand base under him. R414 was moaning in pain with c/o pain in his back, left arm and left shoulder. R414 had a head injury with blood present on the floor. R414 was noted to have cognitive impairment, intermittent nonsensical verbalization, pinpoint eyes, eyes wrenching, a left forehead hematoma measuring 4 cm x 3 cm with a 2 cm laceration to the middle of the hematoma, and no urine output in the urine Foley bag. The charge nurse and hospice were notified. Hospice instructed the facility staff to not send out R414 for evaluation prior to hospice doing an evaluation. The facility nurse applied pressure to R414's head injury site and remained with R414 in the fall position until hospice arrived for evaluation. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Documentation from Hospice Progress notes dated 10/29/23 at 9:34 pm indicates R414 had an unwitnessed fall and sustained a head injury. R414 denied pain but was observed to be wincing with movement. Documentation from Hospice indicates as needed (PRN) pain medication was given due to R414 likely being sore and probably having a headache. R414 was observed to be alert and oriented and tolerating changing his shirt without the facility staff in R414's room. Hospice reports facility staff chose to leave R414 on the floor with a pillow under his head until hospice arrived for evaluation. R414 was assisted back to bed using a Hoyer lift. Hospice attempted to contact R414's POA who was unavailable. Hospice left a message. The hospice nurse applied steri strips to R414's head wound and a new Foley catheter was inserted with 2400 cc of dark amber urine and large amounts of thick fibrous tan drainage was noted. Surveyor notes there is no documentation of collaboration of care between the facility, hospice, the MD or the POA to discuss treatment options for R414's significant change in condition with R414's fall and retaining large amounts of urine nor discussing the option of evaluation after this significant change. Surveyor interviewed Licensed Practical Nurse (LPN)-S on 3/14/23 at 11:00 am. LPN-S indicated R414 is typically alert and oriented and able to make his needs known. LPN-S reported R414 being weak and requires assistance of one with ambulation, toileting and transferring. LPN-S stated the facility staff had to frequently remind R414 to contact staff when needing to transfer as R414 frequently ambulated independently without calling for assistance. LPN-S indicated she could clearly tell R414 had a head injury on 10/29/23 at 9:10 pm after R414 had a second unwitnessed fall from his bed while reaching for the call light that was out of reach. LPN-S applied pressure to R414's head to help control bleeding and stayed with R414 for approximately 30-40 minutes in the fall position while she waited for hospice to come and evaluate R414. LPN-S described herself as being old school and thought residents had the option to be sent out for evaluation with a significant change in condition even though they are receiving hospice care. LPN-S indicated R414 wasn't dying from his hospice diagnosis and was told not to send out R414 for evaluation by hospice. LPN-S stated she did not feel comfortable with this decision as she knew R414 clearly had a brain injury with R414's eyes being dilated and changed. LPN-S was unsure if R414's POA was contacted to discuss the significant change in condition and whether the POA was given the option to send R414 out for evaluation. LPN-S indicated she was fearful of the head and neck injury R414 sustained. LPN-S indicated she noticed no urine output in R414's urine Foley catheter bag while holding pressure on R414's head injury and notified hospice upon arrival. LPN-S indicated she does not recall if the MD was notified by the hospice nurse. Surveyor interviewed DON-B on 3/18/24 at 10:09 am who indicates facility staff are to contact hospice with any residents having a change in condition. Surveyor reviewed with DON-B that facility staff were interviewed and reported not feeling comfortable with coordination and care being provided to R414 by hospice staff on 10/29/23 at the time of R414 having a second unwitnessed fall. DON-B indicated staff are to contact clinical leadership if they do not feel comfortable with orders given by the hospice staff. DON-B indicates she was not aware of the facility staff not feeling comfortable with orders being provided by hospice indicating R414 is to not be evaluated due to being on hospice. DON-B indicated clinical leadership should have been notified with this significant change on 10/29/23 and the facility staff not feeling comfortable with hospice recommendations to not send resident out for evaluation. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed the facility fall investigation dated 10/29/23 at 9:10 pm indicating R414 sustained a hematoma and laceration to the face along with a skin tear to the left hand. R414 is oriented to person, the facility NP (Nurse Practitioner) was notified on 10/30/23 at 3:53 pm, and POA was notified on 10/30/23 at 3:29 pm. Surveyor notes the MD was not notified of the significant change in condition. Surveyor also notes the facility NP and POA were notified the following day approximately 18+ hours after the significant change in condition. Surveyor notes documentation does not state was what discussed with the facility NP and POA at that time of phone call and if it the option for R414 to seek further evaluation was discussed. There is no collaboration of care between the facility, hospice, the MD or the POA. On 3/18/24 at 8:57 am, Surveyor spoke with Medical Director (MD)-O of the facility. Surveyor reviewed the change in condition with R414 that occurred on 10/29/23. MD-O indicated he does not recall being notified of the change in condition with R414 on 10/29/23. MD-O stated, if the facility does not agree with hospice recommendations, the facility is to reach out to the MD to discuss the change in condition with the resident. MD-O indicated the resident has the option to go to the emergency room for further evaluation while receiving hospice services. Surveyor notes, facility documentation does not reflect the change in condition with R414 being discussed with MD-O. Surveyor reviewed the facility neuro check documentation on 10/30/23 at 1:00 am indicating R414's pupils not being equal in size, with the right pupil being fixed, left pupil being sluggish, and R414 being unable to grasp hands. Surveyor reviewed the facility neuro check documentation on 10/30/23 at 2:00 am indicating R414's is aphasic (a person who is unable to communicate), right pupil is fixed, left pupil is sluggish, and unable to grasp hands. Facility progress note dated 10/30/23 at 2:59 am was reviewed by the surveyor and notes the facility placed a call to hospice with an update on R414's neuro checks and R414 being unresponsive. Hospice advised the facility to continue with keeping R414 comfortable and provided no additional interventions. Surveyor notes clinical leadership and the MD were not notified of these changes. There was no collaboration of care between the facility, hospice, the MD, and the POA. Facility progress note dated 10/30/23 at 3:04 am indicates the facility contacted R414's POA with an update. Surveyor notes the facility did not document what was discussed with R414's POA and if options to send out R414 for evaluation was provided. Surveyor also notes clinical staff and MD were not updated of the significant changes in condition with R414. Surveyor reviewed facility progress note dated 10/30/23 at 3:13 am indicating the facility contacted hospice with updates on neuro checks and R414 being non-responsive. Hospice stated if R414 had a brain bleed that there is nothing that can be done for his condition. Surveyor notes MD and clinical leadership were not updated at this time. Surveyor reviewed hospice progress note dated 10/30/23 at 9:15 am indicating R414 requires meals set up, decreased appetite, increased dysphagia, choking and coughing with thinned liquids, increased pain, total dependence with bathing, and is bedbound with assistance of a Hoyer lift after two unwitnessed falls on 10/27/23 and 10/29/23. R414 is requiring head support with a rolled towel to prevent neck pain and is unable to move his own head/neck. Urine is noted to be dark concentrated with sediment in Foley catheter tubing. (continued on next page)

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Alden Estates of Countryside, Inc	1130 Collins Road Jefferson, WI 53549

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed the Interdisciplinary Team (IDT) note dated 10/30/23 at 11:42 am indicating the 10/27/23 fall for R414 was reviewed for safety and a new intervention was placed. Surveyor notes the 2nd fall from 10/29/23 was not reviewed, the MD was not notified of the significant changes in condition, and there was one change to the care plan to include medication adjustments per hospice for R414 being a high risk of falls. Surveyor also notes it is unclear if clinical leadership is present for the IDT meeting. Surveyor reviewed the Hospice Comprehensive Review Assessment note dated 10/30/23 at 11:21 pm indicating hospice sent an email to the POA and DON-B with R414 having an increase in lethargy, rambling speech, reduced appetite, and trouble swallowing post falls. Facility progress note dated 10/31/23 at 12:30 am indicates the facility contacted hospice with concerns of R414 having a low-grade fever, elevated BP and R414 complaining of neck pain. Hospice instructed the facility to administer Morphine for pain and apply a cool cloth to reduce the fever. Surveyor notes the MD was not notified of this change. Surveyor reviewed the facility progress note dated 10/31/23 at 2:05 pm indicating the POA was visiting with R414 and expressed concerns with hearing cracks in R414's neck when he moves. The facility progress note indicates Morphine was administered to R414 for neck pain and notified the charge nurse and hospice with an update. Surveyor notes the MD was not notified of this significant change. Hospice Progress note dated 10/31/23 at 3:30 pm indicates R414 is in pain, increased sleeping, withdrawn, minimal responsiveness, barely opening his eyes, abdominal respirations, slow capillary refill in his nail beds, pallor, crackles in his lungs (fluid building up in the lungs), skin cool to touch, skin mottled in areas (lack of blood flow to the skin), and unable to respond to tell staff how he feels. Hospice Progress Note dated 11/1/23 at 10:00 am indicates R414 is unresponsive, having irregular heart rates, breathing through his mouth, eyelids barely opening, shallow respirations, crackles to his lungs, coughing to clear his airway, unresponsive to touch or voice however, R414 jerks and gasps when the hospice nurse swabs R414's lips. Documentation indicates the hospice nurse noted no PRN medications (Lorazepam and Morphine) given since last visit on 10/31/23 at 3:30 pm. Hospice updated the POA however, Surveyor notes documentation does not indicate what was discussed with POA. Surveyor notes the facility documentation on 11/2/23 at 2:48 am indicates R414's POA contacted the Nursing Home Administrator (NHA)-A regarding R414's current condition. The POA expressed concerns with R414 needing to eat more. NHA-A educated the POA on the risk of intake when R414 is not alert and oriented. The NHA-A suggested the POA reach out to hospice for additional support. Surveyor notes the POA is not comprehending the severity of R414's current prognosis and significant change in condition and the NHA-A advised POA to contact hospice. Hospice Progress Note dated 11/2/23 at 11:00 am notes R414 is having an elevated pulse, rapid respiratory rate (RR) of 36 (normal RR is 16), gasping for air, abdominal respirations, using accessory muscles with breathing, coughing, short of breath, and moderate discomfort with breathing. Documentation indicates hospice updated the POA and administered 1 dose of Morphine for shortness of breath. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility progress note dated 11/2/23 at 10:50 pm indicates the CNA called the nurse into R414's room. R414 was pulseless and not breathing. Hospice and the facility charge nurse were notified by the facility staff. Surveyor interviewed RN-U with Hospice on 3/14/24 at 11:42 am. RN-U indicated if a resident has a significant change in condition the MD is notified by hospice staff. RN-U indicated the whole care team including hospice and the facility MD are notified with any significant change in condition. RN-U reported the family and/or POA are contacted to discuss possible hospital evaluations and options for care after a significant change in condition. RN-U stated hospice can have portable x-rays performed in the facility for residents with suspected changes in conditions related to a fall. RN-U indicated these options such as portable x-rays and emergency room (ER) evaluation are to be discussed with the MD with any significant changes in condition. Surveyor notes portable x-rays and ER evaluation were not documented that they were discussed with R414 or his POA after the changes in conditions related to his head and neck injuries. Surveyor interviewed Hospice DON-Q on 3/14/24 at 1:21 pm who indicated hospice documentation did not reflect that hospice was aware of R414 hitting his head on 10/27/23. Hospice DON-Q indicated hospice will talk with the family and the POA to give options to seek treatment with any significant changes in condition. Hospice DON-Q reported it is a collaborative effort with the facility and hospice staff to discuss changes in condition and treatment options. Hospice DON-Q indicated hospice documentation does not state R414 was offered to be evaluated in the ER. Hospice DON-Q indicated the facility and hospice are to discuss all options with R414 and the POA after the significant change occurred on 10/27/23. Hospice DON-Q reports there is no documentation from hospice indicating further treatment was discussed with R414 or R414's POA on 10/27/23 through 11/2/23. On 3/18/24, at 10:09 AM, Surveyor notified Nursing Home Administrator-A and Director of Nursing-B of concerns with the following: ~ Assessments between the facility and hospice being contradictory. ~ Interview with facility staff not being comfortable with recommendations provided by hospice staff. ~ The lack of education for facility staff on how to move forward if facility staff are not in agreement with resident care. ~ The failure of coordination of care between hospice and the facility. The facility documented the assessments with the significant change in condition with R414 and R414 continued to decline. ~ The failure of the facility designating a member of the interdisciplinary team who is responsible for collaborating with hospice representatives and coordinating facility staff in the significant change in condition for R414. ~ MD not being updated with R414's significant changes in condition on 10/28/23, 10/29/23, 10/30/23, 10/31/23, and 11/1/23 for possible alterations in treatment. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ Interview with MD-O indicated he was unaware of the change in conditions occurring with R414. DON-B notified MD-O would have discussed the options for further evaluation should he have been updated. MD-O indicated the facility is to contact him should there be a conflict between hospice and facility recommendations. ~ Facility staff did not contact clinical leadership on 10/29/23 when not agreeing and feeling uncomfortable with recommendations from hospice for R414 to not receive further evaluation after significant changes. The facility's failure to establish a communication process to ensure that the needs of R414 are addressed/met, designate a member of the facility's interdisciplinary team who is responsible for working with hospice to coordinate care for R414, and ensure a plan of care to attain and maintain R414's highest practicable well-being delayed medical intervention for R414 and increased a reasonable likelihood for serious harm, thus creating a finding of Immediate Jeopardy. The Immediate Jeopardy was removed on 3/19/24 when the Facility completed the following: -All residents receiving hospice care were reviewed for changes in condition, falls and hospice service and care plans were updated as indicated. -All nursing staff and clinical managers were educated by the Director of Nursing or designee to notify the physician when a change of condition occurs with a resident. -All nursing staff and clinical managers were educated by the Director of Nursing or designee on proper collaboration with the hospice provider. This education included when it would be appropriate to discuss a change in the treatment/care plan of the residents based on the resident's needs. -All nursing staff and clinical managers were educated by the Director of Nursing or designee on hospice collaboration and the need to ensure resident choice is honored while providing the care and treatment to their highest practicable level of care. -A meeting with the hospice company in question was held. All other hospice companies were contacted to improve collaboration and responsibilities of both the facility and the hospice company. -The Nursing Home Administrator, Director of Nursing, Nurse Consultant, and Medical Director reviewed policies and procedures as it related to the hospice service. -The DON or designee is responsible for coordinating services between the hospice provider and the facility. -A review for compliance using a Quality Assurance audit tool was completed and will be conducted 4 times a week for 4 weeks, and monthly for three months. -The results of the audits will be reviewed by the Facility QAPI team including the Medical Director to determine and necessary changes. (continued on next page)

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F 0849 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An emergency QA meeting was held on 3/18/24 by the Nursing Home Administrator with the Interdisciplinary Team and Medical Director. In the meeting the team discussed collaboration between the Facility and the hospice agency.

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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. 21855 Based on observation, interview, and record review, the facility did implement effective infection prevention measures. This included N95 mask fit testing for staff with the potential to effect all 115 residents in the facility. This includes Foley bag maintenance in 1(R85) of 4 residents observed with Foley bags. * The facility did not ensure all staff exposed to COVID-19 were properly fit tested for a N95 mask to prevent the spread of infection. * The facility did not ensure R85's Foley bag was maintained in a sanitary manner. Findings include: The facility policy and procedure for Management of Residents with Confirmed or Suspected COVID-19 Infection or Identified as a Close Contact, dated 1/5/24, was reviewed by Surveyor. The section: Residents with Confirmed COVID-19 documents: . 3. Isolate using Transmission-Based Precautions, . 10. Staff must wear full PPE (Personal Protective Equipment) (N95 respirator, gown, gloves, eye protection) when providing care. The facility did not have a specific policy and procedure for Foley bag infection prevention. 1.) On 3/11/24 upon entering the Facility for the Recertificaiton and Complaint Survey the Facility identified R65 as having COVID and on the appropriate isolation precautions in place. This was verified through observation by Surveyor. There was no concerns identified with staff donning and doffing PPE (personal protective equipment) when caring for R65. On 3/13/24 at 9:00 AM, Surveyor interviewed, and reviewed, the Facility's Infection Control program with NC-F (Nurse Consultant) and IP-H (Infection Preventionist). Surveyor asked to review the staff list for N95 mask fit testing due to the facility having COVID positive residents. NC-F indicated several staff perform the mask fit testing. Surveyor was informed that MR-N (Medical Records) performs the N95 mask fit testing and keeps the records. The facility has an investigation summary for March COVID tracking. This tracking indicates R65 was positive for COVID on 3/4/24 and contact tracing did not reveal any positive COVID. There has been no staff with positive COVID. On 3/13/24 at 1:44 PM, Surveyor spoke with MR-N and Nursing Home Administrator-A. The facility was trying to fit test staff in coordination with their anniversary date. They got behind and do not know who is currently up to date with N95 fit testing. Nursing Home Administrator-A indicated they keep the same staff assigned to care for a COVID positive resident. They are doing all staff N95 fit testing in March and will do it annually every March. All staff were fit tested originally. Surveyor notes not all staff are up to date with their N95 fit testing. The Facility stated they would provide a list of staff that are up to date on the N95 mask fit testing and that have cared for R65. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/24 at 8:16 AM, Surveyor received N95 mask fit testing for staff that have worked with COVID positive residents. There were 30 staff listed with 10 of the staff up to date on their fit testing. The facility line list for COVID indicates 1 resident tested positive on 3/4/24 and 1 resident on 3/10/24 and one on 3/12/24. A total of 3 residents total tested positive for COVID in March. On 3/14/24 at 9:33 AM, Surveyor spoke with ANHA-C (Assistant Nursing Home Administrator) and Nursing Home Administrator-A whom stated there are no COVID positive staff. The staff list provided to Surveyor was staff that worked on R65's unit that were not up to date on N95 fit testing and this March all staff that come in to pick up paychecks will be fit tested . The facility issues paper pay checks so all staff come to the facility. They will track staff and follow-up with those who need to be re-tested . 46214 2.) The facility policy entitled, Indwelling Catheter dated 9/2020, states: Indwelling catheters will be utilized to facilitate urinary drainage when medically necessary. #4. Secure catheter tubing as appropriate to minimize movement of catheter. #8. Utilize Standard Precautions when manipulating catheter site. On 03/11/24, at 11:54 AM, during the initial screening of residents, R85 informed Surveyor they have a catheter. On 03/12/24, at 08:11 AM, Surveyor observed R85 in their bedroom. R85 was sitting in the wheelchair next to the bed. Surveyor observed the entire catheter bag and some tubing laying on the floor under the wheelchair. On 03/12/24, at 08:18 AM, Surveyor observed Certified Nursing Assistant (CNA)-L enter R85's room to provide cares and shut the door. At 08:23 AM, CNA-L open R85's bedroom door and transports R85 to the dining room. Surveyor observed a covered catheter bag drag on the floor under the wheelchair during the transport. R85's physician orders document to change catheter every 30 days, active date of 2/28/24 and may use indwelling urinary catheter Foley, 18F size 10cc (cubic centimeters) balloon size due to urinary retention, active date 1/15/24. R85's electronic, and paper medical record, did not contain a comprehensive plan of care with individualized interventions for bowel and bladder or an indwelling catheter. Surveyor reviewed a hospital discharge summary dated 1/15/24 which documents, Patient had urinary retention for which he was initially straight catheterize. They had recurrent urinary retention for which an indwelling Foley catheter was placed. Patient was initially significantly confused with the acute urinary retention. Confusion has resolved completely following placement of indwelling Foley catheter .Planned follow-up with Urology in 2 weeks for further evaluation of urinary retention. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/12/24, at 08:25 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-L who informed Surveyor she was trained on catheter care which would include checking the tubing for any kinks, keeping the bag covered when outside of the bedroom and keeping the bag below hip level and off of the floor. CNA-L stated she typically emptied the bag in the morning when getting resident out of bed and then will empty it again later in the afternoon. Surveyor asked CNA-L if she observed the catheter bag to be on the floor when she went in to provide cares. CNA-L confirmed the catheter bag was on the floor and that it must have fallen. CNA-L also confirmed the catheter bag should not be dragged on the floor during transport. She stated she was not aware that the bag was dragging earlier when she transported R85 from the bedroom to dining room for breakfast. On 03/13/24, at 10:34 AM, Surveyor interviewed Registered Nurse (RN)-J who informed Surveyor catheter bags should not touch the floor and they should never be dragged across the floor. RN-J confirmed R85 does have a history of UTI's (urinary tract infections) and R85 has been assessed by the urologist who plans on keeping the catheter in long term due to urinary retention. On 03/14/24, at 08:23 AM, Surveyor interviewed Director of Nursing (DON)-B who informed Surveyor all staff are trained on catheter care as it is part of orientation as well as yearly competency. DON-B confirmed catheter bags should not be touching the floor which would include laying on the floor and being dragged on the floor during transport. On 03/14/24, at 03:28 PM, during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Assistant Nursing Home Administrator (ANHA)-C, Surveyor shared concerns regarding two observations of R85's catheter bag touching the floor. No additional information was provided.