STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525273	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloit Health and Rehabilitation Center	1905 W Hart Rd Beloit, WI 53511

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review, the facility did not ensure each resident had the right to a safe, clean, comfortable, and homelike environment for 3 of 3 sampled Residents (R35, R52, & R15) and 1 of 1 supplemental (R49). R35 and R49's floor in their room had not been cleaned and had visible dirt on the floor. R15's room was not homelike with visible repairs needed. R52 voiced concern that R52 is unable to use closet in bedroom because of roommate thinking R52 is stealing clothes. R52 voiced concern that her dresser is broken as well. R52 indicated she has to keep all of her clothes and items in boxes in R52's room. Surveyor observed R52 to have boxes stacked up in her room. This is evidenced by: Facility Policy entitled 'Routine Cleaning and Disinfection,' dated 8/2022, states in part: Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products.Policy explanation and compliance Guidelines: 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms and at the time of discharge . Example 1 Facility cleaning schedule sheets dated 9/9/24 indicates Needlepoint, Birchway, and Chapelway Halls were not cleaned by housekeeping. On 9/10/24 at 8:04 AM, Surveyor was going down Needlepoint Hallway observing the environment and rooms. Two Surveyors observed R35 and R49's rooms to have an unclean floor, more than half of the room appeared unclean with visible dirt on the floor. Surveyor took a wet paper towel and wiped an area on the floor that appeared to be unclean and was able visible remove dirt off the floor in both R35 and R49's room. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 at 8:06 AM, Surveyor interviewed Housekeeper J (HSK) regarding the floors. HSK J indicated he's only at the facility on Tuesdays, Wednesdays, and Fridays to clean the floors. Surveyor asked HSK J who would clean the floors when he's not there, HSK J replied to no one deep cleans the floors when he's not there, but Housekeepers are to mop and sweep each room every day. HSK J indicated he cleans R49's floors really good on Fridays. HSK J indicated that R35 and R49's floors were not cleaned. On 9/10/24 at 9:34 AM, Surveyor interviewed R35 regarding his floor. R35 indicated his floor has been unclean for a little while and was unable to say how long the floor was dirty. On 9/10/24 at 12:22 PM, Surveyor interviewed HSK K regarding cleaning. HSK K indicated she cleans the sink, the toilet, and the bathroom, then removes the trash before she sweeps and mops on her assigned side. HSK K who was currently in R49's room indicated this unit was not her assigned unit or side. HSK K indicated she was just called down to clean the floor for the 3rd time as R49 has a habit of peeing on the floor. HSK K indicated the other housekeepers work every other day and the person normally down here on the other days up and quit on Friday. Surveyor asked HSK K who the housekeeping manager is and HSK K indicated it is NHA A (Nursing Home Administrator) currently. On 9/10/24 at 12:37 PM, Surveyor interviewed NHA A regarding observations on Needlepoint Hall. NHA A indicated that the usual housekeeper quit on Friday. NHA A indicated that no one cleaned down Needlepoint yesterday (9/9/24) due to a miscommunication with staff. NHA A indicated that the CNA's did take trash out of the rooms, but no one swept or mopped the floors yesterday. 44552 Example 2 R52 was admitted to the facility on [DATE] with a diagnoses including parkinsonism, asthma, diabetes, respiratory failure, depression, anxiety disorder, and insomnia. R52 most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/6/24, indicates R52 has a Brief Interview for Mental Status (BIMS) score of 13 indicating R52 is cognitively intact. R52 is own person. On 9/9/24 at 4:25 PM, R52 indicated R52 is unable to use her closet. R52 indicated her dresser is broken so she has to keep clothes and personal items in boxes. Surveyor observed boxes to be lined up against wall in R52's room. R52 indicated she has reported these concerns to staff. On 9/12/24 at 9:34 AM, MD Q (Maintenance Director) indicated staff are able to report maintenance issues through their computer system. MD Q indicated he was not aware of R52's concern with her dresser and closet. MD Q indicated he would expect staff to report maintenance issues through reporting system so he can track and prioritize projects. MD Q indicated he would go talk to R52 now and fix her dresser. On 9/12/24 at 12:14 PM, SW D (Social Worker) indicated she would follow up with R52 regarding her closet and dresser and ensure someone assists her with unpacking boxes. SW D indicated she would expect residents to have a dresser and an area to have personal items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50285 Example 3 R15 was admitted to the facility on [DATE] with diagnoses that include Major Depressive Disorder, unspecified dementia, muscle wasting and atrophy, and anxiety disorder unspecified. R15's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R15 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicates he has severe cognitive impairment. On 9/10/24 at 10:28 AM, Surveyor observed the condition of R15's room and noted that the trim was pulling away from the wall by the sink, a large area of peeling paint and drywall near the foot of the bed, multiple brown scuff marks on the wall next to the bed, and a large blackish stain on the overhead ceiling tile. On 9/10/24 at 11:40 AM, Surveyor interviewed R15's Power of Attorney (POA) and RR U (Resident Representative). RR U stated that overall, the facility could do a better job with the cleaning and maintenance of the building. RR U commented that the trim in R15's room was coming loose, and the drywall was disintegrating. RR U stated that the room had been in this state of disrepair for months. RR U said that she had come in to visit R15 and noticed drops of urine on the floor that she had cleaned up herself. On 9/11/24 at 7:43 AM, Surveyor interviewed Maintenance Q, who stated that he was aware of the condition of R15's room, and that the repairs were on his priority list. Maintenance Q stated that the black stain on the ceiling tile was not mold, but was condensation sweat from the black pipe that was above the ceiling, and that he had ordered new ceiling tiles. Surveyor asked Maintenance Q if R15's room would be considered a homelike environment, and Maintenance Q said no, it was not a homelike environment. On 9/12/24 at 10:16 AM, Surveyor interviewed NHA A (Nursing Home Administrator), who stated that next year the facility would be getting new flooring and when they do that, they will also fix the peeling wallpaper and paint. Surveyor asked NHA A if the scuff marks, crumbling wall, and peeling paint in R15's room would be considered a homelike environment, and NHA A stated no, that is not a homelike environment.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849 Based on observation, interview, and record review, the facility did not ensure grievances were documented and thoroughly resolved for 1 of 24 sampled residents (R23). R23 reported a grievance regarding her Hoyer (full body lift) transfers, and this was not documented or thoroughly resolved. R23 reported a grievance regarding an interaction with a staff member and this was not documented or thoroughly resolved. Evidenced by: The facility policy, Grievance Guideline, revised on 5/31/23, indicates, in part: Purpose: To provide a process to voice grievances (such as those about treatment, care .or violation of rights) and respond with prompt efforts to resolve while keeping the resident and/or representative appropriately apprised of progress toward resolution . Guideline: .Filing a Grievance .A grievance or concern may be expressed orally or in writing to the Grievance Officer or facility staff .Grievances may be given to any staff member who will forward the grievance to the Grievance Officer, or they may file the grievance anonymously .Response: Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Official. Grievances will be recorded and logged through Grievance Portal or written Grievance Form. Upon receipt of a grievance or concerns, the Grievance Official will review the grievance, determine immediately if the grievance meets a reportable complaint consistent with the facility Abuse Prevention Policy .The Grievance Officer will initiate the appropriate notification and investigation processes per individual circumstances and facility guidelines .Resolution: The Grievance Official and/or designee will complete a response within 5 days of receipt to the resident and/or resident representative which includes: Date of grievance, Summary of grievance, Investigation steps, Findings, Resolution outcome and actions taken with the date decision was determined . Example 1 R23 was admitted to the facility on [DATE]. R23's Activities of Daily Living (ADL) Care Plan, with a revision date of 5/2/23, indicates R23 requires staff intervention to complete ADL's. Interventions include, in part: .Hoyer (full body lift) sling with hole cut out for bed side commode toileting needs. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 3:00 PM, Surveyor interviewed R23 who indicated the facility now has a different Hoyer lift that is too short and so when the staff transfer her from her bed to the commode, they cannot lift her high enough and her buttock rubs across the bed which also hurts her right hip and causes a burning sensation. R23 indicated she was told the Hoyer they use to have is being repaired but it has been a month. R23 indicated that DON B (Director of Nursing) and NSD W (Nutrition Services Director) were in her room when she was in the sling and were making suggestions, but that everything they tried did not work. Of note, NSD W, is also a CNA (Certified Nursing Assistant). On 9/10/24 at 4:25 PM, Surveyor interviewed CNA AA who indicated she does assist R23 from her bed to the bedside commode. CNA AA indicated she does not like the big boy Hoyer, it is the biggest one we have, and it causes friction on R23's bottom. CNA AA indicated they used to have a different one that was able to lift R23 all the way and this one is a rental, and it doesn't lift her all the way. CNA AA indicated that R23 isn't happy with this one because it rubs. CNA AA indicates that R23 does complain of pain with the transfers, mostly her bottom, but she has issues already with her legs and will complain of pain in her right hip. CNA AA indicated when she is done assisting R23 she will report to the nurse, not specifically that it is from rubbing, but states they know because CNA BB has told them. CNA AA indicated she knows staff have told nurses, DON B, ADON/IP C (Assistant Director of Nursing/Infection Preventionist), Maintenance Q. CNA AA indicated Surveyor should talk with CNA BB. On 9/10/24 at 4:52 PM, Surveyor interviewed CNA BB who indicated that R23 does rub across the bed when they get her up to the commode. CNA BB indicated the big boy Hoyer is new because the other one broke. They have been using this one for about a month. CNA BB indicated that DON B was in R23's room one night and saw the rubbing. CNA BB indicated she has reported to DON B that the rubbing causes R23 pain to her hips. CNA BB indicates when they added the weight scale, that's when it started not clearing. On 9/10/24 at 4:43 PM, Surveyor observed R23 being transferred with the Hoyer lift from her bed to the bedside commode. During the observation it was noted that the lift did not raise enough for R23 to be clear of the bed causing her buttock to rub across the bed during the transfer. R23 did not voice concerns with pain during this transfer. On 9/12/24 at 11:47 AM, Surveyor interviewed DON B who indicated staff had reported to her that the Hoyer they were using for R23 didn't raise high enough. DON B indicated this one has a scale on it and so it's a little lower and that it is a rental, and they are trying to get a new one. DON B indicated the staff were told to lower the bed as far as they can prior to moving R23 and she did not know it was still an issue or that it was causing pain. DON B indicated a grievance should have been filed. The facility failed to ensure all grievances were documented and resolved. Example 2 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at approximately 10:16 AM, R23 requested to speak to Surveyor. R23 indicated that CNA L is rude and said to her that she can go home but you (R23) can't, and this made her feel rotten. R23 indicated she reported this to DON B in a letter. R23 then provided a copy of the letter to Surveyor. The letter has a date at the upper right corner of 1/8/24. The letter indicated that on this day R23 had a concern with CNA L's (Certified Nursing Assistant) response to her during a conversation in R23's room. The letter indicates, in part, that at one point in the conversation CNA L responded to R23 by saying: She (CNA L) said that she is going home, but you (R23) can't, you can't get up! I am going home to a nice comfortable house, but you can't because you can't move! R23 indicated she asked a CNA to make a copy of the note and put it under DON B's door and that she has done this before with concerns. However, during the interview she realized she had two copies of the letter and so is not sure if a copy was placed under DON B's door or if the staff member copied it and gave it back. R23 indicates no one has followed up with her on this. Of note, R23 was unable to provide the name of the CNA that copied the letter. On 9/12/24 at approximately 12:00 PM, Surveyor interviewed DON B and reviewed the letter from R23. DON B indicated she had never received any information about this incident. DON B indicated that sometimes she will get letters from R23. DON B indicated that if a staff member made the copy for R23, the concern should have been reported so they could follow through. DON B indicated she will speak with R23 and will begin staff education. The facility failed to ensure all grievances were documented and resolved.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure that information from the baseline care plan was reviewed with the resident/resident representative and a copy of or summary of the care plan was provided to the resident/resident representative within 48 hours of admission for 1 of 3 residents (R27) reviewed for baseline care plan out of a sample of 24 residents. R27 did not have a baseline care plan review within 48 hours of admission. Evidenced by: The facility policy, entitled Baseline Care Plan dated February 2023, states, in part: .The baseline care plan will be developed within 48 hours of the resident's admission.A written summary of the baseline care plan shall be provided to the resident and representative . R27 was admitted to the facility on [DATE] with diagnoses that include anoxic brain damage and personal history of traumatic brain injury. R27's Care Conference Interdisciplinary Team (IDT) note dated 6/18/24, states met with guardian. Discussed plan of care and discharge goals. Concerns addressed. No other questions or concerns. On 9/10/24 at 9:53 AM, Surveyor interviewed Guardian T who indicated not being involved in initial care planning and had desire to have been involved. On 9/11/24 at 11:32 AM, Surveyor interviewed MDS M (Minimum Data Set) and asked the process for initial care planning. MDS M stated that the initial care plan is created through the initial evaluation package (assessments completed in Electronic Health record by the nurse). MDS M stated the assessments will trigger items to build the care plan. MDS M indicated that after the initial care conference specificity is added to the care plan by MDS M. Surveyor asked if a copy of the care plan is given to the resident/resident representative. MDS M stated if it is requested. Surveyor asked how the initial care plan is communicated with the resident/representative. MDS M stated when we have their initial care conference, we discuss this. Surveyor asked when is initial care conference. MDS M stated within the first 72 hours. Surveyor asked when R27's initial care conference was held. MDS M stated 6/18/24. On 9/11/24 at 11:51 AM, Surveyor interviewed LPN O (Licensed Practical Nurse) and asked when the initial care plan is reviewed with resident/representative. LPN O stated at care conference, within a week, not 100% sure of the exact timing. Surveyor asked if nurses review the plan of care with the resident prior to the care conference. LPN O stated no. On 9/11/24 at 1:23 PM, Surveyor interviewed SW D (Social Worker) and asked when the initial care conference is held. SW D stated MDS M creates the schedule. SW D stated she does the admission care conference within 72 hours. Surveyor asked when the care plan is reviewed with the resident/representative. SW D stated at the care conference. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 2:17 PM, Surveyor interviewed DON B (Director of Nursing) and asked when the initial care conference is scheduled. DON B stated that SW D sets up the care conference within 48 hours, it might be 72 if it is over the weekend, but she gets them in right away. Surveyor asked if there is discussion with the resident/representative about the care plan prior to the care conference. DON B stated she could not say for sure. Surveyor informed DON B of MDS M and SW D stating that they are scheduling meetings for 72 hours and LPN O states that nurses do not discuss the initial care plan with the residents. Surveyor asked if DON B would expect that the staff was sharing the initial care plan with the resident/representative within 48 hours. DON B stated yes.

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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** 39849 Based on observation, interview, and record review, the facility did not develop a comprehensive person-centered care plan for 1 of 3 (R54) residents reviewed for person-centered care plans out of 24 total sampled residents. R54's Activities of Daily Living (ADL) care plan was reviewed by Surveyor. The care plan does not contain R54's individualized preferences in regard to her left arm. Evidenced by: The facility policy, Comprehensive Care Plans, implemented 1/2024, indicates, in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. .Definitions: Person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . Policy Explanation and Compliance Guidelines: . 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . f. Resident specific interventions that reflect the resident's needs and preferences . R54 admitted to the facility on [DATE] with diagnoses that include, in part: Hemiplegia .affecting left nondominant side (paralysis of one side of the body), Malignant Neoplasm of Brain (Cancerous Brain Tumor that can spread), Anxiety, and depression. R54's Minimum Data Set (MDS) Quarterly Assessment, dated 9/3/24, shows R54 has a Brief Interview of Mental Status (BIMS) score of 10, indicating R54 has a moderate cognitive impairment. On 9/10/24 at 10:01 AM, Surveyor interviewed R54 who indicated that she has nerve issues on the left side of her body after having two surgeries and is also paralyzed on the left side. R54 indicated that the staff do not pick up her left arm the way she needs them to so that it does not cause her pain. R54's ADL care plan, indicates in part: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: The resident has an ADL self-care performance deficit r/t (related to) Hemiplegia, Limited Mobility, Musculoskeletal Impairment. Date Initiated: 5/29/24. Revision on: 6/5/24 Goal: The resident will improve current level of function through the review date. Date Initiated: 5/29/24. Revision on: 6/5/24. Interventions, in part: 1/4 side rail x 2 for repositioning with cares. Date Initiated: 5/31/24. Bed Mobility: The resident requires substantial/max assistance by staff to turn and reposition in bed. Date initiated: 5/29/24. Revision on: 6/5/24. R54's Certified Nursing Assistant (CNA) Bedside Kardex indicates, in part: Bed Mobility: The resident requires substantial/max assistance by staff to turn and reposition in bed. Of note, no information regarding how to touch, move, or hold onto R54's left arm during movement/transfers was found on either the care plan or the CNA Kardex. On 9/12/24 at 9:11 AM, Surveyor observed CNA CC and CNA L assist R54 from her recliner to her bed to provide a check and change of her brief. After R54 was in the bed, CNA CC was moving R54 and grabbed onto her left mid forearm during turning and R54 said, Ow. CNA CC then attempted to assist from the shoulder area and R54 said for her to stop, and she would do it herself because it hurt. During the cares R54 complained of dizziness and nausea when being turned side to side. After cares were completed, Surveyor interviewed CNA CC, and asked if she had been trained not to grab onto R54's left arm during cares by either the facility or R54 herself. CNA CC indicated R54 says don't touch it all the time. Surveyor asked CNA CC why she grabbed onto R54's left arm today if she asks her not to regularly. CNA CC indicated she felt it was just out of habit and that she usually says I'm going to lift your arm and R54 will breathe, and she will be ok. Surveyor asked CNA CC what she should do if a resident is complaining of pain/dizziness/nausea during cares. CNA CC indicated most of the time she will stop. On 9/12/24 at 12:07 PM, Surveyor interviewed DON B (Director of Nursing) and reviewed concern from R54, and observation of cares provided to R54 by CNA's. DON B indicated the CNA should have stopped when R54 had pain and dizziness and get the nurse to assess. DON B indicated staff should listen to the resident and how her arm should be moved and if they don't understand go get the nurse. DON B indicated staff should also slow down if R54 is having dizziness and nausea with the turning. DON B indicated R54's specific preferences should be care planned and are not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on interview and record review, the facility did not ensure each resident (R), or their representative had the right to participate in the care planning process for 2 of 24 total sampled Residents (R48 & R14). R48 indicated she does not have quarterly care plan meetings to discuss her care. R14's care plan was not revised to address her change in code status. This is evidenced by: Facility policy entitled 'Comprehensive Care Plans,' dated 8/22, states in part: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care assessment areas (CAAs) triggered by the MDS (Minimum Data Set) will be considered in developing the plan of care.3.f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated . 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to a. The attending Physician or non-physician practitioner designee involved in the resident's care if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition service staff. e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in discipline as determined by the resident's needs or as requested by the resident . 5 The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . Example 1 R48 was admitted on [DATE] with diagnoses that include critical illness myopathy (weakness or fatigue of muscles), Acute respiratory distress syndrome, Morbid (severe) obesity, asthma, and acute respiratory failure with hypoxia (low oxygen). R48's Minimum Data Set (MDS) dated [DATE] indicates R48's Brief Interview of Mental Status (BIMS) is a 15 out of 15, indicating R48 is cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 12:26 PM, Surveyor interviewed R48 during the initial screening process. Surveyor asked R48 if she has care plan meetings where they discuss her care and go over her care plans, R48 stated, No. Surveyor reviewed R48's medical record and was only able to locate a care conference completed in January of 2024 and July of 2024. R48 should have had another care planning conference between that time frame. On 9/10/24 at 5:07 PM, Surveyor interviewed SW D (Social Worker) regarding the care conferences. SW D indicated that the facility does do them annually and quarterly. SW D indicated that the MDS director plans the care conferences with the MDS schedule. SW D indicated she sets up the initial one with their admission. SW D was only able to locate a care conference on 7/8/24 and 1/3/24. SW D indicated that R48 should have another one (care meeting) between those two dates. On 9/11/24 around 11:00 AM, SW D came back and indicated she was not able to find documentation of a quarterly care plan meeting being done during that time. R48 was not able to participate or discuss her care in a care plan meeting between her admission/initial care conference and her most recent quarterly care conference. 39849 Example 2 On 9/11/24 Surveyor was reviewing R14's chart for hospice information. Surveyor noted R14's paper chart contained a signed Wisconsin State DNR (Do Not Resuscitate) form from July 2024. Surveyor noted R14's code status of DNR in The Hospice Care Plan, Physician Orders and the Electronic Health Record (EHR) Banner. Surveyor reviewed the Facility Comprehensive Care Plan which indicated R14's code status as Full Code. On 9/12/24 at 8:41 AM, Surveyor interviewed MDS M (Minimum Data Set) who indicated he is responsible for updating care plans. MDS M indicated updates that occur between the quarterly care conferences, such as declines or a resident joining hospice, are discussed in morning meeting and he then updates the care plan. Surveyor reviewed R14's facility care plan, EHR banner, and signed Wisconsin DNR form with MDS M. MDS M indicated that he recalled R14 being admitted to hospice, that he must have missed updating her facility care plan, and that it should have been updated when the DNR form was signed. On 9/12/24 at 8:51 AM, Surveyor interviewed ADON/IP C and asked who is responsible for updating care plans. ADON/IP C indicated MDS M, and that herself and LPN E (Licensed Practical Nurse) assist as well. Surveyor reviewed R14's facility care plan, EHR banner, and the signed Wisconsin DNR form with ADON/IP C. ADON IP/C indicated the facility care plan should have been updated to show R14's correct code status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38725 Based on interview and record review the facility failed to ensure that services provided by the facility meet professional standards of quality for 1 of 21 residents (R45) reviewed for orders out of a total sample of 24. R45 received orders and those orders were not transcribed for two (2) days. This is evidenced by: The Facility's Policy and Procedure entitled Medication Orders dated 4/16/24, documents the following in part: .a. Handwritten Order Signed by the Physician- The charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format, if not written by the physician . R45's wound documentation shows that R45's right heel wound was healed on 6/21/24 with placement of graft. Documentation from R45's Physician dated 6/26/24 includes the following orders: 1) Ensure 1 bottle 2x (2 times) a day in-between meal 2) Daily dressing change of pressure ulcer of right foot 3) General surgery for debridement of the thumb of left hand 4) Keflex 500mg (milligrams) 1 cap (capsule) q (every) 8 hours x (times) 10 days (antibiotic medication) 5) Lipid profile soon 6) Month follow-up The facility has a grievance form that documents the following, in part: .Incident date: 6/26/24 . Grievance Details: The patient received orders via fax on 6/26/24 from .the primary care provider. Orders were delayed and not processed until 6/28/24. Summary of Investigation: After completed investigation, there is no disputing that the orders were not processed in a timely manner. There was a delay in treatment, but the patient had no adverse effects from delay. PCP (Primary Care Provider) as well as family aware of delay. Summary of Findings: The patient's orders were not processed by nursing in a timely manner. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Summary of Actions Taken: All nursing staff educated on the importance of processing orders in a timely manner and education will be ongoing with Agency nurses as well. DON (Director of Nursing)/ADON (Assistant Director of Nursing) will randomly audit orders at the nurses' station to ensure compliance to education provided. [SIC] R45's Infection Report Form dated 6/28/24, documents the following, in part: .Site: Right Heel .Cellulitis, Soft Tissue, or Wound Infection .1. pus . It is important to note that R45's Physician wrote the above order for an antibiotic on 6/26/24. On 9/11/24 at 1:14 PM, Surveyor interviewed LPN O (Licensed Practical Nurse). Surveyor asked LPN O when orders should be transcribed, LPN O stated, The day received. On 9/11/24 at 2:48 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C what she could recall about R45's orders from 6/26/24, ADON/IP C explained that the orders came on PM shift, R45's daughter was aware, R45's Physician called here and alerted us on 6/28/24; ADON/IP C said we apologized, filed a grievance, educated the staff, and are attempting to review randomly now. Surveyor asked ADON/IP C when orders should be transcribed, ADON/IP C stated when received. On 9/11/24 at 4:21 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when you would expect orders to be transcribed, when the orders are given.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review the facility did not ensure that a resident who is unable to carry out activities of daily living (ADLs) receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 4 of 24 total sampled Residents (R48, R38, R15 & R16). R48 did not receive her showers twice a week every week. R38 did not receive the appropriate oral hygiene care recommended by the dentist. R15 did not receive oral hygiene daily R16's nails were visibly long and staff did not assist R16 in trimming them. Evidenced by: Facility policy entitled 'Oral care,' dated 8/22, states in part: Policy: It is the practice of this facility to provide oral care to residents in order to prevent and control plaque- associated oral diseases. Equipment and supplies. soft- bristle tooth brush, toothpaste; tongue depressor; penlight; mouthwash (optional); dental floss; emesis basin; glass of cool water; face towel; gloves. Policy explanation and compliance guidelines: .4. Apply toothpaste to brush. Holding brush over emesis basin, poor small amount of water over toothpaste. 5. Resident may assist with brushing if able. 6. Hold toothbrush at 45-degree angle to gum line. be sure that bristles rest against and penetrate under gum line. Brush inner and outer surfaces of upper and lower teeth by brushing from gum to crown of each tooth.13. Allow resident to floss and assist as needed. Floss between all teeth. Hold floss against tooth while moving it up and down sides of teeth and under gum line. Avoid flossing if Resident has a tendency to bleed . Facility policy entitled 'Activities of Daily Living (ADLs),' dated 10/24/22, states in part: Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. bathing, dressing, grooming and oral care; 2. transfer and ambulation; 3. toileting; 4. eating to include meals and snacks; and 5. using speech, language, or other functional communication system. Policy explanation and compliance guidelines: .3. a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.5. The facility will maintain individual objectives of the care plan and periodic review and evaluation. Example 1 R38 was readmitted on [DATE] with diagnosis that include parkinsonism and unspecified dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R38's Quarterly Minimum Data Set (MDS) dated [DATE] indicates R38 has a Brief Interview of Mental Status (BIMS) of 6 out of 15 indicating that R38 is severely cognitively impaired. Section B indicates R38 has clear speech is understood by others and usually understands others. Section GG indicates R38 requires set up assist with oral hygiene. Section L indicates no oral/dental concerns marked. R38's Care plan indicates assist resident with brushing teeth/dentures, oral care (4/19/23). R38's CNA care guide provided to Surveyor on 9/11/24 indicates set up with oral care. R38's Oral hygiene documentation for the last 30 days shows R38 only received oral hygiene care once a day instead of twice per day on the following dates: 8/16/24, 8/20/24. 8/21/24, 8/25/24, 8/29/24 ,9/1/24, 9/3/24 and 9/4/24. R38's Health Drive Dental visit signed on 8/26/24, states in part: Exam date 8/24/2024 . Teeth .soft plaque/food debris buildup: heavy.Action required by nursing home staff. Continue daily oral care: brush along gumline in a circular motion; assist patient with brushing and flossing twice daily; morning and evening; patient cannot brush for themselves, please brush and floss patient's teeth twice daily. On 9/9/24 at 2:43 PM, Surveyor interviewed R38 regarding her cares. R38 stated they hurt while showing Surveyor her mouth and teeth. Surveyor asked R38 and her husband if R38 has seen a dentist? R38 replied I would like to go. Surveyor observed R38's teeth to have a gray discoloration, and slightly pink/red along gum line near her teeth. On 9/10/24 at 5:54 PM, Surveyor interviewed DON B (Director of Nursing) regarding R38's oral cares. DON B indicated that based on the health drive information she should have flossing on her care plan. Surveyor asked DON B to look at R38's care plan to see if assisting with brushing and flossing twice daily was on there, DON B indicated it's not on there and should be. On 9/11/24 at 9:03 AM, Surveyor interviewed CNA L (Certified Nursing Assistant) regarding R38's oral care. CNA L indicated that she sets her up by putting tooth paste on her tooth brush, and she (R38) brushes her teeth. Surveyor asked CNA L if she offers to floss R38's teeth or if R38 flosses her own teeth, CNA L indicated they don't have any floss sticks or floss, she has never seen floss in a nursing home. R38's dental care is not being provided per recommendations of the dentist. Example 2 R48 was admitted on [DATE] with diagnosis that include critical illness myopathy (weakness or fatigue of muscles), Acute respiratory distress syndrome, Morbid (sever) obesity, asthma, and acute respiratory failure with hypoxia (low oxygen). R48's Minimum Data Set (MDS) dated [DATE] indicates R48's Brief Interview of Mental Status (BIMS) is a 15 out of 15, indicating R48 is cognitively intact. R48's Care plan states in part: Bathing/showering: The resident requires by staff [sic] with bathing/showering (12/28/23). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R48's CNA care guide indicates Showers are on Thursday AM shift and Tuesday PM shift. On 9/9/24 at 12:08 PM Surveyor interviewed R48 regarding choices. R48 indicated she doesn't really get a choice regarding her showers. R48 indicated she receives a shower when staff can do it. R48 indicated she's supposed to get a shower two times a week Tuesday and Thursday but would like them every other day. R48 states I feel gross going from Thursday to Tuesday without a shower. R48's Shower documentation shows she did not get her scheduled showers on Tuesdays and Thursdays on the following dates: 7/2/24, 7/16/24, 7/18/24, 7/23/24, 7/25/24, 8/6/24, 8/13/24, or 9/5/24. On 9/10/24 at 5:30 PM, Surveyor interviewed DON B (Director of Nursing) regarding showers for R48 and oral hygiene for R38. DON B indicated she would expect R48 to receive her showers on Tuesdays and Thursdays as scheduled and extra if needed. DON B indicated that she would expect R38's dental recommendation to be added to the care plan and staff to follow the recommendations. 50285 Example 3 R15 was admitted to the facility on [DATE] with diagnoses that include Major Depressive Disorder, unspecified dementia, muscle wasting and atrophy, and anxiety disorder unspecified. R15's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R15 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicates he has severe cognitive impairment. R15's Functional Ability, Section GG of the MDS states in Section 6 sub-part B: Oral hygiene: Partial to moderate assist . R15's Care Plan states in part: Focus dated 11/9/22: Self-care deficit related to activity intolerance, cognitive deficits, decreased mobility, disease process, fatigue, generalized weakness. Intervention dated 11/9/22: Oral care requires staff assist with oral cares .Focus dated 5/8/23: ADL (Activities of Daily Living) Function requires staff intervention to complete ADLs. Intervention dated 5/8/23: Dependent with oral care . R15's record did not have evidence to show R15 receives oral care daily. Surveyor reviewed POC (Point of Care) history, which indicated R15 as Independent with oral care three times, Set up assistance three times, and N/A (not applicable) 28 times. On 9/10/24 at 11:40 AM, Surveyor interviewed R15's Power of Attorney (POA) and RR U (Resident Representative), who voiced concerns that the facility could do a better job assisting R15 with oral cares. RR U stated that R15 is completely dependent on staff assistance for brushing his teeth, and that he recently had to have several teeth extracted. On 9/11/24 at 8:35 AM, Surveyor interviewed CNA R (Certified Nursing Assistance), who stated that R15 was fully dependent on staff for assistance with brushing his teeth. CNA R stated that R15 gets his teeth brushed every day. Surveyor asked CNA R where oral hygiene was documented. CNA R indicated that they chart in Point Click Care (PCC) in the POC (point of care) charting. CNA R did not know why the POC charting would indicate that R15 was independent, or why N/A had been marked. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/11/24 at 8:45 AM, Surveyor interviewed CNA F who stated that she attempted to assist R15 with brushing his teeth, but that sometimes he refuses. CNA F indicated that charting is completed in the POC screen of PCC, and that sometimes staff members chart N/A when a resident refuses assistance. On 9/11/24 at 2:50 PM, Surveyor interviewed DON B (Director of Nursing) regarding oral hygiene and documentation. DON B indicated that staff should not be documenting N/A, but should be documenting Resident Refused, which would be more accurate. 36253 Example 4 On 9/9/24 at 11:16 AM, Surveyor observed R16 in his room. His fingernails were visibly long and yellowing. There was visible dirt under many of his fingernails. When asked if he likes his fingernails long or if he would like them to cut, R16 stated that he wanted them cut but did not have a pair of fingernail clippers and staff are usually busy. R16's hands were visibly shaking when he held his hands out. When asked if he could trim his own fingernails, R16 said, I don't know. On 9/11/24 at 1:18 PM, Surveyor interviewed CNA F (Certified Nursing Assistant) who stated that she noticed R16's nails were long a few days ago and that they should be cut but because staff typically get behind doing certain cares and tasks, fingernails often get forgotten. On 9/11/24 at 1:21 PM, RN G (Registered Nurse) stated that she was unsure if R16 could trim his own nails, but that she would get it done. RN G stated that they were long and needed to be cut.

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F 0686 Level of Harm - Minimal harm or potential for 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** 38725 Based on interview and record review the facility did not ensure that residents with pressure injuries receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new injuries from developing for 3 of 5 (R34, R45 and R14) residents reviewed for pressure injuries out of a total sample of 24. R34 did not have his wound treatments completed as ordered. R45 did have her wound treatments completed as ordered. R14 did not have wound treatments completed as ordered. This is evidenced by: The Facility's Policy and Procedure entitled Wound Treatment Management dated 2/14/23, documents in part: .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change .7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. Example 1 R34 has the following diagnoses: paraplegia complete, chronic pain, schizophrenia, bipolar disorder, pressure ulcer of sacral region stage 4, pressure ulcer of left buttock stage 4 and pressure ulcer of right buttock stage 4. R34 was out of the facility on therapeutic leave for the following dates: 6/13/24-6/14/24 6/18/24-6/19/24 6/21/24-6/22/24 6/25/24-6/26/24 6/28/24-6/29/24 7/1/24-7/2/24 7/4/24-7/5/24 7/26/24-7/29/24 8/26/24-8/28/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/4/24-9/6/24 9/9/24-9/10/24 R34's Risk vs (versus) Benefit Documentation dated 6/14/24, documents in part: Education: R34 left the facility yesterday morning and did not come back to the facility until after midnight. He did not take his medications with him or have his treatments completed. Noncompliance with medications and treatments can put R34 at risk for infection, medical complications, and even death. Response: If you leave the facility, you should alert nursing and sign out. You should ensure that you take medications with you and have treatment completed prior to discharge. Acknowledgement: Having another individual in your bed reduces the pressure relieving qualities of your specialty mattress and makes repositioning difficult. This could worsen your chronic wounds. R34 was hospitalized for the following dates: 7/12/24-7/13/24 7/14/24- 7/15/24 7/15/24-7/17/24 7/25/24-7/26/24 7/27/24-7/28/24 8/2/24-8/3/24 8/5/24-8/6/24 8/19/24-8/20/24 8/24/24 back same day 9/2/24-9/3/24 R34's Physician orders for wound care was as follows: June: 6/12/24 Ischial tuberosity bilateral (lower buttock): Cleanse wound with Hibiclens, use wet to dry pack with Dakin's moistened gauze, and cover with Mepilex (foam) twice daily. Discontinued 7/15/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/12/24 Sacrum remove dressing and cleanse wound with Hibiclens and cover with Mepilex (foam) twice daily. Discontinued 7/15/24. July: 7/16/24 R/L (right and left) Ischial tuberosity; cleanse with 1/4 S. Dakin's, followed by NS (normal saline), protect peri-wound with skin prep, apply alginate with silver to wound bed and cover with bordered gauze daily. Discontinued 8/1/24. 7/17/24 Sacrum: cleanse with 1/4 Dakin's followed by NS, protect peri-wound with skin prep, cover wound with foam dressing MWF (Monday, Wednesday, Friday). August: 8/1/24 R/L ischial tuberosity: cleanses with 1/4 Dakin's, followed by NS, protect peri-wound with skin prep, apply alginate with silver to wound bed and cover with bordered gauze BID (twice a day). Discontinued 8/13/24. 8/13/24 R/L ischial tuberosity: cleanses with 1/4 Dakin's, followed by NS, protect peri-wound with skin prep, apply alginate with silver to wound bed and cover with bordered gauze BID. R34's TAR (Treatment Administration Record) documents the following dates that treatments weren't completed: June- 6/17/24 no AM Tx's done (total of 3- right ischium, left ischium, sacrum) July- 7/6/24 PM not done (total 2- R/L ischium's), 7/22/24 no AM Tx's done (total of 3), 7/23/24 AM not done (total of 2- R/L ischium's) August- 8/1/24 AM not done (total of 2- R/L ischium's), 8/4/24 PM not done (total of 2- R/L ischium's), 8/7/24 PM not done (total of 2- R/L ischium's), 8/10/24 PM not done (total of 2- R/L ischium's), 8/13/24 AM and PM not done (total of 2- R/L ischium's), 8/14/24 AM and PM not done (total 3- right ischium, left ischium, sacrum), 8/17/24 PM not done (total of 2- R/L ischium's), 8/21/24 AM not done (total of 2- R/L ischium's), 8/14/24, 8/21/24 no AM Tx's done (total of 3- right ischium, left ischium, sacrum) September- All Tx's documented On 9/11/24 at 1:07 PM, Surveyor interviewed LPN O (Licensed Practical Nurse). Surveyor asked LPN O should R34 have his wound treatments done before or after medication administration, LPN O said we complete his wound care as he allows. Surveyor asked LPN O are R34's wound treatments done consistently at the same time of day; LPN O replied no it's as he allows. On 9/11/24 at 2:42 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C should R34 have his wound treatments done before or after medication administration, ADON/IP C said sometime on the shift. Surveyor asked ADON/IP C, are R34's wound treatments done consistently at the same time of day, ADON/IP C stated no, they are completed on his schedule. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 R45 has the following diagnoses: hemiplegia and hemiparesis following cerebrovascular accident affecting left dominant side, diabetes mellitus, peripheral vascular disease, metabolic encephalopathy, morbid obesity, and acquired absence of left leg below knee. R45's Physician orders for wound care was as follows: June: 5/9/24 R (right) heel: Cleanse with NS (normal saline), protect peri-wound with skin prep, apply bacitracin followed by dry dressing and apply Tubigrip from base of toes to below knee every evening shift. Discontinued 7/16/24. 6/29/24 Apply dry dressing to R (right) heel q (every) 3 days and PRN (as needed). Discontinued 7/3/24. July: 7/4/24 Cleanse R heel with NS, pat dry, protect peri-wound with skin prep, and apply foam dressing every other day and PRN. Discontinue 9/4/24. August: No treatment changes. September: 9/4/24 Cleanse R heel wound with NS, pat dry, protect peri-wound with skin prep, apply collagen with silver to wound bed and cover with foam dressing every other day and PRN (as needed.) R45's TAR documents the following dates that treatments weren't completed: June- 6/3/24, 6/8/24, 6/12/24; for a total of 3 days in June. July- 7/7/24; for a total of 1 day in July. August- 8/9/24; for a total of 1 day in August. September- 9/4/24, 9/9/24; for a total of 2 days in September. On 9/11/24 at 1:14 PM, Surveyor interviewed LPN O (Licensed Practical Nurse). Surveyor asked LPN O what it means if there is a blank in the TAR (Treatment Administration Record), LPN O said it wasn't done or was missed. Surveyor asked LPN O should wound care be completed as ordered, LPN O stated yes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 2:48 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C if R45's right heel wound was healed on 6/21/24, ADON/IP C explained that it was freshly healed, scant healing. Surveyor asked ADON/IP C if R45's right heel wound re-opened/graft no longer adhered on 7/1/24, ADON/IP C said yes. Surveyor asked ADON/IP C should wound care be completed as ordered, ADON/IP C stated yes. On 9/11/24 at 4:21 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what it means if there is a blank in the TAR, DON B said it wasn't done. Surveyor asked DON B would you expect wound care to be completed as ordered, DON B stated yes. 39849 Example 3 R14 was admitted to the facility on [DATE] with diagnoses that include, in part: Paraplegia, Type II Diabetes, Malignant Neoplasm of Left Bronchus or Lung (Lung Cancer), and Morbid Obesity. R14's Physician orders indicate the following: June: Start date of 6/22/24. R (right) buttock wound; cleanse with 1/2 S. (Solution) Dakin's, apply wet to dry gauze with 1/2 S. Dakin's solution and cover with bordered foam BID (twice daily) and PRN (as needed) dressing soiled or loose. Every day and evening shift for wound care. Discontinue date of 6/25/24. Start Date of 6/25/24: R (right) buttock wound; cleanse with 1/2 S. (Solution) Dakin's, apply wet to dry gauze with 1/2 S. Dakin's solution and cover with bordered gauze, then foam dressing over top BID (twice daily) and PRN (as needed) dressing soiled or loose. Every day and evening shift for wound care. Discontinue date: 7/1/24. R14's TAR (Treatment Administration Record) indicates treatments were not documented as completed for the following dates: June: 6/23/24 Evening, 6/27/24 Day and Evening, 6/28/24 Evening; for a total of 4 missed treatments in June. On 9/11/24 at 4:21 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what it means if there is a blank in the TAR, DON B said it wasn't done. Surveyor asked DON B would you expect wound care to be completed as ordered, DON B stated yes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review the facility did not ensure each residents environment was free of accidents and hazards for 3 of 24 total sampled Residents (R48, R34 and R52.) R48 indicated she smokes. R48 did not have a smoking assessment or care plan completed for smoking even though nursing staff were aware that she smoked occasionally. R34's electric wheelchair was charging in his room. R52 indicated she would use her electric scooter and go out in the community on her own. Therapy did not complete an assessment for safe operation of electrical wheelchairs/scooters until after R52 went out in community by herself. Evidenced by: Facility policy entitled 'Smoking Policy,' (no date), states in part: when the resident requests to smoke, the interdisciplinary team will assess the resident capabilities and deficits to determine appropriate supervision and assistance. Smoking will only be allowed in designated (outdoor) area(s) in the facility that are not near flammable substances or where oxygen is in use. Residents, resident representatives, and visitors will be informed of the facility smoking policy. Procedure: .Electronic cigarettes .are battery-powered devices that deliver nicotine by producing a heated vapor. Fires and/or explosions caused by e-cigarettes can happen but are rare. Most occur during charging of the battery. Procedure: 1. any resident choosing to smoke will be assessed by a member of the interdisciplinary team utilizing the smoking evaluation: a. will be completed upon admission, quarterly, with a change of condition and as needed. b. individualized approaches and directions for safety and assistance will be documented in the resident plan of care and communicated to direct care staff .2. if a resident chooses to smoke electronic cigarettes (e-cigarettes, vapes, vaporizers, vape pens etc.) they must smoke them in designated smoking areas outside. 3. charging of the e-cigarette should only be accomplished using power sources approved by the manufacturer to recharge the lithium-ion battery (i.e., those that came with the device). 4. do not charge the e-cigarette overnight. 5. replace the battery/batteries if wet or damaged . The Facility's Policy and Procedure entitled Power Mobility Device dated 1/1/24 documents the following, in part: .The purpose of this policy is to ensure power mobility devices (Motorized wheelchairs) are charged safely in the facility .Locations for charging the electronic mobility device must: Not obstruct hallways, The charging area must have impermeable flooring, and Be well ventilated .: The facility policy, Power Mobility Device, dated 01/24, states, in part; .Our facility will: evaluate and document the resident's need regarding the use of a power mobility device. The individualized needs will be identified. A care plan with appropriate interventions to meet the resident's needs will be developed. Interventions must be reviewed quarterly or when a significant change in condition occurs Example 1 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R48 was admitted on [DATE] with diagnosis that include critical illness myopathy (weakness or fatigue of muscles), Acute respiratory distress syndrome, Morbid (sever) obesity, asthma, and acute respiratory failure with hypoxia (low oxygen). R48's MDS (Minimum Data Set) dated 7/4/24 indicates R48's BIMS (Brief Interview of Mental Status) is a 15 out of 15, indicating R48 is cognitively intact. On 9/9/24 at 12:37 PM, Surveyor interviewed R48 regarding smoking during initial pooling. R48 indicated she smokes a couple times a week with her boyfriend. On 9/10/24 Surveyor reviewed the facility Survey binder for the list of smokers. R48 was not listed on the list of smokers provided to Surveyors. On 9/11/24 at 8:39 AM, Surveyor interviewed RN G (Registered Nurse) regarding R48 smoking. RN G indicated she thinks (R48) smokes in the evening with her boyfriend, but RN G has not seen her smoke. Surveyor asked if RN G knew if R48 smoked cigarettes or vaped, RN G indicated she heard it's a vape. Surveyor asked RN G if R48 has an assessment or care plan for smoking, RN G indicated she would expect her to have one. RN G looked in the electronic health record and stated, I did not see an evaluation for her. On 9/11/24 at 8:41 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) regarding R48 smoking. CNA F indicated she has not seen R48 smoke, but heard she does with her boyfriend. CNA F indicated that R48 has a vape in her room and asks us (CNA's) to charge it. On 9/11/24 at 8:46 AM, SW D (Social Worker) was at the nurses station while Surveyor interviewed RN G and CNA F. SW D stated she doesn't have an evaluation because she wasn't a smoker on her referral. Surveyor indicated to SW D that Surveyor was informed by CNA F that R48 has a vape in her room and R48 told Surveyor she smokes. SW D stated someone should have told me. On 9/11/24 at 9:26 AM, SW D indicated to Surveyor that R48 was hiding a vape in her room, and that SW D did a smoking evaluation today and R48 is to be a supervised smoker and SW D updated the smoking list. A copy of R48's smoking evaluation dated 9/11/24 was provided to Surveyor. R48's smoking evaluation indicates R48 vapes 1-2 times per day in the evenings, not able to light own cigarette (vape is hand written) R48 is supervised - Resident needs someone to push her out and bring her back in and to light her cigarette. Of note: R48 does not have a smoking care plan. Nursing staff were aware that R48 smoked outside with her boyfriend. There is no smoking evaluation completed, no smoking care plan was developed and R48 was not indicated as a smoker on the facility's smoking list. 38725 Example 2 On 9/11/24 at 1:40 PM, Surveyor observed R34's electric wheelchair charging in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 1:43 PM, Surveyor interviewed CNA P (Certified Nursing Assistant). Surveyor asked CNA P where R34's electric wheelchair is charged, CNA P said I'm not sure, I'll find out and get back to you. On 9/11/24 at 1:47 PM, CNA P returned and told Surveyor R34's electric wheelchair should not be charging in his room. Surveyor asked CNA P where it should be charging, CNA P said I'm not sure. On 9/11/24 at 2:07 PM, Surveyor interviewed ADON/IP C (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP C where staff charge R34's electric wheelchair, ADON/IP C said it should not be charged in R34's room. Surveyor asked ADON/IP C where should R34's electric wheelchair be charged, ADON/IP C stated at the end of the hall in the lounge. Surveyor asked ADON/IP C if she was aware that R34's electric wheelchair was charging in his room currently, ADON/IP C stated no, I was not aware that it is charging in his room currently. On 9/11/24 at 2:27 PM, Surveyor interviewed LPN O (Licensed Practical Nurse). Surveyor asked LPN O where staff charge R34's electric wheelchair, LPN O said it should not be charged in his room. Surveyor asked LPN O where should R34's electric wheelchair be charged, LPN O stated at the end of the hall in the lounge or in therapy. On 9/11/24 at 4:10 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B where R34's electric wheelchair is charged, DON B stated it should not be charged in his room. Surveyor asked DON B where should R34's electric wheelchair be charged, DON B said at the end of the hall. Surveyor asked DON B if she was aware that R34's electric wheelchair had been charging in his room today, DON B stated someone told me that today. 44552 Example 3 R52 was admitted to the facility on [DATE] with a diagnoses including parkinsonism, asthma, diabetes, respiratory failure, depression, anxiety disorder, and insomnia. R52 most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 8/6/24, indicates R52 has a BIMS (Brief Interview for Mental Status) score of 13 indicating R52 is cognitively intact. R52 is own person. On 9/9/24 at 4:25 PM, R52 indicated she did not believe she had an assessment completed for using her electric scooter. Surveyor reviewed R52's progress notes. R52's progress notes indicate resident utilized electric scooter while out in community on 5/5/24 and 5/8/24. On 9/12/24 at 8:26AM, DR X (Director of Rehab) indicated R52 had passed her assessment for safe operation of an electric scooter. DR X indicated therapy is responsible for completing the assessment. DR X provided Surveyor R52's evaluation for safe operation of electrical wheelchairs/scooters assessment. Surveyor asked DR X if the assessment was initiated on 5/10/24, DR X indicated it was. DR X indicated the assessment should be completed before a resident uses an electric device to ensure safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 1:15PM, Surveyor interviewed DON B (Director of Nursing) regarding R52's scooter assessment. DON B indicated R52 should have had an assessment to determine R52 is safe to operate a scooter before the scooter is used. Surveyor asked for any additional information. No further information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 6 of 24 sampled residents (R53, R25, R23, R35, R27 and R15) and 1 of 1 (R51) Supplemental residents reviewed for staffing. Residents voiced concern regarding long call light wait times due to not having enough staff. Staff voiced concern of not being able to get tasks done due to not having enough staff. Evidence by The facility policy, Call Lights: Accessibility and Timely Response, dated 8/28/24, states, in part; .Call lights will directly relay to a staff member, hallway or centralized location to ensure appropriate response . Example 1 R53 was admitted to the facility on [DATE] with a diagnoses including scoliosis, depression, insomnia, and dysphagia. R53's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/17/24, indicates R53 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R53 is cognitively intact. R53 is his own person. On 9/9/24 at 2:31PM, R53 indicated there are times that he has had to wait over an hour for the call light to be answered. R53 indicated this happens around once a week. R53 indicated when this happens, he gets frustrated. R53 indicated he knows staff get very busy and R53's only option is to wait for assistance. On 9/12/24 at 8:56AM, CNA Y (Certified Nursing Assistant) indicated there is not enough staff. CNA Y indicated there are things that do not get done due to not having enough staff. CNA Y indicated restorative doesn't always get done like assisting residents in walking. CNA Y indicated there are times call lights do not get answered timely as well. On 9/12/24 at 9:08AM, CNA Z indicated there are tasks that do not get done due to not having enough staff. CNA Z indicated staff do not always answer call lights timely because there is not enough staff and the staff working might be busy with someone else. 39849 Example: 2 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23 was admitted to the facility on [DATE] with diagnoses that include in part: polyosteoarthritis (arthritis where at least 5 joints are affected), Polyneuropathy, Lymphedema (A buildup of lymph fluid that causes swelling), Difficulty in walking, and Low back pain. R23's chart indicates she is her own decision maker. R23's ADL (Activities of Daily Living) Care Plan, with a revision date of 5/2/23, indicates R23 requires staff intervention to complete ADL's. Interventions include, in part: .Hoyer (full body lift) sling with hole cut out for bed side commode toileting needs. On 9/9/24 at 3:00PM Surveyor interviewed R23 who indicated about once a month she waits an hour to get assistance with toileting. R23 indicated that a month ago she was sitting on the bedpan or the commode, could not recall which for certain, and after an hour called the front desk 3 to 4 times and no one came so she called the police. The police did not come as someone came to help her then and she called to tell them she received assistance. R23 said when this happens it makes her feel forgotten. Example 3 R35 was admitted to the facility on [DATE] with diagnoses that include, in part: Parkinson's (A chronic brain disorder that affects movement, balance, and coordination), Type II Diabetes, Sick Sinus Syndrome (A type of heart rhythm disorder), and Presence of Cardiac Pacemaker. R35's most recent MDS (Minimum Data Set) with a target date of 7/25/24, indicates R35 has a BIMS (Brief Interview for Mental Status) score of 11, indicating R35 has a mild cognitive impairment. Of note, R35's chart indicates he is his own decision maker. R35's ADL (Activities of Daily Living) Care Plan, with a revision date of 9/20/23, indicates, in part: .R35 requires extensive assist for ADLs/mobility . On 9/10/24 at 8:20AM Surveyor interviewed R35 who indicated when he puts his call light on staff will come in and shut the light off prior to assisting him. Staff say they will be back and don't come back. R35 indicated after 15 minutes he will put his light back on. R35 indicated when they shut the light off then if there is someone that has a minute, they don't know I need help. R35 indicated the facility is shorthanded and so he tries to be understanding, but around 2 to 3 times a week he will wait 30 to 60 minutes for assistance. R35 indicated sitting in my piss makes me mad. 50228 Example 4 R27 admitted to facility on 6/14/24 with diagnoses that include, in part, Anoxic Brain Damage (occurs when the brain's oxygen supply is completely cut off resulting in death of brain cells) and personal history of traumatic brain injury. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 at 9:53 AM, Surveyor interviewed R27's guardian, Guardian T and asked about timeliness of staff answering call lights. Guardian T stated staff will come in to the room, turn the call light off to go get help and never come back, Guardian T stated she will turn the call light back on 40 min later and R27 still has to wait. This is frustrating. 50285 Example 5 R15 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus, Major Depressive Disorder, unspecified dementia, muscle wasting and atrophy, hypertension, and anxiety disorder unspecified. R15's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R15 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicates he has severe cognitive impairment. R15's Functional Ability, Section GG of the MDS states that R15 is dependent or substantial/maximum assistance of staff for all Activities of Daily Living (ADLs) including hygiene, dressing, and mobility. On 9/10/24 at 11:40 AM, Surveyor interviewed R15's Power of Attorney (POA) and RR U (Resident Representative) who voiced concerns that there does not seem to be sufficient staff at times, especially on the weekends. RR U stated that R15 does not always get his teeth brushed every day, and that she has had to clean urine stains off R15's floor herself. Example 6 R25 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus, heart failure, dementia, hypertension, major depressive disorder, and generalized weakness. R25's Quarterly MDS dated [DATE] documented that R25 had a BIMS score of 6 out of 15, which indicates he has severe cognitive impairment. R25's Functional Ability, Section GG of the MDS states that R25 is dependent or substantial/maximum assistance of staff for all ADLs including hygiene, dressing, and mobility. On 9/09/24 at 2:22 PM, Surveyor interviewed R25 who stated that he has had to wait 30 minutes or more at times for staff assistance. R25 indicated that it makes him upset to have to wait that long, especially if he is in pain or needs to use the bathroom. R25 stated that he can wait a while if he has to, but that he wants to know that there is someone there to help him if there is something wrong. Example 7 R51 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), hypertension, Major Depressive Disorder, weakness, and urinary tract infections. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R51's Quarterly MDS (Minimum Data Set) dated 7/18/24 documented that R51 had a BIMS (Brief Interview of Mental Status) score of 14 out of 15, which indicates she is cognitively intact. R51's Functional Ability, Section GG of the MDS states that R51 requires substantial/maximum assistance of staff for all ADLs (Activities of Daily Living), including toileting and dressing, and partial/moderate assistance with mobility. On 9/10/24 at 8:09 AM, Surveyor interviewed R51, who voiced concern that the facility needed more people to help on the weekends, especially Sundays. R51 stated that one Sunday a few weeks ago, she had to wait over an hour to go to the bathroom. R51 indicated that she has a history of urinary tract infections, and that she can't always wait to go to the bathroom. The facilities' Facility assessment dated [DATE] states in part: . Information about our staffing patterns: Average Nurse Aide to Resident Ratio (Direct Care Staff): 1 - 10 . On 9/10/24 at 3:33 PM, Surveyor interviewed Agency CNA V (Certified Nursing Assistant) who stated she was responsible for the care of 13 residents today. On 9/11/24 at 8:38 AM, Surveyor interviewed CNA R who stated that they could use more staff. CNA R stated that she was responsible for 12-13 residents each shift. On 9/11/24 at 8:46 AM, Surveyor interviewed CNA F who stated there is not enough staff to care for the residents at times due to high resident care needs. CNA F stated that it can be difficult to get things done like showering and teeth brushing, but that she always tries to get everything done on her shift. CNA F stated that both her and the other CNAs working on that hall had 12 residents to care for today. On 9/11/24 at 1:19 PM, Surveyor interviewed CNA S, who indicated that there is not enough staff to safely care for the residents. CNA S stated that some residents have very high needs which makes it difficult to get everything done. CNA S stated that showers and teeth brushing are the first things that get left undone, and that Range of Motion (ROM) exercises are not being completed on a regular basis. CNA S stated these things should be done, as they improve the resident's quality of life. CNA S stated that he had voiced his concerns to DON B (Director of Nursing). CNA S stated that he is always responsible for no less than 12 residents on his shift. On 9/11/24 at 2:04 PM, Surveyor interviewed Scheduler E, who stated that she always staffs a 1:10 ratio (one CNA to care for 10 residents). Scheduler E indicated that an acceptable wait time for a call light to be answered would be five minutes. On 9/12/24 at 1:12 PM, Surveyor interviewed DON B (Director of Nursing), who stated that an acceptable wait time for a call light to be answered would be 10-15 minutes. DON B indicated that they do not have any documentation of call light audits, but that management is always on the floor assisting the staff. DON B stated that they are using the facility assessment as a tool to determine appropriate staffing levels.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36192 Based on observation, interview and record review, the facility did not provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's to meet the needs of each resident for 1 of 1 Supplemental Resident (R32). On 9/10/24 R32 had a lidocaine patch still on her arm that was not removed the night before. Evidenced by: Facility policy entitled, Medication Administration General Guidelines, dated 01/24, states in part: . medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so . Procedures: Medication Preparation: .3.Prior to administration, review and confirm medication orders for each individual resident on the medication administration record. Compare the medication and dosage schedule on the Resident's MAR (Medication Administration Record) with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule . Medication administration: 1. Medications are administered in accordance with written orders of the prescriber. Documentation: .2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example the resident is not in the nursing care center at scheduled dose time or a starter dose of antibiotics is needed),.an explanatory note is entered on the reverse side of the record provided for PRN documentation . Facility policy entitled 'Medication Error reporting and counseling procedure,' dated 12/12/23, states in part: Policy: This policy outlines the steps to be followed when a medication error occurs at the nursing facility. It aims to ensure the safe and effective management of medication errors and provide appropriate employee follow-ups, including use of a medication error counseling form, for those involved.Compliance guidelines: Procedure: 1. Reporting the medication error: a. the person who identifies a medication error should immediately report it to the charge nurse of the designated nursing supervisor and ultimately the Director of Nursing. when a medication error occurs, the licensed nurse/employee needs to be able to report the error, and without fear of penalty, to Nursing management.2. Assessing and Documenting the Medication error: a. A prompt assessment of the resident(s) involved to be completed to determine harm or potential risk to the resident. Document all relevant details of the medication error in the resident's record and incident report .3. Notify the Provider(s): a. the facility will inform the primary or prescribing physician(s) of the medication error in a timely manner and document notification in the medical record . R32's September 2024 MAR (medication administration record) indicates: Lidocaine external patch 5% apply to affected pain areas topically one time a day for pain. start date 8/10/24 discontinue date 9/10/24. This is signed out on 9/10 with a 4 which means other/see nurses notes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lidocaine external patch 4% apply to Left shoulder topically one time a day for pain and remove per schedule start date 9/11/24. On 9/10/24 at 7:33 AM during medication administration for R32, LPN I had moved R32s left arm sleeve up to place R32's patch then indicated she realized while in R32's room that the Lidocaine patch is a 4% not a 5%. Surveyor observed R32 to have a lidocaine patch still on her left arm with no date or initials. LPN I indicated there was not a date on it, we apply a new one every morning it's scheduled to be removed at night. LPN I did remove lidocaine patch that was still on R32 at this time. On 9/10/24 at 10:41 AM, R32's progress note states in part: . lidocaine external patch 5% . medication out of stock writer has called (pharmacy name) to reorder STAT (Right away). On 9/10/24 at 1:58 PM, R32's Progress note states in part: .Writer informed (Nurse Practitioner name) that lidocaine patch 5% needs to be reordered. 5% patch is not available in facility at this time per (Nurse Practitioner) switch order to lidocaine patch 4% daily. (Of note: there is no documentation indicating that the NP was updated on R32 having her lidocaine patch left on until morning.) On 9/10/24 at 5:30 PM Surveyor interviewed DON B (Director of Nursing) regarding medication observation. DON B indicated observation with R32 was a medication error. DON B indicated that the lidocaine patch should have been removed the night prior and the nurse should have called the doctor regarding the lidocaine patch error to know if to hold or continue with administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36192 Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 3 errors out of 28 opportunities that affected 2 out of 4 supplemental residents (R32 & R31) included in the medication pass task, which resulted in an error rate of 10.71%. RN H (Registered Nurse) did not give R31 the correct dosing of his Sevelamer (phosphate binder to prevent low levels of calcium) LPN I (Licensed Practical Nurse) omitted R32's lidocaine patch and dispensed R463s medication into R32's medication cup. Evidenced by: Facility policy entitled, Medication Administration General Guidelines, dated 01/24, states in part: . medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so . Procedures: Medication Preparation: .3. Prior to administration, review and confirm medication orders for each individual resident on the medication administration record. Compare the medication and dosage schedule on the Resident's MAR (Medication Administration Record) with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule . Medication administration: 1. Medications are administered in accordance with written orders of the prescriber . 8. Check expiration date on package/container. No expired medications will be administered to a resident.b. The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. c. Certain products or package types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating once opened, to ensure medication purity and potency .position statements from American Society of Ophthalmic Registered Nurses and American Society of Cataract & Refractive Surgery (ASCRS) state that the multi-use eye drops and ointments should be disposed of 28 days after initial use . 9. Verify medication is correct three (3) times before administering the medication. a. when pulling medication package from med cart. b. when dose is prepared. c. before dose is administered.16. Medications supplied for one resident are never administered to another resident.Documentation: .2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotics is needed) an explanatory note is entered on the reverse side of the record provided for PRN documentation . Example 1 R31's September 2024 MAR (Medication Administration record) indicates Sevelamer Carbonate oral tablet 800 mg give 2 tablets by mouth three times a day. On 9/9/24 at 3:30 PM, Surveyor observed RN H prepare R31's medications. RN H prepared the following medications: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Gabapentin 300 mg (milligrams) 1 cap 2. Sevelamer carbonate 800 mg 1 tablet. R31's medication card indicated give 2 tabs by mouth three times a day for ESRD (end stage renal disease) RN H only dispensed 1 tab. 3. Deep Sea nasal saline spray 1 spray each nostril. On 9/9/24 at 3:33 PM, Surveyor asked RN H how many medications she had for R31, RN H replied 2 pills plus a nasal spray. On 9/9/24 at 3:36 PM Surveyor stopped RN H while heading down hall to R31's room. Surveyor asked RN H to re-look at R31's medication card. RN H indicated she looked and I saw 800, I didn't see 2 tabs. Surveyor asked RN H should R31 have 2 tabs of Sevelamer, RN H replied yes. RN H pulled out a 2nd card and popped out a 2nd pill and then delivered R31's medications to him. Example 2 R32's Physician Orders indicate: Lidocaine external patch 5% (lidocaine) apply to affected pain areas topically one time a day for pain. Apixaban oral tablet 2.5 mg (milligrams) give 1 tablet by mouth two times a day. (also known as Eliquis) On 9/10/24 at 7:13 AM Surveyor observed LPN I prepare R32's medications and LPN I prepared the following: 1. Acetaminophen 325 mg (milligrams) 2 tabs (stock) 2. Amlodipine besylate 5 mg tab 3. Combivent Respimate 20-100 mg 1 puff 4. R463's Eliquis 2.5 mg (milligram) tablet was popped out of R463's medication card. LPN I placed the card back into the cart, Surveyor asked LPN I to re-look at the Eliquis card and read the name on the card. LPN I indicated that it was R463's medication, she removed that medication from the med cup, then retrieved R32's Eliquis 2.5 mg card and dispensed the medication from R32's medication card. Surveyor asked if R463 was the correct resident LPN I indicated no. 5. Metoprolol ER 25 mg tablet 6. Potassium chloride ER 10meq (milliequivalent) tab 7. Lidocaine pain-relief gel patch 4% lidocaine. 8. Losartan 100 mg tablet. LPN I indicated I need to get from stock at 7:39 AM Losartan 25 mg tab x 4 tabs pulled from contingency to make 100 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Furosemide 20 mg 1 tab from contingency pulled on 9/10/24 at 7:39 AM 10. Fluticasone propionate and Salmeterol 250 mcg (micrograms)/50 mcg (micrograms) - 1 puff daily. On 9/10/24 at 7:33 AM LPN I realized while in R32's room prior to putting on R32's Lidocaine patch that the patch is 4% not 5% and LPN I did not apply the patch. During this time Surveyor observed R32 to have a Lidocaine patch still on her left arm with no date or initials. LPN I indicated not a date on it we apply a new one every morning the patch should be removed at night. LPN I left the room to get a different patch. LPN I was unable to find a 5% patch and stated 5% must be out, I will need to order that STAT (as soon as possible) from the pharmacy. On 9/10/24 at 1:58 PM, R32's Progress note states in part: .Writer informed (Nurse Practitioner (NP) name) that lidocaine patch 5% needs to be reordered. 5% patch is not available in facility at this time. per (Nurse Practitioner) switch order to lidocaine patch 4% daily. (Of note: there is no documentation indicating that the NP was updated on R32 having her lidocaine patch left on her arm or that the lidocaine patch was not applied during AM medication pass.) On 9/10/24 at 5:30 PM, Surveyor interviewed DON B regarding medication observation. DON B indicated observation with R31 was a medication error and observation with R32 was a medication error. DON B indicated wrong patients medication card is a medication error, DON B indicated that the Lidocaine patch should have been removed the night prior and the nurse should have called the doctor regarding the lidocaine patch error to know if to hold or continue with administration.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure that residents were free of any significant medication errors for 1 of 1 resident (R57) reviewed for significant medication errors. R57 did not receive scheduled insulin at 8:00AM on 7/24/24 and did not have blood glucose monitoring in place. R57 was hospitalized on the evening of 7/24/24 with acute hyperglycemia (a medical emergency that occurs when blood sugar levels are extremely high) requiring treatment with insulin drip (administration of insulin through intravenous line.) Evidenced by: Facility policy entitled Medication Administration, dated 05/2024, states in part: Policy: Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice . 20. Sign MAR (Medication Administration Record) after administered . R57 admitted to the facility on [DATE] with diagnoses that include, in part: Type 2 Diabetes Mellitus without complications (a condition that occurs when the body doesn't produce enough insulin or can't use insulin properly, resulting in high blood sugar levels.) Of note, R57 was admitted from the hospital after being treated for hyperglycemia. R57's MDS (Minimum Data Set) dated 8/7/24 indicates that R57 has a BIMS (Brief Interview of Mental Status) of 15, indicating R57 is cognitively intact. R57's physician orders dated 7/23/24, state in part: insulin glargine (Lantus) 20 units subcutaneous once a day (in the morning). It is important to note there were no physician orders for monitoring blood glucose levels. R57's MAR (Medication Administration Record) for July 2024 shows: 7/24/24 8:00 AM--Medication not administered. Important to note: R57's TAR (Treatment Administration Record) for July 2024 shows no record of blood glucose monitoring on 7/23/24 or 7/24/24. R57's SBAR (Situation, Background, Assessment, and Recommendation) Communication Form and Progress Note dated 7/24/24 8:00PM states, in part: .resident yelled out for help, writer went to resident's room. Resident stated he did not feel well. Resident diaphoretic (sweating), shaking, cold to touch, BP (blood pressure) low. Glucometer (device to test blood sugar level) reads HI (reading beyond the level which the machine can report). R57's Nephrology Consult Note dated 7/25/24, states, in part: .sent back to the ED (emergency department), where his BS (blood sugar) was noted to be in the 900's. Was started on an insulin drip. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R57's hospital discharge summary dated 7/27/24, states, in part: Discharge Diagnosis: acute hyperglycemia . On 09/10/24 at 8:03 AM, Surveyor interviewed R57, who indicated being hospitalized after admission to facility due to blood sugar issues. On 09/12/24 at 8:26 AM, Surveyor interviewed LPN O (Licensed Practical Nurse) and asked what interventions would be expected for a new admission with a diagnosis of diabetes. LPN O stated accu checks (blood glucose checks / monitoring), insulin or oral meds as needed, parameters, glucagon gel or injection, diet. Surveyor asked what the process would be if there were no blood glucose checks ordered for a new admission. LPN O stated call the physician and double check to ensure it wasn't missed. Surveyor asked if medications are signed for on the MAR when they are administered. LPN O said yes. On 9/12/24 at 9:19 AM, Surveyor reviewed the July 2024 MAR with LPN O and asked if the Lantus ordered for R57 at 8:00AM on 7/24/24 was given. LPN O stated no, it isn't signed out. On 9/12/24 at 8:37 AM, Surveyor interviewed LPN E and asked if blood glucose checks / monitoring would be expected for a new admission with diagnosis of diabetes. LPN E stated yes. Surveyor asked what the process would be if there were no blood glucose checks ordered. LPN E stated check with the doctor. Surveyor asked if medications are signed for on the MAR when they are administered. LPN E stated yes. On 09/12/24 at 9:33 AM, Surveyor interviewed DON B (Director of Nursing) and asked if staff is expected to follow physician orders. DON B stated yes. Surveyor asked if nurses should be signing out meds at the time they are given. DON B stated yes. Surveyor asked if a medication is not signed out on the MAR has it been administered. DON B stated no. Surveyor reviewed July 2024 MAR with DON B and asked if the Lantus had been administered on 7/24/24. DON B said no, that was not given. Surveyor asked if DON B would expect Lantus to be administered if ordered? DON B stated yes. Surveyor asked DON B if blood glucose checks would be expected to be ordered and checked for a resident on Lantus? DON B stated yes, if there is no order, ask the doctor for orders. Surveyor asked DON B is it possible that if R57 had received his Lantus at 8am that the hospitalization would have been avoided. DON B stated yes. On 9/12/24 at 3:18 PM, Surveyor interviewed NP N (Nurse Practitioner) and asked would you expect the facility to administer medications as orders? NP N stated yes. Reviewed MAR indicating that R57 had not received his insulin on 7/24/24 and asked if NP N would expect the facility to have administered this insulin? NP N stated yes. Surveyor asked NP N is it possible that if the facility had administered his AM insulin, his blood sugar would not have been registering high. NP N stated it is not a yes or no, potentially. Surveyor asked NP N if administration of the Lantus may have prevented the need for the insulin drip. NP N stated yes, it is possible. Surveyor asked NP N if the facility had been monitoring blood glucose checks on a regular basis if the need for hospitalization may have been prevented. NP N stated yes. Surveyor asked if NP N would expect that the facility would inquire about doing blood glucose monitoring if R57 was admitted without orders and was on Lantus. NP N stated yes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36192 Based on observation, interview, and record review the facility did not ensure drugs and biological's are labeled in accordance with currently accepted professional standards for 1 of 2 Medication carts and 1 of 1 medication rooms reviewed for medication storage. Medication room had 5 bottles of expired liquid Tylenol on the shelf. Medication room fridge had an undated open insulin vial for R57. Needlepoint medication cart had three bottles of artificial tears that did not have the residents full name or date opened on them. Evidenced by: Facility policy entitled, Medication Administration General Guidelines, dated 01/24, states in part: . Medication administration: 1. Medications are administered in accordance with written orders of the prescriber . 8. Check expiration date on package/container. No expired medications will be administered to a resident.b. The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. c. Certain products or package types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating once opened, to ensure medication purity and potency .position statements from American Society of Ophthalmic Registered Nurses and American Society of Cataract & Refractive Surgery (ASCRS) state that the multi-use eye drops and ointments should be disposed of 28 days after initial use . 9. Verify medication is correct three (3) times before administering the medication. a. when pulling medication package from med cart. b. when dose is prepared. c. before dose is administered.16. Medications supplied for one resident are never administered to another resident.Documentation: .2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotics is needed) an explanatory note is entered on the reverse side of the record provided for PRN documentation . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 3:06 PM, Surveyor conducted medication storage observation of 2 medication carts and 1 medication room. Surveyor observed the Needle point/Birchwood Hall cart with RN H (Registered Nurse). Surveyor found three vials of artificial tears in the cart, that were not properly labeled or dated. One bottle had no first or last name on it with an open date of 6/20/24. The other two bottles had only first names of residents on it and no open date. RN H indicated that one of the eye drops belonged to R25 and the other belonged to R33. RN H indicated she is not able to say who the third bottle of artificial tears belonged to. Surveyor asked based on the labels having only the first names, would staff be certain they belong to R25 or R33? RN H indicated No, especially if you had two residents with the same first names. RN H indicated the one bottle has an open date of 6/20/24 and the others do not have an open date. RN H indicated there should be full resident names on the eye drops along with an open date to know if they're still good. Surveyor observed the medication room with RN H after reviewing the cart. Surveyor and RN H observed 5 bottles of liquid Tylenol on the shelf with an expiration date of 7/2024. RN H indicated the Tylenol should not be in the medication room due to being expired. Surveyor and RN H observed an open vial of Lantus for R57 in the medication room refrigerator. RN H was unable to say when it was opened or how long it was opened for. On 9/9/24 at 3:24 PM Surveyor interviewed LPN E (Licensed Practical Nurse) regarding medication storage. LPN E indicated R57's Lantus vial is opened and was dispensed on 7/28/24, and there is no open date on it, it should be dated. LPN E indicated the insulin is only good for 28 days once it's opened. LPN E indicated eye drops are only good for 30 days after they have been opened unless specified. On 9/10/24 at 5:30 PM, Surveyor interviewed DON B (Director of Nursing) regarding medication storage/expiration dates. Surveyor asked DON B if Tylenol with an expiration date of 7/2024 should be in the med room, DON B indicated it was expired and should not be in there. Surveyor asked about dating insulin and eye drops, DON B indicated they should have an open date. DON B indicated that everyone should be checking expiration and labeling dates.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure that all residents receive food at a palatable temperature for 1 of 1 sampled (R467) and 1 of 1 supplemental residents (R41) and 1 of 1 test trays. Residents R467 and R41 voiced concerns with receiving hot foods cold. Test tray was observed to have hot foods served cold and food not palatable. Evidenced by: The facility policy, Record of Food Temperatures, dated 3/24, states, in part; .It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperatures before trays are assembled .11. No food will be served that does not meet the food code standard temperatures . Example 1 R467 admitted to the facility on [DATE] with diagnoses that include, in part, Type 2 Diabetes Mellitus, Essential Hypertension, atherosclerotic heart disease. On 9/9/24 at 11:16 AM Surveyor interviewed R467 and asked about the food. R467 stated the food is cold. Example 2 R41 was admitted to the facility on [DATE]. R41's most recent MDS (Minimum Data Set) with a target date of 6/12/24, indicates R41 has a BIMS (Brief Interview for Mental Status) score of 12, indicating R41 has a mild cognitive impairment. On 9/9/24 at 11:26AM Surveyors met with residents for the resident council task. R41 was present and indicated that sometimes hot food is provided luke warm and that she has sent food back to the kitchen that was cold. Example 3 On 9/10/24 at 12:30PM, Surveyor received test tray. Meat and gravy temped at 111F, noodles 109F, and mixed vegetable 115F. Surveyor observed the noodles to be not palatable and mushy in texture. On 9/12/24 at 9:49AM, NSD W (Nutrition Services Director) indicated he would expect hot foods to be served hot and foods served palatable. NSD W indicated the facility is working on getting new equipment and hot plates. NSD W indicated meal temperatures have been an ongoing issue because staff will leave the warming box open while they are placing trays into it and the heat goes out. (continued on next page)

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Beloit Health and Rehabilitation Center	1905 W Hart Rd Beloit, WI 53511

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure all residents receive food at a palatable temperature.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure each resident received meals at their desired time in accordance with resident needs, preferences, or requests. This has the potential to affect all 58 residents residing at the facility. Residents (R8, R41, and R35) voiced concern regarding meals being served over an hour after the scheduled time. Surveyors observed meals being served 1-1.5 hours after the scheduled mealtimes. Evidenced by: The facility policy, Frequency of Meals, dated, 7/17, states, in part: .The following mealtimes have been established by our facility for residents, Breakfast 7:45AM, Lunch 11:45AM, Dinner 4:45PM . Example 1: R8 was admitted to the facility on [DATE]. R8's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/14/24 indicated R8 has a BIMS (Brief Interview for Mental Status) score of 13 indicating R8 is cognitively intact. R8 is own person. On 9/10/24 at 8:28AM, R8 indicated meals are often served over an hour after the scheduled mealtimes. R8 indicated today they didn't get lunch until after 1:00PM in the dining room. R8 indicated there has been times that supper doesn't come until 6:00PM or later. R8 indicated she will order snacks and get them sent to the facility; these snacks help hold her over because meals are often delivered so late. R8 indicated she was raised on a farm and her personal preference is to have breakfast before 8am, lunch at noon, and supper at 5pm. R8 indicated she always eats her meals in the dining room. R8 indicated staff know the meals are often late. Example 2: R41 was admitted to the facility on [DATE]. R41's most recent MDS (Minimum Data Set) with a target date of 6/12/24, indicates R41 has a BIMS (Brief Interview for Mental Status) score of 12, indicating R41 has a mild cognitive impairment. On 9/10/24 at 4:12PM, R41 indicated meals are always served late. R41 stated, It bothers me .it bothers everyone. R41 indicated R41 eats meals in the dining room and meals are often served an hour or more after the scheduled meal times. Example 3: (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R35 was admitted to the facility on [DATE]. R35's most recent MDS (Minimum Data Set) with a target date of 7/25/24, indicates R35 has a BIMS (Brief Interview for Mental Status) score of 11, indicating R35 has a mild cognitive impairment. On 9/10/24 at 8:28AM, Surveyor observed R35 receive breakfast tray in his room. On 9/11/24 at 8:33AM, Surveyor interviewed R35 who indicated that about 3 - 4 times a week his breakfast tray is late. R35 indicated that he eats slower due to his Parkinson's. R35 stated because the meals are served late when lunch comes, I will not want to eat again because the meals will be too close together. Example 4: On 9/9/24, Surveyor observed lunch being served in dining room at 1:00PM. On 9/10/24, Surveyor observed breakfast being served at 9:00AM in dining room. Surveyor observed the following posting of mealtimes: Breakfast 7:45AM, Lunch 11:45PM, Dinner 4:45PM in dining room. On 9/12/24 at 9:49AM, NSD W (Nutrition Services Director) indicated he has been working on building his team in the kitchen. NSD W indicated he had multiple new staff start for a couple weeks and then quit. NSD W indicated he knows the meals have been served late and this is due to call ins and one of the cooks is still getting down the routine. NSD W indicated he would expect meals to be served during the scheduled mealtimes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on observation, interview, and record review the facility did not ensure food was stored or labeled in accordance with professional standards for 1 of 2 medication room refrigerators. Three cartons of thickened liquids and two half gallons of chocolate milk were opened and expired in the medication room refrigerator. Evidenced by: Facility policy entitled 'Food Safety Requirements,' states in part: .Policy explanation and compliance guidelines: .3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage.c. Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include: .iv. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by its use-by date, or frozen . On [DATE] at 3:20 PM, Surveyor observed the medication room refrigerator and found the following: One Ready care thickened apple juice with an open date of [DATE], Directions on the carton indicate refrigerate prior to serving. shake well before using. Twist the cap to open then pour and serve. After opening may be kept up to 7 days under refrigeration. Two Trumoo ,d+[DATE] (half) gallons of chocolate milk with a sell by date of [DATE]. One had an open date of [DATE], the other did not have an open date, both milks jugs were partially gone. One Hormel Med Pass 2.0 vanilla shake indicated as being opened [DATE], the carton indicated for storage & Handling: after open, consume product within 4 days if properly refrigerated. One Hormel Thick & Easy nectar consistency dairy product with an opened date of [DATE], the carton indicated Storage & Handling: refrigerate after opening, discard if not used within 4 days of opening. On [DATE] at 3:24 PM, LPN E (Licensed Practical Nurse) indicated the 2nd refrigerator in the medication room is the resident refrigerator. LPN E indicate supplements and food items should be discarded if the items are expired. LPN E was unable to say who the chocolate milk belonged to. On [DATE] at 9:30 AM, NHA A (Nursing Home Administrator) indicated to Surveyor that only R3 and R26 receive nectar thick liquids. On [DATE] at 5:30 PM, Surveyor interviewed DON B (Director of Nursing) regarding expired items in the medication room fridge. DON B indicated if the items in the medication refrigerator should have open dates and if expired should be discarded. DON B indicated that night shift cleans out the medication refrigerator and that everyone should be checking for expiration and open dates.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure accurate reporting of the mandatory submission of staffing information based on payroll data to the Centers for Medicare & Medicaid Services (CMS.) This has the potential to affect all 58 residents residing within the facility. The facility failed to enter accurate data in their Payroll Based Journal (PBJ) reporting and triggered for five fiscal year quarters, dated 4/1/23 - 6/30/24, for inadequate weekend staffing. This is evidenced by: Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal, Long-term Care Facility Policy Manual, dated June 2022, states in part: Chapter 1: Overview, 1.1 introduction .(U) mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.1.2 Submission Timelines and Accuracy. Direct care staffing and census data will be collected quarterly and is required to be timely and accurate . Report Quarter: staffing and census data will be collected for each fiscal quarter. Staffing data includes the number of hours paid to work by each staff member each day within a quarter. Census data includes the facility's census on the last day of each of the three months in a quarter. The fiscal quarters are as follows: Fiscal Quarter, Date range: 1 October 1 - December 31, (quarter 1) 2 January 1 - March 31, (quarter 2) 3 April 1 - June 30, (quarter 3) 4 July 1 - September 30 (quarter 4) . PBJ Staffing Data Report, CASPER Report (Certification and Survey Provider Enhanced Reports) 1705D for Fiscal year Quarter 3 2024 (April 1 - June 30), ran on 9/4/24 indicates the following: Metric: Excessively Low Weekend Staffing, Result: Triggered, Definition: Triggered = (equals) Submitted Weekend Staffing data is excessively low. PBJ Staffing Data Report, CASPER Report 1705D for Fiscal year Quarter 2 2024 (January 1 - March 31), ran on 9/4/24 indicates the following: Metric: Excessively Low Weekend Staffing, Result: Triggered, Definition: Triggered = Submitted Weekend Staffing data is excessively low. PBJ Staffing Data Report, CASPER Report 1705D for Fiscal year Quarter 1 2024 (October 1 - December 31), ran on 9/4/24 indicates the following: Metric: Excessively Low Weekend Staffing, Result: Triggered, Definition: Triggered = Submitted Weekend Staffing data is excessively low. PBJ Staffing Data Report, CASPER Report 1705D for Fiscal year Quarter 4 2023 (July 1 - September 30), ran on 9/4/24 indicates the following: Metric: Excessively Low Weekend Staffing, Result: Triggered, Definition: Triggered = Submitted Weekend Staffing data is excessively low. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PBJ Staffing Data Report, CASPER Report 1705D for Fiscal year Quarter 3 2023 (April 1 - June 30), ran on 9/4/24 indicates the following: Metric: Excessively Low Weekend Staffing, Result: Triggered, Definition: Triggered = Submitted Weekend Staffing data is excessively low. The facility's Facility assessment dated [DATE] states in part: .This facility assessment will be used to inform staffing decisions to ensure that there are a sufficient number of staff . consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population . consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population . The facility's Facility Assessment indicates Nurse Aide Hours per Resident Day (HRD) as 1.686 HRD, Nurse Aide Case Mix Hours per Resident Day as 2.291 HRD, and Nurse Aide Adjusted Hours per Resident Day as 1.656 HRD. On 9/10/24, Surveyor reviewed the facility's Daily Nurse Staffing Forms which indicated the following: On 1/6/24, the Certified Nursing Assistant (CNA) hours compute to 1.60 HRD. On 6/30/24, the CNA hours compute to 1.53 HRD. On 6/29/24, the CNA hours compute to 1.55 HRD. On 6/16/24, the CNA hours compute to 1.46 HRD. On 6/15/24, the CNA hours compute to 1.39 HRD. On 6/9/24, the CNA hours compute to 1.64 HRD. On 6/2/24, the CNA hours compute to 1.39 HRD. On 7/6/24, the CNA hours compute to 1.46 HRD. On 9/11/24 at 2:04 PM, Surveyor interviewed Scheduler E, who stated that she staffed according to census. Scheduler E was unsure about the facility assessment. Scheduler E stated they have no staffing concerns right now. Surveyor reviewed with Scheduler E the PBJ Staffing Data Report. Scheduler E stated that she did not understand how they could be triggering for low staffing. On 9/11/24 at 2:45 PM, Surveyor interviewed MDS Coordinator M (Minimum Data Set), who stated that the hours in the facility assessment are historical. MDS Coordinator M indicated that the facility assessment case mix hours would be used if there was higher acuity. MDS Coordinator M stated that the facility assessment staffing hours were sent to corporate who reviewed and approved the HRD for CNAs. On 9/11/24 at 2:50 PM, Surveyor interviewed DON B (Director of Nursing), who stated that the facility assessment had baseline hours for staffing that could be adjusted up or down based on acuity. Surveyor reviewed with DON B the PBJ Staffing Report. DON B indicated that June was a tough month for weekend staffing but that they always have a department head in the building on the weekends to help pass trays and answer call lights. DON B stated that these manager hours are not reflected in the PBJ staffing numbers.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on observation, interview, and record review, the facility has not established an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections such as COVID-19. This has the potential to affect the census of 58 residents (R). The facility infection prevention and control policies have not been updated annually. The facility did not ensure contact tracing and testing was completed accurately and timely during a COVID outbreak. Surveyor observed cares for R35 with breaches in infection control technique. Evidenced by: The facility policy titled Infection Prevention and Control Program dated 5/16/23, states, in part: The facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per acted national standards and guidelines . All staff are responsible for following all policies and procedures related to the program . A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards . The RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections . Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible. Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 . If healthcare-associated transmission is suspected or identified, the facility may consider expanded testing of HCP (Health Care Personnel) and residents as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. If and expanded testing (e.g., affected unit as opposed to the entire facility) approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days . Annual Review: a. The facility will conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures based upon the facility assessment which includes any facility and community risk. b. Following review, the infection and prevention control program will be updated as necessary. Example 1: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The following is a list of facility policies with their last review dates: -Infection Prevention and Control Program 5/16/23 -Infection Outbreak Response and Investigation 5/16/23 -Influenza Vaccination 8/30/23 -Pneumococcal Vaccine (Series) 8/30/23 -Legionella Surveillance no date -COVID-19 Vaccination 5/16/23 -Hand Hygiene 10/23 -Antibiotic Stewardship Program 12/23/22 On 9/11/23 at 2:57PM, Surveyor interviewed DON B (Director of Nursing) and ADON/IP C (Assistant Director of Nursing/Infection Preventionist). ADON C indicated she is the infection preventionist. DON B indicated she oversees the infection prevention and control program. DON B indicated policies should be reviewed annually. DON B indicated these policies listed have not been reviewed annually. Example 2: The facility had a COVID-19 outbreak in March 2024. The facility provided Surveyor with an outbreak folder containing documentation related to the outbreak. A document titled 3/5/24 COVID outbreak summarizing the facility COVID outbreak states: 1. 3/5/24 R613 began to have a change in condition with a cough and increased shortness of breath. Provider phoned and gave order to send patient to [Town Name] ER (emergency room). 2. 3/5/24 Around 10 pm nurse called to check on status of patient. ER explained the patient was being admitted for fluid overload and was COVID positive. 3. 3/6/24 Outbreak status initiated in facility and signage posted to notify visitors and outside providers. Housekeeping increasing sanitation of common areas. [Medical Director Name] the facility medical director notified. 4. R614 came to the nurses station early AM requesting her temperature be taken. Temperature taken and elevated at that time. R614 was then tested for COVID with positive results. COVID hallway opened and R614 placed on isolation. PCP (Primary Care Provider) phoned to notify. Contact tracing completed with R614. 5. R614 reported she had possibly exposed 4 other residents. The first resident being previously positive R613, whom she was seated by during tornado warning. She also reported possibly exposing R28, R618 and R13. All three of exposed residents COVID tested and negative at this time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. [County Name] county health department phoned and updated, and line list sent. 7. 3/8/24 PM shift R28 reported having a new cough and requested to be testing [sic] again for COVID with positive results. R28 placed on contact droplet isolation. R28 denies being within 6 ft (feet) of any peers for more than 15 minutes without a mask on. 8. 3/9/24 The other 2 exposed residents tested for COVID. R618 and R13 both testing negative for COVID. 9. 3/11/24 staff member DON B (Director of Nursing) tested positive for COVID and has not been in the facility without a mask on. Symptoms began 3/8/24 in the evening. R618 and R13 tested again for COVID with negative results. [County Name] health department RN (Registered Nurse) [Nurse Name] phoned and updated of newly positive staff member as well as resident. All residents updated of COVID status and residents contacted [sic] notified. 10. 3/12/21 R616 having increased abdominal girth along with lower extremity edema. Patient sent to ED (Emergency Department) and admitted COVID positive. R616 returned from hospital and readmitted to facility. Resident placed on COVID hall on isolation. 11. 3/13/24 Line list updated and sent to [County Name] Health department. [County Name] health department phoned and updated. All residents and resident contacts updated of ongoing COVID status. 12. 3/14/24 R617 went to ER 3/13/24 and tested positive for COVID. She returned 3/14/24 and was placed on COVID isolation in room. [County Name] Health department updated, and this nurse spoke to nurse [Nurse Name] related to ongoing outbreak. Line list updated and sent to [County Name] health department. 13. 3/15/24 Handwashing audits completed in all departments. Housekeeping continues to increase sanitation to high trafficked areas. All residents notified and resident contacts notified of ongoing COVID outbreak. 14. 3/18/24 R47 had an emesis and was tested for COVID and positive. Patient was moved to COVID hall and placed on isolation precautions. PCP and family updated. Roommate R8 tested and negative at this time. 15. 3/19/24 contact tracing initiated for R47, and table mates tested for COVID. R9 noted to be positive for COVID. Patient moved to COVID hall and placed on isolation precautions. PCP updated as well as family. R619 tested as was a tablemate and negative at this time. All residents in facility updated of ongoing COVID outbreak as well as resident contacts. R18 reported generalized malaise. Resident tested for COVID and positive. Roommate [sic] R43 tested and negative for COVID per contact tracing protocol. 16. 3/21/24 Per contact tracing protocol R8 re-tested for COVID and positive at this time. R8 was moved to COVID hall and placed on isolation precautions. PCP (Primary Care Provider), Family as well as residents in building updated on continue [sic] COVID outbreak. Ongoing enhanced cleaning of highly traffics [sic] area ongoing for 2 weeks post last positive patient. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	17. COVID outbreak officially closed 4/1/24. Please see line list for dates. [County Name] updated. On 9/11/24 at 2:57PM, Surveyor interviewed DON B and ADON C. Surveyor asked why contact tracing had not been completed for R613, the first resident with COVID. ADON C indicated R613 never leaves her room and eats in her room. Of note, there was a tornado drill where R613 exposed a minimum of one other resident, R614. Surveyor asked if contact tracing had been completed for R616 after testing positive for COVID. DON B and ADON C indicated since they had not added contact tracing to the summary, they did not complete contact tracing for her. They indicated she always stays in her room. Surveyor presented a nurse progress note dated 3/8/24 at 13:56 (1:56PM) that states pt (patient) up in w/c (wheelchair) and to the MDR (Main Dining Room) for meals, pleasant and cooperative so far this shift and has no c/o (complaints of). DON B indicated contact tracing should have been completed for R616 if she was eating her meals in the main dining room. Of note, contact tracing was not completed for R613 and R614. R47 tested positive on 3/18/24 after having an emesis. R47's nurse progress note dated 3/18/24 at 22:40 (10:40PM) states, in part, Writer informed by CNA (Certified Nursing Assistant) that resident has large emisis [sic] of undigested food . Resident has had a slight cough this weekend, Rapid COVID test done showing Positive results . On 9/12/24 at 8:40AM, Surveyor interviewed DON B. Surveyor asked if the facility should have waited until Monday 3/18/24 to test R47 for COVID as she was showing signs and symptoms over the weekend. DON B indicated she would have expected the facility to test R47 sooner and should not have waited until Monday if she was showing signs over the weekend. The COVID outbreak folder also contained testing documentation completed during the outbreak. On 3/6/24, R614 indicated she possibly exposed three other residents, R28, R618, and R13. R28 was tested on [DATE] and positive. R618 and R13 were tested on [DATE] and 3/11/24. On 9/12/24 at 8:40AM, Surveyor interviewed DON B. Surveyor asked if testing was completed per the facility policy and standard of practice for R28, R618, and R13 as these residents should have been tested on [DATE]. DON B agreed R28, R618, and R13 should have been tested on [DATE] and were not. On 3/18/24, R8 was exposed. R8 was tested on [DATE] with negative results and again on 3/21/24 with positive results. On 9/12/24 at 8:40AM, Surveyor interviewed DON B. Surveyor asked if testing was completed per the facility policy and standard of practice for R8 as she should have been tested on [DATE]. DON B agreed R8 should have been tested on [DATE] and was not. On 3/18/24, R619 and R43 were exposed to a positive resident. R619 and R43 were tested on [DATE], 3/22/24, and 3/24/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/12/24 at 8:40AM, Surveyor interviewed DON B. Surveyor asked if testing was completed per the facility policy and standard of practice for R619 and R43 as testing should have been completed on 3/19/24, 3/21/24, and 3/23/24. DON B agreed testing should have been completed on 3/19/24, 3/21/24, and 3/23/24 and was not. R12, R26, R41, and R14 were tested on [DATE], 3/24/24, and 3/27/24. On 9/12/24 at 8:40AM, Surveyor interviewed DON B. Surveyor asked if testing was completed per the facility policy and standard of practice for R12, R26, R41, and R14 as they should have been tested on [DATE], 3/23/24, and 3/25/24. DON B agreed testing should have been completed on 3/21/24, 3/23/24, and 3/25/24 and was not. The facility did not review policies and procedures within the required time frame of annually. The facility did not contact trace for two residents, R613 and R614. The facility did not test for COVID timely for 11 residents, R8, R12, R13, R14, R26, R28, R41, R43, R47, R618, and R619. 39849 Example 3: R35 was admitted to the facility on [DATE]. On 9/12/24 at 10:18AM, Surveyor observed CNA DD (Certified Nursing Assistant) and CNA R assist R35 in getting washed up. CNA R took clean washcloths to the sink, wet the washcloths under the running water and set each washcloth on the edge of the sink while she wet the next one. CNA R then used these washcloths to wash R35's upper body and for peri-care with the brief change. During cares CNA R obtained a container of zinc oxide from a shelf in R35's room. CNA R then took her gloved hand and placed it into the container of zinc oxide and applied it to R35's buttock. CNA R then placed the same gloved hand back into the container of zinc oxide and applied it to bilateral groin areas. After cares were completed, Surveyor interviewed CNA R. During this interview CNA R indicated the sink could be considered contaminated and that she should not have set the washcloths on the edge of the sink prior to using them for cares. CNA R indicated she has not been trained not to use a gloved hand to remove the zinc oxide from the container. CNA R indicated that after applying the zinc oxide to R35's buttock she should not have used the same gloved hand to obtain more zinc oxide from the container and she should not have applied to the groin area with that same gloved hand after she had applied to his buttock. On 9/12/24 at 11:53AM, Surveyor interviewed DON B (Director of Nursing) and reviewed the above observation. During the interview, DON B indicated that the washcloths should not have been set on the sink, they should be wet and then go straight to the resident for use. DON B indicated the CNA should not have reinserted her gloved hand into the container of zinc oxide, should put the zinc oxide in a cup using a plastic spoon, and should not use a gloved hand directly in the container. DON B indicated that the CNA should have either applied the zinc oxide from front to back or should have changed gloves between application to buttock and groin area.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility did not ensure they followed their Antibiotic Stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 2 of 6 sampled residents (R16 and R34) and 1 supplemental resident (R612) reviewed for antibiotic stewardship. R16 is being cited at severity level 3 (actual harm). R34 and R612 are being cited at severity level 2 (potential for more than minimal harm). The facility did not follow Standards of Practice for Antibiotic Stewardship: R16 has a history of antibiotic resistance and was prescribed antibiotics without meeting criteria. R16 was prescribed antibiotics for five events between March 26, 2024 and July 5, 2024, for asymptomatic bacteremia (presence of bacteria that does not cause symptoms thus not requiring antibiotic treatment). The facility did not thoroughly review R16's urine culture and sensitivities, and therefore, did not recognize R16 had developed resistance to a prescribed antibiotic. R34 was prescribed an antibiotic for Urinary Tract Infection (UTI) twice in the month of July without meeting criteria. R612 was prescribed and received an antibiotic for Acute Kidney Injury (AKI). R612 did not meet criteria for the prescribed antibiotic. Evidenced by: The facility policy titled Antibiotic Stewardship Program with a date of 12/23/22, states in part: It is the policy of this facility to implement and Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . 4. The program includes antibiotic use protocols and a system to monitor antibiotic use . ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections. iv. The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. v. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. vi. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized . Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness . According to National Institutes of Health (NIH), Asymptomatic bacteriuria is very common in clinical practice and its incidence increases with age .most patients with asymptomatic bacteriuria will never develop symptomatic urinary tract infections and will have no adverse consequences from asymptomatic bacteriuria . most patients will not benefit from treatment (www.ncbi.nlm.nih.gov). The facility form titled Infection Report Form is used for the facility's infection control program. The Infection Report Form identifies criteria that must be present to meet surveillance criteria for an infection. (continued on next page)

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F 0881 Level of Harm - Actual harm Residents Affected - Few	Example 1 R16 was admitted to the facility on [DATE]. R16's medical diagnoses list does not indicate any diagnoses related to UTI or Multidrug-Resistant Organism (MDRO). R16's admission Minimum Data Set (MDS) assessment dated [DATE] states in part, Section I Active Diagnoses Infections does not have a check mark for I1700. Multidrug-Resistant Organism (MDRO), I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS). This indicates R16 does not have an MDRO and does not currently have a UTI and has not had a UTI in the previous 30 days. Event 1 R16's 3/22/24 Urine Culture and Sensitivity Report states, in part: >100,000 cfu/ml Methicillin-Resistant Staphylococcus aureus (MRSA) isolated. 30,000 cfu/ml Mixed flora (multiple species present). Resistant to Oxacillin, Penicillin G, and Tetracycline (antibiotics). R16's 3/21/24 Infection Report Form (facility form used for antibiotic stewardship) does not have any criteria marked under the UTI section, indicating R16 has no symptoms of UTI. Of note, R16 does not meet criteria. In the follow up section the report states Resident returned from appt (appointment) - order for UA (urinalysis)/microalbum, creatinine. Asymptomatic bacteremia [sic] (presence of bacteria that does not cause symptoms). Of note, the follow up section indicates the urinalysis was obtained as a routine lab from a consulting provider. R16's March 2024 Medication Administration Record (MAR) indicates R16 received 4 doses of Bactrim DS oral tablet 800-160 for asymptomatic bacteremia. Event 2 R16's 4/4/24 Urine Culture and Sensitivity Report states, in part: >100,000 cfu/ml Enterococcus faecalis isolated. Resistant to Gentamicin and Tetracycline. 30,000 cfu/ml Methicillin-Resistant Staphylococcus aureus isolated. Of note, this is the same bacteria as the previous event. Resistant to Oxacillin, Penicillin G, and Tetracycline. R16's 3/26/24 Infection Report Form, in section two of UTI criteria, has marked At least 105 cfu/ml or no more than 2 species of microorganisms in a voided urine sample. Of note, section one of the UTI criteria has no marks, indicating R16 does not meet criteria. R16's 4/5/24 physician order states, Bactrim DS 800-160 give one tablet by mouth two times a day for UTI until 4/11/24. R16's April 2024 MAR indicates R16 received 12 doses of Bactrim DS 800-160 for asymptomatic bacteremia. R16's 4/24/24 Urine Culture and Sensitivity Report states, in part: >100,000 cfu/ml Enterococcus faecalis isolated. Resistant to Gentamicin and Tetracycline. 20,000 cfu/ml Methicillin-Resistant Staphylococcus aureus isolated. Resistant to Oxacillin, Penicillin G, and Tetracycline. Of note, these are both the same bacteria as the previous event. (continued on next page)

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F 0881 Level of Harm - Actual harm Residents Affected - Few	Event 3 R16's 4/24/24 Infection Report Form does not have any criteria marked under the UTI section, indicating R16 has no symptoms of UTI. Of note, R16 does not meet criteria. In the follow up section the report states, switched to this after report next to Nitrofurantoin (antibiotic) 100 mg po (by mouth) BID (twice a day), indicating the Amoxicillin (antibiotic) order was discontinued and changed to Nitrofurantoin. R16's 4/25/24 physician order states Amoxicillin 500 MG give 1 tablet by mouth four times a day for UTI. R16's physician order on 4/29/24 states Nitrofurantoin Macrocrystal oral capsule 100 MG give one capsule by mouth two times a day for UTI for 14 days. R16's April 2024 and May 2024 MAR indicates R16 received 13 doses of Amoxicillin 500 MG and 27 doses of Nitrofurantoin 100 MG. R16 received antibiotics for a total of 18 days. Of note this is the 3rd time R16 was treated and had asymptomatic bacteremia. A 5/2/24 Urology note states in part; Recent MRSA (Methicillin Resistant Staph Aureus and Enterococcus UTI known to be a MRSA carrier-probably the MRSA is could be [sic] primary source in the bladder or could be secondary and seeding from somewhere else staff [sic] is known to do that. Event 4 R16's 6/4/24 Urine Culture and Sensitivity Report states, in part: >100,000 cfu/ml Proteus mirabilis isolated. Resistant to Ampicillin, Gentamicin, Nitrofurantoin, Tetracycline, and Trimethoprim/Sulfa (is also known as Bactrim DS). Of note, R16 is now resistant to Bactrim DS and Nitrofurantoin. R16's 6/5/24 Infection Report Form, in section two of UTI criteria, has marked At least 105 cfu/ml or no more than 2 species of microorganisms in a voided urine sample. Of note, section one of the UTI criteria has no marks, indicating R16 does not meet criteria. In the follow up section the report states Asymptomatic Bacteremia [sic]. R16's 6/5/24 physician order states Keflex Oral Capsule 500 MG (antibiotic) give 500 mg by mouth four times a day for UTI for 5 days. R16's June 2024 MAR indicates R16 received 20 doses of Keflex. Event 5 R16's 7/2/24 Urine Culture and Sensitivity Report states, in part: >100,000 cfu/ml Proteus mirabilis isolated. Of note, this is the same bacteria as the previous event. Resistant to Ampicillin, Gentamicin, Nitrofurantoin, Tetracycline, and Trimethoprim/Sulfa. (continued on next page)

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F 0881 Level of Harm - Actual harm Residents Affected - Few	R16's 7/2/24 Infection Report Form does not have any criteria marked under the UTI section, indicating R16 has no symptoms of UTI. Of note, R16 does not meet criteria. In the follow up section the report states Asymptomatic Bacteremia [sic]. R16's 7/2/24 physician order states Nitrofurantoin 100 MG give 1 capsule by mouth two times a day for UTI for 10 days. Of note, R16's previous culture and sensitivity noted R16 was resistant to Nitrofurantoin. R16's 7/5/24 physician order states Cipro oral tablet 500 MG (broad spectrum antibiotic) give 1 tablet by mouth two times a day for UTI for 10 days. R16's July 2024 MAR indicates R16 received 6 doses of Nitrofurantoin and 20 doses of Cipro. On 9/12/24 at 8:33AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated she oversees and participates in the infection prevention program. DON B indicated R16 has had no symptoms for these five events. Surveyor asked DON B if R16's asymptomatic bacteriuria should be treated. DON B indicated if a resident is asymptomatic, not showing signs of UTI, the facility should not treat. DON B indicated she expects antibiotic stewardship to be followed. Surveyor asked DON B if the prescribing physicians have been educated on antibiotic stewardship for R16's asymptomatic bacteriuria. DON B could not present evidence that the facility has educated the physicians regarding treating asymptomatic bacteremia. Example 2 R34 was admitted to the facility on [DATE] with diagnoses that include neuromuscular dysfunction of bladder (bladder muscles are not functioning properly, causing problems with urination) and paraplegia (affects the ability to move or feel the lower half of the body). R34's 7/11/24 Urine Culture and Sensitivity Report states >100,000 cfu/ml Mixed flora (multiple species present). Suggest appropriate recollection if clinically indicated. Of note, mixed flora is indicative of a contaminated urine sample. R34's 7/11/24 Infection Report Form does not have any criteria marked under the UTI section, indicating R34 has no symptoms of UTI. Of note, R34 does not meet criteria. R34's 7/11/24 physician order states Cefpodoxime Proxetil oral tablet 200 MG (antibiotic) give 1 tablet by mouth every 12 hours for 10 days for UTI. R34's July 2024 MAR indicates R34 received 5 doses of Cefpodoxime Proxetil 200 MG. On 9/12/24 at 8:33AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated she oversees and participates in the infection prevention program. DON B indicated the facility did not obtain a recollection of urine for R34 per the recommendations of the 7/11/24 Urine Culture and Sensitivity Report. Example 3 (continued on next page)

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F 0881 Level of Harm - Actual harm Residents Affected - Few	R612 was admitted to the facility on [DATE] with diagnoses that include benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate). R612's 6/29/24 Urine Culture and Sensitivity Report states 70,000 cfu/ml Mixed flora (multiple species present). R612's 6/27/24 Infection Report Form does not have any criteria marked under the UTI section, indicating R612 has no symptoms of UTI. In the follow up section, the report indicates the antibiotic ordered was for an acute kidney injury. Of note, R612 does not meet criteria. R612's 6/29/24 physician order states Macrobid Oral Capsule 100 MG (antibiotic) give 1 capsule by mouth two times a day for UTI for 5 days. R612's June 2024 and July 2024 MARs indicate R612 received Macrobid for 4 days (8 doses). On 7/2/24, after R612 received 4 days of Macrobid, physician discontinued the order. Nurses progress notes dated 7/2/24 at 14:19 (2:19PM) states in part Dr. (Doctor's name) responded back to the UA (Urinalysis) stating that it does not appear that R612 has a UTI .you may discontinue this medication. On 9/12/24 at 8:33AM, Surveyor interviewed DON B (Director of Nursing). DON B indicated she oversees and participates in the infection prevention program. DON B agreed R612 did not meet criteria for an antibiotic and should not have received the antibiotic. The facility treated R16's asymptomatic bacteriuria five times. R16 now has resistance to Nitrofurantoin. R34 and R612 received treatment for UTIs that did not meet criteria. DON B indicated the facility did not follow antibiotic stewardship.