STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER: Ssm Health St Mary's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3401 Maple Grove Dr Madison, WI 53719	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported to the administrator and other officials, and that the residents are protected during the facilities investigation for 2 of 3 abuse investigations reviewed (R43 and R41) of a total sample of 27 residents. During R43's investigation, the alleged staff member named in allegation was not suspended per the facility's Abuse Policy and Procedure. On 4/17/24 the facility became aware that R41's narcotic pain patch was unable to be located and this was not reported to the administrator. This is evidenced by: The Facilities Abuse, Neglect, and Exploitation Policy and Procedure, dated November 2023, documents in part: .It is also the policy of this community to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property (alleged violations) are reported immediately to the administrator of the community .it must be reported to the State agency immediately but no later than two hours after forming the suspicion per State and Federal regulation .If the suspected perpetrator is .An employee, family, friend, or visitor, THEN .The Administrator places the employee on immediate investigatory suspension while completing the investigation . Example 1 R43 is a long-term resident of the facility. R43 has the following diagnoses multiple sclerosis, dementia, fibromyalgia, muscle weakness, and dependence on wheelchair. R43's most recent Minimum Data Set (MDS) dated [DATE] documents a score of 13 on her Brief Interview of Mental Status (BIMS), which indicates that she is cognitively intact. On 4/30/24 at 3:08 PM, Surveyor interviewed R43. Surveyor asked R43 if she had any concerns with the staff or their treatment of her, R43 said she had no concerns with staff, that she didn't need them much. Surveyor reviewed a Facility Reported Incident (FRI) dated 4/22/24, it documents the following: (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON B (Director of Nursing) returned call to the Complainant and was told that the staff were teasing and blaming R43, two staff had entered R43's room and were laughing at R43, a nurse called Complainant to report R43 was refusing to go to bed, refusing cares, and refusing her CPAP (Continuous Positive Airway Pressure- machine that uses mild air pressure to keep breathing airways open while you sleep), but she was on toilet at the time of this, all of this is abuse, she stated. Reported to Police and State Agency. Interviewed R43, other residents, and staff with no concerns voiced. Education provided on abuse to staff. Investigation completed, unsubstantiated. On 5/1/24 at 3:32 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if the CNA (Certified Nursing Assistant) that was named in this investigation had been suspended, DON B replied, I believe so, I'll check with NHA A (Nursing Home Administrator). On 5/1/24 at 4:45 PM, Surveyor interviewed DON B and NHA A. DON B reported to Surveyor that the named CNA was not suspended. DON B went on to explain that the reason she was not suspended was because it appeared as a customer service issue, rather than abuse; NHA A then stated the only reason it was submitted as an allegation of abuse is because the Complainant used the verbiage abuse. DON B went on to explain that when she interviewed the staff, it did not appear as abuse. DON B explained that when she interviewed the accused CNA, she and the staff that accompanied her into room stated that she only smiled, did not laugh, and was then asking DON B if she shouldn't smile. On 5/2/24 at 8:21 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F when there is an allegation of abuse, what do you do if there is a staff person named, LPN F stated contact the abuse coordinator or DON immediately. On 5/2/24 at 1:19 PM, Surveyor interviewed NHA A. Surveyor asked NHA A how the facility protected the residents if the named CNA was not removed from work, NHA A stated the CNA was removed from R43's care. Surveyor asked NHA A what the named CNA did during investigation, NHA A said she continued to work that shift, just not with R43. Surveyor asked NHA A how she ensured protection of the residents, NHA A replied when this was brought to my attention, it was not a concern of abuse (shame, laughing) but we had to determine if it was abuse or customer service concern. Surveyor asked NHA A if shaming or laughing at a resident could that be an allegation of abuse, NHA A stated yes it could. 49436 Example 2 R41 was admitted to the facility on [DATE] with diagnoses, in part, pain in right knee, other congenital malformations, and unspecified convulsions. R41's most recent Minimum Data Set (MDS) dated [DATE] documents a score of 10 on her Brief Interview for Mental Status (BIMS), which indicates she has a moderate cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 11:20 AM, Surveyors reviewed R41's nurses notes. A note on 4/17/24 at 8:15 AM included the following, in part: .Call placed to provider regarding patch. Patch not present this morning .New orders received and noted. Replace patch this morning .Nurse Manager updated. On 5/1/24 at 11:00 AM, Surveyors interviewed RN K (Registered Nurse) regarding the above nurse's note she authored. RN K indicated she noted R41's patch was not there at the beginning of her shift that morning. RN K contacted the provider and reported it to LPN/IP D (Licensed Practical Nurse/Infection Preventionist) who RN K indicates was the nurse manager on duty. RN K verified the patch referenced in her note was R41's Buprenorphine Transdermal Patch, which is classified as a narcotic pain reliever. On 5/2/24 at 11:46 AM, Surveyors interviewed LPN/IP D regarding R41's missing narcotic patch. LPN/IP D indicated she did not recall RN K reporting this to her. RN K indicated if someone reported this to her, she would follow protocol and let DON B (Director of Nursing) know. On 5/2/24 at 2:03 PM, Surveyors interviewed DON B. DON B indicated she did not recall anyone reporting this to her. DON B indicated if a narcotic patch cannot be found it should be reported up the chain and she should at least be notified. DON B indicated this could be a potential misappropriation and/or diversion and should be reported. On 5/2/24 at approximately 3:40 PM, Surveyors reviewed the above information with NHA A (Nursing Home Administrator) who indicated understanding of the concern with this not being reported. Of note, the facility did not report R41's missing Buprenorphine Transdermal Patch. Of note, during the exit conference the facility indicated they had submitted a report to the state agency regarding this incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility failed to investigate a potential misappropriation of a narcotic medication for 1 of 2 residents (R41) reviewed for abuse. On 4/17/24 the facility became aware of a potential misappropriation involving R41's narcotic pain patch and this was not reported to the Nursing Home Administrator so that an investigation could be completed. This is evidenced by: The Facility Policy, titled Abuse, Neglect, and Exploitation, with a reviewed date of November 2023, indicates, in part: Policy: it is the policy of this community to take appropriate steps to prevent the occurrence of Abuse, Neglect, Misappropriation of resident property .The community investigates each such alleged violation thoroughly .Procedure: .Investigation: a. Any person who knows or has reasonable cause to suspect that a resident has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the administrator .c. Allegations of abuse, neglect, or exploitation will be thoroughly investigated. The investigation will be initiated upon receipt of the allegation. The administrator, or designee, will complete the investigation process . R41 was admitted to the facility on [DATE] with diagnoses, in part: pain in right knee, other congenital malformations and unspecified convulsions. R41's most recent Minimum Data Set (MDS) dated [DATE] documents a score of 10 on her Brief Interview for Mental Status (BIMS), which indicates she has a moderate cognitive impairment. On 4/30/24 at 11:20 AM, Surveyors reviewed R41's nurses notes. A note on 4/17/24 at 8:15 AM included the following, in part: .Call placed to provider regarding patch. Patch not present this morning . On 5/1/24 at 11:00 AM, Surveyors interviewed RN K (Registered Nurse) regarding the above nurse's note she authored. RN K indicated she noted R41's patch was not there at the beginning of her shift that morning. RN K verified the patch referenced in her note was R41's Buprenorphine Transdermal Patch, which is classified as a narcotic. On 5/2/24 at 2:03 PM, Surveyors interviewed DON B (Director of Nursing) and asked if a narcotic pain patch cannot be found if it should be investigated as a potential misappropriation and/or diversion. DON B indicated it should have been investigated and was not. On 5/2/24 at approximately 3:40 PM, Surveyors reviewed the above information with NHA A (Nursing Home Administrator) who indicated understanding of the concern with this not being investigated. Of note, the facility did not complete an investigation into R41's missing Buprenorphine Transdermal Patch. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note, during the exit conference the facility indicated they had submitted a report to the state agency regarding this incident.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on record review and interview, the facility did not ensure comprehensive assessments were completed as required for 1 of 3 closed records reviewed for Minimum Data Set (MDS) assessments (R12). R12 passed away on [DATE] and the facility failed to complete a discharge MDS assessment. Evidenced by: Facility policy, entitled MDS (Minimum Data Set) Timing, dated [DATE], includes It is the policy of this community to follow the guidance for the RAI (Resident Assessment Instrument) Manual when determining the timing of MDS assessments. Centers for Medicare and Medicaid Services' RAI Version 2.0 Manual, includes: Factors Impacting the Skilled Nursing Facility Medicare Assessment Schedule: . Resident expires or transfers .If a resident dies or is discharged . whatever portions of the RAI that have been completed must be maintained in the resident's discharge record . A discharge- return not anticipated is completed when it is determined that the resident is being discharged with no expectations of return . A discharge with return not anticipated can be a formal discharge to home, to another facility, or when a resident dies. R12 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease. R12 was receiving end of life care by the facility and a hospice agency. R12's Nurse Notes, dated [DATE], include Hospice RN (Registered Nurse) . came into the facility and formally pronounced the resident as deceased as well as reached out to the family and funeral home . On [DATE] at 2:00 PM, Surveyor reviewed R12's medical record noting there was no discharge MDS completed upon R12's passing. On [DATE] at 2:29 PM, DON B (Director of Nursing) indicated R12's medical record should have a discharge MDS and does not. DON B indicated the facility contracts with a company who completes the MDS assessments, and she would have to call and ask them to complete it.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review, the facility failed to ensure that the assessments must accurately reflect the resident's status for 1 of 1 (R43) Minimum Data Set reviewed for accuracy of a total sample of 27. R43's MDS dated [DATE] does not have her Continuous Positive Airway Pressure (CPAP; machine that uses mild air pressure to keep breathing airways open while you sleep) coded correctly. This is evidenced by: The Facility does not have a Policy and Procedure for MDS accuracy. The Facility follows the Resident Assessment Instrument (RAI) manual. Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/23, documents the following, in part: .The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status . R43's Physician Orders include: - CPAP orders start 6/16/22 R43's MDS dated [DATE] documents the following, in part: .Section O . G1. Non-invasive Mechanical Ventilator CPAP . marked .NO . On 5/2/24 at 3:08 PM, Surveyor interviewed MDSC H (MDS Coordinator). Surveyor asked MDSC H if R43's MDS dated [DATE] has her CPAP coded accurately, MDSC H stated she needed to review R43's orders and administration record; after that, MDSC H stated no it was not coded correctly. Surveyor asked MDSC H what it should be coded as, MDSC H said it should be coded as yes. Surveyor asked MDSC H what needs to occur now for it to be correct, MDSC H stated a modification would need to be done. On 5/2/24 at 3:26 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A would you expect MDS's to be completed accurately, NHA A stated yes.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on record review and interview, the facility did not complete the Preadmission Screening and Resident Review (PASARR) Level II when it was realized that a resident would reside in the facility for more than 30 days. This affected 2 of 2 sampled residents reviewed for PASARR out of a total sample of 27 (R89, R41) and 2 supplemental residents (R36, R103). R89, R41, R36, and R103 stayed longer than 30 days in the facility and required a PASARR Level II screen, but the facility failed to complete. Evidenced by: Facility policy, entitled Pre-Admission Screening and Resident Review (PASARR), revised 1/2017, includes: . Complete a PASARR Level I screen on all new admissions . Those residents whose attending physician has certified, before admission to the community that the individual is likely to require less than 30 days of nursing facility services, do not require a PASARR (Level 2 screen) to be completed. Example 1 R41 admitted to the facility on [DATE] with diagnoses including Generalized Anxiety Disorder, unspecified convulsions, symptomatic epilepsy and epileptic syndromes with complex partial seizures, symptoms and signs involving cognitive functions and awareness, and Depression. R41's Physician Orders, dated May 2024, indicate R41 takes the following antipsychotic medication: Risperidone. R41's PASARR level I screen, dated 7/31/23, includes: The resident is suspected of having a serious mental illness. The resident has not displayed any of the following symptoms that may suggest the presence of a major mental illness: suicidal statements, hallucinations, delusions, severe and extraordinary thoughts, or mood disorders. There is a diagnosis or history of intellectual disabilities. There is a diagnosis of . epilepsy . that results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons and requires treatment or services similar to those requires for these persons and was manifested before the person was age 22. Hospital Discharge Exemption/30 days Maximum: Is this person entering the nursing facility from a hospital for the purpose of convalescing from a medical problem for 30 days or less? Yes. It is important to note the facility did not provide evidence of a PASARR level II screen being completed once R41 exceeded the 30-day exemption. Example 2 R89 admitted to the facility on [DATE]. She has diagnoses including Major Depressive Disorder and Anxiety Disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R89's Physician Orders, dated May 2024, indicate R89 takes the follow psychotropic medications: Duloxetine. R89's PASARR level I screen, dated 10/27/23, includes: The resident is suspected of having a serious mental illness. Does the person have a serious mental disorder .: Yes . Within the past six months, has this person received psychotropic medications: Yes, Duloxetine . Has the person displayed any of the following symptoms: No . Is there a diagnosis or history of intellectual disabilities: Yes . Hospital Discharge Exemption/30 days Maximum: Is this person entering the nursing facility from a hospital for the purpose of convalescing from a medical problem for 30 days or less? Yes. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after the resident exceeded the 30-day exemption. Example 3 R36 admitted to the facility on [DATE] with the following diagnoses: traumatic shock, metabolic encephalopathy, and Major Depressive Disorder. R36's Physician Orders, dated May 2024, indicate R36 is on the following psychotropic medication: Lexapro. R36's PASARR level I screen, dated 2/8/24, includes the resident is suspected of having a serious mental illness. Does the person have a serious mental disorder . Yes . Within the past six months, has this person received psychotropic medications: Yes. Has the person displayed any of the following symptoms: No . Is there a diagnosis or history of intellectual disabilities: No . Hospital Discharge Exemption/30 days Maximum: Is this person entering the nursing facility from a hospital for the purpose of convalescing from a medical problem for 30 days or less? Yes. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after R36's exceeded the 30-day exemption. Example 4 R103 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and anxiety disorder. R103's Physician Orders, dated April 2024, indicated R103 was on the following psychotropic medication: Alprazolam, Divalproex Sodium, Lamotrigine, and Quetiapine. R103's PASARR level I screen, dated 2/23/24, includes Does the person have a major mental disorder: Yes. Has the person displayed symptoms that may suggest the presence of a major mental disorder: Yes. Has the person received psychotropic medications to treat symptoms or behaviors of a major mental disorder: Yes . Hospital Discharge Exemption/30 days Maximum: Is this person entering the nursing facility from a hospital for the purpose of convalescing from a medical problem for 30 days or less? Yes. It is important to note the facility did not provide evidence of a PASARR level II screen being completed after R103 exceeded the 30-day exemption. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at 3:32 PM, DON B (Director of Nursing) indicated there was a change in who was responsible for completing PASARR assessments so R103's, R36's, R89's, and R41's were missed. On 5/2/24 at 11:05 AM, NHA A (Nursing Home Administrator) stated, We don't have the PASARRs. We are in between social workers. I will do a house-wide audit and complete those. These were not completed and should have been.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and record review, the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This affects 3 of 3 sampled residents (R41, R79, R24) reviewed for activities out of a total sample of 27 and 4 supplemental residents (R42, R53, R22, and R59). R41, R79, R24, R42, R53, R22, and R59 voiced concerns during Resident Council of the facility's activity program. Evidenced by: (It is important to note the facility has two separate resident neighborhoods, one is called long term care and the other is a semi-locked unit called memory care.) The facility policy, entitled Activities, issued February 2021, includes, in part: . Policy: To provide each resident with activities and lifestyle choices that are appropriate, stimulating, and promote the physical, mental, and psychosocial well-being of the residents . Procedure: The program provides appropriate activities for each resident, Activities reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities, and skills that have meaning and purpose for the resident. The resident's interests are considered when the written plan for activities is developed for the upcoming month to include planned activities for all days of the week, including weekends and evenings. Activities are planned to support the residents care plan and are consistent with the program statement and occupancy policies. A written calendar of activities is developed at least monthly . a variety of individualized and group activities as scheduled as an opportunity for stimulation, socialization, the chance to maintain physical endurance and alertness ., as well as the opportunity for outings and activities outside of the community . R79 admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 2/2/24, indicates R79's cognition is intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. R41 admitted to the facility on [DATE]. Her most recent MDS, with ARD of 2/6/24, indicates R41's cognition is moderately impaired with a BIMS score of 10 out of 15. R24 admitted to the facility on [DATE]. Her most recent MDS, with ARD of 2/1/24, indicated R24's cognition is intact with a BIMS score of 15 out of 15. R42 admitted to the facility on [DATE]. Her most recent MDS, with ARD of 3/25/24, indicates R42's cognition is intact with a BIMS score of 14 out of 15. R53 admitted to the facility on [DATE]. His most recent MDS, with ARD of 3/9/24, indicates R53's cognition is moderately impaired with a BIMS score of 10 out of 15. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22 admitted to the facility on [DATE]. Her most recent MDS, with ARD of 2/8/24, indicates R22's cognition is intact with a BIMS score of 15 out of 15. R59 admitted to the facility on [DATE]. Her most recent MDS, with ARD of 2/20/24, indicates R59's cognition is intact with a BIMS score of 14 out of 15. Resident Council Meeting Minutes, dated 2/19/24, include: R53 wants more activities at all times of the day . (Staff member named) went on to say she is always looking for volunteers to help lead programs during the evenings and weekends but has not found someone as of yet . R42 wants weekend activities . (Staff member named) brought up looking for volunteers to run weekend programming . will explain further that activity team needs to be here during the week for care conferences and other meetings . On 5/2/24 at 10:29 AM, Surveyors conducted a Resident Council Meeting. R41, R79, R42, R24, R53, R22, and R59 voiced concerns with only having facility led activities for about one hour on Saturdays around 10:00 AM and nothing on Sundays. Surveyor asked what residents would like to do for activities on Saturdays and Sundays. R41, R70, R42, R24, R53, R22, and R59 indicated they used to wake up Sunday mornings and attend a church service with their family and this is what they would like to do. R41 indicated she can't wait for the weekends to be over because it is so boring with no activities, and she does not have a lot of company/visitors. The facility Long Term Care (LTC) Upcoming Activities weekly schedules, 1/26/24-5/5/24, include: Saturday activities: 2/3 10:00 AM Guess five letter word, 11:00 AM (Proper Name) on piano 2/10 10:00 AM Give a penny/Take a penny game. 2/17 10:00 AM Pic Wits Board Game 2/24 10:00 AM Dice Game 3/2 10:00 AM Word Ladders 3/9 10:00 AM Large Dice Toss Game 3/17 10:00 AM Feeling Lucky Game 3/23 10:00 AM Ace in the Hole Card Game 3/30 10:00 AM Easter Family Feud Game 4/6 10:00 AM Five Second Game 4/13 10:00 AM Guess the 6-letter word. 4/20 10:00 AM [NAME] Dice Game (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ssm Health St Mary's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Maple Grove Dr Madison, WI 53719	

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/27 10:00 AM Earth Day Bingo, 11:00 AM Piano Music with (Proper Name) 5/4 10:00 AM Kentucky [NAME] Horse Racing Game and Mock Mint Juleps Sunday activities: 10/31 10:45 AM Easter Sunday Service The facility LTC monthly calendar, includes in part: February Saturdays: 2/3 10:00 AM Guess the Five Letter Word, 11:00 AM (Proper Name) on Piano 2/10 10:00 AM Give a penny/Take a penny game. 2/17 10:00 AM Pic Wits Board Game 2/24 10:00 AM Dice Game Sundays: None listed. March Saturdays: 3/2 10:00 AM Word Ladders 3/9 10:00 AM Large Dice Toss 3/16 10:00 AM Feeling Lucky St. Patrick's Day Game 3/23 10:00 AM Ace in the Hole Game 3/30 10:00 AM Easter Family Feud Game Sundays: 3/31 10:45 AM Easter Sunday Service April Saturdays: (continued on next page)

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

4/6 10:00 AM Five Second Rule Game

4/13 10:00 AM Guess the 6-letter word.

4/20 10:00 AM [NAME] Dice Game

4/27 10:00 AM Earth Day Bingo, 11:00 AM Piano with (Proper Name)

Sundays:

None listed.

May

Saturdays:

5/4 10:00 AM Kentucky [NAME] Horse Racing Game and Mock Mint Juleps

5/11 10:00 AM Word Bingo

5/18 10:00 AM Blank Slate Board Game

5/25 Memorial Day Themed Games

Sundays:

None listed.

On 5/2/24 at 3:11 PM, during an interview AA L (Activity Aide) indicated she is a full-time employee in the activity department. AA L indicated there is one group activity planned on Saturdays at 10:00 AM and once a month there is a piano player here at 11:00 AM on Saturdays. AA L indicated she chooses activities for the residents based on what has worked in the past, what season we are in, and requests coming from Resident Council. AA L indicated she also tries to introduce new activities to the residents when she comes up with them. AA L indicated there are no other activities on the weekends and no activities on the evenings pass 4:30 PM usually.

On 5/2/24 at 3:29 PM, AD M (Activity Director) indicated there is no one scheduled to run activities on the LTC side of the home in the evenings. AD M indicated on the weekends there are no activities on Sundays and there is one activity scheduled on Saturdays at 10:00 AM and then once a month there is piano music at 11:00 AM on Saturdays. AD M indicated she has heard residents voice concerns related to having little to no activities on the weekends and not having evening activities. AD M indicated she is looking for a volunteer to do more activities on the weekends and she does not know how she can schedule her staff to work weekends as this would cause them to miss a day during the week. AD M indicated the facility has a Pastoral Team, but they do not work on Sundays as of now.

(continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 4:02 PM, during an interview NHA A (Nursing Home Administrator) indicated she was aware LTC residents have voiced concerns regarding no evening and little to no weekend activities during Resident Council Meetings. NHA A indicated activity staff should be offering activities for LTC residents in the evenings and on the weekends if this is what they are asking for. NHA A indicated the pastoral team could have church on Sundays or they could play it on a TV in the chapel for residents to gather. On 5/2/24 at 4:15 PM, AA N indicated she is a full-time employee on the Memory Care Unit. AA N indicated LTC residents do not participate in activities on the Memory Care Unit, and they have their own calendar of activities that are available to them. AA N indicated there is one scheduled group activity on Saturdays at 10:00 AM and sometimes there is a piano program that follows. AA N indicated there are no scheduled activities on the evenings or on Sundays for LTC residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on observation, staff interviews, and record review, the facility did not ensure treatment and care in accordance with professional standards of practice for 1 of 1 resident's reviewed for wound out of a total sample of 27 residents (R85). R85 does not have weekly measurements documented for left stump wound. This is evidenced by: Facility policy titled Pressure Ulcer/Skin Integrity with a reviewed date of 4/2022 contains, in part: Policy .A resident receives care, consistent with professional standards of practice . Procedure: 6. Documentation a. Routine ongoing documentation should be conducted related to the resident's skin condition and the resident's response to the care and treatment of the skin. The frequency of documentation shall be determined based on the resident's individual needs in accordance with accepted standards of practice. b. Wound documentation is more detailed than routine skin documentation and shall include information related to the wound based on a clinical assessment. Of note, the facility policy does not indicate defined parameters of the clinical assessment of the wound, i.e., wound measurements, wound bed description, peri-wound assessment, etc. R85 was admitted to the facility on [DATE] with the following diagnoses, in part: Acquired Absence of Left Leg, Peripheral Vascular Disease, and Multiple Sclerosis. R85's most recent Minimum Data Set (MDS) dated [DATE] documents a score of 14 on his Brief Interview of Mental Status (BIMS) which indicates he is cognitively intact. Surveyor reviewed Weekly Skin Check Tool documentation for R85's wound to left stump. Documentation from section I. Body Audit . c. Additional information contains, in part: 2/8/24 - .Old scabbing area to left stump came off, open area noted . 2/15/24, 2/22/24, 2/29/24, 3/7/24 all state - .Mepilex (dressing) applied to stump on left leg. Area is open . 3/14/24 - .Mepilex applied to stump on left leg, Area is scabbing . 3/21/24 - .Mepilex on left lower leg stump . 3/28/24, 4/4/24, 4/11/24 - no information regarding stump wound documented in this section. 4/18/24, 4/25/24 - .Open area on left kneecap, treated as ordered . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed nursing progress notes regarding R85's wound to left stump. Documentation from the progress notes contains, in part: 2/11/24 - Left stump is red and blanchable. There is an area 0.4 x 0.4 at end of stump . 3/20/24 - Open area to left stump 1 x1 x 0.1 cm . 4/17/24 - .Wound measures 0.05 x 0.5 x 0.1 cm . On 5/2/24 at 4:06PM Surveyors interviewed RN E (Registered Nurse). RN E indicated she is the wound nurse and is wound care certified. RN E indicated she does not follow R85 for wounds. RN E indicates there should be weekly wound measurements on any open wound. On 5/2/24 at 2:08PM Surveyors interviewed DON B (Director of Nursing) regarding weekly wound measurements. DON B indicated that yes weekly measurements should be done if there is an open wound. On 5/2/24 at 3:29PM Surveyors interviewed DON B who indicated the area on the left stump first opened on 2/8/24. DON B indicated we do not have weekly measurements and we should. It is important to note from 2/8/24 through 5/2/24 there should have been 12 weekly wound measurements for R85's stump wound, and the facility could only provide 3.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48623 Based on observation, interview, and record review, the facility did not ensure the nurse staffing posting was accurate and posted in an accessible area which has the potential to affect the census of 106. Multiple daily staff postings did not reflect the actual hours of the nursing staff. The posting was posted up high on the wall with small text making it difficult to read. Findings include: On 5/2/24, Surveyor observed the posted nurse staffing (utilized to communicate to residents and the public daily staffing levels per census) dated 4/17/24, 4/18/24, 4/19/24, and 4/27/24 did not reflect the actual hours of the nursing staff. The Daily Census/ Staffing document reflects the first shift of each day begins at 6:00 AM to 2:30 PM, the second shift is 2:00 PM to 10:30 PM and the night shift is from 10:00 PM to 6:30 AM. On 5/2/24, Surveyor reviewed nurse staffing postings dated 4/17/24, 4/18/24, 4/19/24, and 4/27/24 and cross-referenced actual hours worked per the facility schedule and noted the following: On 4/17/24, the Daily Staff Roster (schedule) did not reflect that LPN D (Licensed Practical Nurse) was scheduled as the nurse manager for day shift. The Daily Staff Roster shows 2 PM LPN's scheduled; however, the Daily Census/ Staffing document indicates that there are no LPN's scheduled for PM shift. The night Daily Staff Roster shows that there is one LPN scheduled for night shift, but the Daily Census/ Staffing document shows that there are 2 LPN's scheduled for the night shift. On 4/18/2024, the Daily Staffing Roster does not reflect that LPN D was scheduled as the second nurse manager for day shift. The Daily Staffing Roster shows that there are 12 CNAs on the schedule however, the Daily Census/ Staffing document has 14 CNAs listed as working the day shift. On 4/19, 2024 the Daily Staffing Roster does not reflect that LPN D was scheduled as the second nurse manager for day shift. The Daily Staffing Roster has 14 CNAs scheduled but the Daily Census/Staffing document shows 12 CNAs are scheduled for day shift. On 4/27/24 the Daily Staffing Roster had 3 LPNs scheduled and the Daily Census/Staffing reflected the 2 LPNs were working. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 5/2/24 at 9:34 AM, Surveyor interviewed Scheduler O. Surveyor asked Scheduler O to observe the daily census/staffing posting and noted the posting was posted up high on a bulletin board near the elevator. Surveyor asked Scheduler O if Residents would be able to read it from wheelchair height, Scheduler O replied not as good as they could. Surveyor asked Scheduler O regarding the process for daily postings. Scheduler O indicated staff that are scheduled to work go on the sheet, if there is inadequate number of staff Scheduler O attempts to find staff to fill in or pick up any holes they may have. Scheduler O indicated the census posting is created the day before and sent to the night nurse. The charge nurses can update the daily posting and is updated by 2 PM on the day of the posting. Surveyor asked why a Nurse manager was listed on the schedules for the weekend and not on the postings. Scheduler O indicated that the Nurse manager is always on the schedule, and the posting would say zero if he/she wasn't here. Scheduler O indicated the posting should reflect what is on the schedules and be updated to match. Scheduler O indicated on April 27th day shift there were 3 LPNs working and the posting should reflect 3 LPNs instead of 2. Scheduler O indicated for April 19th there were 2 RN managers on the posting and only 1 listed on schedule, she believes LPN D was filling in and this date should have been updated to reflect the posting. Scheduler O indicated for Day shift the CNAs should reflect 11 working instead of 12 listed on the posting. Scheduler O indicated for April 17th that LPN D should be on the schedule as the Nurse Manager. The PM shift should reflect 2 LPNs for pm shift not zero, the 2 should have been down a line. Night shift had 2 LPNs, and we did not update the posting we must have had a call in. On 5/2/24 at 10:51 AM, Surveyor asked R68 and R15 if they could read the daily staff posting. R15 indicated she was not able to read the posting that's posted on the bulletin board due to location and lettering is too small to read. R68 indicated the lettering was too small to read and it's never correct anyways.

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that residents are free from significant medication errors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49436

Based on interview and record review, the facility did not ensure that residents are free of significant medication errors for 1 of 1 supplemental resident's (R19) reviewed for medication errors.

R19 was not administered two doses of an antipsychotic medication in April as directed by the physician order.

This is evidenced by:

The facility policy entitled, Medication Administration, dated 1/23, states, in part: .

Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.

Procedures:

Medication Preparation: .3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record .

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 antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initiated and circled .If two consecutive doses of a vital medication are withheld or refused, the physician is notified .

R19 was admitted to the facility on [DATE] with diagnoses that include, in part: Schizophrenia, Major Depressive Disorder, and Insomnia.

R19 has a physician order, with a start date of 2/1/23, for Pimozide 5mg by mouth one time a day related to Schizophrenia.

Of note, Pimozide is classified as an antipsychotic medication.

On 4/30/23, Surveyors reviewed the facility medication error log provided by the facility, R19's Medication Administration Record (MAR), and Nursing Progress Notes. The medication error log contains three columns for Resident Name, Date and Time, and Immediate Action Taken. The entry for R19 indicates a Date and Time of 4/29/24 at 10:04PM and Immediate Action Taken indicates, in part: Nurse Manager and Provider were updated about resident missing medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's MAR for 4/28 and 4/29 contain initials and the code 13. Per the Chart Codes on the MAR, 13=Med Not Available (F/U (follow-up) required). R19's Nursing Progress Notes contain, in part: 4/29/24 9:59PM .Resident did not have her medication Pimozide 5mg tablet two days in a row. Medication re-ordered and call placed to pharmacy today. Medication still not available. Call placed to pharmacy this morning .Nurse Manager updated . and provider updated about resident missing medication. 4/29/24 9:55 PM electronic Medication Administration Record (eMAR) .Note Text: Pimozide Oral Tablet Give 5 mg by mouth one time a day related to Schizophrenia .Medication still not available. Call placed to Pharmacy this morning but medication still unavailable . 4/28/2024 5:27 PM eMAR .Note Text: Pimozide Oral Tablet Give 5 mg by mouth one time a day related to Schizophrenia .medication unavailable. 4/28/2024 5:24PM eMAR .Note Text: Pimozide Oral Tablet Give 5 mg by mouth one time a day related to Schizophrenia .Medication not available on cart and not available in contingency. Pharmacy is closed on Sundays. Med was re-ordered on 4/22 and only a partial dose was delivered on 4/23. medication re-ordered on 4/28. On 5/2/24 at 3:42 PM, Surveyors interviewed RN K (Registered Nurse) regarding the note documented on 4/29/24 at 9:59 PM. RN K indicated she contacted the pharmacy who informed her they could not fill the medication due to an insurance issue and she reported this to the nurse manager. RN K indicated the facility protocol is if the first dose is missed to call the pharmacy. If there is a second missed dose call the pharmacy, the nurse manager, and the provider. On 5/2/24 at 3:57 PM, Surveyors interviewed ADON S (Assistant Director of Nursing) and asked what would be considered a medication error. ADON S indicated anything that is against the physician order including if a medication is not given. On 5/1/24 at 3:03 PM, Surveyors interviewed DON B (Director of Nursing) regarding the two missed doses for R19. DON B indicated if staff do not have a medication, they need for a resident they should check to see if it was delivered or is it in the med room or in the bottom drawer of the cart and just hasn't been put away yet. If not there, look in contingency. If not there, call pharmacy and depending on the time of day if they can get it and give it then that could be it. If it is not going to get here in time, they should be calling the provider for direction. Since the facility has started with the new pharmacy the new policy states to call them day 1 and call the provider day 2, but best practice is to notify the doctor if they can't get the medication the same day.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49436 Based on observation, interview, and record review, the facility did not ensure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional practices and include the expiration date when applicable in 1 of 2 medication rooms and 4 of 7 medication carts reviewed for compliance. Surveyor observed the following: --undated, open stock medication in medication room. --medications that should be refrigerated were in the medication carts and not refrigerated. --undated, open eye drops in a medication cart. --different medication administration routes co-mingled in the same bag. --unlabeled medications in medication carts. --expired medications in medication carts. --medications with illegible expiration dates in medication cart. This is evidenced by: Surveyor reviewed the facility Medication Storage policy with a reviewed date of 1/24. Policy, in part, Medications and biologicals are store properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration . Procedures, in part,4. Medications should be stored so that various routes of administration are separated .6. Eye medications are stored separately from ear medications and inhalers, etc. Steroidal Ophthalmic suspensions must be stored upright. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Medications for oral inhalation are stored in the dispensed containers following manufacturer guidelines for positioning and priming. 8. Medications for nasal inhalation are stored in the dispensed containers following manufacturer guidelines for positioning and priming .a. Calcitonin bottles should be stored in the upright position in the medication cart .11. Medications requiring refrigeration or temperatures between 2? (36?) and 8? (46?) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place may be refrigerated unless otherwise directed on the label as cool temperature are those between 8? (46?) and 15? (59?) . 12. Insulin products should be stored in the refrigerator until open. Note the date on the label for insulin vials and pens when first used. The open insulin vial may be stored in refrigerator or at room temperature. Open insulin pens should be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use. (Refer to section 9.10 - Medications with Shortened Expiration Dates) Example 1 On 5/1/24 at 2:13 PM, Surveyor observed medication room on the 400 unit with RN P (Registered Nurse). Surveyor observed an open vial of Tuberculin purified protein with no date open documented. Surveyor interviewed RN P. RN P indicated the vial should have a date when it is open and if it is not dated it should be discarded. RN P was unable to state how long the vial has been open. Surveyor interviewed DON B who indicated the vial should be labeled with a date when open and discarded after 30 days. Manufacturer recommendation states a vial of Tuberculin purified protein which has been entered and in use for 30 days should be discarded. Example 2 On 5/1/24 at 2:25 PM, Surveyor observed the 600-wing medication cart with RN Q. Surveyor observed a bottle of Florajen in the medication cart. The Florajen bottle has no open date and no date indicating when the bottle was removed from the refrigerator. RN Q indicated they thought the medication was good for 25 to 30 days after being removed from the refrigerator and thought the bottle had been open about 10 days. Manufacturer recommendation for Florajen states Florajen should be refrigerated for maximum freshness and potency, and it can be stored at room temperature for up to two weeks and still maintain effectiveness. Surveyor interviewed DON B who indicated she would expect a date on the bottle when the medication was removed from the refrigerator. Example 3 On 5/1/24 at 2:39 PM, Surveyor observed the 500-wing medication cart with RN R. Surveyor observed R45's bottle of gericare (artificial tears) with the instructions to instill 1 drop in both eyes daily in a bag. The bottle was not labeled with a date open. The bottle was dispensed on 3/8/24. RN R indicated the medication should be disposed of after 30 days. Surveyor observed R45's bottle of Azelastine hcl (nasal spray) dated with an open date of 3/25/24. There was no resident label or instructions on the bottle of medication for usage. R45's eye drop bottle and nasal spray bottler were in the same bag. RN R indicated without a label she would not know who the nasal spray belonged to. RN R also indicated that nasal spray and eye drops should not be stored together in the same bag. Example 4 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed R101's Latanoprost 0.005% (eye drops for glaucoma) bottle with instructions to instill 1 drop in left eye daily was not labeled with a date open. The medication was dispensed on 2/7/24. RN R indicated the medication should have been discarded on 3/5/24. Manufacturer recommendation states once a bottle is opened for use, it may be stored at room temperature .for 6 weeks. The discard date should have been 3/20/24. Example 5 Surveyor observed R8's Fluticasone nasal spray with instructions to use 2 sprays in each nostril once a day for 1 week then as needed. The expiration date on the bottle was not legible. The label was worn off. RN R indicated she was not able to read the expiration date and therefore would not be able to say when it expired. Example 6 Surveyor observed R5's Advair diskus 250/50 (fluticasone propionate and salmeterol inhalation powder, inhaler) without a label. It was not labeled with a resident name and did not contain directions or instructions of use. There was no open date and no dispense date on the diskus. RN R indicated without a label or open date on the diskus she would not know who the medication belonged to or when it would expire. Manufacturer recommendation states to discard the diskus 1 month after removing from foil. Example 7 Surveyor observed an open foil package of Ipratropium bromide 0.5mg and albuterol sulfate 3mg vials (liquid medication used in a breathing machine for inhalation). There were 5 vials left. The vials were not contained in the original package to know when they were dispensed. There was no label indicating who the medication belonged to. There was no open date. Manufacturer recommendations indicate the vials should remain stored in the protective foil at all times to protect the medication from light and once removed from the foil package, the individual vials should be used within one week. RN R indicated she thought she had opened the package sometime last week but could not say for certain what day. Example 8 Surveyor observed R19's Promethegan 25mg suppository with instructions to insert 1 suppository rectally every 6 hours as needed for nausea. The label said refrigerate and the medication was in the cart. RN R indicated the medication should be in the refrigerator and was unable to say if the medication was still effective after being stored in the cart. Example 9 On 5/2/24 at 8:59 AM, Surveyor observed the 300-wing medication cart with RN T. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed R82's tube of nighttime lubricant ointment with instructions to apply ointment in both eyes twice daily for ectropion (a condition which the eyelid turns outward leaving the inner eyelid exposed and prone to irritation). The ointment had a dispense date of 3/21/24. There was no open date on the bag or tube. RN T indicated she did not know if the medication had been open for greater than 30 days. Manufacturer recommendations states to discard after 30 days of being opened. Example 10 Surveyor observed R52's tube of genteal eye gel in a bag. There was no label and no open date. RN T indicated it was a stock medication that the nurse puts in a bag and writes the room number and resident initials on. RN T indicated there is not an open date and there should be. Example 11 Surveyor observed R34's bottle of Latanoprost 0.005% eye drops with instructions to instill 1 drop in left eye daily for secondary glaucoma (a condition of the eye). The bottle had no open date. The dispensed date was 2/7/24. RN T indicated she did not know when the bottle was open. Manufacturer recommendation states once a bottle is opened for use, it may be stored at room temperature .for 6 weeks. The discard date should have been 3/20/24. Surveyor observed R34's bottle of Dorzolamide hcl & Timolol Maleate opth (eye) soln (solution) 22.3mg/6. 8mg. There was no label on the bottle, no resident name, and no open date. RN T indicated the medication bottle should have a label, it should contain the residents name and it should have an open date. Example 12 Surveyor observed R51's Fluticasone nasal spray in the same bag that contained eye drops. RN T indicated the medications should be kept in separate bags. Example 13 On 5/2/24 at 9:48 AM, Surveyor observed the 200-wing medication cart with RN P. Surveyor observed R81's had 2 Lantus insulin vials in the medication cart. One vial had an open date of 3/24/24 with instructions to inject 65 Units at bedtime. The second vial had no label and no open date. RN P indicated without a label he is unable to say who the medication belongs to and with no open date unable to determine if the medication is still effective. Manufacturer recommendation states the product expires 28 days after first use or removal from refrigerator, whichever comes first. On 5/2/24 at 1:10 PM, Surveyor interviewed DON B regarding the observations made in the medication room and on the medication carts. DON B indicated the eye drops should be discarded after 28 days, all medications should be labeled with a date open, nasal sprays should not be co-mingled with eye drops, medications should have labels on them, labels should have a readable expiration date on them, and if a medication has a refrigerate label then it should be stored in the refrigerator.

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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** 36253 Based on observation and interview, the facility did not ensure that food and drink that is palatable, attractive, and at a safe and appetizing temperature for 1 of 27 residents observed during dining (R7). R7 was given cold food. Findings include R7 was admitted to the facility on [DATE] and has diagnoses that include dementia. Her most recent Minimum Dat Set (MDS), dated [DATE], did not include a Brief Interview for Mental Status (BIMS) score as she is rarely understood. Additionally, this MDS indicates R7 requires moderate assistance for eating and is able to perform less than half the task herself. On 4/29/24 at 11:42 AM, Surveyor observed R7 sitting at a dining room table, asleep in her wheelchair with a plate of food in front of her. Surveyor continuously observed this plate of food sit in front of R7 until 12:16 PM at which time CNA C (Certified Nursing Assistant) sat next to R7 and began feeding her a portion of the lasagna on her plate. R7's eyes remained closed and only slightly moved her lips to accept the food. At this time, Surveyor asked if staff would gather the temperature of the lasagna on R7's plate. Facility staff agreed and used a clean thermometer and the temperature read 113 degrees fahrenheit. Facility staff then replaced R7's food.

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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. This has the potential to affect all 106 residents (R) in the facility.

The facility did not ensure daily infection control surveillance for staff.

The facility's infection control line lists for staff and residents are incomplete.

The facility's monthly infection control rates were not calculated according to current standards of practice.

The facility's March 2024 COVID outbreak summary was incomplete and inaccurate.

CNA G did not disinfect R80's bedside table after placing a urinal on it without a barrier in place.

This is evidenced by:

The facility policy titled, Infection Prevention and Control Program (General), with a reviewed/revised date of 2/2024, includes, in part:

Policy: The community will maintain an organized, effective community-wide program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors, and team members. This program involves the collaboration of many programs and services within the community and is designed to meet the intent of regulatory and accrediting agencies .

Surveillance for facility-Associated infections: Facility wide surveillance will be performed to identify opportunities to prevent and/or reduce the rate of infection in our residents, employees, and visitors. Our surveillance system includes use of a data collection tool and standardized definition of infection (McGeer and/or NHSN) for long-term care facilities. Data will be: Collected by concurrent and/or retrospective chart review, review of microbiological reports, reports from resident care providers and review of other documents, as appropriate. Collected by review of employee health logs. Trended internally for historical comparison .

Surveillance priorities: 1. Symptomatic Urinary Tract Infections: .2. Respiratory Tract Infections .3.Eye, Ear, Nose and Mouth Infections. 4. Skin infection. 5. Gastrointestinal tract infection .Rates are calculated using the number of infections as the numerator and resident days as the denominator and reported per 1000 resident days .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Outbreak investigation: An outbreak investigation may be required when there is a cluster of infections above expected levels (endemic vs epidemic) or when an unusual or an epidemiologically significant pathogen is identified or as defined by the State Public Health Department. The medical director, in collaboration with administration, and the IP will: Facilitate the outbreak investigation and will report activities to the administration and others as appropriate. Document follow-up activity in response to important surveillance findings (e.g., outbreaks). Notify the local county health department and adhere to their recommendations . Employee/Resident Health: .Policies and procedures include: Screening all staff for exposure and/or immunity to communicable disease .Educated on work restrictions due to illness. In the event a resident is exposed to a communicable disease they will be provided with or referred for assessment, testing, immunization, prophylaxis/treatment, or counseling. A log of all incidents of infection and communicable disease of all staff (resident care, nonresident care, employees, and volunteers) will be maintained . The facility policy titled, Infection Prevention and Control - Addendum COVID 19 General Policy, with a review date of 4/5/24, included, in part: .Employee Management of Suspected or Confirmed COVID 19 infection. 1. Employees should not report to work AND should immediately notify the Director of Nursing and Community Infection Preventionist if any of these criteria are met: a. A positive viral test for SARS-CoV-2 (COVID 19). b. Symptoms of COVID 19. c. A high-risk exposure of COVID 19 .3. Employees with suspected or confirmed COVID-19 infection may return to work per the most up to date guidance from Center for Disease Control for Healthcare workers . .Outbreak Management. When performing an outbreak response to a known case, communities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in any HCP (health care professional) or resident should be evaluated to determine if others in the community could have been exposed .Testing is recommended immediately (but not earlier than 24 hours after the 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 . Example 1 On 5/02/24 at 8:25 AM, Surveyors completed the infection control interview with LPN/IP D (Licensed Practical Nurse/Infection Preventionist) and RN I (Regional Nurse) with RNC J (Regional Nurse Consultant) via telephone. LPN/IP D indicated the facility does not have documentation of daily surveillance for staff and she was unsure when this was last completed. LPN/IP D provided Surveyors with a staff call in log, however it does not always indicate symptomology. Surveyors reviewed staff call in logs for February 2024, March 2024, April 2024 provided by the facility. The logs contain four columns: Name, Occurrence Date, Shift, Comments. February log: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4 occurrence dates that indicate sick under the comments section. 1 occurrence date that is either blank or indicates no reason listed. March log: 12 occurrence dates that indicate sick under the comments section. 23 occurrence date that is either blank or indicates no reason listed. April log: 6 occurrence dates that indicate sick under the comments section. 17 occurrence date that is either blank or indicates no reason listed. LPN/IP D indicated if staff are symptomatic, they inform their supervisor, the supervisor then contacts her. If it's a weekend LPN/IP D follows up with the staff on Monday. LPN/IP D indicated she does not have documentation of phone calls or follow up with staff. Of note, without daily surveillance of staff, the facility would not be able to ensure correct exclusionary criteria, return to work dates, and prevent, identify, report, investigate and control infections and communicable diseases. Example 2 Surveyors reviewed infection control line lists for January 2024 through April 2024 provided by the facility. On 4/30/24 at 1:10 PM, Surveyors were approached by RNC J (Regional Nurse Consultant) who indicated the following the facility identified in January 2024 that line lists for Residents and staff were not being completed except for COVID. Rates were not correct. Only Urinary Tract Infections (UTIs) and Catheter Associated Urinary Tract Infections (CAUTIs) were being reported in Quality Assurance Process Improvement (QAPI). RNC J stated the facility reviewed documentation to recreate line lists back to October 2023 as part of a QAPI initiative. The facility is unable to determine the last time line lists were being completed in real time prior to this being identified in January 2024. Review of line lists include the following: Resident LTC (Long Term Care) Respiratory Surveillance Line List with a date of 12/13/23 (Handwritten note at top of page indicates COVID Line List [DATE]-[DATE]) indicates the following: --R85 --Symptom onset date of 1/9/24. --Type of specimen collected NP (nasopharyngeal) swab. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Type of test ordered is blank. --Pathogen detected is blank. --Symptom resolution is blank. --hospitalization is blank. Facility provided test results for R85 that indicate he was tested for COVID, influenza A, influenza B and RSV (Respiratory Syncytial Virus) on 1/9/24 and R85 was positive for RSV and negative for the other tests. On 5/2/24 at 8:25 AM, Surveyors reviewed R85's 1/9/24 lab result indicating RSV positive and COVID negative and the entry for R85 on the COVID Line List with LPN/IP D. LPN/IP D indicated R85 should not have been on the COVID Line List. Of note, due to this discrepancy, it is unclear if there are other types of respiratory infections on the COVID line list as the facility indicated to Surveyors, they were only supposed to contain COVID positive cases. Staff LTC (Long Term Care) Respiratory Surveillance Line List with a date of 12/13/23 (Handwritten note at top of page indicates Staff Dec-Feb) indicates the following: January dates: --Contains 4 staff member. --4 of 4 staff do not have date last worked recorded and there is no place to record this on the line list. --4 of 4 staff do not have what organism is being tested . --4 of 4 staff do not have pathogen detected documented. --1 of 4 staff does not have symptom resolution date documented. --4 of 4 staff do not have return to work date recorded and there is no place to record this on the line list. February dates indicate the following: --Contains 1 staff member. --Date last worked is not recorded and there is no place to record this on the line list. --Type of test ordered is blank. --Pathogen detected is blank. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--No return-to-work date is recorded and there is no place to record this on the line list. Resident LTC (Long Term Care) Respiratory Surveillance Line List with a date of 3/9/24 (Handwritten note at top of page indicates COVID Line List March 24) indicates: --Contains 10 residents. --10 of 10 residents do not have what organism is being tested . --10 of 10 resident do not have pathogen detected documented. --9 of 10 residents do not have symptom resolution dates documented. Staff LTC (Long Term Care) Respiratory Surveillance Line List with a date of 2/24/24 (Handwritten note at top of page indicates Staff March) indicates: March dates indicate the following: --Contains 8 staff members. --8 of 8 staff do not have date last worked is not recorded and there is no place to record this on the line list. --8 of 8 staff do not have what organism is being tested . --8 of 8 staff do not have pathogen detected recorded and there is no place to record this on the line list. --8 of 8 staff do not have symptom resolution dates. --8 of 8 staff do not have return to work dates recorded. On 5/2/24 at 8:25 AM, Surveyors completed the infection control interview with LPN/IP D (Licensed Practical Nurse/Infection Preventionist) and RN I (Regional Nurse) with RNC J (Regional Nurse Consultant) via telephone. During this interview, LPN/IP D indicated the COVID staff line lists are related to positive COVID cases only and other infection types were not being tracked. Resident COVID line lists were for COVID positive cases only. LPN/IP D stated she agrees staff and resident line list are incomplete and should contain the last date worked (staff), test completed, results, symptom resolution dates and return to work dates for staff. Example 2 Surveyors reviewed the document titled March 2024 COVID Outbreak Summary and compared it to the March 2024 line list information. Surveyors noted a discrepancy on the line list vs. the outbreak summary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The staff line list contains 6 staff members that are not identified in the outbreak summary. Therefore, outbreak management (i.e., contact tracing, mitigation, and source control) surrounding these staff members are not available in the summary. On 5/2/24 at 8:25 AM, Surveyors completed the infection control interview with LPN/IP D (Licensed Practical Nurse/Infection Preventionist) and RN I (Regional Nurse) with RNC J (Regional Nurse Consultant) via telephone and reviewed March 2024 COVID Outbreak Summary and March Line list. LPN/IP D indicated the March 2024 COVID Outbreak Summary was not complete. Example 3 On 5/2/24 at 8:25AM Surveyors completed the infection control interview with LPN/IP D (Licensed Practical Nurse/Infection Preventionist) and RN I (Regional Nurse) with RNC J (Regional Nurse Consultant) via telephone. During this interview, LPN/IP D indicated she had not been calculating monthly infection control rates before April. In April, a total overall infection rate was calculated but rates were not calculated per type of infection. LPN/IP D indicated this should be completed by infection type and be completed monthly. Of note, the facility presented information from their QAPI initiative as documented above, however, had not followed through on the entirety of their action plan. 50228 Example 5 On 5/2/24 at 8:31 AM, Surveyor observed CNA G (Certified Nursing Assistant) assisting R80 with catheter care. During this observation, CNA G went into R80's bathroom and gathered a urinal and alcohol wipes to be used for emptying the catheter drainage bag. CNA G walked towards R80's bed, then sat the urinal down on R80's bedside table, next to his drinking water glass. CNA G then went back to the bathroom to gather additional supplies. CNA G returned to bedside, took the urinal from the bedside table, and proceeded to empty the catheter bag. Surveyor interviewed CNA G regarding cross contamination. CNA G stated that she should not have placed the urinal on the bedside table. CNA G stated that she should have wiped down the table with disinfectant after setting the urinal on the table. On 5/2/24 at 8:59 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked if a urinal should be placed on a resident's bedside table. LPN F stated absolutely not. LPN F stated that the table should be disinfected due to the risk of cross contamination and there should be education for the staff. On 5/2/24 at 9:42 AM, Surveyor interviewed LPN/IP D (Licensed Practical Nurse/Infection Preventionist). Surveyor asked if a urinal should be placed on a resident's bedside table. LPN/IP D stated, no, that causes cross contamination, especially next to the water glass.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 of 5 (R24, R80, and R83) of 27 sampled residents and 1 of 1 (R70) supplemental resident's reviewed for antibiotic stewardship. R24 continued an antibiotic for 3 days without an appropriate indication. R70 was ordered and took an antibiotic without an appropriate indication. R83 was given an antibiotic before test results were returned and continued to take it after results despite lack of appropriate indications for its use. R80 received a prophylactic antibiotic from November until May without a rationale to why it was being given and no end date indicated. This is evidenced by: The facility policy titled Infection Prevention and Control Program (General), with a review date of 2/2024, includes, in part: Policy: The community will maintain an organized, effective community-wide program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors, and team members .Antibiotic Stewardship Program. The antibiotic stewardship program includes protocols to monitor antibiotic use and resistance including Optimizing the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic. Reducing the risk of adverse events, including the development of antibiotic-resistant organisms from unnecessary or inappropriate antibiotic use, and Implementing [sic] a facility-wide system to monitor the use of antibiotics. Example 1 R24 was readmitted to the facility on [DATE] from the hospital. Hospital documentation indicates the following: --1/23/24 at 6:02AM R24 had a urinalysis completed. Urinalysis culture results indicated >10,000 CFU/ml Escherichia coli and >10,000 CFU/ml aerococcus urinae. At that time, R24 was started on ceftriazone (antibiotic) for UTI (Urinary Tract Infection). --1/26/24 discharge summary indicates Leukocytosis: etiology unclear, afebrile, [sic] Due to above resolved. --Hospital discharge orders dated 1/26/24 indicate to start taking cefprozil (antibiotic) 500 mg 1 tab by mouth 2 times daily for 3 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyors reviewed the facility Monthly Infection Control Log (Line List) for January 2024. R24 was listed on the log for UTI. The log indicated R24 was taking cefprozil and date resolved was 1/29/24. The column Infection Definition Met? is marked N indicating infection definition was not met. On 5/2/24 at 11:51 AM, Surveyors interviewed LPN/IP D (Licensed Practical Nurse/Infection Preventionist) regarding the above information related to R24's prescribed antibiotic on hospital discharge. LPN/IP D indicated when a resident comes from the hospital, she uses McGeer criteria to ensure they meet the infection definition. She gathers the hospital documentation, labs, including culture and sensitivity and enters the resident on the line list. If they do not meet, she contacts the provider to discuss and asks the provider to provide rationale in a note. LPN/IP D stated she does not always document her discussions with the provider. LPN/IP D indicated R24 did not meet McGeer's criteria for a UTI and she did not contact the provider regarding this and should have. Example 2 R70 was admitted to facility on 1/21/19. On 4/18/24, R70 had a urine culture completed with results indicating 10,000-50,000 CFU/ml Mixed normal urogenital flora. On 4/19/24 R70's provider ordered Augmentin (antibiotic) 500 mg PO (by mouth) BID (twice a day) UTI (Urinary Tract Infection) x (for) 7 days. R70's medication administration record indicates he received Augmentin for 7 days for UTI between 4/19/24 through 4/26/24. Surveyors reviewed the facility Monthly Infection Control Log (Line List) for April 2024. R70 was listed on the log for UTI. The log indicated R70 was taking Augmentin and date resolved was 4/26/24. The column Infection Definition Met? is marked N indicating infection definition was not met. On 5/2/24 at 2:20 PM, Surveyors interviewed LPN/IP D regarding R70. LPN/IP D indicated R70 did not meet infection criteria and she requested the physician add the rationale for starting an antibiotic when R70 did not meet criteria to the physician note. LPN/IP D stated she does not always document her discussions with the provider. On 5/2/24 at 2:42 PM, LPN/IP D provided the physician note from 4/19/24. Surveyor reviewed note with LPN/IP D and the physician note does not include documentation of a discussion with LPN/IP D regarding R70 not meeting criteria, nor does it provide an indication for continuing the antibiotic based on current standards of practice. 36253 Example 3 R83 was admitted to the facility on [DATE]. On 2/14/24, R83's Nurse Practitioner (NP) ordered a urinalysis due to dysuria with urination. Records indicate the urinalysis was collected on 2/14/24 at 7:50 PM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0881

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A nursing home visit note, dated 2/15/24, states, .Ampicillin 500 QID started--culture still pending .

Results returned on 2/16/24 at 10:14 AM that stated, >=100,000 CFU/mL mixed gram-positive flora. No further workup performed .suggest recollection if clinically indicated.

R83's NP again visited him on 2/19/24 with the NP noting, Patient treated for UTI due to gross hematuria and positive UTI, culture showed mixed morphology. Plan to stop treatment--he will have had a 5 day plus one tablet coarse. Continue to monitor.

Facility Medication Administration Record (MAR) for R83 indicates the Ampicillin order was 4 times per day for 10 days, starting 2/15/24. R83 took this antibiotic three times on 2/15/24, four times on 2/16/24--2/19/24, and once on 2/20/24.

On 5/2/24 at 9:45 AM, Surveyor interviewed DON B (Director of Nursing) who stated that due to the mixed flora of R83's culture, the lab does not run a sensitivity. DON B stated that typically if there is an indication that symptoms are continuing, provider may plan to keep resident on antibiotic and that R83's NP regularly orders antibiotics for residents before sensitivity reports come back. Additionally, DON B stated that residents should never be put on an antibiotic until the sensitivity results come back. DON B stated that the NP was educated on facility expectations for antibiotic stewardship on 4/2/24; however, DON B stated that she did not receive any notice from nursing staff regarding R83's use of the antibiotic without the appropriate sensitivity and did not know why R83 had received the Ampicillin on 2/20/24.

50228

Example 4

R80 was admitted on [DATE] with diagnoses that include Quadriplegia (the paralysis of both arms and legs due to various conditions), neuromuscular dysfunction of bladder (condition that affects bladder function due to nervous system injury or disease), retention of urine, calculus of kidney, long term use of antibiotics, personal history of urinary tract infections.

On 4/30/24 at 11:02 AM, Surveyor noted the following Physician's Order: Penicillin V give 500 mg (milligrams) by mouth two times a day for streptococcal skin/soft tissue suppression. Take in morning and bedtime. It is important to note that the start date on the order is listed as 11/29/23, date of R80's admission to the facility, and there is no duration listed for the medication and the medication was currently being administered. Surveyor asked the facility for additional information at this time.

On 5/1/24 at 10:13 AM, a fax from R80's Physician states in part: .I inherited this patient with these antibiotics already being prescribed .He can stop the penicillin .

On 5/2/24 at 9:45 AM, Surveyor interviewed RN E (Registered Nurse) about antibiotic stewardship. Surveyor asked what the protocol is when a resident is admitted to the facility on an antibiotic. RN E stated that the medication is reviewed and clarified, as necessary. RN E stated that in regard to R80, there was documentation in the hospital discharge that stated the reason for the antibiotic and there was no need for further clarification.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Ssm Health St Mary's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Maple Grove Dr Madison, WI 53719	

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Of note: RN E did not provide the documentation from R80's hospital stay.) R80 has been receiving this medication since November 2023 to current. On 5/2/24 at 10:58 AM, Surveyor interviewed LPN/IP D (Licensed Practical Nurse/Infection Preventionist) regarding antibiotic stewardship. IP D stated that upon admission to the facility, medications are reviewed for complete orders. IP D stated that the hospital records are reviewed to determine why they are on an antibiotic, how long the resident will be on the medication, and to determine if they met McGeer's Criteria (guidelines for identifying infection). Surveyor asked if there was a duration listed for the antibiotic ordered for R80. LPN/IP D stated no. Surveyor asked if LPN/IP D would expect staff to clarify the duration of an ordered antibiotic. LPN/IP D stated yes, LPN/IP D would expect that staff would reach out to the physician for clarification. On 5/2/24 at 11:35 AM, Surveyor interviewed DON B (Director of Nursing) regarding antibiotic stewardship. DON B stated that she would expect nurses to follow up with the physician on admission orders and clarify duration of medications. Surveyor requested additional documentation from R80's admission regarding reason for continued antibiotic use and/or clarification of duration. On 5/2/24 at 1:44 PM, Surveyor spoke with NHA A (Nursing Home Administrator). NHA A stated that there is no additional information regarding R80's antibiotic order at time of admission. NHA A stated there was no clarification completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility must develop policies and procedures to ensure that residents and/or the resident's responsible party receives education regarding the benefits and potential side effects of the immunization prior to offering the immunization and documentation is noted in the medical record on whether the resident received or declined the immunization. This affected 3 of 5 residents (R41, R63, and R102) reviewed for pneumococcal immunizations. R41's medical record contained a consent form titled Pneumococcal Vaccine (Prevnar 20) Consent/Declination without evidence of administration. R63 and R102's medical records did not contain evidence of a declination, consent, or administration of Pneumococcal Vaccinations. This evidenced by: The facility policy titled, Immunization: Pneumococcal with a review date of 4/4/2024 indicates, in part: Policy: All residents are encouraged to obtain all pneumococcal vaccines for which they are eligible unless contraindicated. There is a system to assure that all eligible residents are offered pneumococcal vaccines at the time of admission. 1. After admission immunization history will be obtained, consideration will be given to PCV7 (Pneumococcal Conjugate Vaccine), PCV13, PCV 15, PPSV23 (Pneumococcal Polysaccharide Vaccine) or other applicable pneumonia vaccines .3. Prior to administering immunizations, the resident or resident's legal representative will receive education regarding the benefits and risks related to the immunization, such as the current Vaccination Information Statement (VIS) from the CDC (Centers for Disease Control and Prevention). https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. 4. The medical record will be updated to reflect: a. Immunizations provided. b. Education provided. c. Refusal of immunizations offered. d. Immunizations not provided due to being medically contraindicated. Example 1 R41 was admitted to the facility on [DATE] with diagnoses that include, in part: other pulmonary embolism (blood clot that has traveled to the lungs and caused a blockage), Hypoxemia (low oxygen), Personal history of COVID-19. On 5/2/24 at 3:30 PM, Surveyors reviewed the immunization history in R41's electronic medical record as part of the infection control task. R41's immunization documentation indicates a Prevnar 20 Consent was signed without documentation of administration. Surveyors Requested documentation of pneumococcal immunization information from the facility for R41. On 5/2/24 at 4:24 PM, Surveyor interviewed LPN/IP D (Licensed Practical Nurse/Infection Preventionist) regarding the signed Prevnar 20 consent for R41 dated 3/15/24. During this interview LPN/IP D indicated the immunization should have been given as the consent was signed and she could not locate evidence it was administered. Example 2 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R63 was admitted to the facility on [DATE] with diagnoses that include, in part: Anemia, High Blood Pressure, Arthritis, and Peripheral Vascular Disease. On 5/2/24 at 3:30 PM, Surveyors reviewed the immunization history in R63's electronic medical record as part of the infection control task. No pneumococcal immunization administration dates or consent/declination were noted in the records. Surveyors requested documentation of pneumococcal immunization information from the facility for R63. On 5/2/24 at 4:24 PM Surveyor interviewed LPN/IP D after the facility provided a Wisconsin Immunization Registry (WIR) documents for R63 and R102. The WIR document for R63 does not contain any pneumococcal vaccination dates under the history information. Under Vaccines Recommended by Selected Tracking Schedule, it indicates that the Pneumo-poly vaccination has a recommended and overdue date of 3/15/1997. During this interview LPN/IP D indicated that she was unable to find any information regarding R63's pneumococcal vaccination administration or consent/declination. Example 3 R102 was admitted to the facility on [DATE] with diagnoses that include, in part: Pleural Effusion (water on the lungs), Anemia, High Blood Pressure, Anxiety, and Depression. On 5/2/24 at 3:30 PM, Surveyors reviewed the immunization history in R63 and R102's electronic medical record as part of the infection control task. No pneumococcal immunization administration dates or consent/declination were noted in the records. Surveyors requested documentation of pneumococcal immunization information from the facility for R63 and R102. On 5/2/24 at 4:24PM Surveyor interviewed LPN/IP D after the facility provided a WIR (Wisconsin Immunization Registry) documents for R102. The WIR document for R102 contains a Prevnar 13 administration date of 5/5/15. The Vaccines Recommended by Selected Tracking Schedule, indicates that the Pneumo-poly - Pneumococcal 23 vaccination has a recommended date of 5/5/16 and an overdue date of 5/5/20. During this interview LPN/IP D indicated that she had sent out consents to R102's Power of Attorney with a return envelope and did not receive anything back. LPN/IP D indicated she does not recall when this was completed and does not have documentation of this. LPN/IP D indicated she should have followed-up again with the Power of Attorney regarding the pneumococcal vaccinations for R102. The facility did not have complete documentation in R41, R63, and R102's electronic medical records regarding administration, consent and/or declination of pneumococcal vaccines prior to Surveyor's inquiry.