STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure that R7 & R16, a married couple, have the right to share a room together after both consented. R7 & R16 informed Surveyor they wanted to live in the same room but this was not being allowed by the facility. Findings include: The facility's policy titled Resident Right to Share a Room implemented on 10/1/23 documents under the Policy section: It is the policy of this facility to support and facilitate a resident's right to share a room with their roommate of choice when practicable and to the extent possible. Under Policy Explanation and Compliance Guidelines section it documents: 1. The facility will permit a resident to share a room with his or her spouse, when married residents live in the same facility and both spouses consent to the arrangement. R7 was admitted to the facility on [DATE] with diagnoses which includes anxiety disorder, chronic pain syndrome, depressive disorder, diabetes mellitus, hypertension and dementia. R7's Quarterly MDS (Minimum Data Set) dated 3/11/24 documents a BIMS (Brief Interview for Mental Status) score of 8, which indicates that R7 has moderate cognitive impairment. R16 was admitted to the facility on [DATE] with diagnoses which include congestive heart failure, hypertension, cardiomegaly, benign prostatic hyperplasia, and arthritis. R16's Quarterly MDS dated [DATE] documents BIMS score of 15, indicating that R16 is cognitively intact. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 9:30 a.m., Surveyor observed R7 sitting in a regular chair in her room. Surveyor noted R7 did not have a roommate. During the conversation with R7, R7 informed Surveyor her husband lives downstairs. R7 informed Surveyor her husband asked a facility representative if they could share a room together. The representative said they don't do that. R7 stated they say I have dementia. If I have dementia then you two ladies, referring to the 2 Surveyors, do too. R7 informed Surveyor she would like to live with her husband. Surveyor asked R7 the name of her husband and R7 replied [first name of R16]. Surveyor asked R7 if she still would like to live with her husband in the same room. R7 replied yes but they won't allow it. R7 informed Surveyor that her husband, R16, comes up in the early afternoon to see her. On 5/14/24 at 10:11 a.m., Surveyor spoke with DSS (Director of Social Service)-H regarding R7 & R16. DSS-H informed Surveyor R7 lives upstairs and her husband lives downstairs. Surveyor asked DSS-H if there has been any conversation regarding R7 & R16 living together. DSS-H replied, no, we understood she has a diagnosis of dementia and he did not. Surveyor asked DSS-H if R16 voiced he wants to be in the same room with his wife. DSS-H replied not to me, I don't think [first name of R16] has said anything. Surveyor asked if R7 has said anything to her about sharing a room with her husband. DSS-H replied she had not. On 5/14/24 at 10:18 a.m. Surveyor asked SW (Social Worker)-I if R7 has said she would like to share a room with her husband. SW-I replied she has. SW-I explained R7 has dementia that's why she's on the dementia unit and he (referring to R16) does not. Surveyor asked SW-I if anyone has asked R16 if he would like to live with his wife. SW-I replied she didn't, I don't know if [first name of DDS-H] did. SW-I informed Surveyor when they were admitted she guessed that at their sister facility they were told they could live together. SW-I informed Surveyor R7 has dementia. Surveyor asked SW-I after R7 informed her she would like to live with her husband did SW-I address this. SW-I informed Surveyor she spoke to NHA (Nursing Home Administrator)-A. Surveyor asked SW-I what NHA-A said to her. SW-I informed Surveyor that R7 has dementia that's why she's upstairs and R16 did not. SW-I informed Surveyor at the time R7 had a roommate and now R7 is in a single room. Surveyor asked when R7's roommate left. SW-I informed Surveyor 3/21/24. SW-I informed Surveyor she has not said anything to her recently and that it was said in the beginning when SW-I first got here. Surveyor informed SW-I, R7 had spoken to Surveyor about wanting to share a room with her husband and that the facility wasn't allowing this. SW-I informed Surveyor she would address it again. On 5/14/24 at 2:25 p.m. Surveyor asked R16 if he wanted to share a room with his wife, R7. R16 replies yes. R16 informed Surveyor he has spoken to the facility quite a few times. R16 informed Surveyor the nurses and CNA's (Certified Nursing Assistant) told him she doesn't belong up there, referring to his wife R7 who lives on the dementia unit. Surveyor asked R16 if he spoke to anyone in management. R16 informed Surveyor he has spoken to [first name of NHA-A], then pointed up and indicated it's like speaking with the ceiling. Surveyor asked R16 if they told him why they can't live together. R16 informed Surveyor he wasn't bad enough to go up there. Surveyor again asked R16 if he would like to share a room with his wife and R16 replied yes. Surveyor asked about R7 coming downstairs. R16 replied I mentioned that to [first name of NHA-A]. She [NHA-A] said she (R7) would get out and never come back. R16 stated she's never been to Kenosha in her life. Surveyor asked R16 if he remembers speaking to DSS-H about sharing a room with his wife. R16 replied yes. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 3:26 p.m., during the end of the day meeting with NHA-A and DON (Director of Nursing)-B, Surveyor asked if there were any reasons why R7 & R16 couldn't live in the same room. NHA-A informed Surveyor they had offered R16 to go upstairs to the dementia unit but R16 doesn't want to stay up there. NHA-A informed Surveyor R7 would attempt to elope if she lived on the first floor and has safety issues. Surveyor informed NHA-A that Surveyor could not locate any documenation in R7 or R16's medical records regarding any conversation of R7 & R16 sharing a room. On 5/15/24 at 9:22 a.m. Surveyor spoke with R16. Surveyor asked R16 if he spoke to anyone about sharing a room with his wife. R16 informed Surveyor he talked with first name of NHA-A three months ago about why he can't go upstairs or his wife coming downstairs. R16 informed Surveyor they don't want his wife to come downstairs as they are scared she will run away. R16 informed Surveyor that DSS-H had spoken to him after he spoke with Surveyor. R16 informed Surveyor he's moving upstairs stating she's (R7) has been wanting it and I've been mentioning it several times but that was as far as it got. No additional informtion was provided as to why the facility did not ensure that R7 & R16, a married couple, shared a room together after both consented.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48391 Based on interview and record review, the facility did not ensure grievances and recommendations discussed during resident group meetings (Resident Council) were acted upon promptly and did not to demonstrate their response and rationale for such requests. The grievance log generated from Resident Council Meetings does not identify the name of the resident filing the grievance, grievance details, how the grievances were investigated, or the outcome of each grievance investigation. This has the potential to affect all 98 residents residing at the facility. Findings include: The facility's Resident Council Meetings policy and procedure implemented 12/23/22 documents: This facility supports the rights of residents to organize and participate in resident groups, including a Resident Council. This policy provides guidance to promoting structure, order, and productivity in these group meetings. Definitions: Resident or family group is defined as a group of residents or residents' family members that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; support each other; plan resident and family activities; participate in education activities; or for any other purpose. Policy Explanation and Compliance Guidelines: 1. The Resident Council is a formal resident group with a President who is appointed by other residents. 2. All residents are eligible to participate in the Resident Council and are encouraged by facility staff to participate. 3. The President serves as a liaison between the group and facility staff. In the absence of a President, facility staff shall communicate with active members of the Resident Council, as noted by participation logs. 4. The Resident Council meets at least quarterly, but no less than as determined by the group. The date, time, and location of the meetings are noted on the Activities calendar. 5. The Activity Director or Resident Care Coordinator shall be designated, if approved by the group, to serve as a liaison between the group and the facility's administration and any other staff members. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. If the Activity Director or Resident Care Coordinator is not approved by the group, the group's designee shall serve as the liaison, and documentation shall be maintained to reflect the group's designation. b. The designated liaison shall be responsible for providing assistance with facilitating successful group meetings and responding to written requests from the group meetings. 6. The group may appoint a resident to take notes/maintain meeting minutes or may elect that the Activity Director/designated liaison to take notes/maintain minutes. Meeting minutes may include, but are not limited to: a. Names of the residents in attendance. b. Follow up from previous meetings. c. Issues discussed. d. Recommendations from the group to facility staff. e. Names of staff members, speakers, and other guests present in the meeting (as invited by the group to attend). 7. The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council. Surveyor reviewed the facility documented minutes from the Resident Council meeting dated 12/20/23. The minutes documented: Administrative Issues: ~ Council Members Residents stated that she was told she could not get her food tray because the staff needed to go pick up their own personal food before they gave out the resident's food. The resident then had to wait an extra 40 minutes before they got the food tray, and it was then cold. The resident also stated this happens in the morning with certain Certified Nursing Assistants (CNA)s who will wait an extra 30+ minutes before passing trays. Nursing and CNA Issues: ~ Council Members and Residents stating they have been noticing CNA's and Nurses have been having their ear buds in a lot more in the hallways and even when coming into their rooms. Residents state the staff are taking personal phone calls and speaking very loudly in the hallway and rooms when cares are being performed and during medication pass. ~ Council Members and Residents are stating they are seeing the staff sitting in the dining areas eating and watching TV during their shifts. Residents do not know if the staff are on break because they are also eating at the nurses station while call lights are going off. ~ Council Members and Residents are asking to get their showers on the scheduled shower days. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance Issues: ~ Resident mentioned her wheelchairs needs to be oiled. ~ Resident mentioned some channels on his TV are not working and resident stated another resident was also missing channels. The previous Activities Director asked if residents can get a list of TV channels. Dietary Issues: Kitchen: - Christmas dinner will be on Christmas day in the South Dining Room. Residents asked about what food would be served. Kitchen staff answered with Roast Beef, vegetables, potatoes, and 3 bean salad. Kitchen staff will be doing a vote for which dessert the residents will want (pie). Kitchen staff stated she will get a specific resident 2 brats for Christmas Day like asked. Kitchen staff explained why she cannot do ham for a meal. ~ When will we be going back to eating in the dining rooms? Kitchen staff stated she will check with Management about when they can go back. ~ Kitchen staff mentioned how a specific resident supplies the cupcakes and everyone thanked this resident. ~ Residents asked if they could have hot water added to the carts for tea. Kitchen staff stated yes. Housekeeping / Laundry Issue: ~ Council Member and Residents state personal laundry is taking a very long time to get back after it has been sent down. ~ Council Member Residents have stated housekeeping staff are not knocking before entering resident rooms. Sometimes cares are happening, and they are asking for them to be reminded to knock. Residents also mentioned how housekeeping staff does not leave their doors the way they were when they entered the room. ~ Council Member Resident stated housekeeping continues to put a wet floor sign right in the middle of his doorway causing him to not be able to get through with his chair. Resident has asked housekeeping to come and pick it up after they finish mopping however this is not happening. No other concerns were raised. Activity Department Issues: ~ Council Member Residents are complaining about how in bingo residents are fighting over the body wash. Residents are stating that it is becoming more of a problem. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Second week of January 2024 Activities Director Implemented new BINGO prizes get picked up, this will be at the end of BINGO in order of [NAME] even if someone won more than one time. After two months of trying the new way, we will go over to see if this is helping. Date set for March 20, 2024. ~ Council Member and Residents are requesting a move outing. ~ Activity Director informed council and residents we can try and set something up in the New Year. No concerns were raised. Social Work Issues: No concerns were raised. Future Projects / Activity Suggestions Stay Informed: Holiday lunch will be on the 21st in 1 South Dining Room, there will be live music after. R13 will be Resident Council President until January/ February when we will hold resident council elections. Miscellaneous Issues: Resident mentioned his doctor has been wanting him to get physical therapy and they are telling him that he cannot. Will get this handled privately too by Director of Therapy-Y. Surveyor reviewed the facility documented Resident Council Notes dated 12/20/23. The Resident Council Notes include documentation from the 12/20/23 Resident Council Minutes however, the following is noted in 12/20/23 Resident Council Notes and not in the 12/20/23 Resident Council Minutes documents: ~ When will we be going back to eating in the dining rooms? Facility staff stated they will check with NHA-A about when they can go back. Maintenance: Resident asked about the curtains in the shower room. They are only hung up by 1 curtain hook. Nursing: ~ Resident mentioned the CNA attitudes are not okay. ~ Residents are stating that she was told that they had to go pick up their personal lunch and the dining trays sat for an extra 40 minutes and it was cold. Resident Coordinator mentioned that she could be notified so notes can be given and filled out for these issues. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Residents stated that they are not getting showers like they are scheduled for since staff is saying they do not have help/shower aide and they do not have time to give showers. They are then not getting showers for multiple days at a time. ~ Resident stated that yesterday he wasn't even asked if he wanted a shower, he was just gotten up without a shower even though it was his day. ~ Residents are complaining about how in bingo residents are fighting over the body wash. They are stating that it is becoming more of a problem because of how gross the regular soap is and how it doesn't make them feel clean and now residents are causing a scene if someone takes the body wash before them. Activities: ~ Resident asked about adding darts and that nobody plays. Resident Coordinator stated she will be adding darts one more time to have residents to come play. Resident Council President mentioned over the weekend [sic] was able to bring both games and it was a nice change that they were able to play both things. Resident mentioned it would be nice to know if something different was being offered that they could have went and told everyone that something new was being offered. Resident Coordinator clarified this issue and stated how it works. ~ Resident stated how [sic] always comes in late and takes very long to give out coffee etc and then has to clean up quickly for the next activity. Resident Coordinator stated how she will speak to her about coming in late and how coffee should not be cleaned up until the very end. Coffee should be something that can stay out during all activities because residents stated how they enjoy having coffee. ~ Resident Coordinator has stated she has always told her staff to have multiple things on the carts so that if something happens there can be a variety of things offered for an activity to happen. ~ Employee of the month is incorrect and it should be voting for the same month not future months. ~ Resident asked for coffee more often since it helps bring people together more and gets people talking and engaged better. Resident Coordinator mentioned we need to watch how much coffee and caffeine at activities since it is offered during all meals also. ~ Resident mentioned there is never enough coffee given and another pot needs to be made so they have enough. Resident Coordinator mentioned that she cannot give out coffee to one person. What is done for 1, has to be done for all. Resident Coordinator helped and explained about HIPPA violations and how she cannot give out personal details on why she cannot give something to someone. ~ Cotton candy will be something offered opposite week of cookie sales. Resident also asked about it to be on Monday's and movie days as well for 25 cents. Resident Coordinator will be asking with nursing about the risk and benefits of offering cotton candy that much. Resident Coordinator said she thinks having it on the opposite weeks of cookie sales will be okay. Resident is trying to help get money together for better prizes on bingo cart and maybe even some outings. Laundry: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Resident stated the usual that personals have not been coming back quickly. Facility staff stated she has a new schedule in place and she has someone in personals 4 hours a day so they can be done daily. On the weekend, no personals have been getting done. She stated that her workers said she did not know it was supposed to be done. ~ Resident asked why they can only have 1 person in laundry to do personals because it is taking longer. Facility staff stated they are working on getting more hours for the staff to help with this. She did mention they are really far behind. ~ Resident asked why he doesn't understand that personals keep getting pushed to the side. Facility staff stated that she told her staff and said how laundry and personals should be done at the same time. ~ Resident stated they are coming into the rooms while they are sleeping. Facility staff stated housekeeping is supposed to knock and they shouldn't be in the resident rooms before breakfast. If the resident tells them not to come in because of sleeping, the staff are supposed to come back later. Residents also expressed staff are leaving doors open after leaving even when the door was closed when they entered. ~ Resident stated they are not knocking when coming into her room and she is getting dressed sometimes. ~ Resident stated they always leave the wet floor sign in the middle of the doorway and it never gets moved or picked up. Facility staff stated once a room is mopped it needs to be put in the middle of the doorway and then picked up later. Resident stated that [sic] does not even pick it up so how is her staff supposed to do it if she doesn't. Facility staff did say she can set it to the side so that resident can get through his doorway. Notes from previous: Resident stated nobody came and spoke to him about his concern from previous resident. Surveyor reviewed the Facility documented minutes from the Resident Council meeting on 1/17/24 which included: Administrative Issues: ~ Council Members and Residents stated they enjoy eating in the dining rooms but would like some courtesy regarding their eating and staff putting the wheelchairs, lifts, etc. in the dining room. Council Members and Residents asked if there is a place that could be the designated spot to keep the wheelchairs, lifts, etc. instead of the halls or dining rooms. ~ Council Members and Residents asked if the facility has a dress code for residents in public areas, and if so would like current and new resident informed on it. Facility staff addressed this stating that it should be decent and being appropriate when coming out of your rooms they need to be dressed accordingly. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No concerns were raised Dietary Issues: ~ Council Members and Residents stated some residents come to the dining room at meal time and ask for the alternate meal. Dietary manager informed resident they cannot wait until the very last minute to be served the alternate meal. If a resident wants the alternate meal it must be called to kitchen ahead of time. Lunch alternate to be called down before 10:30 am, dinner alternate to be called down before 4:30 pm Kitchen Phone Extension 1030 No concerns were raised Housekeeping / Laundry Issue: Housekeeping Manager informed Council Members and Residents that all laundry being cleaned by the facility needs to be sent down for it to be cleaned. Housekeeping Manager also informed Council she has heard in the past some laundry staff would personally pick up and do residents laundry, which is not the correct way this should have been done. ~ Council Members and Residents have some questions on how resident's personal clothing is brought down to laundry. ~ Housekeeping Manager informed Council Members and Resident that residents should have CNAs send personals down the laundry chute daily if needed. If the residents' names are not on the clothing they should have their name put on a bag and laundry will make sure the clothes are labeled. Council Members and Residents want to know why the soap that is used to clean the floors make wheelchairs sticky. ~ Housekeeping Manager informed Council Members and Residents she found out that using both hot and cold water makes more floor cleaner come out. So, by only using hot water the right amount of floor clean comes out. ~ Resident understands that the wet mop signs need to be out but is asking for it to not be in the middle of his room floor, and not have it blocking his door to enter his room. ~ Housekeeping Manager informed Council Members and Residents of the importance of the wet floor signs. Housekeeping Manager talked to department staff about leaving the floor sign outside the door closer to the corner. also, make sure the wet floor signs are picked up before leaving for the day. No other concerns were raised Activity Department Issues: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activity Director Informed residents the importance of being respectful to all other residents and if there is ever a confrontation or problem in an activity that they need to be asked to leave or the resident should excuse themselves from the activity. ~ Council Members and Residents proposed to have shelving unit with games and cards etc. so resident can sign out. Also would like it to be located in the Activity Directors office for easy access. ~ Activity Director informed ~ Resident stated she has a hard time getting ahold of the Activity Director. Activity Director informed ~ Council Members and Residents would like for other residents to be more courteous when in an activity. Asking for residents to excuse themselves from the activity if they get a phone call so it doesn't disrupt others. Residents stated activities are doing a good job! No concerns were raised Social Work issues: Second floor resident stated they are doing a good job, keep it up. No concerns were raised. Therapy Issues: Therapy stated if anyone needs to be assessed with therapy they can come and see them. No concerns were raised Business Office Manager Issues: No concerns were raised Miscellaneous comments: Per Administrator, Activity Director was to inform resident council and residents that Resident Care Coordinator would be taking over Resident council. Activity Director advised Administrator that it should be put it in the council's hands and Council Members and Residents should be the ones to vote on it. Activity Director informed Council Members and Residents and there was a vote, the vote was a tie, Council Members and Residents stated if it is not broken do not fix it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident stated that he overall likes that people are approachable, stated Teacher referring to Activity Director handles residents' concerns along with the Resident Care Coordinator. Resident stated Resident Care Coordinator is doing a good job and listens to all the concerns and problems without judgment. Looking in to getting the facility windows updated Surveyor reviewed the Facility documented Resident Council Notes dated 1/17/24. The Resident Council Notes include documentation from the 1/17/24 Resident Council Minutes however, the following is noted in 1/17/24 Resident Council Notes and not in the 1/17/24 Resident Council Minutes. It documents: ~ Residents asked about having a dress code in the hallways. Director of Social Services-H addressed this stating it should be decent and being appropriate when coming out of your rooms they need to be dressed accordingly. ~ When there is an activity happening and a resident phone is going off, then they need to be considerate and answer it not in the middle of an activity. Director of Social Services-H addressed this stating it should be decent and being appropriate when coming out of your rooms they need to be dressed accordingly. Residents stated CNAs have attitudes. Resident stated that he is thinking he has heard about things getting stolen but he does not know for. Surveyor notes this sentence is not complete and follow up by facility staff is not provided. Surveyor reviewed the Facility documented minutes from the Resident Council meetings on 2/13/24 which included: Administrative Issues: ~ Follow up with department heads after any grievance is put in, residents really liked that NHA-A came down and spoke with them about past grievances. ~ Residents feel like Resident coordinator and administration are truly listening to concerns and working on changes. Dietary Issues: Residents stated they are now seeing changes happening in the building. They like eating in the dining room for dinner. Resident stated they liked the wings the other night and was excited kitchen staff provided them. Food has been a lot warmer with eating in the dining room at lunch and dinner. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance Issues: Resident stated the water pressure in the shower room was too low; Maintenance staff stated it was already fixed and taken care of Resident stated that maintenance staff needs an extra break he does a lot of work and is keeping up with everything. Residents asked about the elevator being fixed and maintenance staff let them know that they came out and already did their inspections and fixed what needed to be done. ~ Resident asked her personally about her money. Facility staff informed her she will let her know personally when it comes in and to see her outside of resident council if she has personal questions. ~ Residents stated that [sic] does a really good job and like her a lot. Social Work Issues: Last night the residents were woken up by people that were possibly drinking. A resident stated that she is upset because she was up all night and is now tired today. Social services stated she thinks the best solution would be that if it would just stop all together and she is working on things and a solution that will take care of the issue that have been happening. Social services asked how many people are affected by this and 5 residents raised their hands. Residents stated that the staff on the floors were aware of what was happening and did not stop it. Residents' right poster to get posted up and in the main areas. Resident coordinator stated she has no problem getting the posters up so that others can see and know their rights. Housekeeping/Laundry Issues: It still takes too long to get personals back was stated by 1 resident. 4 other residents stated they have been getting her clothes back a lot better now that they have someone in there every day. When residents are eating, they are asked not to come in and be cleaning. Housekeeping staff told them she is having a meeting tomorrow to make sure this is told to them. ~ Housekeeping staff also stated that she has let her staff know that when it's lunchtime for the residents this is when housekeeping should be taking their breaks, so they aren't trying to clean while meals are being served. Residents stated this is not always what happens. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident stated she has heard her tell her staff about the issues that are coming up by residents (meaning she is openly addressing her staff about what the residents are requesting) Therapy staff stated if you are ever in need of therapy to please make sure you reach out and get in touch with them. Nursing CNA Issues: Earbuds and talking on their phones is still happening. Texting down the hallways and ignoring call lights. Singing with their earbuds and when they are talking to residents, they cannot hear them. Resident with concerns for his dressings for his bottom / Facility staff indicated dressing were not done for a week Nursing staff said to please let her know right away if this does not happen so she can get someone to complete this immediately and follow up with the staff on that day for any actions needed. It's hard to fix something weeks / days later. Residents asked about how the aides have certain rooms and when they all go on break at the same time, and no lights get answered if the other CNA is gone. Nursing staff did address this with the resident and stated she has a meeting with them every month now and they will get spoken to about that if one aide is on break then the others should be answering the lights and nurses as well. Resident stated he mentioned to a nurse about a CNA sitting down in the library upstairs and the nurse told him she is allowed to do that, and he shouldn't be worried about it. Resident was upset because he stated he pays a lot of money to be here so she should be up working and not sitting down on her phone getting paid for it. DON stated she will have conversations with this nurse and CNA about the issue and investigate it in more detail. Activity Department Issues: Resident Care Coordinator-E has been a breath of fresh air coming into activities. More residents are coming to activities, coffee, and news in the morning so possibly getting another pot of coffee. Surveyor reviewed resident council minutes dated 3/6/2 and they document: Kitchen Staff - No complaints, love the new menu. Maintenance - Great job! No complaints Nursing Staff - No complaints, doing a wonderful job. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeping - Personals are a lot better Social Services - Great job, no complaints Activity Department Issues: No complaints Surveyor reviewed resident council minutes dated 4/3/24 and they document: Dietary Issues: no complaints, Great job! Maintenance Issues: Always fixes everything when asked. Nursing and CNA Issues: Nursing Staff - Takes a long time to answer call lights, still putting medication in hand without any gloves. Housekeeping/Laundry Issues: No complaints, a lot better! Social Work Issues: Doing a great job! Physical Therapy: No complaints, great job! Miscellaneous Issues: Some staff wearing earbuds. Surveyor reviewed resident council minutes dated 5/1/24 and they document: Dietary Issues: Kitchen staff - more biscuits and gravy, other than that doing a great job Maintenance Issues: no complaints, great job Nursing Staff - Resident wants all his grievances Housekeeping/Laundry Issues: no complaints, a lot better Social Work Issues: no complaints, doing a great job Physical Therapy: No complaints, wonderful job Activity Department: No complaints, wants coffee earlier Surveyor reviewed the Facility Grievances from 12/1/23 - 5/4/24. Surveyor noted the following number of grievances that were filed without a resident name: 12/11/23 - 1 grievance 12/20/23 - 7 grievances (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/17/24 - 15 grievances 2/10/24 - 1 grievance 2/13/24 - 6 grievances Surveyor noted that these grievances without resident names, had identified concern categories as listed below: Nurse/CNA Behavior Care Concern Customer Service/Interaction Laundry Dining Experience Missing Items Other Activities Other Housekeeping Maintenance Issue Cleanliness Privacy Concern On 5/14/24 at 8:18 am, Surveyor interviewed R17 who indicated she use to attend Resident Council once a month but recently stopped going due to medical changes. R17 confirmed she attended Resident Council on 12/20/23 and 1/17/24. R17 reported that facility staff are always in attendance at Resident Council meetings. R17 recalls a discussion between residents about CNAs having earbuds in their ears while performing cares on residents at the 12/20/23 and 1/17/24 Resident Council meetings. R17 does not recall any further topics discussed at the 12/20/23 and 1/17/24 Resident Council meetings. On 5/14/24 at 8:28 am, Surveyor interviewed R10 who stated she attends Resident Council regularly. R10 indicated residents had been meeting monthly however, the facility changed the meetings to occur every two weeks starting in April 2024. R10 stated the previous Activities Director was in attendance for all meetings prior to leaving the facility sometime after the holidays. R10 indicated the previous Activities Director would pass along grievances to the specific departments after grievances were discussed in Resident Council. R10 stated the biggest concerns brought up in Resident Council at the 12/20/23 and 1/17/24 meetings, were CNAs wearing their earbuds while caring for residents. R10 indicated Activity Director-G and Resident Care Coordinator-E are assisting with Resident Council meetings and the next Resident Council meeting is scheduled 5/15/24. R10 indicated the head of each facility department is asked to attend Resident Council for residents to discuss concerns. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 8:44 am, Surveyor interviewed R13 who is the Resident Council President and attends meetings regularly. R13 confirmed she was at the 12/20/23 and 1/17/24 Resident Council meetings. R13 indicated Resident Council meetings occur monthly and have recently been moved to every two weeks. R13 reports the head of each facility department are invited and attend Resident Council to discuss concerns individually with each department. R13 recalls discussion at the 12/20/23 and 1/17/24 Resident Council meetings with CNAs wearing earbuds while performing cares. On 5/14/24 at 9:21 am, Surveyor interviewed Activity Director-G who stated she has worked at the facility for about one and half months. Activity Director-G indicated she has attended 3 Resident Council meetings (two in April 2024 and one in May 2024) along with Resident Care Coordinator-E. Activity Director-G stated she technically shouldn't attend Resident Council but was asked by the facility to attend and help coordinate the attendance of managers from each department to attend Resident Council. Activity Director-G stated Resident Council meetings increased to every two weeks prior to her starting at the facility. Activity Director-G stated that grievances had increased, and the facility was recommending increasing Resident Council meetings to every two weeks to help take care of the increased number of grievances. On 5/14/24 at 11:12 am, Surveyor interviewed Director of Social Services (DSS)-H who indicated she is the facility's grievance officer; however, all management staff have access grievances. DSS-H indicates she is notified of grievances verbally from staff, residents, or from the facility daily stand-up meetings that occur every morning. DSS-H stated once she is notified of a grievance,

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not provide notice of resident rights and services prior to or upon admission for 40 (R2, R18, R19, R20, R21, R12, R22, R23, R24, R25, R11, R26, R27, R28, R29, R30, R16, R31, R32, R33, R34, R35, R10, R36, R37, R38, R39, R40, R41, R5, R42, R43, R44, R45, R46, R47, R48, R49, R50, R1) of 40 residents reviewed. *R2 was admitted to the facility on [DATE] and was handed a facility admission agreement packet to sign on [DATE]. R2 does not currently have a signed admission agreement on file for the facility. *R18, R19, R20, R21, R12, R22, R23, R24, R25, R11, R26, R27, R28, R29, R30, R16, R31, R32,R33, R34, R35, R10, R36, R37, R38, R39, R40, R41, R5, R42, R43, R44, R45, R46, R47, R48, R49, and R50 did not have signed admission agreements when they were admitted to the facility. *R1 was admitted to the facility [DATE]. His activated Power of Attorney for Healthcare (POA-HC) was not provided with the facility's admission agreement until [DATE], the day before his discharge, and refused to sign it. Findings include: The facility policy titled Admission Agreement and dated as revised on ,d+[DATE] states: All residents have a signed and dated Admission Agreement on file. Policy Interpretation and Implementation 1. At the time of admission, the resident (or his/her representative) must sign and Admission Agreement (contract). 2. The Admission Agreement (contract) will reflect all changes for covered and non-covered items, as well as identify the parties that are responsible for payment of such services. 4. A Copy of the Admission Agreement is provided to the resident or his/her representative (sponsor), and a copy placed in the resident's permanent file. 5. Residents will be informed of any change(s) taking effect. Changes in services, charges, payments, etc. will require that new agreements be signed. 6. Inquiries concerning the facility's Admission Agreement should be referred to the administrator and/or business office. R2 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia Left dominant side, type 2 diabetes mellitus, and major depressive disorder. R2's admission minimum data set (MDS) dated [DATE] and most recent quarterly MDS dated [DATE] document a BIMS (Brief Interview for Mental Status) score of 15, indicating that R2 is cognively intact. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:30 AM, Surveyor observed R2 lying in R2's bed. R2 stated that RCC (Resident Care Coordinator)-E brought in an admission agreement packet to sign last night ([DATE]). Surveyor asked R2 if R2 remembers signing an admission agreement when R2 was admitted to the facility. R2 was not able to recall if R2 ever signed one. Surveyor asked R2 if anyone went through or explained the admission agreement packet to R2 or just asked R2 to sign it. R2 stated that RCC-E was going to go back to R2 and review the document. Surveyor reviewed R2's medical record and did not locate a signed admission agreement for R2. On [DATE] at 10:40 AM, Surveyor interviewed RCC-E who stated she started to take over doing admission agreements for about one and half months now. RCC-E stated that the facility had noted some residents did not have signed admission agreements on file. RCC-E handed Surveyor a 4 page packet of residents RCC-E was trying to get signed admission agreements for. Surveyor asked RCC-E why the residents did not have an admission agreement on file. RCC-E stated the facility used to do admission agreements on paper and then it went to a CareFeed program and does not know if admission agreements were transferred over. Surveyor asked RCC-E when is a resident expected to sign the admission agreement. RCC-E stated that RCC-E tries to get it upon arrival to the when the facility but sometimes the residents do not want to sign it at that time. When this occurs, RCC-E, tries to go back to have them sign it. Surveyor asked RCC-E what happens when a resident gets admitted after hours or on the weekend. RCC-E was not sure who would be in charge of getting the resident to sign the admission agreement at that time if the resident was admitted to the facility after hours or on a weekend. Surveyor asked RCC-E if RCC-E has received training regarding admission agreements. RCC-E stated RCC-E has received training and knows RCC-E needs to get the admission agreement signed right after the resident is admitted to the facility. Surveyor asked how RCC-E is getting signatures for the residents that are deceased or discharged . RCC-E stated RCC-E has calls out to the residents and family members, but no one is getting back to RCC-E. RCC-E stated RCC-E does not know what else to do. Surveyor reviewed the residents listed as needing an admission agreement signed from the sheet RCC-E handed Surveyor. The following residents did not have a signed admission agreements on file when admitted to the facility: R18 was admitted to the facility on [DATE]. R18 did not have a signed admission agreement on file until [DATE]. R19 was admitted to the facility on [DATE] and has an activated power of attorney (POA). R19 does not currently have a signed admission agreement on file. R20 was admitted to the facility on [DATE]. R20 did not have a signed admission agreement on file until [DATE]. R21 was admitted to the facility on [DATE]. R21 did not have a signed admission agreement on file until [DATE]. R12 was admitted to the facility on [DATE]. R12 did not have a signed admission agreement on file until [DATE]. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22 was admitted to the facility on [DATE] and has a legal guardian. R22 does not currently have a signed admission agreement on file. R23 was admitted to the facility on [DATE] and has an activated POA. R23 discharged from the facility on [DATE] and does not have a signed admission agreement on file. R24 was admitted to the facility on [DATE] and has an activated POA. R24 discharged from the facility on [DATE] and does not have a signed admission agreement on file. R25 was admitted to the facility on [DATE]. R25 did not have a signed admission agreement on file until [DATE]. R11 was admitted to the facility on [DATE]. R11 did not have a signed admission agreement on file until [DATE]. R26 was admitted to the facility on [DATE]. R26 did not have a signed admission agreement on file until [DATE]. R27 was admitted to the facility on [DATE]. R27 did not have a signed admission agreement on file until [DATE]. R28 was admitted to the facility on [DATE] and has an activated POA. R28 does not currently have a signed admission agreement on file. R29 was admitted to the facility on [DATE]. R29 did not have a signed admission agreement on file until [DATE]. R30 was admitted to the facility on [DATE]. R30 does not currently have a signed admission agreement on file. R16 was admitted to the facility on [DATE]. R16 did not have a signed admission agreement on file until [DATE]. R31 was admitted to the facility on [DATE] and has a legal guardian. R31 does not currently have a signed admission agreement on file. R32 was admitted to the facility on [DATE] and has a legal guardian. R32 does not currently have a signed admission agreement on file. R33 was admitted to the facility on [DATE] and has a legal guardian. R33 does not currently have a signed admission agreement on file. R34 was admitted to the facility on [DATE] and has a legal guardian. R34 does not currently have a signed admission agreement on file. R35 was admitted to the facility on [DATE] and had an activated POA. R35 passed away on [DATE] and did not have a signed admission agreement on file. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10 was admitted to the facility on [DATE]. R10 did not have a signed admission agreement on filed until [DATE]. R36 was admitted to the facility on [DATE] and has an activated POA. R36 does not currently have a signed admission agreement on file. R37 was admitted to the facility on [DATE] and has a legal guardian. R37 does not currently have a signed admission agreement on file. R38 was admitted to the facility on [DATE] and has a legal guardian. R38 does not currently have a signed admission agreement on file. R39 was admitted to the facility on [DATE] and has a legal guardian. R39 does not currently have a signed admission agreement on file. R40 was admitted to the facility on [DATE] and has a legal guardian. R40 does not currently have a signed admission agreement on file. R41 was admitted to the facility on [DATE] and has a legal guardian. R41 does not currently have a signed admission agreement on file. R5 was admitted to the facility on [DATE] and has a legal guardian. R5 does not currently have a signed admission agreement on file. R42 was admitted to the facility on [DATE]. R42 discharged from the facility on [DATE] and does not have an admission agreement on file. R43 was admitted to the facility on [DATE] and has a legal guardian. R43 does not currently have a signed admission agreement on file. R44 was admitted to the facility on [DATE] and has a legal guardian. R44 does not currently have a signed admission agreement on file. R45 was admitted to the facility on [DATE] and has an activated POA. R45 does not currently have a signed admission agreement on file. R46 was admitted to the facility on [DATE] and has a legal guardian. R46 does not currently have a signed admission agreement on file. R47 was admitted to the facility on [DATE] and has a legal guardian. R47 does not currently have a signed admission agreement on file. R48 was admitted to the facility on [DATE] and has an activated POA. R48 does not currently have a signed admission agreement on file. R49 was admitted to the facility on [DATE]. R49 did not have a signed admission agreement on file until [DATE]. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R50 was admitted to the facility on [DATE]. R50 did not have a signed admission agreement in file until [DATE]. On [DATE], Surveyor informed Nursing Home Administrator (NHA)-A regarding the multiple residents that do not have admission agreements signed. NHA-A stated they noted they knew about the issue and were correcting it by getting the signatures as soon as they can for the residents. No additional information was provided. 22692 R1 was admitted to the facility [DATE]. His activated Power of Attorney for Healthcare (POA-HC) was not provided with the facility's admission agreement, that included a notice of rights and services, until [DATE]. R1 was admitted to the facility on [DATE], and discharged on [DATE] to another facility. On [DATE] R1's medical record was reviewed and no admission contract, consent for treatment or notification of resident rights and responsibilities was found. On [DATE] at 1:05 PM Administrator-A was interviewed and indicated on [DATE] R1's POA was contacted and asked to sign an admission agreement (9 days after admission) and refused to do so. Administrator-A indicated she knows it's a problem and the facility is working on it. The above findings were shared with the Administrator and Director of Nurses on [DATE] at 3:00 PM. Additional information was requested if available. No additional information was provided as to why the facility did not provide notice of resident rights and services prior to or upon admission for 40 of 40 residents reviewed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 20483 Based on interview and record review the facility did not report 3 of 4 incidents to the State survey agency and/or Nursing Home Administrator during the required timeframe. This has the potential to affect R6, R12, R13, R14, R15, R10, & R11. R6's sexual abuse allegation was not reported to Nursing Home Administrator-A & State agency immediately but not later than 2 hours after the allegation is made. The allegation of possible drug diversion was not reported to the Nursing Home Administrator and State agency within 24 hours for R12, R13, R14, R15, & R11. R11's allegation of misappropriation was not reported to the State agency within 24 hours. Findings include: The Abuse, Neglect, and Exploitation policy implemented 9/18/2023 documents under the Policy section: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Under Policy Explanation and Compliance Guidelines under VII Reporting/Response documents: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily harm. 1.) R6's diagnoses includes dementia, congestive heart failure, atrial fibrillation, anxiety, hypertension, and bipolar disorder. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's nurses note dated 2/18/24 at 20:25 (8:25 p.m.) documents: Writer informed by CNA (Certified Nursing Assistant) that Rsdt (Resident) [R6's initials] hugged and tried to kiss another female Rsdt ([R7's initials, room number]). Writer spoke to both [R6's initials] and [R7's initials] separately alone regarding incident. [R7's initials] said she felt uncomfortable but expressed that he quickly lost interest when she told him she was married. Writer strongly advised Rsdt [R6's initials] to stop inappropriately accosting female Rsdt's and staff. Staff informed to continue to closely monitor [R6's initials]. DON (Director of Nursing) aware. This nurses note was written by LPN (Licensed Practical Nurse)-W. Surveyor reviewed the facility's reported incident for affected person [R7's name] and accused person [R6's name]. The allegation type is documented as abuse. For the date occurred it documents 2/18/24, time occurred 12:10 PM and date discovered 2/19/24. Report submitted date documents 2/19/2024 4:44:31 PM. Under brief summary of incident documents Resident stated that another resident kissed her on the mouth. Resident unable to give further description of the kiss. All parties involved have diagnosis of dementia with low BIMS (brief interview mental status) scores. Roommate denies seeing anything occur and was present when male resident was in the room. In an abundance of caution the facility has placed the male resident on 1:1 while medical and psych workups are being completed. Trauma informed care assessment has been completed with no adverse findings identified. Care plan and behavior monitoring have been updated. Interviews of staff so far indicate no witnesses to the occurrence or past behaviors. Awaiting [Name] Police Department arrival. MD (medical doctor) and POA (power of attorney) have been updated. On 5/15/24 at 8:00 a.m. Surveyor spoke with NHA (Nursing Home Administrator)-A regarding the facility's reported incident involving R6 & R7. Surveyor asked NHA-A why the allegation of abuse wasn't reported until 2/19/24. NHA-A replied that's when I was made aware. Surveyor asked NHA-A if she should have been called on 2/18/24. NHA-A replied they probably should have called me. Surveyor informed NHA-A this allegation should have been reported to her & the State agency immediately but not later than 2 hours after the allegation was made. 47094 2.) R13's diagnoses include chronic obstructive pulmonary disease (COPD), epilepsy, major depressive disorder, schizophrenia, anxiety, pain, and muscle weakness. 3.) R14's diagnoses include multiple sclerosis, COPD, Parkinson's disease, major depressive disorder, and muscle weakness. 4.) R12' diagnoses include paraplegia, type 2 diabetes mellitus, pain, neuromuscular dysfunction of bladder, muscle weakness, and depression. 5.) R15's diagnoses include necrotizing fasciitis, type 2 diabetes mellitus, muscle weakness, congestive heart failure, major depressive disorder, and chronic kidney disease stage 3. 6.) R10's diagnoses include chronic kidney disease stage 3, type 2 diabetes mellitus, congestive heart failure, lymphedema, major depressive disorder, and anemia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed the facility's reported incident. The allegation type is misappropriation of property. The date and time when occurred is unknown and the date discovered is 12/18/2023. Under brief summary of the incident it documents a licensed practical nurse (LPN) called nursing home administrator (NHA)-A and stated LPN had a substance use disorder and needed to resign from LPN's job effective immediately. NHA-A asked if LPN took medications from any residents and LPN stated LPN had not and that LPN had own supply of medications. During staff interviews LPN-AA mentioned possible discrepancies with controlled substance medications for R13, R14, R12, R15, and R10 and noted that to be on 12/16/2023. Investigation was initiated, police contacted, resident interviews and pain assessments completed, and staff education completed. On 5/20/2024 at 11:45 AM Surveyor interviewed NHA-A. Surveyor asked why LPN-AA did not report possible medication discrepancy on 12/16/2023. NHA-A stated LPN-AAm had stated LPN-AA wanted more information before LPN-AA brought it to NHA-A's attention. NHA-A stated education was provided to LPN-AA regarding reporting anything regardless of how much information was available. Surveyor shared concerns with NHA-A regarding LPN-AA not reporting the concern on 12/16/2023. NHA-A agreed the concern should have been reported right away on 12/16/2023 when LPN-AA had the initial concern. 22692 7.) R11 was admitted to the facility on [DATE] with diagnosis that included Depression and Anxiety. R11's Quarterly Minimum Data Set (MDS) dated [DATE] indicated R11 had a Brief Score for Mental Status of a 15 (fully intact cognitive status). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 R11's progress note dated 1/7/24 at 12:18 AM written by Registered Nurse (RN)-C documents: At 7:30 PM to 11:00 PM on 1/6/24 called into R11's room and patient sitting on edge of bed with blood dripping from right foot. When further assessed it was noted that the patient had pulled his whole toenail out of the third toe on right foot with a cuticle cutting instrument that family had brought him. RN and Certified Nursing Assistant (CNA) then proceeded to apply pressure to the wound so a pressure dressing could be applied to the wound. Writer was able to apply the dressing and told the patient to elevate the leg and to stay off it so it could slow the bleeding. Writer told the CNA to grab the cuticle instrument as it was sharp, and patient could hurt himself again. R11 began to yell at writer and CNA for stealing his belongings and writer tried to explain that the clippers are what caused, the injury and we would need to take them to prevent further injury. Patient stood up and grabbed his cane and proceeded to swing it at the writer and CNA. Writer grabbed the cane to protect self and CNA. Then writer then tossed the cane towards the wall away from staff and patient. Patient began to say racial slurs and patient began to lunge at writer and staff. Writer and staff walked away to protect selves from patient. Patient then called the police stating the staff including writer assaulted him and stole his property. Writer called management immediately to notify of the incident. Police took statement from R11, writer and CNA. No further action was taken from the police. Patient then proceeded to walk around in his room and put pressure on his foot. Wound began to bleed and Emergency Medical Services (EMS) was called. EMS arrived and advised going to the hospital. Patient refused and told EMS Just wrap it better than that nurse did. EMS explained a pressure dressing was applied already and that they would reinforce with more gauze. Writer and CNA explained to EMS that medical attention should be sought but R11 still refused to go, and the patient was advised by EMS to stay off the injured foot. EMS left. Writer then shortly after heard more yelling coming from patients room. R11 again was at his door yelling in the hall racial slurs and making rude/harsh statements to staff. He accused staff of denying him medical attention and that he called EMS again. The same EMS that came prior came again and were in the front lobby when the patient told EMS that they refused him treatment. EMS explained that they tried to take him earlier, but he had refused. R11 again denied he stated that he refused to go. EMS was finally able to get him on a stretcher and patient again was yelling at staff. I'm calling state on your ass. Wait and see if you have a job tomorrow. Writer explained to EMS that there were probably some underlying mental issues that he should be assessed for. R11 turned to writer and called out racial slurs and further called names out loudly. Patient left around 11:00 PM with EMS and to be transported to the hospital. Advised to be a buddy system until further notice. On 5/14/24 the facility reported incident report regarding the above incident with R11 was reviewed and indicated the date of occurrence was 1/6/24 at 7:00 PM. It also indicated the Administrator was made aware of the allegation on 1/8/24 and the initial report was submitted to the state agency on 1/8/24 at 5:16 PM (46 hours after the allegation). On 5/14/24 at 1:05 PM, Administrator-A was interviewed and indicated that she was not made aware of R11's allegations until 1/8/24 and should have been called immediately. Administrator-A indicated that's why the initial report was late to the state agency. On 5/14/24 The facility's policy Titled Abuse, Neglect and Exploitation dated 2/23 was reviewed and documented: Reporting of all alleged violations to the Administrator and state agency within specified timeframe's. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 3:00 PM Administrator-A and Director of Nurses-B were informed of the above concerns. No additional information was provided.

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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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not notify the state mental health authority promptly after a significant change in 1 (R6) of 1 Residents mental illness. R6 was diagnosed with bipolar disorder on 2/22/24 and started receiving Depakote Delayed Release Sprinkles 250 mg (milligrams) twice a day on 2/23/24. The Facility did not submit a level 1 PASARR (Preadmission Screening and Resident Review) until 5/13/24 and the level 1 did not include the bipolar disease diagnosis or Depakote. Findings include: The Resident Assessment- Coordination with PASARR Program policy implemented on 1/18/23 documents under the Policy section: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Under the Policy Explanation and Compliance Guidelines it documents: 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment. R6 was admitted to the facility on [DATE] with diagnoses includes dementia, congestive heart failure, atrial fibrillation, anxiety, and hypertension. R6 has an activated power of attorney for healthcare. The physician orders with an order date of 2/19/24 documents Depakote Oral Tablet Delayed release 125 mg (milligrams) (Divalproex Sodium) Give 1 tablet by mouth in the afternoon for dementia, psychosis, agitation, sundowning. This ordered was discontinued on 2/23/24. On 2/22/24 Psychologist-V diagnosed R6 with Bipolar Disorder. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician order with an order date of 2/23/24 documents Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 mg (Divalproex Sodium) Give 2 capsule by mouth every morning and at bedtime for bipolar disorder. Surveyor reviewed R6's Level 1 PASARR located under the miscellaneous tab. Surveyor noted this Level one does not indicate the date when submitted and does not include the diagnosis of Bipolar disorder or Depakote Delayed Release Sprinkles 250mg. On 5/20/24 at 8:20 a.m. Surveyor met with DSS (Director of Social Service)-H to discuss R6. Surveyor informed DSS-H Surveyor had noted on 2/22/24 R6 had been diagnosed with bipolar disorder and started to receive Depakote. Surveyor inquired if a PASARR had been submitted after these changes. DSS-H replied I believe it was. Surveyor asked DSS-H if she knew when the Level 1 was submitted as the Level 1 as Surveyor was able to review the intial PASARR form but the form did not have a date. DSS-H informed Surveyor she put it in but did not give the date. Surveyor asked DSS-H if she could look into when she submitted this Level 1 and let Surveyor know. Surveyor asked DSS-H if she knew why Depakote wasn't listed on R6's Level 1. DSS-H informed Surveyor she put Hydroxyzine in there. DSS-H informed Surveyor Bipolar should have been mentioned and R6 has a diagnosis of anxiety on his orders but Bipolar should have been mentioned. Surveyor asked what about the Depakote. DSS-H replied that too with the Bipolar. On 5/20/24 at 9:30 a.m. Surveyor asked DSS-H if she received a Level 2 or partial Level 2 back. DSS-H informed Surveyor she will have to get back to Surveyor. On 5/20/24 at 10:37 a.m. DSS-H informed Surveyor she redid R6's Level 1 PASARR. DSS-H informed Surveyor the original Level 1 was done on 5/13/24. DSS-H explained R6 was moved to the first floor on 2/28/24 and R6's Level 1 PASARR should have been done by SW (Social Worker)-I upstairs on 2/23/24 when R6 received a diagnosis of Bipolar. DSS-H informed Surveyor SW-I reminded her this month that the Level 1 needs to be done. Surveyor informed DSS-H of Surveyor's concerns regarding R6's Level 1 PASARR was not submitted timely and did not include R6's bipolar disorder diagnosis and Depakote medication. No additional information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 22692 Based on observation, interview, and record review the facility did not provide the necessary ADL (Activities of Daily Living) services for 1 (R4) of 4 residents who were dependent on staff to provide ADL care. R4 was observed with long nails pressing into the palms of her hands due to bilateral hand contractures. R4's care plan indicated her nails should be kept short to prevent injury. Findings include: 1.) R4 was admitted to the facility on [DATE] with diagnoses that included Anoxic Brain Damage and Coma. R4 is unable to make her needs known. On 5/13/24 at 9:00 AM, R4 was observed in bed with long fingernails pressing into both of her palms and no protection to her skin. On 5/13/24 at 12:30 PM, R4 was observed in bed with long fingernails pressing into both of her palms and no protection to her skin. On 5/13/24 at 2:00 PM, R4 was observed in bed with long fingernails pressing into both of her palms and no protection to her skin. On 5/14/24 at 8:00 AM, R4 was observed in bed with long fingernails and a rolled up washcloth in both hands. On 5/14/24 at 11:00 AM, R4 was observed in bed with long fingernails and a rolled up washcloth in both hands. Director of Nurses (DON)-B was brought into R4's room and indicated she agreed R4's fingernails were too long and should be cut. On 5/13/24, R4's Current care plan for Impaired Skin Integrity dated 6/23/23 was reviewed and documented: Intervention- keep nails short to reduce risk of scratching or injury from picking skin with a start date of 3/2/24. On 5/14/24 R4's current CNA care sheet was reviewed and documented: Keep nails short to reduce risk of scratching or injury from picking skin. On 5/14/24 at 3:00 PM, Surveyor informed Nursing Home Administrator-A and Director of Nurses (DON)-B. No additional information was provided as to why the facility did not provide the necessary ADL services for R4 whom is dependent on staff to provide ADL care.

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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** 20483 Based on interview and record review the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices was provided for 2 (R3 & R9) of 9 Residents. R3 was admitted to the facility on [DATE] with a right diabetic foot ulcer and a left below knee amputation surgical incision. Treatments for these areas were not started until 1/19/24, 3 days later. R3's blood pressure, heart rate, and fluids were not monitored according to physician orders. R9's sacrum surgical wound with a wound vac was not comprehensively assessed until 5 days after admission on 12/19/23 when the wound doctor assessed R9's sacrum surgical wound. Findings include: 1.) R3 was originally admitted to the facility on [DATE] with diagnoses which include hypertension, atrial flutter, cirrhosis of liver, left below knee amputation, diabetes mellitus, peripheral vascular disease, congestive heart failure, and depression. The initial wound assessment dated [DATE] documents for type of wound, non pressure. Under site other (specify) documents Rt (right) planter. Under type other (specify) documents Diabetic. Length is 2.5 cm (centimeters), width 2.5, depth 0 and stage n/a (non applicable). For percentage of eschar: A crust of thick, hard black non-viable tissue documents 100. Under the Treatment section for the question are treatments/equipment in place yes is answered. Wound treatment/application of dressing & wound clinic/wound physician consultation are checked for check all treatments that apply. This initial wound assessment was completed by Wound RN (Registered Nurse)-X. The physician orders dated 1/18/24 documents: Betadine swab to right planter foot ulcer every day shift for wound care. R3's January TAR (Treatment Administration Record) documents that the treatment to R3's right planter foot ulcer did not start until 1/19/24, which is three days after admission. The initial wound assessment dated [DATE] documents: Wound Type: non pressure; Site: other (specify): Lt (left) BKA (below knee amputation). Under type: other (specify) documents Surgical Incision. Length is 16.0 cm (centimeters), width 0.1, depth 0, and stage: n/a (non applicable). Under the Treatment section for the question: are treatments/equipment in place? yes is answered. Wound treatment/application of dressing & wound clinic/wound physician consultation are checked for check all treatments that apply. This initial wound assessment was completed by Wound RN (Registered Nurse)-X. R3's physician orders dated 1/18/24 documents: Wash left BKA (below knee amputation) surgical site with saline and pat dry. Cover wound with ABD/Kerlix/Ace wrap every day shift for wound care. R3's January TAR reveals the treatment to R3's left BKA surgical site did not start until 1/19/24, three days after admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 9:30 a.m., Surveyor informed Wound RN (Registered Nurse)-X R3 was admitted to the facility on [DATE] and inquired why the treatment wasn't ordered until 1/18/24 & not started until 1/19/24. Wound RN-X informed Surveyor that may have been the first time she saw him on the Thursday (1/18/24). Surveyor informed Wound RN-X she completed the initial wound assessments for R3's right diabetic foot ulcer & left BKA surgical site on 1/16/24. Wound RN-X explained to Surveyor she is usually only at the Facility on Tuesdays but since they haven't had any unit managers she has been helping out. Wound RN-X informed Surveyor she may have realized there was no treatment started but doesn't have an answer as to why a treatment wasn't started on admission. Wound RN-X informed Surveyor normally they would follow the discharge summary or call the doctor for treatment orders. On 1/26/24 R3 is documented as having a change in condition. NP (Nurse Practitioner)-O's note dated 1/26/24 for chief complaint documents RN called to the room for pt (patient) having BP (blood pressure) was low. Under history of present illness documents [R3's initials] is a 76 y/o (year old) AA M (male) seen today for low BP. I asked the RN to get the patient back into the wheel chair and lie him down for 5 minutes and get a set of VS (vital signs). After just skimming his meds (medication), I arrived to the room. Two PT (physical therapist) were in the room and reported a low blood pressure. I asked them if they could get him into the bed, and they said they do not move patients. I asked the RN to get the hoyer and she said she needed to get the CNAs (Certified Nursing Assistant) to move him. I started to get the hoyer set up because no one was doing anything. Pt looked sleepy he mumbled and appeared like he was sleeping. After I got the sling on him, the Therapist left and they transferred him into the bed and trendelenburged him for 5 min (minutes) and then returned the bed to lying and took a set of VS again. T (temperature) 97.7, HR (heart rate) 112, BP (blood pressure) 136/51, SpO2 96% RA (room air). He was stable lying flat. I asked [initials] if they got a blood glucose, and then got a reading of 598 the second was 49? I called [Physician name] that I have not seen this patient and he did the last visit event. MD said to give 12 units of insulin. I discussed need for fluids due to poor intake over the last few days by his family. I attempted to place an IV (intravenous) after RN obtained supplies. His veins were small, and were hard to palpate not bouncy, during insertion attempt could not get blood to return on one and other vein got blood return and then blew during flushing. Midline team was requested to start IV. Discussed with the RN to push 4 oz (ounce) of water and hr (hour) as tolerated for hydration up to eight 8oz cups of water if he can tolerate it. Give a 500 mL(milliliter) Bolus of NS (normal saline) 0.9% to help with hydration. To do BG (blood glucose) rechecks every two hrs and call with results per MD request. He was more responsive after the insulin dose. R3's January 2024 MAR (medication administration record) documents: Blood pressure check every morning one time a day for HTN (hypertension) with a start date of 1/26/24. Surveyor noted this is checked as being completed on the MAR but Surveyor was unable to locate daily blood pressure recordings in the MAR, under the vital/weight tab, or in R3's progress notes. Surveyor noted under the vital/weight tab for blood pressure there is a blood pressure on 1/20/24 6 days before this order and no other blood pressure was documented until 2/13/24 when R3 returned from the hospital. MD (Medical Doctor)-N's progress note dated 1/30/24 documents under the Assessments and Plans documents: Essential (primary) hypertension-Blood pressure was not being checked on a daily basis, was checked with verbal order yesterday by the nurse practitioner there was some waxes and wanes mainly with the diastolic blood pressure being low, amiloride. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's January 2024 MAR documents Report BG (blood glucose) q2hrs (every two hours) till normalized every shift for hyperglycemia for 2 days with a start date of 1/26/24. Surveyor documents under the vital/weight tab in R3's medical record it documents blood glucose levels on 1/26/24 at 0827 (8:27 a.m.) of 294 and at 1904 (7:04 p.m.) of 355. On 1/27/24 there are blood glucose documented at 1214 (12:14 p.m.) of 173 and at 2153 (9:53 p.m.) of 169. Surveyor was unable to locate blood glucose every two hour in R3's medical record. R3's January 2024 MAR documents: Push fluids, give 4 oz or more per hour, give up to 8, 8oz cuse sic (cups) of fluids for next 24 hrs. One time only for dehydration for 1 day with a start date of 1/26/24. There is no documentation of R3's fluid intake starting on 1/26/24 on the MAR or in R3's progress notes. There is one CNA (Certified Nursing Assistant) entry for fluid intake on 1/26/24 at 06:29 (6:29 a.m.) of 420 ml. There is no documented CNA fluid intake on 1/27/24. R3's January 2024 MAR documents Sodium Chloride Intravenous Solution (Sodium Chloride) Use 500 ml intravenously one time only for hypotension and hydration for 1 day unsupervised self administration. Give 500 mL bolus once, then push fluids Give 4 oz per hr up to 8, 8oz cups in 24 hrs. Mx (monitor) BP (blood pressure) and HR (heart rate) q (every) 4 hrs till tomorrow with a start date of 1/26/24. Surveyor noted under the vital/weight tab for blood pressure there is a blood pressure on 1/20/24 6 days before this order of 131/60 at 14:46 (2:46 p.m.) and not another blood pressure until 2/13/24 when R3 returned from the hospital of 126/75 at 23:12 (11:12 p.m.). There is no evidence R3's blood pressure was monitored every 4 hours in R3's January MAR or progress notes. Surveyor noted under the vital/weight tab for pulse there is a pulse of 80 bpm (beats per minute) on 1/20/24 at 1446 (2:46 p.m.) and after R3 returned from the hospital on 2/13/24 at 2312 (11:12 p.m.) Surveyor was unable to locate monitoring of R3's heart rate every 4 hours in R3's medical record. There is no documentation of R3's fluid intake starting on 1/26/24 on the MAR or in the progress notes. There is one CNA (Certified Nursing Assistant) entry for fluid intake on 1/26/24 at 06:29 (6:29 a.m.) of 420 ml. On 5/20/24 at 9:32 a.m. Surveyor met with DON (Director of Nursing)-B to discuss R3. Surveyor informed DON-B Surveyor had noted a change of condition on 1/26/24 with subsequent orders dated 1/26/24 to monitor R3's blood pressure every morning, to check blood glucose every two hours for two days, push fluids, and to check R3's blood pressure & heart rate every four hours until the next day. Surveyor informed DON-B the nurses initial this as being done but no blood pressure, heart rate or fluids are recorded in R3's medical record according to physician orders. Surveyor asked DON-B to look into this and get back to Surveyor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 11:44 a.m. Surveyor met with DON-B. Surveyor asked DON-B if she had any information on how staff were monitoring R3's blood pressure according to the orders dated 1/26/24. DON-B informed Surveyor they did not chart them explaining the NP (nurse practitioner) didn't know how to put the order into the system correctly for the nurses to put in the vital signs. DON-B informed Surveyor there are only initials with no results. Surveyor inquired about monitoring blood glucose every two hours for two days. DON-B informed Surveyor the order wasn't put in the system for the nurses to record the blood sugars. The nurses were signing it out but were not recording them. Surveyor ask about the order to push fluids. DON-B informed Surveyor there was one nurse who signed it out but they didn't chart the fluids and the ml (milliliters) taken wasn't put into the system. Surveyor inquired about monitoring R3's heart rate. DON-B informed Surveyor the order wasn't set up correctly. Surveyor asked DON-B who reviews Residents orders with MAR to ensure physician orders are being followed. DON-B informed Surveyor it is being monitored more closely now. 47094 2.) R9 was admitted to the facility on [DATE] and has diagnoses that include open wound of lower back and pelvis, Type 2 diabetes mellitus, chronic obstructive pulmonary disease, neuropathy, anemia, chronic kidney disease stage 3, major depressive disorder, muscle weakness, and squamous cell carcinoma of the skin with removal of masses in sacral area. R9's admission minimum data set (MDS) dated [DATE] indicated R9 had intact cognition with a brief interview for mental status (BIMS) score of 15 and the facility assessed R9 needing moderate assist with 1 staff member for toileting and personal hygiene. R9 was assessed to have a surgical wound and pressure injury on admission and at mild risk for pressure injuries with a Braden score of 17 on 12/14/2023. On 12/14/2023 at 13:59 (1:59 PM) in the progress notes director of nursing (DON)-B charted alert and orientated X3, resident came with wound vac to sacrum/buttocks, and has 3 cm X 3 cm (Length X Width X Depth) stage 2 to L (left) buttocks. Surveyor reviewed R9's admission wound assessment on 12/14/2023: 1. Left buttock wound 3 X 3 stage 2 2. Sacrum- wound vac Surveyor noted there was no comprehensive assessment of the surgical wound that the wound vac is covering. Surveyor reviewed R9's hospital discharge paperwork. R9 has a history of squamous cell carcinoma and had a mass removed and radiation treatments performed to R9's sacral area. On 11/24/2023 R9 had irrigation and debridement to the sacrum due to the area not healing and got an infection. The measurements documented on 11/24/2023 in the hospital were 6 cm X 4 cm X 2.5 cm and a wound vac was applied to encourage healing. (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 R9's medical chart and noted the facility did not have wound measurements or comprehensive assessment for R9's sacral surgical wound until wound medical doctor (MD)-F saw R9 on 12/19/2023. The comprehensive assessment for R9's sacral wound on 12/19/2023 performed by the wound MD-F was 4.3 X 2.6 X 1.8, 75% granulations tissue, 25%s slough, moderate amount of serous drainage. Treatment orders were to continue with wound vac. R9's surgical wound on the sacrum continued to be assessed weekly by Wound MD-F throughout R9's stay at the facility. On 5/14/2023 at 10:00 AM, Surveyor interviewed Wound Registered Nurse (Wound RN)-X who stated Wound RN-X is only in the facility on Tuesdays to does wound rounds with wound MD-F. Surveyor's asked wound RN-X what expectations are if a resident admitted with or areas of concern are noted when wound RN-X is not in facility. Wound RN-X stated nursing staff is to get an assessment of the area of concern with measurements, descriptions of the wounds, and initiate a care plan and any orders obtained from the physician and then the next wound rounds wound RN-X and wound MD-F will assess the area of concern. Surveyor asked wound RN-X's expectations if the area is covered and not visible. Wound RN-X stated the bandage should be removed, area assessed, and bandage reapplied per physician orders. On 5/15/2024 at 9:25 AM, Surveyor interviewed DON-B ho stated DON-B did not recall putting in the admission progress note for R9. Surveyor shared concerns with DON-B that R9's sacral surgical wound was not comprehensively assessed on admission (12/14/2023) until 12/19/2023 when wound care did rounds which was 5 days later. DON-B expressed understanding of the concern. No additional information was provided as to why the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices was provided for R3 & R9.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review, the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 3 (R3, R9, & R4) of 5 residents reviewed for pressure injuries. R3 was admitted to the facility on [DATE] with non-pressure areas. A Braden assessment was completed on date of admission which indicated R3 was at moderate risk for pressure injury development. The facility did not develop a skin integrity care plan until R3 developed an unstageable pressure injury on the sacrum. The skin integrity care plan interventions were not person centered. Licensed nursing staff were initialing two different treatments for the sacrum pressure injury at the same time. Weekly skin sheets were not being completed for R3. The facility was not monitoring R3's food, fluid, or repositioning. R3 was hospitalized on [DATE] and returned to the facility on [DATE]. When R3 returned to the facility, R3's sacrum pressure injury wasn't comprehensively assessed as there were no measurements, stage, or wound bed assessment. Data collection upon readmission was completed by an LPN. A comprehensive assessment was not completed until [DATE], one week later, when R3 was seen during wound rounds with Wound RN-X & Wound MD-F. On [DATE], Wound MD-F debrided R3's sacrum pressure injury, ordered a second antibiotic for wound infection, an appetite stimulant, and bed rest. On [DATE], R3 was admitted to the hospital with a necrotizing tissue infection. The facility's failure to provide care to prevent the development of pressure injuries and promote the healing of R3's pressure injuries, the failure to comprehensively assess, to develop and/or update resident's pressure injury care plans and monitor R3's fluid, food, and repositioning created a finding of Immediate Jeopardy (IJ) which began on [DATE]. NHA (Nursing Home Administrator)-A & DON (Director of Nursing)-B were notified of the immediate jeopardy on [DATE] at 4:14 p.m. The immediate jeopardy was removed on [DATE]. The deficient practice continues at a scope and severity of G (harm/isolated) related to the example involving R9 and as the facility continues to implement its action plan. *R9's left buttock pressure injury was not comprehensively assessed until five days after admission when the wound MD assessed this pressure injury as unstageable with slough. Upon admission the facility identified R9 as having a stage 2 pressure injury to the left buttock. The care plan initiated after admission did not include comprehensive, individualized interventions to prevent decline of R9's pressure injury. *R4's air mattress was not set according to R4's weight. R4's pressure injury declined from a Stage 2 to Stage 3. This was identified as actual harm. Findings include: The facility's Pressure Injury Prevention and Management policy implemented [DATE] documents under Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevention infection and the development of additional pressure ulcers/injuries. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Explanation and Compliance Guidelines documents: 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 4. Interventions for Prevention and to Promote healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Provide non-irritating surfaces; and v. Maintain or improve nutrition and hydration status, where feasible. 5. Monitoring a. The RN (Registered Nurse) Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. 1.) R3 was originally admitted to the facility on [DATE]. R3's POA (Power of Attorney) for healthcare was activated on [DATE]. R3's diagnoses include hypertension, atrial flutter, cirrhosis of liver, left below knee amputation, diabetes mellitus, peripheral vascular disease, congestive heart failure, and depression. The nurses note dated [DATE] at 23:36 (11:36 p.m.) documents: Patient arrived via stretcher from [Name] hospital [City] by [Ambulance Company] EMS (emergency medical services). Patient was very nice and pleasant, alert and oriented x (times) 3. Patient arrived with a condom catheter and boot to right foot. Patient is a left amputee and he had a boot on it. Patient's vitals were stable. Blood sugar was 489 @ (at) 2240 (10:40 p.m.) Patient skin check was clear with no wounds. Patient signed to be a full code. Patient has a consistent carb (carbohydrate) diet of ,d+[DATE] gm (grams)/meal with cardiac diet modifier. This nurses note was written by DON (Director of Nursing)-B. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The admission/readmission/routine head-to-toe evaluation dated [DATE] under the skin integrity section is checked for risk for skin alterations. For the question does the resident have any skin alterations? No is checked. This admission/readmission/routine head-to-toe evaluation was completed by DON-B. The Braden assessment dated [DATE] has a score of 15 which indicates moderate risk for pressure injury development. The facility did not develop a baseline skin integrity care plan. The late entry nurses note dated [DATE] at 08:53 (8:53 a.m.) and created on [DATE] at 0956 (9:56 a.m.) documents: Amendment to admission note. Resident is a recent amputee to the left leg with stitches still intact. Has a diabetic ulcer noted on the right foot and has MASD (moisture associated skin damage). This nurses note was written by DON-B. The nurses note dated [DATE] at 23:09 (11:09 p.m.) documents: Resident alert orientated times three complained of pain at hs (hour sleep) gave prn (as needed) dose of pain pill. Resident requires assist with ADLs (activity daily living) tolerates meds (medication) whole. Ate 100% of dinner with no issues noted. Adjusting well watching tv in room. Will monitor. This nurses note was written by Nursing-CC. The admission MDS (minimum data set) with an assessment reference date of [DATE] has a BIMS (brief interview mental status) score of 9 which indicates moderate cognitive impairment. R3 is assessed as requiring set up for eating, partial/moderate assistance to roll left and right, substantial/maximal assistance for chair/bed to chair and toilet transfer. R3 is assessed as always incontinent of urine and bowel. R3 is assessed as being at risk for pressure injuries and is assessed as having a pressure injury, one unstageable slough and/or eschar present upon admission. The pressure injury CAA (care area assessment) dated [DATE] under analysis of findings documents: Res (Resident) has unstageable to sacral area. Res is at risk for further skin alterations d/t (due to) impaired mobility and diabetes. On [DATE] at 9:46 a.m., Surveyor informed MDS/LPN-L Surveyor was unable to locate in R3's medical record the development of the unstageable sacral pressure injury until [DATE] which was after the assessment reference date and asked MDS/LPN-L how she determined R3 came into the facility with the pressure injury. MDS/LPN-L informed Surveyor someone would have given her the information and that someone would have had to tell her and it would have been on the wound log. Surveyor asked if Surveyor could see the wound log MDS/LPN-L was referring to. MDS/LPN-L informed Surveyor she doesn't have the wound log and would have gotten the wound log from Wound RN-X. Surveyor asked MDS/LPN-L to look into this and get back to Surveyor. On [DATE] at 10:08 a.m., MDS/LPN-L informed Surveyor it was her mistake with coding R3 as being admitted with an unstageable pressure injury. MDS/LPN-L informed Surveyor she will go back and modify the MDS. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	MD (Medical Doctor)-N's progress note dated [DATE], under review of systems for skin/breast documents: Positive: Open lesions. Negative: Changes in hair or nails, Changes in skin color, Swelling, Itching, Bruises, Rash, Mass. Notes: The resident has left below-knee amputation surgical wound is clear 16 cm (centimeters) x (times) 0.1 cm and also has a non pressure ulcer on the right plantar 2.5 x 2.5 x 0 unstageable 100% eschar with no abnormalities and no exude. The nutritional note dated [DATE] at 15:22 (3:22 p.m.) by Dietitian-DD documents: Nutritional Assessment: EMR (electronic medical record) reviewed. Code status CPR (cardiopulmonary resuscitation). PMH (present medical history) above. Resident able to make needs known. Renal diet appropriate d/t (due to) AKI (acute kidney injury) with hyperkalemia and elevated renal labs. He has had good appetite since admission and intakes. Noted L (left) BKA. No issues reported with NVDC (nausea, vomiting, diarrhea, constipation) nor indigestion documented. No additional swallowing problems noted on current diet. He is on pureed, renal, cho (carbohydrate), diet consuming ,d+[DATE]% at meals, eats with setup/independence. FLD (fluid) intakes of ,d+[DATE] ml (milliliter)/meal. Diet is adequate to meet EEN (exclusive enteral nutrition diet). Will recommend addition to 30 mL ProSource BID (twice daily) to aid in healing No pressure injuries noted. LBM (last bowel movement) ,d+[DATE] (+) UOP (urinary output). On diuretic therapy, anticipate weight fluctuations from fluid shifts and h/o (history of) edema. Hospital weight used d/t lack of weight in PCC (pointclickcare). DON/Administrator aware of weight discrepancies. The weekly wound assessment dated [DATE] for date of wound measurement date documents [DATE]. Under type of wound pressure is checked. Under the wound description section for site documents 53) sacrum, Type is Pressure, length in centimeters is 8.0, Width 7.0, Depth 0.1 and Stage Unstageable. Percentage of granulation is 50 and Percentage of slough is 50. Under the Other section for other comments/recommendations documents Wound noted to Sacrum Treatment ordered. Resident currently on air mattress. Will continue with repositioning every ,d+[DATE] hours. On [DATE], the facility completed an unavoidable pressure injury form dated [DATE]. This was completed by Wound RN-X and signed on [DATE]. Wound MD-F's signature is also on the form but not dated. Surveyor noted there is a handwritten notation of Wound MD in agreement, wound possible Kennedy ulcer. This is the only documentation of a Kennedy ulcer in R3's medical record. The nurses note dated [DATE] at 16:15 (4:15 p.m.) documents: MD called and updated on Sacral wound-Santyl ordered. Resident and wife aware. This nurses note was written by Wound RN-X. The resident has an ADL (activities daily living) self-care performance deficit r/t (related to) care plan initiated [DATE] includes interventions of: *Bed Mobility: The resident requires (SPECIFY what assistance) by (X) staff to turn and reposition in bed (SPECIFY FREQ (frequency)) and as necessary. Initiated [DATE]. *Eating: The resident requires (SPECIFY what assistance) by (X) staff to eat. Initiated [DATE]. *Toilet Use: The resident requires (SPECIFY assistance) by (X) staff for toileting. Initiated [DATE]. *Transfer: The resident requires (SPECIFY what assistance) by (X) staff to move between surfaces (SPECIFY FREQ) and as necessary. Initiated [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted in the spaces on the care plan where information should be specified for R3, it was blank and did not include the specific assistance or frequency of an intervention for R3. The resident has potential/actual impairment to skin integrity of the (SPECIFY location) r/t (related to) Initiated [DATE] which documents the following interventions: *Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Initiated [DATE]. *Encourage good nutrition and hydration in order to promote healthier skin. Initiated [DATE]. These care plans are not individualized and were not revised after implementation on [DATE]. Additionally, Surveyor noted areas of the care plan to specify locations of wounds were not completed for R3. The treatment order with a start date of [DATE] documents: Sacral area, clean with NSS (normal saline solution) and apply a foam dressing to area daily. One time a day for treatment. This treatment was discontinued on [DATE]. Review of R3's February 2024 treatment administration record reveals this treatment was completed daily from ,d+[DATE] to ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], blank on ,d+[DATE], ,d+[DATE], and blank on ,d+[DATE] & ,d+[DATE]. The treatment order with a start date of [DATE] documents: Santyl External Ointment 250 unit/gm (gram) (Collagenase) Apply to Sacral topically every day shift for wound care. Wash ,d+[DATE] strength Dakin's solution and pat dry. Skin prep peri wound. Apply Santyl to wound bed followed by Bordered gauze. This treatment was discontinued on [DATE]. Review of R3's February 2024 treatment administration record reveals this treatment was completed daily from ,d+[DATE] to ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], blank on ,d+[DATE], ,d+[DATE] and blank on ,d+[DATE] & ,d+[DATE]. Surveyor noted licensed nurses were initialing two different treatments as being completed for R3's sacral pressure injury. The weekly wound assessment dated [DATE] for date of wound measurement documents [DATE]. Under type of wound pressure is checked. Under the wound description section for site documents 53) sacrum, Type is Pressure, length in centimeters is 7.1, Width 6.5, Depth 0.1 and Stage Unstageable. Percentage of granulation is 25 and Percentage of slough is 75. The Other section for other comments/recommendations is blank. R3 was hospitalized on [DATE] and readmitted back to the facility on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 00:30 (12:30 a.m.) documents: Patient was lethargic and unresponsive to questions and commands. Patient had a time where he appeared to have apnea and I had to shake him. Vital signs were b/p (blood pressure) ,d+[DATE], temp 97.7, O2 (oxygen) 95%, RR (respiration rate) 17, pulse 78. I called the doctor and asked to have him sent to the ER (emergency room), approval was granted. I called for follow up @ (at) 0015 (12:15 a.m.) and he was admitted with a UTI (urinary tract infection) and AKI (acute kidney injury). This nurses note was written by Nursing-EE. The admission/readmission/routine head-to-toe evaluation dated [DATE] under the skin integrity section is checked for risk for skin alterations. For the question does the resident have any skin alterations? Yes is checked. For the generic body diagram for site documents 53) sacrum and under description documents open area. Under diagnoses for d. Skin risk care plan: is checked for Focus: The resident has potential/actual impairment to skin integrity of the (SPECIFY location) r/t Focus: The resident has potential/actual skin impairment to skin integrity of the (SPECIFY location r/t Goal: The resident will maintain or develop clean and intact skin by the review date. Intervention: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Intervention: Encourage good nutrition and hydration in order to promote healthier skin. Surveyor noted areas of the care plan to specify locations of wounds were not completed for R3. R3's sacrum open area was not comprehensively assessed as there are no measurements, stage, or description of the wound bed & peri wound. This assessment was completed by LPN (Licensed Practical Nurse)-BB. The Braden assessment dated [DATE] has score of 14 which indicates moderate risk for pressure injury development. The nurses note dated [DATE] at 23:17 (11:17 p.m.) documents: Patient appears lethargic, took couple bites of supper took little fluids. Took medication and was able to answer some questions. VSS (vital signs stable) area to sacral area remains. This nurses note was written by LPN-BB. On [DATE], R3 started receiving Bactrim DS oral Tablet ,d+[DATE] mg with directions to give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 7 days with a discontinue date of [DATE]. The nurses note dated [DATE] at 22:22 (10:22 p.m.) documents: Alert and oriented. No c/o (complaint of) pain or discomfort. ABT/UTI (antibiotic/urinary tract infection). Fluids encouraged. No adverse reaction noted. This nurses note was written by RN-FF. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The weekly wound assessment dated [DATE] for date of wound measurement documents [DATE]. Under type of wound, pressure is checked. Under the wound description section for site documents 53) sacrum, Type is Pressure, length in centimeters is 7.2, Width 7.0, Depth 3.0 and Stage Unstageable. Percentage of granulation is 25 and Percentage of slough is 75. For risk factors undermining is checked. Undermining (describe in reference to clock location in cm) documents ,d+[DATE] at 6.3 cm. The Other section for other comments/recommendations is blank. Surveyor noted this comprehensive pressure injury assessment is 7 days after R3 was readmitted back to the facility. Wound MD-F's assessment of R3's sacral pressure injury on [DATE], prior to debridement, was length 9.55 cm, width 7.95 cm, and depth 0.10 cm. Etiology is Pressure Ulcer Unstageable. Wound bed assessment is slough ,d+[DATE]%. Odor is normal odor. Wound MD-F's assessment of R3's sacral pressure injury on [DATE] post debridement documents: length 8. 77 cm, width 7.22 cm, and depth 3.00 cm. Etiology is pressure ulcer Unstageable. Wound bed assessment is Slough ,d+[DATE]%, drainage amount is documented as small, drain description is serous, odor is normal odor, and periwound is indurated. Under notes documents Undermining ,d+[DATE] o'clock: 6.3 cm, CBC (complete blood count), CMP (comprehensive metabolic panel) [DATE], Prealbumin level now and in three weeks (may draw on [DATE]), bed rest please, and Keflex 500 mg (milligram) PO (by mouth) TID (three times a day) x 2 weeks. The nurses note dated [DATE] at 15:06 (3:06 p.m.) documents: Seen by in house wound MD Sacral wound debrided. Labs ordered, ATB to be started, bed rest, and supplement ordered. Wife at bedside and aware of orders. Primary MD aware. This nurses note was written by Wound RN-X. On [DATE], R3's sacral pressure injury treatment changed to: Cleanse sacral wound with ,d+[DATE] strength Dakin's solution and pat dry. Skin prep peri wound. Pack wound with ,d+[DATE] strength Dakin's moistened kerlix. Pack kerlix to undermining ,d+[DATE] at 6.3 cm Followed by Bordered gauze. Every day and evening shift for wound care. Surveyor reviewed R3's February treatment administration record and noted the treatment for R3's sacral pressure injury is initialed as being completed except on ,d+[DATE] when the day treatment is blank and on , d+[DATE] when the day & evening treatments are blank. On [DATE], R3's order for Bactrim DS oral tablet ,d+[DATE] mg with directions to give 1 tablet by mouth two times a day for UTI was extended until [DATE]. Surveyor noted a second antibiotic was ordered on [DATE] for Keflex oral capsule 500 mg with directions to give 500 mg by mouth three times a day for wound infection until [DATE]. NP (nurse practitioner)-O's progress note dated [DATE] under assessment and plans includes documentation of Diabetes mellitus due to underlying condition with hyperglycemia. BG (blood glucose) is elevated may be due to wound debridement by wound care. He had a sacral abscess. He is currently on oral antibiotics and tolerating them well. [Wound MD-F] with W/C (wound care) is following. Labs are pending per W/C RN. Will continue to mx (monitor) for now. He was placed on supplements to help with healing. Bactrim DS is ordered BID (twice daily). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 15:02 (3:02 p.m.) documents: Spoke with wife regarding wound MD orders again from yesterday. Explained awaiting culture results and lab results to see if another ATB will be needed. Spoke about resident's poor appetite-wound MD updated and will start on Remeron for appetite stimulate. Wife would not give consent for Foley Catheter to be inserted. Wife aware of Remeron order. This nurses note was written by Wound RN-X. The nurses note dated [DATE] at 15:34 (3:34 p.m.) documents: Resident remains on Keflex for infection, no adverse effects noted. Will continue to monitor. This nurses note was written by Nursing-GG. The nurses note dated [DATE] at 16:35 (4:35 p.m.) documents: Resident currently receiving Bactrim and Keflex, no a/r (adverse reactions) to ABT, VSS, afebrile, no c/o pain or discomfort, no a/r to N.O (new order) for Remeron, tolerating well, currently resting in his bed, will continue to monitor. This nurses note was written by Nursing-HH. The nurses note dated [DATE] at 14:51 (2:51 p.m.) documents: Resident continues on antibiotics for sacral wound infection, no adverse reaction noted. V/S WNL (vital signs within normal limits,) no c/o pain noted Dressing clean, dry, and intact. Continue to monitor. This nurses note was written by LPN-II. The nurses note dated [DATE] at 19:45 (7:45 p.m.) documents: Resident was lethargic with altered mental status. VS: BP ,d+[DATE] HR (heart rate) 101 T (temperature) 97.9, RR 16 O2 Sats 88%. Writer administered 2L (liters) of O2 via nasal cannula O2 sats increased to 94%, Writer called Dr. no response. Writer called DON and discussed residents condition. Writer asked to send resident to hospital to be evaluated, writer got the ok, resident was transported to [hospital name] medical center by ambulance at approximately 1930 (7:30 p.m.). This nurses note was written by Nursing-GG. The nurses note dated [DATE] at 00:54 (12:54 a.m.) documents: Patient admitted to [hospital name] r/t necrotizing tissue infection. This nurses note was written by RN-U. The e-mar (electronic medication administration record) dated [DATE] at 07:29 (7:29 a.m.) documents wound infection. This was written by LPN-II. On [DATE], Surveyor requested and received CNA documentation for fluid intake, meal consumption, and turning & repositioning for the time period when R3 resided at the facility as Surveyor is unable to review this information in R3's medical record. The fluid intake is documented as follows: [DATE] at 8:23 p.m. 120 ml. [DATE] at 9:10 p.m. 120 ml. [DATE] at 8:39 p.m. 240 ml. [DATE] at 8:53 p.m. 280 ml. [DATE] at 6:29 a.m. 420 ml. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 8:19 p.m. 300 ml. [DATE] at 10:29 p.m. 240 ml R3 was hospitalized on [DATE] & returned on [DATE]. [DATE] at 9:57 p.m. 60 ml. [DATE] at 9:42 p.m. 60 ml [DATE] at 4:35 p.m. 60 ml. Percentage of meal consumed is documented as follows: [DATE] at 9:11 p.m. 100%. [DATE] at 8:39 p.m. 100%. [DATE] at 8:52 p.m. 50%. [DATE] at 10:57 a.m. 100%. [DATE] at 9:48 a.m. 100%. [DATE] at 9:56 a.m. & 8:12 p.m. 100%. [DATE] at 6:00 p.m. 100% R3 was hospitalized on [DATE] and returned on [DATE]. [DATE] at 10:00 p.m. 25%. [DATE] at 6:00 p.m. 20%. Turned & Repositioned for the question did you turn & reposition is documented as follows: [DATE] at 8:23 p.m. yes. [DATE] at 5:00 p.m. yes. [DATE] at 5:07 p.m. yes. [DATE] at 6:29 a.m. yes. [DATE] at 9:48 a.m. yes. [DATE] at 9:58 a.m. & 8:16 p.m. yes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 4:57 p.m. yes. R3 was hospitalized on [DATE] and returned on [DATE]. [DATE] at 9:57 p.m. yes. [DATE] at 2:29 p.m. & 9:42 p.m. yes. [DATE] at 4:34 p.m. yes. On [DATE] at 9:30 a.m., Surveyor met with Wound RN (Registered Nurse)-X. Surveyor asked Wound RN-X about the process for when a resident is admitted regarding their skin integrity. Wound RN-X informed Surveyor the admitting nurse does the body check, any wounds that are identified are documented and they will follow the discharge orders until they are seen by herself and Wound MD-F. Surveyor asked Wound RN-X how she became aware of R3's pressure injury on [DATE]. Wound RN-X informed Surveyor the nurse or the CNA came to get her. Wound RN-X explained ,d+[DATE] was a Thursday. This is the day she goes to [name of sister facility] but came back here to chart. Surveyor asked Wound RN-X why R3's sacral pressure injury wasn't discovered until it was unstageable. Wound RN-X replied, I have no answer for you and stated this was the first time she saw it. Wound RN-X informed Surveyor R3 was not eating good and Wound MD-F did sign a form, referring to the unavoidable pressure injury form. Surveyor asked Wound RN-X why there wasn't a comprehensive pressure injury assessment on [DATE] when R3 returned to the facility. Wound RN-X informed Surveyor she didn't see R3 until ,d+[DATE]. Wound RN-X informed Surveyor R3 may have been admitted after they completed wound rounds. Surveyor asked Wound RN-X who would have been responsible for completing a comprehensive assessment when R3 returned. Wound RN-X informed Surveyor it would be the admission nurse to follow up on the measurements and orders, stating she should have put measurements in. Surveyor asked Wound RN-X if the wound bed should have been described. Wound RN-X replied yes. Wound RN-X informed Surveyor when they saw R3's pressure injury on [DATE] Wound MD-F debrided the pressure injury, cultured the area and the wife didn't want a Foley stating, I know we asked about that, referring to the use of a Foley catheter. Wound RN-X informed Surveyor R3 had an air mattress and was being seen by therapy. Wound RN-X informed Surveyor R3 may not have been getting enough protein and that R3 liked to lay on his back but they did reposition him. Surveyor asked Wound RN-X who is responsible for a resident's skin integrity care plan. Wound RN-X informed Surveyor they are all responsible as they all work together. Surveyor informed Wound RN-X R3's skin integrity care plan was not implemented until he had the unstageable Pressure injury on [DATE]. Wound RN-X replied I'm sure that's not correct, looked at R3's electronic medical record and then stated yes, that's when she started it. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:00 p.m., Wound MD-F spoke to Surveyor about R3's pressure injury. Wound MD-F informed Surveyor he only saw R3 on [DATE]. Wound MD-F informed Surveyor the pressure injury had 100% slough, the touch was boggy, liquid breaking down tissue, & was possibly infected. Wound MD-F informed Surveyor he debrided the wound and culture it and ordered labs. Surveyor inquired if the labs were done. Wound MD-F informed Surveyor he didn't see the labs and the culture came back after R3 was in the hospital. Wound MD-F informed Surveyor he ordered stat CBC, Prealbumin now & three weeks but doesn't think that was done. Wound MD-F informed Surveyor R3 was on prostat BID, R3 was not eating well, and right before R3 went to the hospital he had a UTI. Wound MD-F informed Surveyor R3's pressure injury may have been a Kennedy ulcer. Surveyor informed Wound MD-F Surveyor has concerns that a skin integrity care plan wasn't developed until after R3 developed the unstageable pressure injury, when R3 returned from the hospital there was not an assessment until a week later when R3 was seen on wound rounds, and the nurses were signing for two treatments for the sacrum. Wound MD-F informed Surveyor he couldn't address this. On [DATE] at 7:44 a.m., Surveyor asked LPN-AA about R3. LPN-AA informed Surveyor she didn't see him too much as she works third shift and R3 was in & out of the hospital. Surveyor asked LPN-AA if R3 ever refused anything from her. LPN-AA replied no, he never refused, pretty much slept. On [DATE] at 7:47 a.m., Surveyor spoke to CNA (Certified Nursing Assistant)-K regarding R3. CNA-K informed Surveyor she went in to change him, got R3 cleaned up and found the bed sore. CNA-K informed Surveyor she notified the nurse he had a big old bed sore. CNA-K informed Surveyor she had been off for a couple of days and when she came back that's when she found the bed sore. Surveyor asked if R3 got out of bed. CNA-K informed Surveyor he would get out of bed but would scream because of his butt, he never stayed up long and wanted to go back to bed. CNA-K informed Surveyor she had to reposition him off his wound and he would let them reposition him as long as he was off his wound. Surveyor asked if R3 would eat & drink. CNA-K informed Surveyor R3 wasn't a big eater or drinker. Surveyor inquired if R3 had to be fed. CNA-K informed Surveyor sometimes he would eat himself and other times they had to feed him. On [DATE] at 7:53 a.m., Surveyor spoke with CNA-JJ regarding R3. CNA-JJ informed Surveyor R3 was a pleasant man, always in pain, and was in & out of the hospital. CNA-JJ informed Surveyor every once in a while R3 had to be fed and as far as his cares he pretty much let them do him. Surveyor asked CNA-JJ if R3 would allow them to reposition him. CNA-JJ replied yes and explained a lot of times he wanted the pillow out, it was back & forth as he was uncomfortable. Surveyor asked CNA-JJ if she remembered when R3 developed the pressure injury on his sacrum. CNA-JJ replied, I don't remember. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:23 a.m., Surveyor met with DON-B to discuss R3. Surveyor asked DON-B who is involved in the care plan process. DON-B informed Surveyor social worker, activities, and nursing management are part of the care plan process. Surveyor asked about R3's ADL care plan. DON-B informed Surveyor it's generated from the head-to-toe admission once it's completed and locked. DON-B informed Surveyor it's her job, her unit managers, or nursing staff to put in the exact information. Surveyor informed DON-B the care plan was not updated as it doesn't indicate how R3 is transferred, his bed mobility, etc. DON-B replied, I understand. Surveyor asked about R3's skin integrity care plan explaining the interventions are not person centered and are the interventions from the admission/readmission head to toe assessment. DON-B informed Surveyor she hadn't gotten to the care plan yet and doesn't have a better answer. Surveyor asked why the nurses were initialing that two different treatments were being completed for the sacrum. DON-B informed Surveyor she will have to follow up with Wound RN-X about this. Surveyor asked DON-B why there wasn't a comprehensive assessment of R3's pressure injury when he was readmitted on [DATE]. DON-B informed Surveyor this was addressed in a facility performance improvement plan (PIP.) Surveyor informed DON-B Surveyor has serious concerns regarding the facility's assessment and treatment of R3's sacrum pressure injury. On [DATE] at 9:17 am., Surveyor asked NHA (Nursing Home Administrator)-A and DON-B where Surveyor would be able to locate weekly skin checks. NHA-A informed Surveyor they are in PCC (PointClickCare) under the evaluation tab. Surveyor asked NHA-A if they aren't under this tab where would Surveyor be able to find them. NHA-A informed they may be on paper. Surveyor informed NHA-A and DON-B Survey

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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** 22692 Based on observation, interview, and record review the facility did not have identified safety devices/supervision in place for preventing falls/accidents or incidents requiring increased supervision for 2 (R4 and R6) of 2 residents reviewed for safety/supervision. * R4 was observed to be left unattended in bed, with the floor mats not in place to both sides of her bed per her plan of care. * R6 exhibited agitated and sexually inappropriate behavior and was not supervised closely enough to prevent future inappropriate behaviors. Findings include: 1.) R4 was admitted to the facility on [DATE] with diagnoses that included Anoxic Brain Damage and Coma. R4 is unable to make her needs known. On 5/13/24, R4's Current care plan for Risk for Falls dated 6/23/23 was reviewed and documented: Intervention- Fall mats to bilateral sides of floor with a start date of 3/2/24. On 5/14/24 R4's current CNA care sheet was reviewed and documented: Fall mats (sic) to bilateral sides of the floor, R4'fall risk assessment dated [DATE] documented that R4 was at moderate risk for falls. Surveyor noted that this assessment was the most recent evaluation of falls for R4. R4's progress notes dated 2/26/24 at 6:41 PM and written by Licensed Practical Nurse (LPN)-NN documented: was walking down the hall and noticed (R4) wasn't in bed. She had slid off of the right side of the bed. This writer got help from the CNA and other nurse to assist back into bed. Resident had a dark brown emesis x (times) 2. No visible bruising or abrasions. Nurse manager assessed and decided to send resident out for evaluation. The hospital records indicated that R4 probably had a seizure that caused the fall and the floor mats to each side of the bed were added as an intervention. On 5/13/24 at 9:00 AM R4 was observed in bed and no floor mats on either side of her bed. On 5/13/24 at 12:30 PM R4 was observed in bed and no floor mats on either side of her bed. On 5/13/24 at 2:00 PM R4 was observed in bed and no floor mats on either side of her bed. On 5/14/24 at 8:00 AM R4 was observed in bed and no floor mats on either side of her bed. On 5/14/24 at 11:00 AM, R4 was observed in bed and no floor mats on either side of her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nurses (DON)-B was brought into R4's room and indicated floor mats should be on each side of R4's bed according to her care plan. Certified Nursing Assistant (CNA)-D, who was assigned to R4, was also in the room and indicated he was unaware R4 was suppose to have floor mats to each side of her bed. On 5/14/24 at 3:00 p.m., Surveyor informed Administrator-A and Director of Nurses-B of the above findings. Surveyor asked if there was any additional information available. None was provided. 20483 2.) R6 was admitted to the facility on [DATE] with diagnoses including dementia, congestive heart failure, atrial fibrillation, anxiety, and hypertension. On 2/22/24 R6 was diagnosed with Bipolar Disorder. R6 has an activated power of attorney for healthcare. The resident is at risk for falls, accidents and incidents care plan initiated 10/31/23 & revised on 11/17/23 documents the following interventions: * Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 10/31/23. * Follow facility fall protocol. Initiated 10/31/23. * Anticipate and meet the resident's needs. Initiated 2/26/24. * Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. Initiated 2/26/24. The quarterly MDS (minimum data set) with an assessment reference date of 2/3/24 has a BIMS (brief interview mental status) score of 5 which indicates severe cognitive impairment. R6 is assessed as having verbal behavior one to three days during the assessment. Behavior has not been exhibited for physical, wandering and refusal of care. R6 is assessed as being independent for eating, toilet hygiene, rolling left & right, chair/bed to chair & toilet transfer and ambulation. The IDT (interdisciplinary team) note dated 12/22/23 at 22:59 (10:59 p.m.) documents Team met to discuss resident to resident altercation. Resident had gotten loud and yelled at another resident up on the dementia unit to get out of his room. Other resident did not move and then it was witnessed seeing him place the other resident in the large cushioned chair in his room. Other resident still seemed upset by this female resident being in his room and so CNA (Certified Nursing Assistant) helped female resident leave room and took her to her own room. Resident calmed down and went to sleep. Care plan reviewed and updated for psych consult related to resident seeming more agitated than usual the past few days. As well as if seeing resident upset to provide quite place for him to deescalate. Stop sign placed for resident to be able to put up when he does not want company in his room. This note was written by DON (Director of Nursing)-B. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 12/23/23 at 03:48 (3:48 a.m.) documents Res (Resident) was seen yelling and grabbed another res by her shoulders that res then fell into a chair causing her to hit her head when she fell into the chair. Staff seen (sic) and heard the incident and intervene (sic) immediately, moving the other res to her own room. Writer assessed both res who were confused at what had just occurred. MD (Medical Doctor), POA (Power of Attorney) and DON (Director of Nursing) aware. Will continue to monitored and keep res away from the other res. This nurses note was written by LPN (Licensed Practical Nurse)-KK. There were no revisions in R6's at risk for the falls, accidents, and incidents care plan or any other care plans & no care plans were developed to increase R6's supervision after the resident to resident altercation on 12/22/23 until 2/19/24 when the Facility developed a behavior care plan. The nurses note dated 2/17/24 at 07:03 (7:03 a.m.) documents: Res noted asking staff for sexual favors and telling staff he's willing to give money. Writer told res it was inappropriate to talk like that and can he stop, he agreed. But an hour later he was talking to another staff member asking for favors again. Stated he's looking for a companion and he's lonely. This was written by LPN-KK. The nurses note dated 2/17/24 at 15:11 (3:11 p.m.) documents: Rsdt (resident) soliciting staff for sex in exchange for money $100. Writer informed Rsdt that offers were inappropriate and to stop solicitations of staff. Rsdt [initials] also repeatedly entered another Rsdts [(room number)] to fraternize with her, AEB (as evidenced by) sitting on the bed touching each other in an affectionate manner while Rsdt [initials] was lying next to him. Rsdt [initials] would become hostile and agitated when writer asked Rsdt to leave, saying What am I doin' wrong?! and I'm just starting a relationship with the woman!. [initials] showed no signs of distress, no screaming, yelling, or calling out of any kind, no struggling or resisting were observed by writer or reported by staff. DON aware, Rsdt placed on 24 hr (hour) board for closer monitoring. This nurses note was written by LPN-W. The nurses note dated 2/18/24 at 20:25 (8:25 p.m.) documents: Writer informed by CNA that Rsdt [initials] hugged and tried to kiss another female Rsdt [(initials & room number)]. Writer spoke to both [R6's initials] and [R7's initials] separately alone regarding incident. [R7's initials] said she felt uncomfortable but expressed that he quickly lost interest when she told him she was married. Writer strongly advised Rsdt [R6's initials] to stop inappropriately accosting female Rsdt's and staff. Staff informed to continue to closely monitor [R6's initials]. DON aware. NP (Nurse Practitioner)-O's progress note dated 2/19/24 under history of present illnesses includes documentation of [R6's initials] is a 73 y/o (year old) male seen today for HTN (hypertension) and report of sexually aggressive behavior by DON. DON explained that on NOC (night) shift the patient was seen in two other patients rooms. One patient was kissed and the other patient shoulder was being rubbed. I did no sic (not) observe this personally. She said he was making sexual comments to staff before this event. Pt has moderate to severe dementia, and aggressive outbursts, wandering, elopement attempts, and pushing other residents that have been reported before today . The nurses note dated 2/19/24 at 18:38 (6:38 p.m.) documents: Resident being monitored 1:1 today. No inappropriate behaviors. Labs and UA (urinalysis) ordered. This nurses note was written by LPN-T. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has a behavior problem (sexually inappropriateness) r/t cognitive impairment care plan initiated 2/19/24 & revised 5/15/24 with an intervention also dated 2/19/24 & revised 5/15/24 of 1:1 supervision. Staff member completing 1:1 supervision should update nurse to anything inappropriate and intervene with peer safety. The nurses note dated 2/21/24 at 06:46 (6:46 a.m.) documents: Res remains on 1:1 for sexual behavior, noted exposing self to staff and asking staff Can I be your boyfriend. Res was redirected several times throughout shift. This nurses note was written by LPN-KK. The nurses note dated 2/22/24 at 05:38 (5:38 a.m.) documents: Resident being monitored 1:1 for sexual behaviors. Resident attempting to push female resident who was sitting in w/c (wheelchair) down the hall x (times) 2. Staff asked resident to allow staff to push resident back by staff, and shortly after, assisted her into bed. Resident becoming aware that he is being monitored and is being increasingly agitated. DON and administrator aware. This nurses note was written by LPN-T. On 5/13/24 at 1:37 p.m. Surveyor spoke to CNA (Certified Nursing Assistant)-LL about R6. CNA-LL informed Surveyor R6 could be agitated at times and wandered picking up a lot of things that didn't belong to him. Surveyor asked CNA-LL to tell Surveyor about R6's wandering. CNA-LL informed Surveyor R6 would go into Resident's rooms looked around and if the Resident was in the room R6 would talk to them. CNA-LL informed Surveyor a Resident in room [number] stated R6 tried to kiss her and then R6 was moved downstairs. CNA-LL informed Surveyor R6 wandered on the 2nd & 3rd shift and not so much on the 1st shift. On 5/13/24 at 1:41 p.m., Surveyor asked CNA-MM if R6 wandered into other Resident's rooms. CNA-MM informed Surveyor not in the morning but heard he was doing it most of the time when Residents were sleeping. On 5/14/24 at 10:24 a.m., Surveyor asked SW (Social Worker)-I what could she tell Surveyor about R6. SW-I informed Surveyor when R6 first got to the facility he wanted to leave and then calmed down. SW-I explained R6 didn't have any behaviors and then kind of changed over night. SW-I explained R6 started to be curt and make more sexual comments. Surveyor inquired if R6 wandered into other Resident's rooms. SW-I replied yes he did, the unit was very aware and controlled R6. Surveyor asked SW-I how the staff controlled R6. SW-I replied redirected him, he was redirectable. Surveyor asked about R6's resident to resident altercation in December and inquired how they were supervising R6. SW-I informed Surveyor she would have to read her notes. Surveyor then read R6's December nurses notes to SW-I. SW-I replied that would be a resident that wandered, she has since passed and stated the name to Surveyor. SW-I informed Surveyor they discussed the incident in a meeting. Surveyor inquired what was done to supervise R6 and prevent an incident from occurring in the future. SW-I informed Surveyor the staff on the unit are very aware of R6 and watch R6 to redirect R6. Surveyor asked SW-I if she would be involved with revising R6's care plan. SW-I replied yes or maybe the DON (Director of Nursing) put in an update. On 5/14/24 at 11:40 a.m., Surveyor spoke with LPN (Licensed Practical Nurse)-W on the telephone. Surveyor asked if R6 wandered into other Residents rooms. LPN-W replied yes but that's not unique. LPN-W explained this is a dementia unit and they have multiple Residents who wander into other Resident's rooms. LPN-W informed Surveyor on the dementia unit behaviors are the norm. Surveyor asked LPN-W about his 2/17/24 & 2/18/24 nurses notes and asked if DON-B gave him any instructions on how R6 should be supervised after these incidents. LPN-W informed Surveyor he doesn't recall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1:37 p.m., Surveyor met with DON-B to discuss R6. DON-B informed Surveyor R6 is now very pleasant, walks around talking to people and goes to activities. DON-B explained when R6 first came he insisted on going back to his girl and then kind of acclimated to the Facility. DON-B informed Surveyor R6 had bouts of agitation, didn't want anyone to go in his room at that time. Surveyor asked if there were any issues with R6 wandering. DON-B informed Surveyor R6 would wander in and out of rooms when he was upstairs. Surveyor asked DON-B after R6's incident with another Resident on 2/17/24 what did staff do to prevent another incident. DON-B replied I know they were monitoring closely. Surveyor inquired what monitoring closely meant. DON-B explained keeping R6 in their eye sight. Surveyor asked if staff was keeping R6 in their eye sight how did he have the incident on 2/18/24 with R7. DON-B informed Surveyor she would have to speak with staff cause she knew they were doing eye distance so not to aggravate R6. DON-B informed Surveyor then R6 was placed on 1 to 1. No additional information was provided as to why the facility did not have identified safety devices/supervision in place for preventing falls/accidents or incidents requiring increased supervision for R4 and R6.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on record review and interview, the facility did not ensure 1 (R9) of 3 residents reviewed received appropriate services related to catheter care and/or fecal incontinence with constipation to prevent urinary tract infections and to restore normal bowel function as possible. R9 had a Foley catheter placed and did not have a comprehensive care plan or orders for care or monitoring of the Foley catheter. R9 developed 2 urinary tract infections. R9 was assessed as being incontinent of bowel on admission and had concerns with constipation and loose stools. R9 did not have a comprehensive care plan for bowels and did not have monitoring or a toileting program to maintain continence and R9 became incontinent of bowel. Findings include: The facility policy entitled, Indwelling Catheter Use and Removal implemented on 10/20/2023 states: It is policy of this facility to ensure that indwelling catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice. Compliance Guidelines: . 3. The facility will conduct ongoing assessments for residents at risk for urinary catheterization or on residents with indwelling catheters to determine if the catheter needs to be continued or removed if the catheter is no longer necessary. 4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: . b. Timely and appropriate assessments related to the indication for use of an indwelling catheter. c. Identification and documentation of clinical indications for the use if the catheter as well as criteria for discontinuation of the catheter when the indication for use is no longer present. d. Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. e. Response of the resident during the use of the catheter. f. Ongoing monitoring for changes in condition related to potential catheter associated urinary tract infections, recognizing, reporting, and addressing such changes. 8. Catheters and drainage bags should be changed based on clinical indications such as infection, obstruction, or when the closed system is compromised . The facility policy entitled Incontinence, implemented on 10/20/2023 states: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines: 1. The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, service, and assistance to maintain continence unless his or her clinical condition is or becomes that continence is not possible to maintain. 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. R9 was admitted to the facility on [DATE] with a diagnoses that include open wound of lower back and pelvis, Type 2 diabetes mellitus, chronic obstructive pulmonary disease, neuropathy, anemia, chronic kidney disease stage 3, major depressive disorder, muscle weakness, and squamous cell carcinoma of the skin. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R9's Admission Minimum Data Set (MDS) dated [DATE] documents that R9 has intact cognition with a brief interview for mental status (BIMS) score of 15 and the facility assessed R9 as needing moderate assist with 1 staff member for toileting and personal hygiene. The facility did not assess bowel continence for R9 and indicated R9 had an indwelling catheter. Surveyor reviewed R9's discharge paperwork from the hospital. Per a therapy assessment of R9 dated 11/24/2023, R9 was assessed as using a toilet with assistance at baseline, R9 was able to pull clothes down and up, and R9 stated R9's wife assisted with pericare. R9's head to toe assessment completed on 12/14/2023 documented that R9 was continent of bladder and bowel. On 12/15/2023 at 8:16 AM, nursing documented: .uses urinal during NOC (night/3rd) shift with staff assistance. On 12/15/2023 at 16:14 (4:14 PM) nursing documented: new order for Foley for wound protection. On 12/15/2023 at 16:35 (4:35 PM)nursing documented: foley inserted with no issues. Foley intact and patent, flowing clear yellow urine. Continue to monitor. On 12/16/2023 at 13:13 (1:13 PM) Director of Nursing (DON)-B documented: bladder evaluation summary: Resident currently has a catheter. Bowel Evaluation Summary: Continent of bowel . R9's medical record did not have physician orders for catheter care and no orders/treatment details to indicate what size of catheter or when to change R9's catheter/catheter bags and there were no orders for monitoring/caring for the catheter insertion site. Surveyor reviewed R9's care plan and noted there was no comprehensive care plan for R9's catheter use. On 12/18/2023 at 10:32 AM, nursing documented: noted scant amount hematuria (blood in the urine) in Foley. NP (nurse practitioner) gave new order for UA (urinalysis). On 12/21/2023 the NP (nurse practitioner) documents: UA results positive for candida . urinary tract infection . patient will complete Augmentin 875/125 twice a day (antibiotic for wound infection) on 12/22/2023. Resident currently has UTI with Candida. Plan to treat on 12/26/2023 after discussing with wound doctor course of antibiotic. Surveyor noted that there were still no orders for catheter care/monitoring, or a care plan initiated for R9's Foley catheter. On 12/26/2023, another UA was ordered to rule out contamination. On 12/29/2023 in the progress notes, NP documents: .seen today for follow up with UA. Discussed to start Fluconazole 200 mg qd (every day) for confirmed UTI with Candida until 1/17/2024. Resident denies problems with Foley. Urine is amber and some white sediment in line . (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that R9's Fluconazole medication was not started until 1/3/2024 with the following order: Fluconazole Oral Tablet 200 MG (Fluconazole) - Give one tablet by mouth in the morning for UTI with Candida for 14 days (start: 1/3/2024, discontinue (D/C): 1/14/2024). Surveyor noted that there were still no orders for catheter care/monitoring, or a care plan initiated for R9's Foley catheter. On 1/12/2024 at 10:55 AM in the progress notes, nursing charted: Resident noted to be confused this am. Medical doctor (MD) here with NP and assessed resident. STAT (right away) lab orders in place but lab will not be leaving due to weather. Order to send to ER (emergency room). Ambulnz (sic) called . and picked up at 11:22 AM to [Hospital name]. On 1/12/2024 at 21:53 (9:53 PM) in the progress notes, nursing charted: returned to the facility approx. 1700 (5:00 PM). To start BACTRIM twice daily for 14 days for UTI. First dose given today. On 1/22/2024 in the progress notes, NP documents: .For UTI resident is taking Bactrim DS with end date 1/26/2024. Foley has amber colored urine with white sloff (sic) coated on tubing, was placed for wounds and incontinence. Surveyor noted R9 was noted to be continent upon admission to the facility and there were still no orders for catheter care/monitoring, or a care plan initiated for R9's Foley catheter. On 2/10/2024 at 13:40 (1:40 PM) in the progress notes, nursing charted resident was complaining of bladder pain and no urine output, Writer changed catheter, output was 950 cc. Resident stated felt relief. MD was notified and aware of foley change and output. Surveyor noted that MD was notified after nurse changed out R9's foley and there still are no orders regarding monitoring or care for R9's foley catheter or indication what size of catheter to use. On 5/14/2023 at 1:21 PM, Surveyor interviewed Wound MD-F who was seeing R9 due to a sacral and left buttock wound. Wound MD-F recalled R9 having frequent stools that were at times liquid and not good for the healing of R9's wounds. Wound-MD stated sometimes facility staff had a hard time keeping up with R9's stools. Wound MD-F stated R9 was incontinent but was unsure if R9 used the toilet at times. Surveyor reviewed Certified Nursing Assistant (CNA) documentation for R9's bowels. CNA documentation was not consistent in documenting R9's bowel habits/patterns and did not indicate if R9 was continent or incontinent. R9's activities of daily living (ADL) care plan initiated on 12/14/2023 had the following interventions: TOILET USE: The resident requires extensive assistance by 2 staff for toileting. PERSONAL HYGIENE: I require extensive assistance of 1 for personal hygiene. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that there was not a care plan to specifically address R9's bowel continence/incontinence or issues related to R9's bowels. R9 was noted to be continent of bowels upon admission. Surveyor reviewed R9's progress notes and noted there was no charting documenting if R9 was having liquid stools or how staff were managing R9's bowels in addition to keeping R9's sacral wounds clean and free of stool. Surveyor noted that physician notes indicated R9 had bouts of constipation and was scheduled: Docusate Sodium oral tablet 100 MG-Give 1 tablet by mouth in the morning for constipation (start 1/28/2024.) Surveyor noted Prior to R9's Docusate medication being scheduled every day it was scheduled as PRN (as needed) and Surveyor noted that staff did not sign out as being given when R9 had constipation. Surveyor reviewed R9's medication administration records (MARs) during admission and noted that nursing staff was signing out R9's Docusate sodium as being given every day. On 2/12/2024 in the progress notes, NP documents . (R9) complained pain a little worse. Registered Nurse (RN) said RN just cleaned it, patient said they cleaned out the wound again and BM (bowel movement) gets in there sometimes and it is uncomfortable . On 5/15/2024 at 8:35 AM, Surveyor interviewed Physical Therapy Assistant (PTA)-Z who stated R9 was working on a goal to be able to be independent with self-cares. PTA-Z stated that when R9 was admitted R9 could use the toilet but then started to become incontinent and was not always able to tell when R9 had to have a bowel movement. On 5/15/2024 at 8:43 AM, Surveyor interviewed CNA-K who stated CNA-K took care of R9 a lot during R9's admission to the facility. CNA-K recalled R9 being incontinent of bowel majority of the time and had a lot of stools. Surveyor asked if R9 having a lot of stools was communicated to nursing. CNA-K does not recall if CNA-K ever told nursing about R9 having a lot of stools. Surveyor asked how CNAs document bowel movements/toileting habits of residents. CNA-K stated they give report and will sign out in the CNA tasks. Surveyor asked if CNA-K ever took R9 to the bathroom to use the toilet. CNA-K stated that sometimes when R9 put the call light on CNA-K would take R9 to the toilet if CNA-K got to R9 on time, otherwise CNA-K had to change R9's brief and wash R9 up. Surveyor asked CNA-K what kind of foley catheter cares were done for R9. CNA-K stated that CNA-K emptied the catheter bag for R9. Surveyor asked where CNA-K would find information regarding care for a catheter. CNA-K stated that it would be on the CNA Kardex for the resident and in the CNA task check off. Surveyor reviewed R9's CNA Kardex. Surveyor noted there is no mention of R9 having a catheter or any catheter care for R9. Surveyor also noted there is no toileting program for R9. The CNA Kardex has the following interventions: TOILET USE: the resident requires extensive assistance by 2 staff for toileting. PERSONAL HYGIENE: I do require extensive assistance of 1 for personal hygiene. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 5/15/2024 at 9:29 AM, Surveyor interviewed DON-B who stated DON-B could not recall doing a bladder evaluation summary for R9. DON-B stated DON-B recalled R9 having a catheter. Surveyor asked DON-B if R9 should have had a care plan and orders for catheter care/monitoring if R9 had a catheter. DON-B stated yes R9 should have had those in place if R9 had a catheter. Surveyor asked DON-B what kind of bowel monitoring or toileting program is done for residents to asses bowel habits for R9. DON-B stated DON-B was not aware of what R9's bowel habits were. Surveyor requested policies for bowel monitoring/assessment. On 5/15/2024 at 12:46 PM, DON-B stated the facility did not have a bowel monitoring policy. DON-B also stated that R9 was admitted to the facility with the Foley catheter in place already. Surveyor showed DON-B documentation that does not match up with R9 having been admitted with a Foley catheter in place. Surveyor shared concerns regarding R9's catheter and not having a care plan, or orders for catheter care/monitoring and R9 ended up with UTIs. Surveyor also shared concern that R9 was assessed as being continent of bowel and bladder on admission but then got a foley catheter placed and became incontinent of bowel and did not have a toileting program or monitoring in place. DON-B stated that DON-B and Nursing Home Administrator (NHA)-A are aware of the lack of monitoring. DON-B stated there was some documentation in the CNA charting, but not enough. No further information was provided as to why R9 did not receive appropriate services related to catheter care and/or fecal incontinence with constipation to prevent urinary tract infections and to restore normal bowel function as possible.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure 2 (R10 & R3) of 2 residents reviewed for nutrition maintained acceptable parameters of nutritional status. *R10's weights were not obtained per facility guidelines. No weights were obtained in November 2023 or April 2024. *R3 should have been weighed on 1/16/24, 1/17/24, 1/18/24 and one time during the week of 1/21/24 to 1/27/24. Upon return to the facility on [DATE], R3 should have been weighed on 2/13/24, 2/14/24, 2/15/24 and during the week of 2/18/24 to 2/24/24. No weights were obtained on those dates. Findings Include: Surveyor reviewed the Weight Monitoring policy and procedure dated 4/10/24 documents: Policy: Based on the Resident's comprehensive assessment, the facility will ensure that all Residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the Resident's clinical condition demonstrates that this is not possible or Resident preferences indicate otherwise. Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight(loss or gain) or insidious weight loss(gradual unintended loss over a period of time) may indicate a nutritional problem. 1. The facility will utilize a systemic approach to optimize a Resident's nutritional status. This process includes: a. Identifying and assessing each Resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary. 5. A weight monitoring schedule will be developed upon admission for all Residents: a. Weights should be recorded at the time obtained b. Newly admitted Residents-monitor weight weekly for 4 weeks c. Residents with changes-monitor RD direction d. All others-monitor weight monthly or per orders (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions f. Observations pertinent to the Resident's weight status should be recorded in the medical record as appropriate. 1.) R10 was admitted to the facility on [DATE] with diagnoses of Chronic Kidney Disease, Stage 3, Type 2 Diabetes Mellitus, Morbid Obesity, Lymphedema, and Major Depressive Disorder. R10 is her own person. R10's 5 day Minimum Data Set (MDS) dated [DATE] documents R10's Brief Interview for Mental Status (BIMS) score to be a 15, indicating R10 is cognitively intact for daily decision making. R10 has no behaviors or mood concerns documented. R10 has no range of motion impairments. R10 requires set-up only for upper and lower body dressing. R10 is independent for mobility and transfers. R10's comprehensive care plan contains the following problem documented in regards to R10's weight: (R10) has risk of unplanned/unexpected weight gain/loss r/t lymphedema and diuretic use 8/26/23 Resident will consume > 75% two of three meals/day. Resident will not develop complications from weight gain such as skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date. Do not tell resident weight. 8/26/23 Monitor and record food intake at each meal. 8/26/23 Notify MD if: Increasing shortness of breath; escalating edema; increased anxiety; inability to lie flat; change in baseline level of orientation/alertness. 8/26/23 Notify nurse if: Increasing shortness of breath; escalating edema; increased anxiety; inability to lie flat; change in baseline level of orientation/alertness. 8/26/23 provide and serve diet as ordered. 8/26/23 Weigh at same time of day and record: (monthly or per MD order) 8/26/23 R10's current physician orders do not contain a physician's order for weights. R10's monthly weights and notes that R10 does not have a monthly weight documented for April 2024 and November 2023. R10's weight at admission 8/21/23 was 277 and the last weight obtained 5/17/24 was 228, a difference of 49 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:37 PM, Director of Nursing (DON-B) informed Surveyor that DON-B does not have a good answer why R10's weights were not obtained and documented. DON-B stated that the expectation is that the weight should be obtained on a monthly basis. DON-B stated there is no physician order for weight to be obtained because it is a standard order. Surveyor shared the concern that R10 is missing two monthly weights. No further information was provided by the facility at this time. 20483 2.) R3 was originally admitted to the facility on [DATE] with diagnoses which include hypertension, atrial flutter, cirrhosis of liver, left below knee amputation, diabetes mellitus, peripheral vascular disease, congestive heart failure, and depression. The physician orders with an order date of 1/17/24 documents Weight x (times) 3 days, then 1 x a week for 4 weeks, then monthly every day shift for 3 days and every day shift every Fri (Friday) for 4 weeks. R3's January 2024 TAR (treatment administration record) documents Weight x 3 day, then 1 x a week for 4 weeks, then monthly every day shift for 3 days with a start date of 1/18/24 and Weight x 3 day, then 1 x a week for 4 weeks, then monthly every day shift every Fri for 4 weeks with a start date of 1/26/24. Surveyor noted there are no documented weights on R3's January TAR. R3 was hospitalized from 2/6/24 to 2/13/24. R3's February 2024 TAR documents Weight x 3 day, then 1 x week for 4 weeks, then monthly every day shift every Fri (Friday) for 4 weeks with a start date of 1/26/24. Surveyor noted there are no documented weights on R3's February 2024 TAR. Under the vital/weight tab there is only one documented weight on 1/29/24 at 12:23 p.m. of 270 pounds. On 5/20/24 at 9:32 a.m., Surveyor asked DON (Director of Nursing)-B where Surveyor would be able to locate R3's weights. DON-B informed Surveyor they are under the vital tab. Surveyor informed DON-B R3's physician orders documents weights are to be taken daily for 3 days, weekly for 4 weeks and then monthly but Surveyor was only able to locate one weight. Surveyor asked DON-B to look into R3's weights and get back to Surveyor. On 5/20/24 at 11:52 a.m., DON-B informed Surveyor R3 refused to be weighed on 1/26/24. Surveyor asked DON-B about R3's physician orders for weights which should be taken daily for 3 days, weekly for 4 weeks and then monthly. DON-B informed Surveyor there isn't any charting for weights and there is only one weight documented in the system. Surveyor asked DON-B should the licensed nurses be following physician orders. DON-B replied yes. Surveyor asked DON-B if there is a protocol when weights are obtained. DON-B informed Surveyor when a Resident comes in, they are weighed the first three days, then weekly for a month four weeks, and then monthly. DON-B informed Surveyor when R3 was admitted the orders should have been inputted for the nurses to monitor. R3 should have been weighed on 1/16/24, 1/17/24, 1/18/24 and one time during the week of 1/21/24 to 1/27/24. Upon return to the facility on [DATE], R3 should have been weighed on 2/13/24, 2/14/24, 2/15/24 and during the week of 2/18/24 to 2/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided as to why the facility did not ensure that R10 & R3 maintained acceptable parameters of nutritional status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation, record review, interview, the facility did not ensure 1 (R4) of 2 residents reviewed had their oxygen administered according to physician's orders. * R4 was observed to have her oxygen administered at 6 liters per minute and her orders were to have her oxygen at 1-5 liters per minute according to her oxygen saturation levels. Findings include: 1. R4 was admitted to the facility on [DATE] with diagnoses that included Anoxic Brain Damage and Coma. R4 is unable to make her needs known. On 5/13/24 at 9:00 AM R4 was observed in bed with oxygen running to her tracheostomy at 6 liters per minute. On 5/13/24 at 12:30 PM R4 was observed in bed with oxygen running to her tracheostomy at 6 liters per minute. On 5/13/24 at 2:00 PM R4 was observed in bed with oxygen running to her tracheostomy at 6 liters per minute. On 5/14/24 at 8:00 AM R4 was observed in bed with oxygen running to her tracheostomy at 6 liters per minute. On 5/14/24 at 11:00 AM R4 was observed in bed with oxygen running to her tracheostomy at 6 liters per minute. Director of Nurses (DON)-B was brought into R4's room and indicated R4 should have her oxygen running per her physicians orders. R4's physician order dated 6/23/23 documented: oxygen at 1-5 liters per trach mask to maintain oxygen saturation above 90%. R4's Treatment Administration Record's (TAR) were reviewed from March 2024 to 5/13/24. R4's TAR documents that R4's oxygen saturation was measured every shift and was never recorded to be under 93% for all entries. The above findings were shared with the Administrator A and Director of Nurses B on 5/14/24 at 3:00 p.m. Additional information was requested if available. None was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525281	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge Health and Rehabilitation Center	3415 N Sheridan Rd Kenosha, WI 53140

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50742 Based on observation and staff interview, this facility did not ensure that confidential medical records were safeguarded against loss, destruction, or unauthorized use. This has the potential to affect up to 30 current residents at this facility. The confidential medical records are not stored in a secure manner to prevent unauthorized access. Findings include: On 5/20/24 at 2:06 PM, Surveyor toured the medical records archive room with Medical Records-OO. The room is in the basement of the facility. Surveyor observed ten cardboard boxes containing approximately 30 current and previous resident medical records sitting on the floor. Surveyor observed the ten cardboard boxes containing medical records to be sitting below a water fire sprinkler. Surveyor noted that the cardboard boxes containing records were open and did not contain lids. Surveyor asked Medical Records-OO how the facility would protect these medical records from water damage if the fire sprinkler were to turn on. Surveyor asked Medical Records-OO how many medical records in the cardboard boxes were from current residents. Medical Records-OO informed Surveyor that she estimated approximately 30 medical records in the boxes were from current residents residing at the facility. Medical Records-OO informed Surveyor that if the fire sprinkler went off, the records would be ruined and informed Surveyor that the medical records should be off the floor and should be covered or secured in a covered metal cabinet. On 5/20/24 at 3:54 PM, during the exit meeting, Surveyor informed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B of the above findings. No additional information was provided as to why the facility did not ensure that confidential medical records were safeguarded against loss, destruction, or unauthorized use.