STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525317	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clare Care and Rehab Center	1414 Jefferson St Baraboo, WI 53913

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility failed to protect a residents right to be free from verbal abuse by a visitor for 1 of 13 residents (R3) reviewed for abuse. R3 was verbally abused on multiple occasions while at the facility by R3's Activated Power of Attorney (POA). The facility failed to ensure measures were in place to prevent verbal abuse from reoccurring. It was reported that R3's POA was yelling at R3 in December 2024. The facility completed an investigation regarding a possible verbal abuse by R3's POA on 3/27/25 and 4/21/25. The facility did not add appropriate interventions to ensure R3 was free from abuse, did not update R3's care plan with interventions, and staff were not aware of the need for extra support and/or monitoring when R3's POA was in the facility. Evidenced by: The facility policy, Abuse, Neglect and Exploitation, dated 4/8/25, states, in part; .Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .IV. Identification of Abuse, Neglect and Exploitation .5. Verbal abuse of a resident overheard .7. Psychological abuse of a resident . The facility Visitation Policy Summary, states, in part; .Visitation may be restricted or denied under the following circumstances: .If the visitor's behavior is disruptive, aggressive, threatening, or emotionally harmful . R3 was admitted to the facility on [DATE] with a diagnoses including unspecified dementia, abnormalities of gait and mobility, major depressive disorder, chronic pain, unspecified mood, and other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. R3's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/18/25, indicates R3 has a Brief Interview for Mental Status (BIMS) score of 11 indicating R3 is moderately cognitively impaired. R3 has an activated power of attorney. R3's Comprehensive Care Plan, states, in part; .Abuse Prevention: At risk and/or potential for abuse vulnerability- areas of vulnerability include: limited family involvement, cognitive impairment .Observe and provide safe environment. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is important to note R3's care plan and Kardex do not include interventions or increased monitoring for R3 or R3's POA. Facility self report, states, in part; .3/27/25 .staff member reported it sounded like R3's granddaughter was talking loudly to R3. Staff first checked on resident and then reported. NHA went to room for further investigation and ensure resident safety. POA exited the room and was leaving the facility .additional residents were interviewed, and staff statements were collected. Facility completed the following: NHA (Nursing Home Administrator) called the POA on 3/30/25 regarding this incident with the DON present. NHA informed POA that loud talking, yelling, and/or swearing in the facility would not be tolerated. 2. DSS G (Director of Social Services) is working with APS on potential guardianship. 3. A memo was placed at the nurses station to contact the NHA immediately if the POA exhibits any unprofessional conduct during future visits . It is important to note that in the 3/27/25 self report there was a statement, that states in part: . In December of 2024 staff notified writer that POA was by the front doors yelling at R3. By the time I was able to get to the doors, R3 had already left with POA. When R3 returned I asked her about interaction R3 told me that her POA was upset R3 stated that this interaction was not distressing to her . Facility self report, states, in part; .4/21/25 .On 4/21/25, around 8:30AM, Nurse and CNA called the DON to R3's room due to loud yelling and profanity, DON notified Administrator. DON and Administrator immediately entered R3's room. POA was yelling at resident and using profanity saying things such as: You don't know what I am f**king going through, because I don't tell you. I am busting my f**king ass to care for you just like I busted my f**king ass to care for my dad. When Administrator and DON entered room, POA's behavior immediately de-escalated with a visible change in demeanor. She welcomed DON into the room. Administrator followed. POA stated they were talking about R3's shingles. POA was then acting like she was comforting R3 by holding her hand and then hugging her Describe the effect .R3 was crying when the DON and Administrator entered the room. However, she reported she is okay and that is how the POA is. R3 confirmed that she wants to continue having visits with her POA and feels safe around her .Explain what steps the entity took .The incident took place in R3's room, with the door shut. There were no additional residents around. Additional residents were interviewed . Facility incident report, states, in part; .4/21/25 .RN O (Registered Nurse) statement .at approx. 9am POA approached writer at my cart and stated, Were you the one that complained that we were being too loud? Writer replied no I was not the one that set that in motion. POA then asked who was because I want to yell at them because I am so sick of this place. Writer replied, I don't feel comfortable telling you this. POA states, Oh that's okay. I will find out. And walked away. Her demeanor was intimidating .Root cause analysis: Based on thorough investigation and statements obtained, staff reported the observations/hearing loud talking and profanity to administration immediately. It is reasonable to believe that this incident is part of R3 and POA's relationship. R3 has reported that this is just how POA is and that she feels safe with POA. Action taken: Police were notified of this incident. In order to prevent escalation of the incident, the police officer has decided to not talk with POA regarding this situation, however, future situations law enforcement will be notified immediately and will come to the facility to intervene. Facility leadership is consulting with the Ombudsmen as well as sending POA a warning letter that future incidents may result in supervised visits going forward. POA [sic] is being closely monitored by nursing and social services for any negative effects from this interaction (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA GG (Certified Nursing Assistant) written statement, states, in part; .On 4/21/25 I overheard yelling coming from R3's room. Her POA was in there with her. I heard POA yell I don't f**king care. I also heard her loudly say I'm not letting you change the f**king subject. I reported this to the nurse right away and she reported to DON right away . (Of note, based on CNA GG's statement, CNA GG did not intervene or protect R3 from verbal abuse.) On 5/8/25 at 8:50 AM, CNA S indicated she is not aware of any interventions in place or any concerns between R3 and POA. CNA S indicated if she witnessed abuse or possible abuse she would report concerns immediately and intervene. On 5/8/25 at 8:58 AM, CNA I indicated she is not aware of any interventions in place or any concerns between R3 and POA. CNA I indicated if she heard verbal abuse she would intervene and immediately report. On 5/8/25 at 9:00 AM, RN E indicated she would immediately report any allegations of abuse. RN E indicated she is not aware of any interventions in place or anything to be mindful of between R3 and R3's POA. RN E indicated there has been a lot of education on abuse recently. On 5/8/25 at 9:05 AM, RN BB indicated she is not aware of any interventions or anything in place for R3 and POA. RN BB indicated if she witnessed possible abuse she would intervene and report to the DON (Director of Nursing). RN BB indicated if she observed abuse between a POA and resident she would ask the POA to leave. RN BB indicated there has been a lot of education regarding abuse the last couple of months and that she can't remember if it was specific to R3. On 5/8/25 at 9:10 AM, S CC (Scheduler) indicated she has heard R3's POA yelling and swearing at R3 before. S CC indicated this was quite awhile ago and a lot more has been done recently to support R3. Surveyor asked S CC how R3's demeanor seems after POA has been yelling and swearing at her. S CC stated, R3 handles it well for as much as she gets yelled at. Sometimes she's upset, most of the time she just brushes it off. S CC indicated there is a posting at the nurse's station and S CC pointed at a note. S CC indicated if staff hear any yelling by POA they need to report it immediately. Surveyor asked if there are new staff or agency staff how does this get relayed to them? S CC indicated staff should communicate this to any new staff. Surveyor asked if this was care planned and S CC indicated it wouldn't hurt to have it on the care plan. On 5/8/25 at 9:15 AM, AA DD (Administrator Assistant) indicated she has not seen any negative interactions between R3 and POA. AA DD indicated if she witnessed possible abuse she would ensure resident is safe and immediately notify administration. AA DD indicated even if the resident said they were fine she would still react the same way. AA DD indicated she has recently received abuse education. Surveyor inquired about a questionnaire that AA DD completed during 1st self report- it stated that AA DD heard POA raise voice to R3. AA DD indicated this was a long time ago and R3 was going for a ride with POA. POA's dad was very sick and AA DD indicated everyone in the family had been stressed. AA DD indicated R3 indicated she was fine and that R3 and POA left the facility together. On 5/8/25 at 9:51 AM, Housekeeper FF indicated she has heard R3's POA yell at R3. Housekeeper FF indicated this had been reported and the nurse talked with R3. Housekeeper FF indicated she would report abuse concerns immediately and she has recently received abuse education. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 10:26 AM, DSS G indicated there has been a couple times where R3's POA has yelled at R3. DSS G indicated she has followed up with R3 regarding her POA. DSS G indicated every time a verbal incident occurs DSS G follows up with R3. DSS G indicated R3 always says that is just how POA is and that's how she talks. Surveyor asked DSS G what is in place now to keep R3 safe? DSS G indicated NHA (Nursing Home Administrator) has sent R3's POA a letter, if staff hear POA yelling they are to immediately call the police, R3 has routine behavior health visits, APS and Ombudsman have been notified, and there is a note posted at the nurse's station. Surveyor asked how do the staff know these interventions? DSS G indicated, I believe this is in her care plan, but I am not certain and would have to look. DSS G indicated staff are to check on R3 and make sure she is safe, but not engage with POA because historically POA can get aggressive. DSS G indicated then staff call the police. It is important to note, through staff interview most were not aware of these interventions in place. The interventions are not in R3's care plan or on R3's Kardex. On 5/8/25 at 1:37 PM, CNA GG indicated she was the CNA that heard R3's POA yelling at R3 on 4/21/25. CNA GG indicated it was a couple weeks ago. CNA GG indicated R3's bedroom door was closed, and CNA GG could hear R3's POA yelling, and she was being very loud. CNA GG indicated she was in the middle of doing multiple things, assisting a co-worker, a call light went off, and going into another resident's bedroom so she asked the nurse to go do something. CNA GG indicated the nurse went and got the DON. CNA GG indicated she could hear some swear words and R3's POA kept interrupting R3. CNA GG indicated there has been a lot of education on abuse recently and CNA GG indicated she would report any possible abuse concerns to administration immediately. CNA GG indicated she didn't see R3 right after the incident, but during lunch she seemed fine. On 5/8/25 at 4:12 PM, RN O indicated she was the nurse on the floor when the incident occurred on 4/21/25. RN O indicated R3's POA is known to have anger issues and a short fuse. RN O indicated this is R3's POA and R3's unusual dynamic. RN O indicated CNA GG reported to RN O she thought she heard yelling coming from R3's bedroom. RN O indicated RN O was by med cart and went down to R3's bedroom. The door was closed, RN O listened to see if she could hear any yelling, RN O did not hear anything and walked back to med cart. RN O indicated RN O was at med cart and saw DON (Director of Nursing) and NHA (Nursing Home Administrator) walking towards R3's bedroom. RN O indicated shortly after R3's POA came up to RN O asking if RN O was the person that reported her. RN O indicated R3's POA is very intimidating and had that look in her eye. RN O indicated that she has known R3 since R3 was admitted to facility and R3 has never said she is afraid of her POA. RN O indicated this is the way it's always been between these two. She (POA) can get very inappropriate with her words .she's always been this way. Surveyor asked if RN O has ever observed R3 yelling and screaming at POA? RN O stated, No, I have not. Surveyor asked RN O is verbal abuse considered a form of abuse? RN O indicated Yes, absolutely. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 8:40 AM, NHA A (Nursing Home Administrator) indicated the first self report investigation occurred on 3/27/25. A staff overheard loud voices coming from R3's bedroom. Staff couldn't make out exactly what was being said. Staff peeked head in bedroom and didn't see anything alarming and then reported to NHA A immediately. DON B and NHA A went down to R3's bedroom and POA was leaving facility. DON B and NHA A asked R3 if she felt safe and had any concerns with POA. R3 indicated she is not scared and values the relationship between the two. DON B and NHA A called POA the next day, interviewed residents and staff. NHA A indicated POA was not pleased with the phone call and NHA A told POA that the police will be notified if further incidents occur. NHA A indicated they reviewed the incident and plan of action in QAPI and felt they handled incident correctly. NHA A indicated DSS G notified APS and all staff were educated on abuse. NHA A indicated it is a fine line promoting R3 and POA's relationship and keeping resident safe. NHA A indicated they made the decision to not put anything in the Kardex and care plan because they didn't want the POA to see that and cause any issues. NHA A indicated staff are educated on the abuse policy and there is a memo at the nurses station for all staff to notify NHA if they hear POA yelling at R3. The memo is in a central location so all staff should know to be on alert when POA is in facility. NHA A indicated second self report investigation occurred 4/21/25. Staff heard yelling coming from R3's bedroom. CNA GG reported the concern to RN O. NHA A and DON B (Director of Nursing) went to R3's bedroom. NHA A indicated they watched POA exit the facility. NHA A indicated facility contacted the police, contacted Ombudsman, sent POA a letter and resources on guardianship, and provided resources to R3 on Ombudsman information, interviewed staff, interviewed residents, and monitored R3. NHA A indicated they did not put interventions on Kardex or care plan because POA sees these documents. NHA A indicated all staff are educated and must follow abuse policy. NHA A indicated all staff are to follow if you see a crime you call law enforcement. NHA A indicated R3 is very adamant that this is their relationship and that it's always been this way. NHA A indicated it is not appropriate. NHA A indicated she does not view the incidents as verbal abuse because R3 does not view it that way. NHA A indicated it would be different if she was upset by it or if it was more physical in nature, since R3 doesn't view it as verbal abuse NHA A does not view it that way. Surveyor asked NHA A if she is aware of R3's past trauma? NHA A indicated she does not know specifics of R3's trauma, but that DSS G would be able to speak more on that. On 5/12/25 at 3:39 PM, DSS G indicated APS was visiting R3 tomorrow. DSS G indicated R3 has shared with her that she was abused by her father as a child. DSS G indicated R3 didn't elaborate or share any more information other than that. Surveyor asked is verbal abuse is considered abuse? DSS G shrugged shoulders and nodded yes. Based on interview and record review, the facility failed to protect R3's right to be free from verbal abuse by a visitor.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility failed to immediately intervene when alleged verbal abuse was observed for 1 of 3 Residents (R3) involved in a facility reported incident. Staff heard an alleged verbal abuse altercation and failed to immediately ensure R3's safety. Evidenced by: The facility policy, Abuse, Neglect and Exploitation, dated 4/8/25, states, in part; .VI. Protection of Resident . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse . R3 was admitted to the facility on [DATE] with a diagnoses including unspecified dementia, abnormalities of gait and mobility, major depressive disorder, chronic pain, unspecified mood, and other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. R3's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 3/18/25, indicates R3 has a BIMS (Brief Interview for Mental Status) score of 11 indicating R3 is moderately cognitively impaired. R3 has an activated power of attorney. R3's Comprehensive Care Plan, states, in part; .Abuse Prevention: At risk and/or potential for abuse vulnerability- areas of vulnerability include: limited family involvement, cognitive impairment .Observe and provide safe environment. Facility self report, states, in part; .4/21/25 .On 4/21/25, around 8:30AM, Nurse and CNA called the DON to R3's room due to loud yelling and profanity, DON notified Administrator. DON and Administrator immediately entered R3's room. POA was yelling at resident and using profanity saying things such as: You don't know what I am f**king going through, because I don't tell you. I am busting my f**king ass to care for you just like I busted my f**king ass to care for my dad. When Administrator and DON entered room, POA's behavior immediately de-escalated with a visible change in demeanor. She welcomed DON into the room. Administrator followed. POA stated they were talking about R3's shingles. POA was then acting like she was comforting R3 by holding her hand and then hugging her Describe the effect .R3 was crying when the DON and Administrator entered the room. However, she reported she is okay and that is how the POA is. R3 confirmed that she wants to continue having visits with her POA and feels safe around her .Explain what steps the entity took .The incident took place in R3's room, with the door shut. There were no additional residents around. Additional residents were interviewed . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility incident report, states, in part; .4/21/25 .Registered Nurse O (RN) statement .at approx. 9am POA approached writer at my cart and stated, Were you the one that complained that we were being too loud? Writer replied no I was not the one that set that in motion. POA then asked who was because I want to yell at them because I am so sick of this place. Writer replied, I don't feel comfortable telling you this. POA states, Oh that's okay. I will find out. And walked away. Her demeanor was intimidating .Root cause analysis: Based on thorough investigation and statements obtained, staff reported the observations/hearing loud talking and profanity to administration immediately. It is reasonable to believe that this incident is part of R3 and POA's relationship. R3 has reported that this is just how POA is and that she feels safe with POA. Action taken: Police were notified of this incident. In order to prevent escalation of the incident, the police officer has decided to not talk with POA regarding this situation, however, future situations law enforcement will be notified immediately and will come to the facility to intervene. Facility leadership is consulting with the Ombudsmen as well as sending POA a warning letter that future incidents may result in supervised visits going forward. POA is being closely monitored by nursing and social services for any negative effects from this interaction Certified Nursing Assistant GG (CNA) written statement, states, in part; .On 4/21/25 I overheard yelling coming from R3's room. Her POA was in there with her. I heard POA yell I don't f**king care. I also heard her loudly say I'm not letting you change the f**king subject. I reported this to the nurse right away and she reported to DON right away . (of note, CNA GG's statement indicates CNA GG did not intervene and protect R3 when hearing yelling coming from R3's room.) On 5/8/25 at 10:26 AM, Director of Social Services G (DSS) indicated there has been a couple times where POA (Power of Attorney) has yelled at R3. DSS G indicated she has followed up with R3 regarding POA. DSS G indicated every time a verbal incident occurs DSS G follows up with R3. DSS G indicated R3 always says that is just how POA is and that's how she talks. Surveyor asked DSS G what is in place now to keep R3 safe? DSS G indicated NHA (Nursing Home Administrator) has sent POA a letter, if staff hear POA yelling they are to immediately call the police, R3 has routine behavior health visits, APS and Ombudsman has been notified, and there is a note posted at the nurse's station. Surveyor asked how do the staff know these interventions? DSS G indicated, I believe this is in her care plan, but I am not certain and would have to look. DSS G indicated staff are to check on R3 and make sure she is safe, but not engage with POA because historically POA can get aggressive. DSS G indicated then staff call the police. On 5/8/25 at 1:37 PM, CNA GG indicated she was the CNA that heard POA yelling at R3 on 4/21/25. CNA GG indicated it was a couple weeks ago. CNA GG indicated R3's bedroom door was closed, and CNA could hear POA yelling, and she was being very loud. CNA GG indicated she was in the middle of doing multiple things, assisting a co-worker, a call light went off, and going into another resident's bedroom so she asked the nurse to go do something. CNA GG indicated the nurse went and got the DON. CNA GG indicated she could hear some swear words and POA kept interrupting R3. CNA GG indicated there has been a lot of education on abuse recently and CNA GG indicated she would report any possible abuse concerns to administration immediately. CNA GG indicated she didn't see R3 right after the incident, but during lunch she seemed fine. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 4:12 PM, RN O indicated she was the nurse on the floor when the incident occurred on 4/21/25. RN O indicated POA is known to have anger issues and a short fuse. RN O indicated this is POA and R3's unusual dynamic. RN O indicated CNA GG reported to RN O she thought she heard yelling coming from R3's bedroom. RN O indicated RN O was by med cart and went down to R3's bedroom. The door was closed, RN O listened to see if she could hear any yelling, RN O did not hear anything and walked back to med cart. RN O indicated RN O was at med cart and saw DON (Director of Nursing) and NHA (Nursing Home Administrator) walking towards R3's bedroom. RN O indicated shortly after POA came up to RN O asking if RN O was the person that reported her. RN O indicated POA is very intimidating and had that look in her eye. RN O indicated that she has known R3 since R3 was admitted to facility and R3 has never said she is afraid of POA. RN O indicated this is the way it's always been between these two. She (POA) can get very inappropriate with her words .she's always been this way. Surveyor asked if RN O has ever observed R3 yelling and screaming at POA? RN O stated, No, I have not. Surveyor asked RN O is verbal abuse considered a form of abuse? RN O indicated Yes, absolutely. It is important to note staff did not immediately intervene when they heard alleged verbal abuse. On 5/12/25 at 8:40 AM, Nursing Home Administrator A (NHA) indicated the self report investigation occurred 4/21/25. Staff heard yelling coming from R3's bedroom. Certified Nursing Assistant GG (CNA) reported the concern to Registered Nurse O (RN). NHA A and Director of Nursing B (DON) went to R3's bedroom. NHA A indicated they watched POA exit the facility. NHA A indicated facility contacted the police, contacted Ombudsman, sent POA letter and resources on guardianship, and provided resources to R3 on Ombudsman information, interviewed staff, interviewed residents, and monitored R3. NHA A indicated they did not put interventions in Kardex or care plan because POA sees these documents. NHA A indicated all staff are educated and must follow abuse policy. NHA A indicated all staff are to follow if you see a crime you call law enforcement. NHA A indicated staff should immediately intervene if they observe alleged abuse and immediately report. NHA A indicated during investigation it was not discovered the delay in intervening. Based on interview and record review, the facility failed to immediately intervene when alleged abuse was observed for R3.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not follow through with the appropriate steps of the Preadmission Screening and Resident Review (PASSR) process for 2 of 5 residents (R23 and R20) reviewed for PASSR screening. R23 did not have a PASSR level I (1) completed. R20 did not have a PASSR level II (2) completed. This is evidenced by: The facility's Resident Assessment-Coordination with PASRR Program, dated 2/2025, states, in part: This facility coordinates assessments with the preadmission screening and resident review program under Medicaid to ensure that individuals with a mental disorder (MD), intellectual disability (ID), or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. A. PASRR Level I-initial pre-screening that is completed prior to admission. i. Negative Level I Screen-permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen-necessitates a PASRR Level II evaluation prior to admission. B. PASRR Level II-a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs.3. A record of the pre-screening shall be maintained in the resident's medical record.6. The Social Services Director shall be responsible for keeping track of each resident's PASRR screening status, and referring to the appropriate authority. Example 1 R23 was admitted the facility on 7/26/21 with diagnoses that include dementia, depression, and mood disorder. Surveyor requested PASSR documentation. No PASSR documentation was provided. On 5/13/25 at 2:49 PM, Surveyor interviewed SW G (Social Worker) and asked if R23 had a PASSR completed. SW G stated SW G could not find any documentation of a PASSR being completed. SW G stated that PASSR should have been completed for R23. 49434 Example 2: R41 was admitted to the facility on [DATE] with diagnoses that include: delusional disorders, and restlessness and agitation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24, R41's PASRR level I was submitted with a documented 30-day exemption. On 5/13/25, Surveyor requested R41's PASRR level II. SW G (Social Worker) was unable to locate the document or provide documentation that a PASRR level II was completed. On 5/13/25 at 3:19 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would expect PASRRs to be completed timely. DON B indicated, yes. Surveyor asked DON B if she would expect PASRRs to be kept within the resident's medical record. DON B indicates, yes. Surveyor asked DON B if R41 should have had a PASRR II completed. DON B indicates, yes.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This affected 1 of 5 residents (R25) reviewed for activities. Surveyor observed R25 on 5/7/25 and 5/8/25 sitting in the hallway with no meaningful activities. Surveyor observed R25 on 5/7/25 at 9:41 am positioned staring at a wall. Surveyor observed R25 again at 10:46am, 11:20am sitting in same position. R25's daily activity documentation showed R25 napped and roamed the halls most days from January 2025-May 2025. Evidenced by: The facility policy, Activities, dated, 2/25, states, in part; .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community 1. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but is not limited to: a. RAI (resident assessment instrument) process: MDS (minimum data set)/CAA(care area assessment)/Care Plan. b. Activity assessment to include resident's interest, preferences and needed adaptations. c. Social History. d. Discharge information, when applicable. 2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Create opportunities for each resident to have a meaningful life. c. Promote or enhance physical activity. d. Promote or enhance cognition. e. Promote or enhance emotional health. f. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. g. Reflect resident's interests and age. h. Reflect cultural and religious interests of the residents. i. Reflect choices of the residents . R25 was admitted to the facility on [DATE] with a diagnoses including dementia and abnormalities of gait and mobility. R25's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 3/24/25, indicates R25 has a BIMS (Brief Interview of Mental Status) score of 99 indicating R25 is severely cognitively impaired. R25 has an activated power of attorney. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's care plan, states, in part; .Activities/Life Enrichment: Need for therapeutic recreation for comfort and interaction 11/16/23 .revision 2/15/24. Will actively participate in 2 activities weekly as well as weekly 1:1 visit with an activity facilitator to increase interaction with others, as evidenced by a relaxed demeanor and positive facial expressions or comments at each event .Inform pet volunteers that they can stop by residents room .Offer supplies for independent activities: offer a doll for comfort, she also has some of her own. Offer magazines and picture books. Assist outdoors as weather permits. Assist as needed. Encourage participation in group activities such as social events, happy hour (is motivated by food), music, sensory programming, pet visits, outdoor events, St. John's Lutheran services, games, and cooking/baking events. Provide with baby dolls for comfort (also has her own). Encourage participation in nail painting. Provide with weekly 1:1 visit with an activity facilitator R25's 2025 Activity Participation record, states, in part; .January: 21x (times) naps, 25x roaming hallway, 3x family visit, 1x hobbies, 3x people watching, and 1x cookies. February: 19x roaming hallways, 24x naps, 1x 1:1 visit, 5x people watching, 2x beauty shop, 2x family visits, 1x animal therapy, and 1x group. March: 23x roaming the halls, 22x naps, 6x people watching, 4x family visits, and 2x animal therapy. April: 23x roaming hallways, 18x naps, 3x family visits, 1x musical entertainment, 1x cookie cafe, and 8x people watching. May: 7x roaming halls, 9x naps, 1x nails, 4x people watching, and 1x children visit . Surveyor observed R25 sitting in wheelchair in the hallway on 5/7/25 and 5/8/25 with no meaningful activities offered. On 5/7/25 Surveyor observed R25 positioned so she was sitting staring at wall. On 5/12/25 at 3:51 PM, Activity Assistant EE (AA) indicated that R25 is not able to structure her own leisure time and needs staff support and encouragement to attend activities. AA EE indicated the documentation does not document how long the activity lasted, participation level, and enjoyment. AA EE indicated some residents are more vocal on their enjoyment on an activity. AA EE indicated if R25 is napping during an activity there isn't another option for an activity for R25. On 5/13/25 at 8:57 AM, Activity Director II (AD) indicated R25 is most happy when she can move freely, she enjoys looking out the window, sunshine, baby dolls, outside, her daughter, dog visits, and loves music. AD II indicated R25 enjoys sensory activities. AD II indicated they are working on updating their activity participation documentation and that they see there is room for improvement. AD II indicated R25 needs staff to assist her to activities and to the activity room. The facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being for R25.

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F 0692 Level of Harm - 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** 44552 Based on observation, interview and record review, the facility failed to ensure residents received adequate nutrition and fluid intake for 3 (R25, R26, R42) of 4 Residents reviewed for nutrition. R25 is being cited at severity level 3 (actual harm). R26 and R42 are being cited at severity level 2 (potential for more than minimal harm). R25 was admitted to the hospital on 12/16/24 for weakness, anorexia, and severe hypernatremia (a high concentration of sodium in the blood often caused by dehydration). R25's sodium was 169. The facility failed to ensure R25 received adequate fluid intakes to maintain acceptable parameters of hydration by failing to total and assess daily fluid intake, accurately assess and complete on-going assessments for signs and symptoms of dehydration (e.g., sunken eyes, cool/clammy skin, dry tongue, dark colored urine, and sticky saliva), and failed to update interventions to encourage hydration as necessary. R25 returned to facility on 12/17/24, the facility failed to update R25's nutritional assessments. R26 experienced weight loss. The facility did not update the MD/NP (Medical Doctor/ Nurse Practitioner) appropriately, started R26 on a nutritional supplement without a physician's order, and did not monitor the amount of the supplement R26 was drinking. The facility failed to monitor R42's fluid intake, notify the physician of severe weight loss of 10% over 2 weeks, add R42's favorite beverage to her care plan per facility policy, and conduct a complete nutrition assessment by the Registered Dietician. R42's fluid intake was also not consistently documented and R42 was not consistently offered snacks. Evidenced by: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility policy, Hydration, dated 2/25, states, in part; .The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health .Compliance Guidelines: 1. The facility will utilize a systematic approach to optimize the resident's hydration status: a. Identifying and assessing each resident's hydration status and risk factors b. Evaluating/analyzing the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revisiting them as necessary. 2. Nursing staff shall assess hydration status upon admission and throughout the resident's stay in accordance with assessment protocols. b. The dietary manager or designee shall obtain the resident's beverage preferences upon admission, significant change in condition, and periodically throughout his or her stay. c. The dietitian will assess hydration as part of the comprehensive nutritional assessment within 72 hours of admission, annually, and upon significant change in condition. Follow-up assessment will be completed as needed .3. Evaluation/analysis: a. The assessment shall clarify the resident's current hydration status and individual risk factors for dehydration or fluid imbalance. b. The dietitian shall use data gathered from the nutritional assessment to the resident's fluid needs and whether intake is adequate to meet those needs .4. Care plan implementation: a. The resident's goals and preferences regarding hydration will be reflected in the resident's plan of care .f. The resident will be monitored for complications associated with interventions. g. The care plan will be updated as needed, such as when a resident's condition changes, goals are met or the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of hydration-related problems are identified .6. Documentation: a. Record observations pertinent to the resident's hydration status in the nurses' notes. b. Record beverage intake in designated locations (meal intake records, MAR (medication administration record) as indicated). c. Record output in designated locations (MAR or output record). d. Record fluid intake via tube or IV on MAR or designated intake record. e. Document physician/family notifications and any responses. f. Document assessments in designated locations (RAI, dietary notes, or nurses' notes) . Per Mayo clinic dehydration occurs when the body uses or loses more fluids than it takes in. Not replacing lost fluids leads to dehydration. Anyone can become dehydrated, but the condition is more serious for older adults .Drinking more fluids usually fixes mild to moderate dehydration, but severe dehydration needs medical treatment right away. Thirst isn't always a good way to tell if the body needs water. Many people, mainly older adults, don't feel thirsty until they're dehydrated .The symptoms of dehydration can differ by age. adults, extreme thirst; urinating less; dark-colored urine; tiredness; dizziness; being confused; skin that doesn't flatten back right away after being pinched, sunken eyes or cheeks. Dehydration can lead to serious complications such as heat injury, urinary and kidney problems, seizures, low blood volume shock. Example 1: R25 was admitted to the facility on [DATE] with a diagnoses including dementia and abnormalities of gait and mobility. R25's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 3/24/25, indicates R25 has a BIMS (Brief Interview for Mental Status) score of 99 indicating R25 is severely cognitively impaired. R25 has an activated power of attorney. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R25's Comprehensive Care Plan, states, in part; .ADL: .EATING: assist of 1; supervise. 11/16/23 . NUTRITION/HYDRATION: Actual/At risk/and/or potential for complications with nutrition/hydration d/t severe dementia, mechanically altered diet and staff dependence to eat. 11/16/23 revision on 4/24/25 .Encourage fluids at and between meals initiated 4/22/25, Diet type: General/standard diet, soft bite sized, ground meat, may have toast, thin liquids .11/16/23, revision 4/22/25, meds/labs/treatments as ordered 11/16/23, record weights a minimum of monthly or per MD/RDN (Registered Dietitian Nutritionist) 11/16/23, set up meal per resident direction and assist with eating as/if needed. Honor food requests as able 2/7/24, Adaptive equipment: provide inner lip dish at all meals. Cups with lids, Partial assistance 2/7/24 . It is important to note, R25's care plan was not updated after being hospitalized on [DATE] for weakness, anorexia (eating disorder, characterized by food restriction), and severe hypernatremia (high sodium) to include interventions to promote hydration. R25's current Kardex, states, in part; .As of 5/13/25 .Eating/Nutrition: Encourage fluids at and between meals .EATING: assist of 1; Supervise .Dining/Eating/Nutrition: Cups with lids, partial assistance . R25's DIET Nutritional Risk Tool, states, in part; .4/25/24 .G. Dining ability: Assistance/cueing needed/slow . meeting needs, skin intact and weight is stable .2. Hydration needs ABW. Adjusted weight yes. Weight adjusted for obesity. Hydration needed: 1325-1590 .Recommendations: BLANK. Meeting needs, skin is intact, and weight is stable. Will continue to monitor and update as needed . It is important to note the facility did not update R25's Nutritional Risk Tool after R25 experienced significant change in condition and was admitted to the hospital on 12/16/24 for weakness, anorexia, and severe hypernatremia. R25's Mini Nutritional Assessment, states, in part; .Effective Date: 10/25/24 .Score 8 .At risk for malnutrition . screening A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? No decrease in food intake. B. Weight loss during the last 3 months: No weight loss. C. Mobility: Bed or chair bound. D. Has suffered psychological stress or acute disease in the past 3 months? Yes. E. Neuropsychological problems: Severe dementia or depression . R25's Dehydration Risk Screening Tool, states, in part; .10/25/24 .mobility: ambulate with 2 assist .fluid intake/eating: extensive physical assist .weight: no weight loss .continence: on bladder management program .risk factor: no risk factor .predisposing factors: 1-2 present .Based on the results of this assessment and your clinical judgment, is this resident at risk for dehydration? .No .Takes adequate fluids at meals and is given fresh water at bedside 3 times per day . R25's fluid intake, states, in part; December 2024 .1st 720ml, 2nd 680ml, 3rd 1200ml, 4th 600ml, 5th 960ml, 6th 720ml, 7th 720ml, 8th 1200ml, 9th 720ml, 10th 720ml, 11th 960ml, 12th 1200ml, 13th 1,020ml, 14th 480ml, and 15th 1200ml . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	It is important to note, the only documentation the facility provided showing R25's hydration needs was from R25's Nutritional Risk Tool dated 4/25/24, that indicated ,1325-1590ml of fluid daily. R25 does not meet this and there is no documentation of interventions attempted or discussed, no updates to R25's care plan and/or nutritional assessments, and no discussion with the Registered Dietician. On December 14th it is also noted R25 drank significantly less than other days, and there is no documentation of other interventions attempted. R25's NP routine visit note, states, in part; .12/11/24 .Pertinent History: major neurocognitive disorder . Today, R25 is in her room when I see her. She is pleasant and confused. She looks to be comfortable. She does not respond verbally to any of my questions but does nod/shake her head appropriately. She is dependent for most ADL's but is able to feed herself independently. Her weight is stable. She has had no falls since her admission to the facility .labs monitored in 12/2023 and are stable .lips and gums pink, moist . Patient Goal: maintain comfort and restore previous level of functioning . R25's Progress notes from December 2024, states, in part; .12/16/24 .9:01 .resident slid out wheelchair went [sic] attempting to propel wheelchair. No injury noted.12/16/24 .14:23 .we have attempted to place I.V. (intravenous catheter that goes into a vein to provide fluid) for hydration as POA (power of attorney) agreed. We were unsuccessful. Update MD (Medical Doctor). She was going to call family to see wished.[sic] 12/16/24 .14:24 .Talked with family also updated. 12/16/24 .14:26 .Just spoke with GNP (Geriatric Nurse Practitioner) family would [sic] resident sent to ER (emergency room). 12/17/24 .10:11 .In hospital. 12/17/24 . 12:01 .Resident is coming back to us from hospital on hospice . NP note from 12/16/24, states, in part; .Regarding hypernatremia found today on routine labs, coupled with resident's recent in past few days of weakness, eating/drinking less, foul smelling urine, it has been discussed earlier with daughter/proxy that she'd favor trying some IV fluids vs heading straight for comfort care (in context of her advanced age/dementia, general decline .) IV 1 L LR (1 liter lactated ringers (sterile IV solution to replace fluids and electrolytes) ordered in SNF (skilled nursing facility). RN (Registered Nurse) tried x 4 to access vein but were unable. Writer then called proxy to discuss options, possible causes/outcomes .it's possible she has an underlying acuity that could be treatable, that further testing may reveal. She talked to her brother and they are favoring trying to treat something if it's there before making peace with an ed of life process. Order given to SNF to send to ED for weakness, hypernatremia, fluid hydration . ED (Emergency Department) note, states, in part; .12/16/24 3:13PM .CHIEF COMPLAINT: Altered mental status (mental decline over the last few days, decreased level of consciousness at the facility. Normally ambulates with a walker. Had blood work done and showed hypernatremia .HISTORY OF PRESENT ILLNESS: R25 history of dementia presents by EMS (emergency medical services) from nursing care facility with decreased mentation and oral intake. She does have a history of dementia. I did review medical packet from the nursing care facility. She is DNR (do not resuscitate) with limited aggressive treatment. Medical history as detailed below .notably she had a sodium of 169 as well as chloride level of 137. [NAME] blood cell count was borderline at 10.8 . (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Additional documentation provided on 5/23/25 by NHA A related to 12/16/25 hospital visit states in part: . 12/17/24 visit . long-standing Alzheimer'sdementia currently hospitalized with dehydration and severe hypernatremia. Her sodium was up to 169, chloride 137 and BUN 51. She was given some free water with modest improvement in values of sodium 163 and chloride 131. Additionally her hemoglobin is 10 (down from recent baseline of 12) despite the fact she is severely dehydrated, meaning if her dehydration was reversed her hemoglobin would be much much lower .She has required feeding assistance recently. She has been having increasing difficulty holding herself upright in her wheelchair and 2 days ago she had a sliding to ground event out of her wheelchair. Patient has had unintended weight loss. Over the past year she has lost 19 lbs which is nearly a 15%weight loss going from 148 to 129 lbs. The patient is dependent in all ADLs . electronically signed by the MD on 12/17/2024 11:51 AM.Final Diagnoses: .1.hypernatremia from dehydration. 2 Advanced dementai. 3. AMS (altered mental status). 4.Hypokalemia 5. Anemia .Presenting history .worsening dementia, and now dehydration and severe hypernatremia .we did discuss that in a SNF this problem is usually the result of the elder declining food and drink due to loss of appetite and thirst due to terminal dementia. And that trying to force-feed people in this condition does not work due to then they aspirate and get pneumonia in addition to the discomfort of it. And that IV fluids will temporarily improve this life-threatening problem but will not change the underlying problem. the risks of treatment are mostly pain from IV starts and q4h lab draws. But the problem will happen again off IV's. the alternative is good comfort care without IVF (intravenous fluids) while offering but not forcing food/fluids . R25's Dehydration Risk Screening Tool, states, in part; .12/17/24 .mobility: bed bound .fluid intake/eating: extensive physical assist .weight: 3lbs weight loss in one month .risk factor: history of refusing liquids . predisposing factors: 1-2 present .Based on the results of this assessment and your clinical judgment, is this resident at risk for dehydration? .Yes .high risk but is hospice . It is important to note, R25's care plan was not updated to include interventions to promote hydration even though R25's dehydration screening tool indicates R25 is at high risk for dehydration. Transition note from NP on 12/18/24, states, in part; .R25 is readmitted .on 12/17/24 for continued care with change to comfort focus and additional hospice support in context of advancing dementia with new onset weakness, anorexia, and hypernatremia. HOSPITAL COURSE: 12/16/24-12/17/24 presented to ED with weakness, anorexia, and severe hypernatremia. She was in her usual baseline state a few days prior, eating well, self-propelling her wheelchair all around the nursing home, largely nonvocal. Then she had a fall and she was noted to be eating and drinking a lot less. On routine lab work her sodium was noted to be 169 . Response to treatment: .On admission she was placed on IV dextrose fluids and electrolytes were checked q (every) 4 hours, her sodium did slowly improve (from 169-163), this AM when I saw her she wasn't responsive voice, won't open eyes, appeared comfortable, vitals were stable .Review of Systems .urine was noted to be foul smelling before hospitalization , likely in setting of dehydration . It is important to note the facility did not update R25's Mini Nutritional Assessment after R25 experienced a significant change in condition and was admitted to the hospital on 12/16/24 for weakness, anorexia, and severe hypernatremia. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R25's dietary progress note after 12/16/24 hospital admission, states, in part; .1/2/25 .Resident is on a pureed diet with small portions and intakes average 50-80%. CBW (current body weight) is 130 which is stable. Skin is intact. Receives inner lip dish, beverages in cups with lids and straws at all meals. Did flag for at risk for malnutrition d.t. (due to) dementia. Will continue to monitor and update as needed . It is important to note this is the only dietary progress note after being hospitalized on [DATE] for weakness, anorexia, and severe hypernatremia. R25's Mini Nutritional Assessment, states, in part; .Effective Date: 1/2/25 .Score 8 .At risk for malnutrition . screening A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? No decrease in food intake. B. Weight loss during the last 3 months: No weight loss. C. Mobility: Bed or chair bound. D. Has suffered psychological stress or acute disease in the past 3 months? Yes. E. Neuropsychological problems: Severe dementia or depression . R25's Mini Nutritional Assessment, states, in part; .Effective Date: 3/17/25 .Score 9 .At risk for malnutrition . screening A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? No decrease in food intake. B. Weight loss during the last 3 months: No weight loss. C. Mobility: able to get out of bed/chair but does not go out. D. Has suffered psychological stress or acute disease in the past 3 months? Yes. E. Neuropsychological problems: Severe dementia or depression . R25's Dehydration Risk Screening Tool, states, in part; .3/17/25 .fluid intake/eating: limited physical assist . weight: no weight loss .risk factor: no risk factor .Based on the results of this assessment and your clinical judgment, is this resident at risk for dehydration? .No .Takes adequate fluids at meals and is given fresh water at bedside 3 times per day . It is important to note, R25 has history of dehydration, has a diagnosis of dehydration, and through interview and observation R25 would be unable to adequately meet hydration needs without staff assistance. On 5/7/25 at 11:52 AM, Surveyor observed R25 receive total assistance from staff for all fluids and food. On 5/7/25 at 3:13 PM, Power of Attorney U (POA) indicated R25 had declined in December and had been admitted to the hospital. POA U indicated she felt like the facility didn't catch that R25 was losing the ability to eat and drink on her own and that led to being hospitalized . POA U indicated R25 came back to facility on hospice. POA U indicated R25 is no longer on hospice. On 5/13/25 at 10:18 AM, Registered Nurse O (RN) indicated if a resident is at risk for dehydration there should be an order stating to encourage fluids and the specific amount of fluids should also be on the MAR/TAR. RN O indicated the nurse on the floor should remind the Certified Nursing Assistants (CNA's) to encourage the residents that need extra fluids and reminders. RN O indicated that R25 needs encouragement and reminders to eat and drink. RN O indicated there are times that R25 will eat and drink around mealtimes and not always during the actual mealtime. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/13/25 at 10:25 AM, Certified Nursing Assistant P (CNA) indicated for the residents that need reminders and are at risk for dehydration CNA P will offer water every time she walks into the resident bedroom when she is assisting them with freshening, changing, and ADL's. CNA P indicated if someone is at risk for dehydration she will push more fluids. CNA P indicated they don't document the fluids but do document fluids during meals. CNA P indicated R25 needs encouragement and assistance to eat and drink. On 5/13/25 at 11:45 AM, CNA Q indicated if a resident is at risk for dehydration he would offer more fluids. CNA Q indicated he would offer fluids during meals and when going into the resident room. CNA Q indicated R25 very seldom will drink on her own and that she has always needed encouragement and assistance to eat and drink. CNA Q indicated R25 is no longer on hospice and CNA Q remembers in December when R25 had a decline in health. CNA Q indicated R25 always wheels herself up and down the hallways and some time in December she wasn't doing that. CNA Q indicated that was a change for R25 and then she was admitted to the hospital. On 5/13/25 at 1:28 PM, Registered Dietician R (RD) indicated the nutritional assessments should be completed quarterly and/or if a resident has a significant change. Surveyor asked RD R how staff would know R25's specific hydration goal and where is it documented? RD R indicated RD R could put in a specific order stating the exact amount. RD R indicated R25 has an order to encourage fluids with meals and in between meals 3 times a day and this order was started after hospitalization . RD R indicated RD R has recently started with the company and that RD R has been doing a lot of nutritional assessments. RD R indicated she was employed at the facility in December, but she was working remotely. Surveyor asked RD R if there are any additional interventions offered if a resident is at risk for dehydration? RD R stated, The people at risk of dehydration are reviewed when I'm doing their assessment. Surveyor asked RD R if she could provide any insight on R25's hospitalization on [DATE]. RD R indicated It's hard to speak on something I wasn't in the loop for. On 5/13/25 at 1:50 PM, CNA S indicated CNA S offers residents fluids when she is in resident rooms, assisting with cares, and during meals. CNA S indicated she assisted R25 with lunch today. CNA S indicated from her experience R25 needs staff physical assistance for meals and all fluids. On 5/13/25 at 2:06 PM, Nurse Practitioner T (NP) indicated she would expect the facility to encourage and provide interventions to promote hydration if the resident was not able to remember to eat and drink on their own. NP T indicated she would also expect the Registered Dietician to be actively involved as well. NP T indicated R25 is at risk for dehydration due to dementia. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/13/25 at 4:25 PM, Director of Nursing B (DON) indicated the facility attempted IV fluid for R25 because labs came back showing sodium level was at 169 and diagnosed with hypernatremia. DON B indicated she vaguely remembers the labs and the incident. DON B indicated the daughter wanted R25 to be sent out to ER. DON B indicated R25 came back on hospice because they were anticipating R25 was going to pass away. DON B indicated one of the interventions that was put in place when R25 came back was ensuring staff were offering her extra sips of water and drinks. DON B indicated in R25's state of dementia she doesn't know to take a drink. Surveyor asked if extra sips and drinks were provided before R25 was hospitalized . DON B stated, I can't say for sure, but probably not. Nurse Supervisor C (NS) indicated she does not recall any changes in R25 prior to 12/16/25. NS C indicated on 12/16/24 R25 slid out of her wheelchair and that was the first change. NS C indicated R25 usually wheels herself around the hallways and she was not doing that. NS C indicated they observed these changes and that is what triggered them to realize something more was going on. NS C indicated the labs were ordered because R25 slid out of her wheelchair, and this was unusual. NS C indicated the labs showing hypernatremia, foul urine, and weakness were all signs they observed on 12/16/24. NS C indicated they tried to start IV fluid at the facility. NS C stated, We couldn't get her IV in because she was so dehydrated. The facility failed to ensure there was a system in place to total and assess daily fluid intake, accurately assess and complete on-going assessments, and failed to update interventions to encourage hydration and nutrition for R25. Additional information was received and reviewed. 42038 Example 2 The facility policy titled Weight Monitoring dated 2/2025 states in part .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 .4. Interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status .6. Weight Analysis: The newly recorded resident weight should be compared to the previous weight. A significant change in weight is defined as: a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in 6 months (180 days) .7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. b. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to the weight loss . The facility policy titled Nutritional and Dietary Supplements dated 2/2025 states in part . 9. Supplements may be provided by dietician recommendation as allowed by physician standing order. 10. The care plan will be updated with the new or modified nutritional interventions. R26 was admitted to the facility on [DATE] with diagnoses that include history of a stroke, dementia, and polyosteoarthritis (arthritis occurring in 5 or more joints simultaneously). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R26's most recent MDS (Minimum Data Set) dated 3/11/25 states R26 has a BIMS (Brief Interview of Mental Status) of 3 out of 15, indicating that R26 is severely cognitively impaired. The MDS also states in Section K: K0300. Weight Loss: Loss of 5% or more in the last month or loss of 10% or more in last 6 months: 2. Yes, not on physician- prescribed weight- loss regimen. R26's care plan revised on 2/21/24 states in part: . Focus: NUTRITION/HYDRATION: Potential for Complications with Nutrition / hydration d/t (due to) Dementia, GERD. Goal: Will eat / drink as desired / accepted / tolerated through next review date. Interventions/ Tasks: Diet: Heart Healthy pureed. Set up meal per resident direction and assist with eating as/if needed. Honor food requests as able. Allow to eat / drink as desired / accepted / tolerated. Adaptive Equipment: All food in small silicone mugs. Two handled spouted cups. Offer fluids between meals . R26 most recent RD Nutritional Risk Tool dated 1/11/24 states in part . 1f. Calories needed 1258- 1363 .2f. ml (milliliters) hydration needed 1500- 1680 . 3g. gms (grams) protein needed 56- 67 . It is important to note that the facility did not have a completed comprehensive dietary assessment for R26 since 1/11/24 that calculates R26's calorie, protein, and hydration needs. R26's weights are as follows: 12/8/24: 152.3 1/8/25: 154 2/8/25: 149 3/8/25: 149.8 4/8/25: 153 5/8/25: 142 From 4/8/25 to 5/8/25 R26 had a weight loss of 7.19 pounds. There is no documentation indicating that the Physician or Nurse Practitioner was updated. Physician's orders: 1/31/25: Mirtazapine Oral Tablet 15 mg (milligram) Give 0.5 tablet by mouth one time a day for BPSD (Behavioral and Psychological Symptoms of Dementia) x 7 days, then 15mg daily. Dietary/ Nutrition Notes state the following: 3/7/2025 3:02 PM Note Text: Weight remains decreased over the past six month and stable over the past month. Current diet is cardiac pureed, Intakes fluctuate does a large breakfast with smaller lunch and supper. Does have special bowls where she can hold and self [sic] as well as cups with spout and two handles. Does take mirtazapine which is also an appetite stimulant. Skin is intact. Will continue to monitor and update as needed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	3/11/2025 11:57 AM Note Text: Resident is here long term. Current diet is cardiac pureed, and intakes fluctuate. Eats . large breakfast and smaller lunch and supper. All food is served in small silicone mugs where she can hold on to and 2 handles spouted cups. CBW (Current Body Weight) is 150# stable over month and decreased over the past six months however BMI (Body Mass Index) remains increased at 29.3. Does take mirtazapine which is also an appetite stimulant. Skin is intact. Will continue to monitor and update as needed. 3/20/2025 10:23 AM Note Text: Weekly weight note: Weight remains decreased over the past six months by 17.2#/10.3. This was related to downgrade in diet and nausea. Is stable over month. Intakes are good. Receives food in small silicone mugs where she can hold and self-feed as well as 2 handled cups with a spout. Does take cups with lids and straws when she is hunched over at meals and cannot use the other cup. Skin is intact. Will continue to monitor and update as needed. 4/10/2025 2:23 PM Weight Change Note: Weight has decreased over the past month by 10#/6.3%. Current diet is pureed, and food is served in cups she can hold and drinks in cups with 2 handles. Takes mirtazapine, which is also an appetite stimulant. Current intakes are 50% which at times is 25% and others 75%. Starting ensure BID. Skin is intact. Will continue to monitor and update as needed. It is important to note that R26 does not have a physician's order for Ensure. Nurse's note with effective date of 1/31/25 and a created date of 4/16/25 states: resident was started on mirtazapine for weight loss. GNP (Gerontologic Nurse Practitioner) in house and updated regarding weight loss. (of note, this note was put in approximately 75 days later.) On 5/7/25 at 9:37 AM, Surveyor interviewed R26. Surveyor asked R26 how she likes the food, R26 stated that she didn't like the food, it's mush. Surveyor asked R26 if she receives any snacks, R26 stated no. On 5/12/25 at 9:34 AM, Surveyor interviewed CNA X (Certified Nursing Assistant). Surveyor asked CNA X how staff knows if a resident is to receive a snack, CNA X reported that it would show up when they are completing documentation. CNA X reported that there is a snack list for PM shift (evening), and a snack cart that is prepared by the dietary staff. Surveyor asked if snacks are provided during the day shift, CNA X stated no, but the kitchen is open, and residents can come in and ask for a snack. Surveyor asked CNA X how staff knows if a resident is to receive Ensure, CNA X stated that it is on the meal ticket and dietary staff gives it during meals. On 5/12/25 at 9:59 AM, Surveyor interviewed DA AA (Dietary Aide). Surveyor asked DA AA how often they are offering R26 Ensure, DA AA stated they offer it every day and that R26 doesn't eat much food. DA AA reported that this morning R26 refused the Ensure. DA AA stated that the thicker Ensure is hard for R26 to drink when she is not feeling well, but she likes the clear, juice like one. Surveyor asked DA AA if the refusals are reported, DA AA stated that they (refusals) are reported to the nurse. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/12/25 at 10:15 AM, Surveyor interviewed DM W (Dietary Manager). Surveyor asked DM W if R26 is being seen by the RD (Registered Dietician), DM W stated that the RD only comes in once a week and if a resident has weight changes, they would be referred to the RD. Surveyor asked DM W why the RD hasn't seen R26 for weight loss, DM W stated that she did not know. Surveyor asked DM W how she would know if the RD was seeing a resident, DM W stated that she wouldn't know. Surveyor asked DM W how they would know what a resident's calorie, protein, and hydration needs are, DM W stated that she would calculate that, and it goes into the MDS quarterly and annual assessments. Surveyor asked if it would be documented in a note, DM W stated that she puts in a note about percents eaten. Surveyor asked DM W if she is able to initiate a nutritional supplement without a physician's order, DM W stated yes. Surveyor asked DM W who tracks if R26 is drinking the Ensure, DM W stated that dietary staff writ [TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on observation, interview, and record review, the facility did not ensure residents who receiving nutrition and medication by G-tube (Gastrostomy tube, a thin flexible tube inserted through a small incision in the abdomen and into the stomach, used to provide nutrition and fluids) receive the appropriate treatment and services. This affects 1 of 1 residents (R42) reviewed for tube feedings. The facility did not properly check placement of R42's G-tube prior to administering tube feeding. This is evidenced by: The facility's policy entitled, Care and Treatment of Feeding Tubes, dated 4/2/25, states, in part: Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . 1. Feeding tubes will be utilized according to physician orders . 4. The facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs . 6. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location . a. Tube placement will be verified before beginning a feeding and before administering medications by auscultation and aspiration (use of a syringe to pull out or check content) of stomach contents . R42 was admitted to the facility on [DATE] with diagnoses that include, in part: encephalopathy (disease or disorder that affects the brain's structure or function), unspecified severe protein-calorie malnutrition, adult failure to thrive, and abnormal weight loss. R42's Admission Minimum Data Set with Assessment Reference Date of 3/18/25 indicates R42 has a Brief Interview for Mental Status (BIMS) score of 99, indicating that the interview could not be completed. Section C indicates R42 has short term and long-term memory problems and has severely impaired decision-making skills regarding tasks of daily life. Section K indicates R42 has a feeding tube. R42's Physician Orders indicate: Enteral Feed Order four times a day for nutrition. Flush feeding tube with 100 cc (cubic centimeters) of H2O (water) four times a day and 60 cc of water before and after each feeding. Start date: 4/9/25. Order status: Active. R42's Comprehensive Care Plan indicates, in part: Focus: Feeding Tube: Actual/At Risk/ and/or Potential for complications with tube feeding. Date Initiated: 3/13/25. Interventions/Tasks: Check for tube placement & gastric contents/residual volume per facility protocol and record. Hold feeding if more than 200 cc (cubic centimeters) aspirated. Date Initiated: 3/13/25. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 9:06 AM, Surveyor observed RN J (Registered Nurse) start a feeding through R42's G-tube. Surveyor observed RN J check the G-tube placement with air, but not by aspiration of stomach contents. (Of note: Facility policy and R42's Comprehensive Care Plan indicate R42 is to have gastric contents aspirated when checking for tube placement and prior to providing feeding.) On 5/12/25 at 10:48 AM, Surveyor interviewed RN J. Surveyor asked RN J if the facility required resident's gastric contents to be aspirated prior to starting a tube feeding. RN J indicated she has tried in the past but that she usually doesn't aspirate any gastric contents. Surveyor asked RN J if she should have aspirated R42's gastric contents prior to starting her tube feeding. RN J indicated yes, but she usually just uses air to test placement. On 5/13/25 at 3:13 PM, Surveyor interviewed NS C (Nursing Supervisor). Surveyor asked NS C what her expectation is for staff when checking for proper G-tube placement. NS C indicates she would expect staff to listen for air flow into the tube and aspirate gastric contents. Surveyor asked NS C if R42 should have had gastric contents aspirated prior to her tube feeding. NS C indicates, yes. On 5/13/25 at 3:19 PM, Surveyor interviewed DON B (Director of Nursing) . Surveyor asked DON B what her expectation is for staff when checking for proper G-tube placement. DON B indicates she would expect staff to flush water and aspirate gastric contents. Surveyor asked DON B if R42 should have had gastric contents aspirated prior to her tube feeding. DON B indicates, yes. On 5/16/25, NHA A (Nursing Home Administrator) provided additional information that included Chapter 17 enteral tube management- Nursing skills, that states in part: REDUCING RISK OF ASPIRATION . Measurement of gastric residual volume (GRV) is performed by using a 60-mL syringe to aspirate stomach contents through the tube. It has traditionally been used to assess aspiration risk with associated interventions such as slowing or stopping the enteral feeding. GRVs in the range of 200-500 mL cause interventions such as slowing or stopping the feeding to reduce risk of aspiration.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview and record review, the facility did not comprehensively assess or develop a person-centered comprehensive care plan to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (R3) reviewed for behavior management. R3's son passed away and R3 experiences on going grief and sadness. R3 receives behavioral health services, but interventions and recommendations have not been care planned. R3 shared she has past trauma, and this has not been care planned to ensure all staff are aware and offer appropriate interventions and support. Evidenced by: R3 was admitted to the facility on [DATE] with a diagnoses including unspecified dementia, abnormalities of gait and mobility, major depressive disorder, chronic pain, unspecified mood, and other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence. R3's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 3/18/25, indicates R3 has a BIMS (Brief Interview for Mental Status) score of 11 indicating R3 is moderately cognitively impaired. R3 has an activated power of attorney. R3's Trauma Screening Assessment, dated 3/28/25, states, in part; . E. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries? 1. YES .G. Has anyone ever made you or pressured you into having some type of unwanted sexual contact? 1. YES .F. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up) a. Happened to me .G. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb) a. Happened to me .H. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm) a. Happened to me .I. Other unwanted or uncomfortable sexual experience a. Happened to me .L. Life-threatening illness or injury a. Happened to me .M. Severe human suffering a. Happened to me .O. Sudden, unexpected death of someone close to you a. Happened to me . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Psychology appointment, dated 12/30/24, states, in part; .Necessity for referral: .Client is exhibiting maladaptive behavioral symptoms that affect functioning, client is experiencing emotional symptoms that affect functioning .Staff report R3 has been socially withdrawn, sleeping a lot more than typical, and has been tearful since the recent passing of her son .Excessive guilt endorsed. Example including feeling as though putting her son's picture in a spot where she does not see him so frequently (Trigger to distress and tearfulness) would be like me forgetting about him.Treatment Recommendations: .2. Writer will focus also on identifying ways to increase positive emotion over time using positive psychological interventions and behavioral modification .4. Writer will integrate faith-based concepts as it relates to comping [sic] and grief/loss whenever appropriate given resident's strong faith. 5. Consider having staff open her blinds daily, especially on sunny days. 6. Continue to encourage and invite resident to attend activities to serve as distraction and to reduce oversleeping during the day. 7. Consider having a roommate for R3 if possible to help increase social contact and reduce isolation. 8. She may benefit from increased spiritual service support whenever available. 9. Recommend staff respond to tearfulness and clear displays of sadness (grief) with Of course you feel this way. It is ok to feel the way you do. With the goal of providing validation and a situation where R3 may feel less inclined to withdraw into her room. 10. Given the recent loss of her son and the closeness of their relationship, R3 will need time to feel less distressed. Writer will coordinate with her PCP (primary care physician) and NP (nurse practitioner) team if her depressive symptoms persist beyond what would be expected or if depressive symptoms intensify further . R3's Comprehensive Care Plan, states, in part; .MOOD/BEHAVIOR: Actual and/or potential for complications with mood/behavior .Encourage/assist to activities of choice. Encourage resident to be out of room . R3's Kardex, states, in part; .Behavior/Mood: Observational Behavior Monitoring . It is important to note R3's care plan does not have recommended interventions from her psychology appointment to support her with her grief from losing her son. On 5/7/25 at 1:10 PM, Surveyor observed R3 laying in bed. R3 indicated her son passed away and he was the only son that lived in Wisconsin. R3 was teary eyed when she talked about her son. R3 indicated she talks to a few nurses about how she is feeling and that has helped. R3 indicated she receives services from behavior health. On 5/12/25 at 8:40 AM, Surveyor interviewed Nursing Home Administrator A (NHA) Surveyor asked NHA A if she is aware of R3's past trauma? NHA A indicated she does not know specifics of R3's trauma, but that DSS G (Director of Social Services) would be able to speak more on that. NHA A indicated R3 receives services with behavior health, and she would expect interventions to be care planned. On 5/12/25 at 3:39 PM, Director of Social Services G (DSS) indicated R3 has shared with her that she was abused by her father as a child. DSS G indicated R3 didn't elaborate or share any more information other than that. DSS G indicated recommendations and interventions made by behavior health should be care planned. DSS G indicated nursing or social services would be responsible for making sure it's care planned. The facility did not comprehensively assess or develop a person-centered comprehensive care plan for R3 to attain or maintain the highest practicable mental and psychosocial well-being regarding her past trauma or the loss of her son.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52027 Based on observation, interview, and record review, the facility did not ensure residents are free of significant medication errors, for 1 of 4 residents reviewed in the medication administration task (R32). Surveyor observed RN J (Registered Nurse) crush R32's Levetiracetam ER (Extended Release) (an anticonvulsant medication used to prevent and control seizures for people with epilepsy) and prepare to administer it to R32. Evidenced by: The facility policy, Medication Administration, dated 2/2025, states in part: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation .17. Administer medications as ordered in accordance with manufacturer specifications .c. Crush medications as ordered. Do not crush medications with do not crush instructions. R32 was admitted to the facility on [DATE] with diagnoses that include generalized idiopathic (unknown cause) epilepsy and epileptic syndromes (seizures). R32's Physician Orders, signed 6/18/24, include, in part, the following medication: Keppra XR oral tablet extended release 24 hour 500 mg (Levetiracetam) Give 2 tablets by mouth every 12 hours related to localization related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable (difficult to control), with status epilepticus (medical emergency characterized by continuous seizures or multiple seizures without recovery time) On 5/12/25 at 8:04 AM, Surveyors observed RN J crush seven of R32's medications, two of them being Levetiracetam ER 500 mg tablets, and prepare to administer them to R32. It is important to note extended-release medications are not to be crushed. According to the Epilepsy Foundation, Keppra [the brand name for Levetiracetam] XR tablets must be swallowed whole. They should not be chewed, broken, or crushed (https://www.epilepsy.com/tools-resources/seizure-medication-list/levetiracetam-xr). Extended release medications dissolve slowly in the body to ensure a longer therapeutic effect. If the medication is crushed and absorbed quickly, there is a greater chance of a seizure occurring. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 8:10 AM, Surveyors stopped RN J before medications were administered to R32. Surveyors asked RN J to verify the uncrushed medication in the separate cup was Metoprolol ER. RN J confirmed the medication was Metoprolol ER. Surveyors asked RN J if the Levetiracetam tablets should have been crushed, since they were an extended release medication. RN J indicated, they shouldn't have been crushed, but she was going to administer them anyway. RN J indicated, R32's chart doesn't specify how to administer his medications, but she had assumed they should be crushed because R32 previously had a stroke and it's difficult for him to take medications. RN J indicated if Surveyors hadn't stopped her, she wouldn't have caught the error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52027 Based on observation, interview, and record review, the facility did not assure drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional practices and include the expiration date when applicable in 1 of 1 medication room. Surveyors observed the following: -6 stock antibiotic ointments were expired, found in the medication room: -3 antibiotic ointments (bacitracin zinc) expired on ,d+[DATE], ,d+[DATE], and ,d+[DATE] -1 triple antibiotic ointment (bacitracin zinc / neomycin sulfate / polymyxin B sulfate) expired on ,d+[DATE] and 2 expired on ,d+[DATE] Evidenced by: The facility policy, Medication Storage, dated ,d+[DATE], states in part: Policy: It is the policy of this facility to ensure all medications house on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations .8. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our Destruction of Unused Drugs Policy. On [DATE] at 2:21 PM, Surveyors observed the medication storage room with DON B (Director of Nursing). Surveyors found six expired stock antibiotic ointment cream: three antibiotic ointments expired in ,d+[DATE], , d+[DATE], and ,d+[DATE], one triple antibiotic ointment cream expired in ,d+[DATE], and two triple antibiotic creams expired in ,d+[DATE]. On [DATE] at 2:30 PM, Surveyors interviewed DON B. DON B verified all six antibiotic ointment creams were expired. DON B indicated, the creams should not be in circulation since they are expired. DON B pulled the antibiotic ointment creams for disposal.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44552 Based on observation, interview, and record review, the facility did not ensure food was prepared and served in a safe and sanitary manner. This practice has the potential to affect all 48 residents who reside at the facility. Surveyor observed dietary staff directly touching food with bare hands. Surveyor observed staff enter kitchen area while food service was taking place, not wearing a hair restraint. Evidenced by: The facility policy, Food Safety Requirements, dated 2/25, states, in part; .7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. a. Staff shall not touch food with bare hands, exhibiting appropriate use of gloves, tongs, deli paper, and spatulas .d. Dietary staff must wear hair restraints to prevent hair from contacting food . On 5/12/25 at 7:26AM, Surveyor observed a dietary staff directly touching sausage with their bare hands. Surveyor observed dietary staff touching inside lip of fruit cups directly touching the food. Dietary staff was not wearing any gloves at the time. No hand hygiene was observed. Surveyor observed staff enter the kitchen area while food service was taking place and was not wearing a hair restraint. On 5/13/25 at 9:46AM, Dietary Aide V (DA) indicated it is never acceptable to touch food with bare hands. DA V indicated tongs should be used or wear gloves. DA V indicated hairnets must be worn any time in the kitchen and service area. On 5/13/25 at 10:00AM, Dietary Manager W (DM) indicated staff should never directly touch food with bare hands. DM W indicated staff should wear gloves. DM W indicated all staff should wear hairnets when in the kitchen and food service area. The facility did not ensure food was prepared and served in a safe and sanitary manner.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on interview and record review, the facility did not maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized in accordance with accepted professional standards and practices in 13 of 13 residents reviewed (R26, R3, R41, R21, R19, R31, R13, R42, R36, R25, R20, R5, & R15). The facility did not have readily accessible MD/NP visit notes for R26, R3, R41, R21, R19, R31, R13, R42, R36, R25, R20, R5, and R15. Evidenced by: The facility policy titled Physician Visits and Physician Delegation dated 2/2025 states in part .1. The Licensed Nurse should: a. Track due dates of physician visits .f. Remind the physician to date and sign all order and write a progress note .3. The Director of Nursing or Designee should: a. Conduct monthly audits for timeliness of physician visits . The facility's policy titled Documentation in Medical Record dated 2/2025 states in part Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy . On 5/8/25, Surveyors discovered that residents in the Resident sample chosen did not have visit notes from their MD/ NP in their EHR or in their paper charts. Surveyors requested visit notes since May 2025 to current; all noted were printed off of [EHR] during this survey. Example 1 R26 was admitted to the facility on [DATE]. R26 did not have any documentation in the facility's EHR (Electronic Health Record) or paper chart regarding any routine or acute MD/ NP (Medical Doctor/ Nurse Practitioner) visits. Example 2 R19 was admitted to the facility on [DATE]. R19 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 3 R31 was admitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R31 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 4 R13 admitted to the facility on [DATE]. R13 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 5 R36 admitted to the facility on [DATE]. R36 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 6 R15 was admitted to the facility on [DATE]. R15 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. 49434 Example 7 R41 was admitted to the facility on [DATE]. R41 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 8 R21 was admitted to the facility on [DATE]. R21 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 9 R42 was admitted to the facility on [DATE]. R42 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. Example 10 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20 was admitted to the facility on [DATE]. R20 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/ NP visits. 44552 Example 11: R3 was admitted to the facility on [DATE]. R3 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/NP visits. Example 12: R25 was admitted to the facility on [DATE]. R25 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/NP visits. Example 13: R5 was admitted to the facility on [DATE]. R5 did not have any documentation in the facility's EHR or paper chart regarding any routine or acute MD/NP visits. On 5/8/25 at 2:29 PM, Surveyor interviewed NS C (Nursing Supervisor). Surveyor asked NS C who is responsible for monitoring the frequency of MD/ NP visits, NS C stated that the clinic monitors the timing of visits. Surveyor asked NS C how the facility would know if a visit was missed, NS C stated that they wouldn't know. Surveyor asked NS C how the facility gets the visit notes and documentation from the visit, NS C stated that she would have to go into the clinic's [EHR]. Surveyor asked NS C if she is doing that, NS C stated that she is not doing it regularly. On 5/12/25 at 7:14 AM, Surveyor interviewed RN J (Registered Nurse). Surveyor asked RN J what the process is for reviewing MD/ NP visit notes, RN J reported that she has access to [EHR], but not everyone does. RN J stated that does not go into the [EHR] every day, but she could if she wanted to. RN J stated that they rely on the supervisors to tell them what they need to know. On 5/12/25 at 7:19 AM, Surveyor interviewed RN O. Surveyor asked RN O how staff can review MD/ NP visit notes, RN O reported that she would ask NS C. Surveyor asked RN O if she had access to [EHR], RN O stated no. On 5/12/25 at 8:03 AM, Surveyor interviewed LPN Y (Licensed Practical Nurse). Surveyor asked LPN Y how staff can review MD/ NP visit notes, LPN Y stated that she does not have access to [EHR] and that she would have to ask NS C or DON B (Director of Nursing). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 11:130 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A who is responsible for obtaining the notes from MD/ NP visits, NHA A stated that the Nursing Supervisor, DON, or Unit Clerk should be getting the documentation. Surveyor asked NHA A who is responsible for tracking MD/ NP visits, NHA A stated that Medical Records tracks the visits. On 5/13/25 at 1:09 PM, Surveyor interviewed MR Z (Medical Records). Surveyor asked MR Z if she is responsible for tracking MD/ NP visits, MR Z stated that in 2024, the facility did a whole house sweep and that a couple of weeks ago they discussed doing it again. MR Z stated that she is currently working on 2025. Surveyor asked MR Z who is responsible for obtaining visit noted from MD/ NP visits, MR Z stated that she will be and that she used to be but hasn't been. The facility did not have readily accessible MD/NP visit notes for R26, R3, R41, R21, R19, R31, R13, R42, R36, R25, R20, R5, and R15 in their health records.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review the facility did not ensure hospice collaboration and communication processes were established to ensure continuity of care between hospice and the facility for 2 of 2 residents (R31 and R41) reviewed for hospice. R31's current hospice plan of care was not available to facility staff. R41's current hospice plan of care was not available to facility staff. This is evidenced by: The facility's Coordination of Hospice Services policy, dated 2/2025, states, in part: When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being.2. The facility and hospice provider will coordinate a plan of care . 4. The facility will communicate with hospice and identify, communicate, follow and document all interventions put in place by hospice and the facility. 5. The facility will monitor and evaluate the resident's response to the hospice care plans. Example 1 R31 admitted to the facility on [DATE] and has diagnoses that include: corticobasal degeneration (a progressive neurological disorder that affects crucial structures in the brain, causing movement and cognitive problems), Alzheimer's Disease (a progressive brain disorder which leads to brain cell death), encounter for Palliative Care (care that focuses on quality of life rather than curative treatments). R31's facility care plan report states, in part: Focus: Hospice SSM Hospice Date 10/4/24 Admitting Dx: Dementia in corticobasal degeneration . Special Requests: comfort Date initated 10/4/24 .Interventions / Tasks . See hospice poc (plan of care) Date initiated 1/23/25 On 5/8/25 at 1:08 PM, Surveyor interviewed RN E (Registered Nurse) and asked about communication with hospice staff. RN E stated facility calls hospice with any concerns and talks with the staff while they are in the building. Surveyor asked if hospice staff share any documentation with the facility. RN E stated there is a binder at the nurse's station that the hospice nurses and CNAs (certified nursing assistants) write in. RN E stated that RN E has never looked in the binder, but believed that there were visit notes with resident vital signs and description of resident's day. Important to note: Surveyor reviewed hospice binder. Binder contained a listing of the hospice care team and a sign in form with hospice staff names and dates of visits. There were no visit notes or hospice plan of care in binder. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 1:50 PM, Surveyor interviewed NS C (Nursing Supervisor) and asked about documentation provided by hospice. NS C stated that visit notes are faxed to the facility. Surveyor asked if the hospice provides a plan of care. NS C stated yes, they (hospice) put it in the Care Plan section of the hard chart (paper chart). Surveyor and NS C reviewed R31's hard chart and did not locate a hospice plan of care. Surveyor asked who the facility's liaison for hospice is. NS C stated it is NS C. Surveyor asked who reviews the hospice plan of care. NS C stated that NS C does not. Surveyor asked who is responsible to ensure that the facility plan of care and the hospice plan of care match. NS C stated that whoever make/updates the facility plan of care along with hospice staff would ensure they match. NS C stated that MDS/IP D (Minimum Data Set / Infection Preventionist) updated the facility plan of care. On 5/8/25 at 2:18 PM, Surveyor interviewed MDS/IP D and asked how information if obtained for an update to the care plan. MDS/IP stated through morning report, talking with staff-nurse, CNA, social worker, therapy, and the 24 hour report. Surveyor asked if there was anything different for a hospice resident. MDS/IP D stated no. Surveyor asked if hospice shares a plan of care with the facility. MDS/IP D stated that at one time, MDS/IP D had asked a hospice nurse if they had a care plan to share and MDS/IP D did not receive anything. On 5/8/25 at 2:43 PM, Surveyor interviewed DON B (Director of Nursing) and asked if the facility is expected to review a hospice plan of care and ensure the hospice plan matches the facility plan of care. DON B stated yes. 49434 Example 2: R41 was admitted to the facility on [DATE], with diagnoses that include: hemorrhagic stroke (brain bleed), quadriplegia (paralysis of all four limbs and torso), and vascular dementia. R41's Significant Change in Status Assessment with an Assessment Reference Date (ARD) of 4/11/25, indicates R41 has a Brief Interview for Mental Status (BIMS) score of 99, indicating the interview could not be completed. Section C indicates R41 has short-term and long-term memory problems and is severely cognitively impaired when making decisions regarding tasks of daily life. Section O indicates R41 is receiving hospice care. R41's Physician Orders include: Hospice Provider: [Hospice Provider Name] . Revision Date: 4/15/25. Order Status: Active. R41's Comprehensive Care Plan indicates: Focus: Patient is on Hospice care related to: End of life care. Date Initiated: 4/15/25. Interventions/Tasks: Coordinate Care Plan with Hospice. Date Initiated: 4/15/25. Evaluate effectiveness of medications/interventions to address comfort. Date Initiated: 4/15/25. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep family informed of change in condition. Date Initiated: 4/15/25. Notify hospice of any change in condition or medication changes. Date Initiated: 4/15/25. Provide for any patient request within reason ie. (in example) Any food (including fast food), flowers, music, special pictures, church on DVD, Pets, etc. Provide religious/spiritual support as needed. Date Initiated: 4/15/25. Respect patient and family wishes. Date Initiated: 4/15/25. On 5/8/25 at 12:51 PM, Surveyor reviewed the hospice binder labeled, Hospice Communication Binder. Included in the binder for R41 is a document titled, Hospice Patient with names of R41's hospice team and a phone number to contact the hospice provider. Additionally, there is a document with columns for date, staff name, type of visit, report given too, and next visit timeframe, with various visits indicated on the document. Surveyor was unable to locate any hospice care plan included in the binder. Surveyor unable to locate a hospice care plan from Hospice within R41's paper chart or electronic medical record. Surveyor requested R41's hospice care plan from facility staff, as they needed to be retrieved from an outside electronic health record. On 5/8/25 at 2:43 PM, Surveyor interviewed DON B (Director of Nursing) and asked if the facility is expected to review a hospice plan of care and ensure the hospice plan matches the facility plan of care. DON B stated yes.

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St Clare Care and Rehab Center	1414 Jefferson St Baraboo, WI 53913

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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 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50228 Based on interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. This has the potential to affect all 48 residents who reside at the facility. The facility is not monitoring the temperature of their water heater or hot water storage tank as part of their control measures per their Water Management Program. This is evidenced by: The facility's infection Prevention and Control Program policy, dated 2/25, states, in part: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors .based upon a facility assessment and accepted national standards. b. The Infection Preventionist (IP) serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility . c. The RNs (Registered Nurses) and LPNs (Licensed Practical Nurses) participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff . 17. Water Management: .b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. The facility's Water Management Program, dated 5/13/25, states, in part: Control Measure Number: DWM38 Category: Domestic Water System Maintenance . Control Measure: Maintain water heater (WH) and hot water storage tank (HWT) outlet temperatures within target range . Monitoring: Either report WH and HWT outlet temperature gauge readings at least once weekly, preferably daily, or use sensors to automatically record readings . Limits: For HWT's and storage WH, the target low must be at least 140 degrees Fahrenheit . According to the State Operations Manual F880 states in part; Water Management . Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. Water management must be based on nationally accepted standards (e.g., ASHRAE (formerly the American Society of Heating, Refrigerating, and Air Conditioning Engineers), CDC (Center of Disease Control), or U.S. Environmental Protection Agency (EPA) and (continued on next page)

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	include: o An assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter) could grow and spread; and o Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them. According to the CDC Water Management Toolkit . monitor to ensure control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Per Centers for Disease Control and Prevention (CDC), 3/15/24 documents, in part: .Cold water guidance: Store and circulate cold water at temperatures below 77 F, although Legionella may grow at temperatures as low as 68 F (20 C). Hot water guidance: Store hot water at temperatures above 140 F (60 C). Ensure hot water in circulation doesn't fall below 120 F (49 C) and recirculate hot water continuously, if possible . Example 1 On 5/13/25 at 7:32 AM, Surveyor interviewed MDir M (Maintenance Director) and MntT N (Maintenance Tech) and asked about how the facility monitors the WH and HWT outlet temperatures. MntT N stated the last maintenance director had done some form of temperature testing, prior to leaving employment about a month ago, but no record logs had been found. MDir M stated there is a work order in the maintenance management computer system assigned for the 15th day of each month which states to check multiple locations for water temperature readings (must be between 110-115 degrees, document finding.). MDir M stated that MDir M has been unable to locate a report of any documented temperature readings. Surveyor asked if there was monitoring of the water temperature at the WH or HWT. MDir M stated no, there are no documented temperatures. Of note, 140 degrees is the temperature required to prevent Legionella. On 5/13/25 at 8:24 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked about temperature testing of the water heater outlet. NHA A stated that the past maintenance director had put a robust plan into place and NHA A believed that there had been testing at the boiler. Surveyor asked NHA A if documentation of temperature testing would be expected. NHA stated yes. The facility was not able to provide documentation of monitoring the temperature of the water heater or hot water storage tank to show they're monitoring their control measures per their water management plan.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review the facility failed to ensure they followed standards of practice for an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 of 17 sampled residents (R42) and 3 of 4 supplemental residents (R300, R16 and R11) reviewed for antibiotic stewardship. R300 had documented urinary symptoms. The facility did not verify that infection criteria was met or monitor symptoms and effectiveness of treatment following the start of an antibiotic. R42 started an antibiotic for urinary tract infection (UTI). The facility did not verify that infection criteria were met, monitor symptoms through time of order for antibiotic treatment, or monitor symptoms and effectiveness of treatment following start of antibiotic. R16 started an antibiotic for UTI. The facility did not verify that infection criteria were met, monitor symptoms through time of order for antibiotic treatment, or monitor symptoms and effectiveness of treatment following start of antibiotic. R11 had change in respiratory status and was started on an antibiotic for pneumonia. The facility did not verify that infection criteria were met or monitor symptoms and effectiveness of treatment following start of antibiotic. Evidenced by: The facility's Antibiotic Stewardship Program policy, dated 4/2025, states, in part: Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control Program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: Nursing staff shall assess residents who are suspected to have an infection . b. Monitoring antibiotic use: Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made. Antibiotic orders obtained upon admission, whether new admission or readmission to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness . 5. Nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic timeout within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory findings and will consult with the practitioner to determine if the antibiotic is to continue or if adjustmens need to be made based on findings .11. Documentation related to the program is maintained by the IP, including, but not limited to: .Assessment forms .data collection forms for antibiotic use, process, and outcome measures . McGeer revised criteria indicates the following: . Urinary tract infection (UTI) surveillance definitions . UTI without indwelling catheter. Must fulfill both 1 AND 2. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. At least one of the following signs or symptoms. - Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate. - Fever or leukocytosis, and greater than or equal to 1 of the following: - Acute costovertebral angle pain or tenderness; suprapubic pain; gross hematuria; new or marked increase in incontinence; new of marked increase in urgency; new or marked increase in frequency. - If no fever or leukocytosis, then greater than or equal to 2 of the following: - Suprapubic pain; gross hematuria; new or marked increase in incontinence; new of marked increase in urgency; new or marked increase in frequency. 2. At least one of the following microbiological criteria. - Greater than 10^5 cfu/ml (colony forming unit per milliliter) of no more than 2 species of organisms in a voided urine sample. - Greater than or equal to 10^2 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter. Pneumonia MUST fulfill 1, 2, AND 3 1. Chest radiograph as demonstrating pneumonia or presence of a new infiltrate 2. At least 1 of the following: 2. At least 1 of the following: - new or increased cough - New or increased sputum production. - O2 saturation <94% on room air or a reduction in O2 saturation of >3% from baseline. - New or changed lung examination abnormalities - Pleuritic chest pain - Respiratory rate >25 breaths/min 3. at least 1 of the constitutional criteria - fever - leukocytosis - Acute change in mental status from baseline (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Acute functional decline. Example 1 R300 admitted to the facility on [DATE] and has diagnoses that include: cystitis (an inflammation of the bladder); chronic kidney disease, stage 4 (moderate to severe kidney damage); gross hematuria (visible blood in the urine). P300's Progress Notes include: 4/8/25 9:32 AM Situation: Resident has hematuria, extreme burning with urination, flank pain.May we check a UA and/or labs? P300's Hospital Emergency Provider Note, date of service 4/8/25 6:12 PM, states, in part: R300 has been having dysuria (painful urination) over the past approximate 24 hours .dysuria is really the only symptom at this time .it is reasonable to send her home with outpatient p.o. (by mouth) antibiotics .Temperature 97.5 P300's April 2025 Medication Administration Record (MAR) includes: Cefdinir (antibiotic) oral capsule 300 mg (milligrams) by mouth every 12 hours two for UTI (urinary tract infection) for 6 days until finished. Order date 4/9/25 Surveyor requested progress notes regarding whether or not there are any further urinary symptoms or regarding antibiotic effectiveness through the end of this course of treatment. No progress notes were provided. Progress note was provided regarding a new episode of urinary symptoms beginning 4/25/25. R300's Progress Notes include: *4/25/25: Resident with complaints I have a bladder infection. Reports burning with urination before and after urination. Also c/o nausea before R300 urinates. Reports some frequency and only going in spurts. States s/s (signs and symptoms) for 3-4 days. Denies lower abdominal pain, denies hematuria. Afebrile (without fever). Fluids encouraged. MD to visit this afternoon. *4/28/25: Resident had a UA (urine test) sent off Friday night and resident has burning, blood in urine also. Could we get her started on some treatment? Important to note: there are no progress notes regarding urinary symptoms between 4/25/25 and 4/28/25. R300's April 2025 MAR includes: Cefprozil (antibiotic) Tablet 250 mg Give 1 tablet by mouth every 12 hours for infection for 7 days. Order date: 4/29/25 Surveyor requested facility documentation of infection meeting criteria, documentation regarding urinary symptoms for the time frame of 4/25 and 4/28/25 and documentation of and whether or not there were any further symptoms after start of and through completion of antibiotic treatment. No documentation was provided. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 10:10 AM, Surveyor interviewed MDS/IP D (Minimum Data Set / Infection Preventionist) and asked if there was monitoring of R300's urinary symptoms between 4/25/25 and 4/28/25. MDS/IP D stated there is no documentation of this. Surveyor asked how the facility determines infection. MDS/IP D stated McGeer's Criteria. Surveyor asked if this was reviewed for meeting McGeer's. MDS/IP D stated McGeer's was not checked due to the resident being seen at the hospital. MDS/IP D stated if a resident admits on antibiotic or has antibiotic prescribed in the emergency room that McGeer's is not verified by the facility. Surveyor asked if there was monitoring of the resident's symptoms and antibiotic effectiveness following start of antibiotic. MDS/IP D stated no documentation was noted. Example 2 R42 admitted to the facility on [DATE] and has diagnoses that include encephalopathy (a dysfunction or disease of the brain that alters its function or structure); adult failure to thrive (a state of decline in older adults that manifests as a downward spiral of health and activity); need for assist with personal care. R42's April 2025 MAR includes: Cefdinir oral capsule 300 mg Give 1 capsule by mouth two times a day for uti until 4/12/25. Order date 4/4/25. R42's Provider Telephone Encounter, dated 4/4/25, states, in part: nitrofurantoin (antibiotic) is generally not recommended for complex or complicated UTIs [for example fever, somnolence (drowsiness)], given its poor tissue penetration. I will order cefdinir.fever has improved and R42 became less somnolent with acetaminophen (medication used to reduce fever). So will monitor closely. Surveyor requested facility documentation of infection meeting criteria and documentation related to resident assessment of symptoms of UTI and whether or not there were any further symptoms after starting antibiotic and through completion of antibiotic treatment. No documentation was provided. On 5/13/25 at 10:10 AM, Surveyor interviewed MDS/IP D (Minimum Data Set / Infection Preventionist) and asked if R42 met McGeer's Criteria. MDS/IP D stated that it had been reviewed at time of antibiotic order, but there was no documentation of the review. Surveyor asked if there was monitoring of the resident's symptoms and antibiotic effectiveness following the start of the antibiotic. MDS/IP D stated no documentation was noted. Example 3 R16 admitted to the facility on [DATE] and has diagnoses that include: multiple sclerosis (a chronic, neurological disease, affecting communication between the brain and body, leading to a wide range of symptoms that may include bladder dysfunction), overactive bladder (a condition where the bladder squeezes urine out involuntarily at the wrong time, leading to sudden and strong urge to urinate), urge incontinence (a condition where there is a sudden, strong urge to urinate which is difficult to control, often resulting in leakage). R16's Provider Progress Note dated 3/27/25, states, in part: .noted to be more confused by nursing home staff. R16 denies urinary changes but has been noted to have frequency, incontinence, and foul-smelling urine per staff observation, history of sepsis (a life-threatening condition caused by the body's extreme response to an infection) secondary to UTI in the past. UA with culture reflex (laboratory test that identifies microorganisms, like bacteria, in a urine sample) has been ordered . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's Provider Telephone Encounter Note dated 3/28/25, states, in part: .urinalysis concerning for UTI. Since afebrile and no systemic symptoms to suggest complicated cystitis, recommend Macrobid 100 mg twice daily for 5 days. R16's Progress Note dated 3/28/25 3:09 PM, states, in part: Situation: with results of lab and urine will start resident on Macrobid (antibiotic) for UTI . R16's March 2025 MAR includes: *Macrobid oral capsule 100 mg give one capsule by mouth two times a day for UTI for 5 days. Order date 3/28/25. D/C (Discontinue) date 3/31/25 *Macrobid oral capsule 100 mg give one capsule by mouth two times a day for UTI until 4/7/25 11:59 PM Take with morning and evening meal. Order date 3/31/25. Surveyor requested facility documentation of infection meeting criteria and documentation related to resident assessment of symptoms of UTI and whether or not there were any further symptoms after the start of and through completion of the antibiotic treatment. No documentation was provided. On 5/13/25 at 10:10 AM, Surveyor interviewed MDS/IP D (Minimum Data Set / Infection Preventionist) and asked if R16 met McGeer's Criteria. MDS/IP D stated that it had been reviewed at time of antibiotic order, but there was no documentation of the review. Surveyor asked if there was facility documentation of symptoms prior to the provider assessment. MDS/IP D stated no documentation was noted. Surveyor asked if there was monitoring of the resident's symptoms and antibiotic effectiveness following the start of the antibiotic. MDS/IP D stated no documentation was noted. Example 4 R11 admitted to the facility on [DATE] and has diagnoses that include chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs); paroxysmal atrial fibrillation (an irregular heart rhythm which can cause fluttering or pounding in the chest and shortness of breath); dependence on supplemental oxygen. R11's Progress Notes include: *2/11/25 9:26 AM .residents vital signs taken. Oxygen saturation was 99% on 2.5L (liter flow of oxygen); however, her respirations were 38. Lung sounds diminished with some coarse crackles heard in the right base, very shallow breathing. Resident denied SOB (shortness of breath) sitting in her chair at the time. Supervisor updated. *2/11/25 7:30 PM .spoke with daughter regarding chest xray which showed pneumonia and that R11 was started on an antibiotic . R11's Provider Telephone Encounter note, dated 2/11/25, states, in part: .Mobile chest xray completed due to new basilar crackles (abnormal lung sounds) and tachypnea (abnormally rapid breathing), vital signs, no hypoxia, patient denies shortness of breath. Concerning for L (left) pneumonia, recommend treating empirically due to frailty .Levofloxacin (antibiotic) 750 mg po (by mouth) every 48 hours x (for)4 doses . (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's February 2025 MAR (Medication Administration Record) includes: Levofloxacin oral tablet 750 mg give 1 tablet by mouth every 48 hours for pneumonia for 4 administrations. Order date 2/11/25. Surveyor requested facility documentation related to resident assessment of symptoms of pneumonia after starting the antibiotic and through completion of antibiotic treatment. No documentation was provided. On 5/13/25 at 10:10 AM, Surveyor interviewed MDS/IP D (Minimum Data Set / Infection Preventionist) and asked if R11 met McGeer's Criteria. MDS/IP D stated that it had been reviewed at time of antibiotic order, but there was no documentation of the review. Surveyor asked if there was monitoring of the resident's symptoms and antibiotic effectiveness following start of antibiotic. MDS/IP D stated no documentation was noted. On 5/13/25 at 1:16 PM, Surveyor interviewed DON B (Director of Nursing) and asked about facility protocol for resident's with new symptoms. DON B stated staff is expected to monitor for at least 72 hours or through course of antibiotic/wellness. Surveyor asked if this monitoring is documented. DON B stated yes. Surveyor asked how infections are determined. DON B stated through McGeer's Criteria. Surveyor asked if McGeer's Criteria is expected to be documented. DON B stated yes.