STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525325	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not provide the opportunity for 2 (R600 and R601) of 3 Residents reviewed to participate in the development and implementation of their person-centered plan of care by not facilitating the inclusion of R600 and R601 in the care planning process. *R600 was admitted on [DATE], and there is no documentation in R600's electronic medical record that R600 and/or representative participated in the development and implementation of R600's person-centered plan of care. *R601 did not have a care conference, that included R601 or R601's representative, in order to develop, implement, or revise a plan of care between 3/19/2024 and R601's discharge on 8/12/2024. Findings Include: The facility's undated policy Care Management Guideline documents: .Guideline: The purpose of the initial Care Management Meeting is to communicate to the patient and patient representative, within 48 hours of admission, the baseline plan of care, barriers to the discharge plan, and care and services to be provided. The Initial Care Management Meeting is an important part of establishing a partnership with the patient and patient representative which in turn contributes to achieving transitional care goals. Ongoing Care Management Meetings allows the Interdisciplinary(IDT) to communicate regarding the patient's progress and to adjust the plan of care should the patient's clinical status and/or stated discharge plans change. The patient and patient representative will be informed of any changes to the plan of care established at the Initial Care Management Meeting. Process: 1. Initial Care Management Meeting Scheduling (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admissions staff will explain the Care Management process to the patient and the patient representative and invited them to the Initial Care Management Meeting. Initial Care Management Meetings scheduled for the day will be announced at the morning stand up. 2. Patient Evaluation Prior to the Initial Care Management Meeting, IDT members complete an evaluation of the patient to identify: -Discharge plans -Specific barriers to the discharge plan -Estimated length of stay IDT members should collaborate on evaluation findings prior to the Initial Care Management Meeting whenever possible 3. Initial Care Management Meeting Guideline: Attendees: Minimum Data Set(MDS) or Nurse Designee/Therapy/SS/Patient and Patient Representative MDS staff or nursing designee documents the meeting utilizing the Care Management Evaluation Initial Care Management Evaluation/baseline plan of care will be printed and given to the patient or patient representative 4. Ongoing Care Management Meeting Guideline: MDS staff or Nurse Designee/Therapy/SS/BOM/other IDT members as needed Ongoing Care Management Meetings occur until barriers are resolved and the transition to the discharge setting is completed. Frequency is dictated by the needs of the patient Should the IDT conclude that the discharge plan is clinically inconsistent with the patient's likely functional outcome, a Care Conference is scheduled with the patient and patient representative to provide education, and modify plans for discharge and ongoing care MDS staff or nursing designee will document the meeting utilizing the Care Management Evaluation . 1.) R600 was admitted to the facility on [DATE] with diagnoses of Generalized Abdominal Pain, Tachypnea, Retention of Urine, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Hypothyroidism, Unspecified Psychosis, Anxiety Disorder, and Major Depressive Disorder. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R600 has a Durable Power of Attorney from the State of Alabama signed and dated on April 12, 2022 which includes both financial and health care decisions. R600's Quarterly Minimum Data Set (MDS) completed on 7/4/24 documents R600's Brief Interview for Mental Status (BIMS) score to be 15, indicating R600 is cognitively intact for daily decision making. R600 has no documented mood or behavior issues. R600 has no range of motion impairment. R600 is independent for upper and lower body dressing and independent for mobility and transfers. On 9/17/24, at 3:07 PM, Surveyor requested at the daily facility exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) information on when R600 had scheduled care conferences. Surveyor shared that Surveyor was unable to locate documentation in R600's Electronic Medical Record (EMR) that R600 and/or R600's representative had been invited to participate in an interdisciplinary (IDT) meeting to discuss ongoing care with patient-centered interventions. On 9/18/24, at 8:10 AM, Social Worker (SW)-D informed Surveyor that the social worker responsible for care conferences no longer worked at the facility and that the facility discovered there was a problem with care conferences being completed for Residents in the facility. SW-D stated the facility is trying to catch up on care conferences and has developed a calendar for care conferences to be held on Tuesday and Thursday with the IDT in attendance. SW-D shared that NHA-A discovered that IDT meetings with Residents and/or representatives getting done was an issue. On 9/18/24, at 1:15 PM, Surveyor interviewed NHA-A regarding care conferences. NHA-A confirmed the previous social worker no longer worked at the facility as of the end of August. NHA-A completed an audit which revealed that care conferences had not been held on a quarterly basis. NHA-A tried to do a touch point care conference to quickly try and meet with everyone in the facility and discuss discharge plans and any concerns. NHA-A stated care conference meetings are in process of getting completed based on a Resident's MDS quarterly schedule. NHA-A understands the concern that R600 has had no documented care conferences since admission on 3/27/23. On 9/18/24, at 3:03 PM, Surveyor shared the concern with NHA-A and Director of Nursing (DON)-B the concern that R600 has had no documented care conferences to discuss R600's ongoing plan of care. No further information was provided by the facility at this time. 49011 2.) R601 was admitted to the facility on [DATE] and discharged on [DATE]. R601 admitted with diagnoses which include chronic obstructive pulmonary disease, type 2 diabetes, phantom leg syndrome, and bipolar disorder. On R601's Quarterly Minimum Data Set (MDS) assessment, dated 6/6/2024, the Facility assessed R601 as having severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 02. R601 was assessed to have clear speech and be usually understood and to usually understand others. R601 has adequate hearing and vision. No behaviors were exhibited during the look back period. R601 is always incontinent of bowel and bladder. No swallowing disorders were noted, R601 was coded to have a mechanically altered diet. Upper extremities have no impairment and lower extremities have an impairment on one side. R601 has an activated Power of Attorney (POA). (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the electronic medical record and found a progress note dated 3/20/2024, type: care conference note, late entry. The care conference was held 3/19/2024. Note text: SS (social services) meet with residence and son. He requested that when his mother has a fall, can someone call him asap. His concern is that he's notified hours or a day after the fall. He's requesting that staff check on his mother more during 2nd shift. He also has concerns regarding his mother's snacks. Son reported that staff is taking his mother snacks that he brings for her. He also reported that staff is always on the phone - 2nd shift staff. SS did put in a Grievance regarding his concerns for his mother. She doesn't do much activities, she likes to watch TV. Therapy did speak with son and provided update. She was in a good mood and eating food that her son provided to her. No other issues or concerns at this time. No care conferences were documented in R601's medical record after 3/19/2024. R601's care plan had been revised multiple times since 3/19/2024. No documentation was found indicating the changes to the care plan had been discussed with R601 or with R601's POA. Surveyor interviewed Social Worker-D on 9/18/2024, at 8:05am, and was told that March was the last care conference for R601. Surveyor notes there were over four and a half months that went by before R601's discharge and care conferences should be held quarterly. On 9/18/2024, at 3:03 PM, during the end of day meeting, Surveyor let the Nursing Home Administrator-A, Director of Nursing-B, Regional Nurse-S and Regional Director of Clinical Operations-T know of the concern that R601 had not had a care conference since 3/19/2024. No further information was provided at this time.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the Facility did not ensure 1 (R600) of 1 Resident's representative was notified when there was a need to alter treatment. R600's electronic medical record (EMR) has no documentation that R600's representative was notified of R600's colonoscopy being rescheduled to 1/3/25. On 8/28/24, R600 was sent to the emergency room (ER) for leg swelling and R600's representative was not notified. On 9/10/24, R600's physician was updated due to lab results and new order to discontinue Levothyroxine re-check TSH (thyroid stimulating hormone) and T4 (Thyroxine) in 5 weeks and Start Potassium (K+) 40Meq (milliequivalents) daily for 4 days due to decreased K+ re-check BMP (basic metabolic panel) and Mg in one week. On 9/12/24, R600's physician ordered new Lab TSH AND T4 and new orders for Levothyroxine 25 Mcg Daily. R600's representative was not notified about the labs and medication changes. Findings Include: The facility's policy Notification of Changes Guideline effective 11/28/17 and last revised on 7/24/19 documents: Purpose: .It is the practice of this facility that changes in a Resident's condition or treatment are immediately shared with the Resident and/or the Resident representative, according to their authority, and reported to the attending physician or delegate. The Resident and/or their representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Nurses and other care staff are educated to identify changes in a Resident's status and define changes that require notification of the Resident and/or their representative, and the Resident's physician, to ensure best outcomes of care for the Resident. Centers for Medicaid and Medicare Services (CMS) Definitions -Significant alteration in treatment-A need to alter treatment significantly. A significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. Objective of the Notification of Change Guideline (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The objective of the notification guideline is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and immediate notification to the Resident and/or Resident representative when there is a change in the Resident's condition, or an accident that may require physician intervention. The intent of the guideline is to provide appropriate and timely information about changes relevant to a Resident's condition or change in room or roommate to the parties who will make decisions about care, treatment and preferences to address the changes. Overview of Components of the Guideline 1. Requirements for notification of Resident, the Resident representative and their physician: 1.) An accident involving the Resident, which results in injury and has the potential for requiring physician intervention. 2.) A significant change in Resident's physical, mental, or psychosocial status 3.) A need to alter treatment significantly (i)A significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. 2. Requirements for notification of Resident and/or Resident representative(s), consistent with their authority (i)A change in room or roommate assignment (ii)A change in Resident rights under Federal or State law regulations (iii)A decision to transfer or discharge the Resident from the facility as specified Notification is provided to Residents and/or Resident representative(s) to promote the Resident's right to make choices about care and treatment and to keep them informed of the Resident's current health status. Procedure For Notification of Changes For Resident Purpose The facility shall promptly notify the Resident and/or Resident representative and his or her physician or delegate of changes in the Resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the Resident's right to make choices about treatment and care preferences. Procedure 1. The nurse will immediately notify the Resident, Resident's physician and the Resident representative(s) for the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. An accident involving the Resident, which results in injury and has the potential for requiring physician intervention. b. A significant change in the Resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complication. d. A need to alter treatment significantly(a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment. e. A decision to transfer or discharge the Resident from the facility 3. Document the notification and record any new orders in the Resident's medical record. Additional Notification to the Resident and/or Resident Representative 1. In addition to a change in the Resident's condition, the Resident and/or representative(s) shall be notified promptly if there is: a. A decision to transfer or discharge the Resident from the facility. Notice must be given before the discharge occurs, and follow the requirements. b. A change in the Resident's room or roommate assignment c. A change in Resident rights under Federal or State law or regulations. 3. Document the notification and the Resident's response in the Resident's medical record. R600 was admitted to the facility on [DATE] with diagnoses of Generalized Abdominal Pain, Tachypnea, Retention of Urine, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Hypothyroidism, Unspecified Psychosis, Anxiety Disorder, and Major Depressive Disorder. R600 has a Durable Power of Attorney from the State of Alabama signed and dated on April 12, 2022 which includes both financial and health care decisions. https://www.nolo.com documents for the state of Alabama: .Your durable power of attorney takes effect as soon as you've signed it. A durable power of attorney (POA) in Alabama is automatically activated when signed, unless the document states otherwise. A POA in Alabama can include a financial power of attorney and a health care power of attorney. The financial POA allows an agent to manage assets, write checks, and sell real estate. The health care POA is similar to a living will and can appoint an agent and inform a doctor of treatment preferences. https://wwwlawdistrict.com documents: .A durable power of attorney (POA) from Alabama is recognized in Wisconsin: Uniform Power of Attorney Act (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wisconsin is one of 26 states that have adopted the Uniform Power of Attorney Act (UPOAA), which means that POAs from other UPOAA states are generally recognized in Wisconsin. Out-of-state POAs. A POA executed outside of Wisconsin is valid if it was executed in compliance with the law of the jurisdiction that determines its meaning and effect. Which states have adopted the Uniform Power of Attorney Act? 26 states have adopted the UPOAA: Alabama, Arkansas, Colorado, Connecticut, Georgia, Hawaii, Idaho, Iowa, Maine, Maryland, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Pennsylvania, South Carolina, Texas, Utah, Virginia, [NAME], [NAME] Virginia, Wisconsin, and Wyoming. On 9/17/23, at 1:02 PM, Surveyor reviewed R600's electronic medical record (EMR) which documents the following changes/altering R600's plan of care that would require notification to R600's POA. -R600's colonoscopy being rescheduled to 1/3/25. -On 8/28/24, R600 was sent to the emergency room (ER) for leg swelling and R600's representative was not notified. -On 9/10/24, physician was updated due to lab results and new order to discontinue Levothyroxine re-check TSH and T4 in 5 weeks and Start Potassium (K+) 40Meq daily for 4 days due to decreased K+ re-check BMP and Mg in one week. -On 9/12/24, R600's physician ordered new Lab TSH AND T4 and new orders for Levothyroxine 25 Mcg Daily. Surveyor notes there is no documentation that R600's representative (POA) was notified about the labs and medication changes, and the transfer to the emergency room . Further, Surveyor is unable to locate a documented hospital transfer form when R600 was transferred to the emergency roiagnom on [DATE]. On 9/17/24, at 2:34 PM, Surveyor interviewed R600. R600 confirmed that R600's POA was not notified of R600's transfer to the emergency room and wants R600's POA to be involved in all decisions. On 9/17/24, at 3:07 PM, Surveyor requested from Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B R600's 8/28/24 transfer form to the emergency room . On 9/18/24, at 12:20 PM, Surveyor confirmed with R600, that R600 wants R600's POA to be notified of all medication changes, transfers to the hospital, significant labs, etc, and R600 stated that R600 wants R600's POA to be a part of any decisions for R600. On 9/18/24, at 1:15 PM, Surveyor interviewed NHA-A regarding R600's required notifications to R600's POA. NHA-A stated there was confusion about R600's POA, however, agreed that as R600's representative, should have been notified of any changes or to discontinue any form of treatment or in the event of being transferred to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 3:03 PM, Surveyor shared the concern with NHA-A that R600's representative (POA) was not notified of labs, medication changes, and R600's transfer to the emergency room . No further information was provided by the facility at this time.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observation, interviews and record review the facility did not address and resolve grievances conveyed on behalf of 1 (R609) of 1 residents reviewed for grievances. On 9/3/24 a grievance was initiated for R609 related to wanting a comfortable mattress and/or a recliner for sleeping. The facility indicated the grievance was resolved when R609 was told the facility does not provide recliners for residents, but the resident could bring one from home and she could not have an air mattress because of a lack of wounds and R609 accepted the explanation. Part of the resolution of the grievance was telling R609 to pursue an air mattress on their own by contacting the Physician. The facility did not attempt to come up with an alternative option or resolution other than stating R609 does not have wounds, therefore, they cannot have an air mattress. R609 has a diagnosis of Amyotrophic Lateral Sclerosis (ALS). As of 9/17/24 R609 was still not provided a resolution to allow them to sleep in a comfortable chair or comfortable bed and was restricted to sitting and sleeping in a small wheelchair R609 described as uncomfortable and she can't move around at all because the space is narrow. On 9/18/24 R609 stated It's horrible being in this all day and night, I can't move at all, I can't turn on my sides or anything because it's too narrow. My legs go numb sometimes and I think they get frustrated when I call so much to change position. I would love to still try an air mattress if you could get them to agree. Findings include: R609 admitted to the facility on [DATE] and has diagnoses that include Amyotrophic Lateral Sclerosis (ALS), Anxiety Disorder, Adjustment Disorder with Depression, Gastro-Esophageal Reflux Disease, Hypertension and Insomnia. R609's Admission Minimum Data Set (MDS) dated [DATE] documents: Mobility - roll left and right: The ability to roll from lying on back to left and right side and returning to lying on back on the bed - Dependent. R609's Braden dated 9/4/24 documents a score of 12, indicating high risk for pressure injuries. At present, R609 has no pressure injuries. On 9/17/24 at 9:00 AM, as Surveyor was walking in the hall, R609 asked to speak with Surveyor. Surveyor observed R609 sitting upright in a wheelchair with footrests and a high back which reclines. Surveyor observed soft blue arm rests on both sides and a blue cushion on the chair. R609 reported she complained to the facility that her bed was uncomfortable and asked for a new mattress. R609 reported she has been sleeping in her wheelchair because the facility has not provided a new mattress and she was told she can't have an air mattress because she doesn't have any wounds. R609 reported she has shared this concern with Assistant Nursing Home Administrator (ANHA)-U, but nothing has improved and she has not received a new mattress. R609 reports she is not comfortable sleeping in the chair and she can't move around at all because the space is narrow. Surveyor noted the wheelchair is narrow and does not allow room to shift from side to side. R609 reported she would prefer to sleep in a bed and would like to at least try an air mattress because the bed she has is way too uncomfortable. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed a grievance filed by R609 dated 9/3/24. The grievance completed by ANHA-U documented: Describe the concern: Resident requested a recliner to sleep in; bed is not comfortable for her. Resolution Action Taken: How did we resolve the concern? 9/3/24 spoke with UM (Unit Manager) regarding bed/mattress - there are no other options available at this time; resident has no wounds to warrant air mattress. Explained this to resident who is accepting of explanation. Advised resident to discuss use of an air mattress with her MD (Medical Doctor). Date of resolution: 9/4/24. Followed up with resident who thanked me for the help and expressed her desire to be at home with significant other. On 9/18/24 at 10:30 AM, Surveyor interviewed ANHA-U. Surveyor asked what did the facility do in regards to R609's complaint and request for a different mattress and why is it R609's responsibility to call the doctor to discuss use of an air mattress. ANHA-U stated: To be honest, I did talk with the UM and the Wound Care Nurse (Wound RN-Q). I wanted her to try the air mattress, but I was told she doesn't qualify for an air mattress because she doesn't have any wounds. Basically all our other mattresses are the same. We did have one we were going to try, but the bed control is on the rail and we can't use rails because they're a restraint. Surveyor asked if R609 was provided a special cushion for the wheelchair, since she sleeps in the chair. ANHA-U reported she did not think so. Surveyor advised ANHA-U R609 still has complaint that she has to sleep in her wheelchair because she does not have a comfortable bed available. Surveyor asked ANHA-U how she determined the grievance to be resolved. ANHA-U stated: Because I spoke with her and explained she couldn't have an air mattress because she doesn't have any wounds, and she accepted the explanation. Surveyor asked what choice did R609 have? AHNA-U stated: I guess none. I did try to get an air mattress for her but was told no. Surveyor asked if anyone at the facility called the doctor to inquire about an air mattress. ANHA-U stated: I don't think so, because she doesn't have any wounds. Surveyor asked why she advised R609 to call the doctor. AHNA-U stated: I just thought that might be an option so she could get one. On 9/18/24 at 11:45 AM, Surveyor observed R609 sitting in her wheelchair in the hall. Surveyor asked if she was still sleeping in her wheelchair. R609 stated: Yes, they said they have no other bed or mattress for me. R609 stated: It's horrible being in this all day and night, I can't move at all, I can't turn on my sides or anything because it's too narrow. My legs go numb sometimes and I think they get frustrated when I call so much to change position. I would love to still try an air mattress if you could get them to agree. Surveyor noted R609's current care plan does not document that R609's sleeps in her wheelchair. In fact, the care plan documents: The resident has actual for an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) ALS. Intervention - Bed Mobility: The resident uses bilateral enabler bars to maximize independence with turning and repositioning in bed - dated 8/16/24. On 9/18/24 at 3:00 PM the facility was advised of concern R609 filed a grievance that her bed is not comfortable. There is no evidence the facility attempted to replace the bed or mattress, thus R609 has been sleeping in her wheelchair. Nursing Home Administrator (NHA)-A reported the grievance was resolved because the resident did not complain about comfort, she reported the bed was broken and she has emails to prove it. Surveyor advised NHA-A the grievance R609 filed on 9/3/24 documents R609 requested a recliner to sleep in; bed is not comfortable for her. Surveyor was provided email chain between the facility and staff at Board of Aging & Long Term Care (BOALTC). (continued on next page)

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	525325	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BOALTC 8/30/24: I am writing on behalf of (R609). (R609) let me know she has been sleeping in her wheelchair because her bed is broken. She mentioned getting a more comfortable bed, but also indicated that even as she looks at other options she would like a bed to be able to sleep in. She was told one would be ordered but that was a while ago. She is unable to lay flat because she is aspirating. Surely there is another bed she can use for sleeping this weekend. BOALTC 9/3/24: Good afternoon. I am sure my email got buried over the long weekend. I tried calling the facility and was disconnected after the gal answered. I am following up regarding (R609). She currently does not have a bed to sleep in, reports her hospital bed is broken and is sleeping in her wheelchair. I know you all must be very busy. If you are not able to assist me please let me know, and could you connect me with a Director of Nursing (DON) or Social Worker there who would be able to assist? Having a resident without a bed is a huge concern. Facility 9/3/24: In response to your concerns .(R609)'s bed is not broken, the foot board is out of its bracket. I placed a maintenance request for this to be corrected, which should be completed today. (R609) explained to me that she is sleeping in her chair due to her breathing issues and not being comfortable in her bed. She originally requested a recliner to sleep in; however, we do not have recliners here for residents to sleep in, which I explained to (R609). I suggested perhaps we could look into an air mattress for her. I stand corrected on that - after speaking with nursing staff, I now understand (R609) does not require the use of an air mattress, as she has zero wounds at this time. R609 filed a grievance on 9/3/24 requesting a recliner to sleep in; bed is not comfortable for her. There were no attempts to provide R609 a new bed or mattress for comfort which resulted in R609 resorting to sleeping in her wheelchair. On 9/26/24 the facility submitted additional information for review which included the grievance dated 9/3/24 and notes to indicate the facility is not obligated to provide a recliner or air mattress to R609. The note from the facility implies the Ombudsman from the BOALTC agreed with the facility's position it did not have to provide such items and the grievance was resolved. As noted above the Ombudsman shared with the facility F609 was not comfortable in the wheelchair she is presently sitting and sleeping in each day and wants a bed with a different mattress for comfort. As of the time of exit from the survey (9/19/24) the facility had not resolved the grievance and followed through on discussing options with R609's physician or the medical durable products company to discuss options R609 may qualify for or options beyond the current wheelchair R609 is using.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and staff interviews, the facility did not ensure that 2 allegations of injuries of unknown origin involving 2 Residents (R603 and R606) were reported immediately to the State Survey Agency. *R606 was noted to have bruising and swelling to right eye on 8/20/24. The injury of unknown origin was not immediately reported to Nursing Home Administrator (NHA)-A and to the State Survey Agency. *On 7/27/24, R603's x-ray results showed a left hand fracture which was not reported immediately to the State Survey Agency. Findings Include: The facility's Abuse, Neglect and Exploitation policy implemented 9/2020 and last revised on 1/5/24 documents: .III. Prevention of Abuse, Neglect and Exploitation B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of Resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff to meet the needs of Residents, and assure that the staff assigned have knowledge of the individual Residents' care needs and behavioral symptoms D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of Residents with needs and behaviors which might lead to conflict or neglect IV. Identification of Abuse, Neglect, and Exploitation 3. Physical injury of a Resident, of unknown injury V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to NHA-A, state agency, adult protective services and to all other required agencies within specified timeframe's: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Not later that 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . 1.) R606 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia, Anxiety Disorder, Epilepsy, Hemiplegia and Hemiparesis, and Paroxysmal Atrial Fibrillation. R606 has an activated Health Care Power of Attorney (HCPOA). R606's Admission Minimum Data Set (MDS) completed 8/13/24 documents R606 has both short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R606's MDS documents that R606 has fluctuating inattention and disorganized thinking is continuously present. R606's Patient Health Questionnaire (PHQ-9) documents minimal depression. R606 has physical behaviors 1-3 days and other behaviors 1-3 days that significantly put R606 at risk for physical illness/injury, interferes with cares, participation in activities and social interactions. R606 also demonstrates a rejection of cares and wandering 1-3 days. R606's MDS also documents that R606 has range of motion impairment on 1 side for both upper and lower extremities. R606 is dependent for tub/shower transfers and upper and lower body dressing. R606 requires partial/moderate assistance for rolling left and right and substantial/maximum assistance for chair/bed to chair transfer. R606 is dependent on tube feeding for nutrition. On 8/21/24, at 7:30 AM, Licensed Practical Nurse (LPN)-G documented: .I was able to get a good look of right face and observed right eye is swollen and black. Assistant Director of Nursing (ADON) and Director of Nursing (DON)-B notified. On 8/21/24 at 3:34 PM, LPN-G documented: .Nurse Practitioner (NP) and Activated HCPOA made aware of swelling and discoloration to right eye. HCPOA reports nurse on 8/20/24 reported R606 may have fallen and sitter said the same thing. DON-B made aware of statement coming from activated HCPOA. On 9/17/24, at 1:18 PM, Surveyor reviewed R606's electronic medical record (EMR) and notes there is no documentation on 8/20/24 of R606 having a fall or any incident where R606 would have sustained an injury which would explain the bruised and swollen right eye of R606. Surveyor also notes that R606 has had a 1:1 assigned to R606 since admission to the facility. On 9/17/24, at 3:07 PM, at the daily facility exit with Nursing Home Administrator (NHA)-A and DON-B, Surveyor requested further information concerning R606's bruised and swollen right eye. DON-B reported that the facility believes (R606) was rolling around on the mat and hit head on the bed frame. Per DON-B, DON-B could not get the Certified Nursing Assistant who provided 1:1 to R606 on 8/20/24 to come into the building and provide a statement. DON-B stated that (LPN-E) who worked on 8/20/24 did not report to NHA-A or DON-B the incident or complete a fall packet. DON-B stated when LPN-G reported the bruised and swollen eye, neurochecks were initiated. DON-B stated there is risk management information that DON-B will provide to Surveyor. On 9/18/24, at 9:23 AM, Surveyor interviewed LPN-G regarding R606's injury. LPN-G stated LPN-G notified DON-B and ADON right away because LPN-G was very concerned how R606 would have gotten the bruised and swollen right eye. LPN-G stated that R606 is combative a lot. LPN-G is not aware of anytime that R606 has rolled out of bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 10:04 AM, Surveyor interviewed DON-B regarding R606's injury. DON-B stated that LPN-E worked on 8/20/24, and that LPN-E stated R606 slid off the mattress. DON-B stated LPN-E said LPN-E looked at R606 and saw nothing. DON-B confirmed that LPN-E did not have an RN do an assessment of R606 and did not report the incident to DON-B or NHA-A. DON-B stated DON-B obtained CNA-F's statement over the phone. CNA-F was the 1:1 assigned to R606 on 8/20/24. CNA-F informed DON-B that R606 was crawling around on the mat and did not slide off the mattress. DON-B does not know how LPN-E assumed that R606 slid off the mattress. Surveyor shared the concern with DON-B at this time that neither LPN-E or CNA-F reported an incident involving R606 which resulted in a bruised and swollen right eye, and both LPN-E and CNA-F provided conflicting statements. DON-B shared that DON-B provided a re-education to LPN-E on 9/17/24. On 9/18/24, at 3:03 PM, Surveyor shared the concern with NHA-A and DON-B that R606's injury of unknown injury was not reported immediately to NHA-A and the State Survey Agency. No further information was provided by the facility at this time. 38146 2.) R603 admitted to the facility on [DATE] and has diagnoses that include Dementia, Cerebrovascular Disease, Hypertension, Anemia, Gastro-Esophageal Reflux Disease, Anxiety and Depression. On 9/17/24 at 1:02 PM Surveyor spoke with R603's daughter by phone. She reported a concern regarding a fracture that occurred to R603's finger. She reported it was initially thought the swelling may have been gout because she (R603) had that before, but it wasn't. R603's sister reported the facility did keep her updated, but she just wanted to try to find out what happened, like if she fell or something. She advised Surveyor she is aware R603's dementia is getting worse and she can be resistive and combative with cares. On 7/20/24 facility progress notes documented: Left hand swollen from finger tips to above wrist. Area warm, ROM (Range of Motion) limited to fingers. Denies pain. Advanced Practice Nurse Practitioner (APNP) will come early in AM to assess. On 7/21/24 NP note documented: Registered Nurse (RN) notified provider about left hand swelling which was first noted on 7/20/24. Left hand is warm to touch. Patient denies any pain, no fever noted, VSS (vital signs stable). Complete Blood Count (CBC) pending. Power of Attorney (POA) was notified and aware. On 7/24/24 NP note documented: Edema of left hand, common for pt (patient), will do uric acid to r/o (rule out). Surveyor noted R609's uric acid level result was 4.5 which was within normal limits (WNL) (reference range 2. 5 - 6.2). On 7/25/24 NP note documented: Edema of left hand, common for pt. Uric acid WNL. Likely inflammation of arthritis. Today with warm to touch on left thumb. Tubigrips ordered. Pt is no acute distress. On 7/26/24 Facility progress notes document: POA called, concern about swelling not going down. NP in building assessed, reviewed labs, decided on X-ray of left hand/wrist. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/26/24 Left hand 3+ view X-ray report findings: Oblique acute fracture of midshaft of 2nd metacarpal bone. Degenerative changes along carpometacarpal joint of 1st finger. Mild degenerative is noted along radioulnar joint. Tiny foci of calcification noted along the distal ulnar bone. There is no evidence of dislocation or osseous lesion. The carpal bones are well aligned. The soft tissues are unremarkable. The joint spaces are well-preserved. Surveyor noted R603 was seen by ortho and fitted for a splint, however she frequently removed the splint and was eventually casted. Surveyor noted the facility completed an investigation regarding the injury of unknown origin, but did not submit a Self Report to the State Agency. Director of Nursing (DON)-B reported the reason a Self Report was not filed was because the investigation of the injury led them to a probable cause. Surveyor advised DON-B that a Self Report should have been submitted for the injury of unknown origin before the investigation was initiated. On 9/18/24 at 3:00 PM, the facility was advised of the above concern. No additional information was provided.

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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** 38829 Based on record review and staff interviews, the facility did not ensure that 1 allegation of injury of unknown origin involving 1 Resident (R606) of 2 allegations of injury of unknown origin reviewed were thoroughly investigated. *R606 was noted to have bruising and swelling to R606's right eye on 8/20/24. The injury of unknown origin was not thoroughly investigated including obtaining statements from staff. Findings Include: The facility's Abuse, Neglect and Exploitation policy implemented 9/2020 and last revised on 1/5/24 documents: .III. Prevention of Abuse, Neglect and Exploitation B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of Resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff to meet the needs of Residents, and assure that the staff assigned have knowledge of the individual Residents' care needs and behavioral symptoms D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of Residents with needs and behaviors which might lead to conflict or neglect IV. Identification of Abuse, Neglect, and Exploitation 3. Physical injury of a Resident, of unknown injury V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation 3. Investigating different types of alleged violations 4. Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s) 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause 6. Providing complete and thorough documentation of the investigation . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R606 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia, Anxiety Disorder, Epilepsy, Hemiplegia and Hemiparesis, and Paroxysmal Atrial Fibrillation. R606 has an activated Health Care Power of Attorney (HCPOA). R606's Admission Minimum Data Set (MDS) completed 8/13/24 documents R606 has both short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R606's MDS documents that R606 has fluctuating inattention and disorganized thinking is continuously present. R606's Patient Health Questionnaire (PHQ-9) documents minimal depression. R606 has physical behaviors 1-3 days and other behaviors 1-3 days that significantly put R606 at risk for physical illness/injury, interferes with cares, participation in activities and social interactions. R606 also demonstrates a rejection of cares and wandering 1-3 days. R606's MDS also documents that R606 has range of motion impairment on 1 side for both upper and lower extremities. R606 is dependent for tub/shower transfers and upper and lower body dressing. R606 requires partial/moderate assistance for rolling left and right and substantial/maximum assistance for chair/bed to chair transfer. R606 is dependent on tube feeding for nutrition. On 8/21/24, at 7:30 AM, Licensed Practical Nurse (LPN)-G documented: .I was able to get a good look of right face and observed right eye is swollen and black. Assistant Director of Nursing (ADON) and Director of Nursing (DON)-B notified. On 8/21/24 at 3:34 PM, LPN-G documented: .Nurse Practitioner (NP) and Activated HCPOA made aware of swelling and discoloration to right eye. HCPOA reports nurse on 8/20/24 reported R606 may have fallen and sitter said the same thing. DON-B made aware of statement coming from activated HCPOA. On 9/17/24, at 1:18 PM, Surveyor reviewed R606's electronic medical record (EMR) and notes there is no documentation on 8/20/24 of R606 having a fall or any incident where R606 would have sustained an injury which would explain the bruised and swollen right eye of R606. Surveyor also notes that R606 has had a 1:1 assigned to R606 since admission to the facility. On 9/17/24, at 3:07 PM, at the daily facility exit with Nursing Home Administrator (NHA)-A and DON-B, Surveyor requested further information concerning R606's bruised and swollen right eye. DON-B reported that the facility believes R606 was rolling around on the mat and hit head on the bed frame. Per DON-B, DON-B could not get the Certified Nursing Assistant who provided 1:1 to R606 on 8/20/24 to come into the building and provide a statement. DON-B stated that the (LPN)-E who worked on 8/20/24 did not report to NHA-A or DON-B the incident or complete a fall packet. DON-B stated when LPN-G reported the bruised and swollen eye, neurochecks were initiated. DON-B stated there is risk management information that DON-B will provide to Surveyor. DON-B confirmed there was no documented investigation submitted to the State Survey Agency. On 9/18/24, at 9:23 AM, Surveyor interviewed LPN-G regarding R606. LPN-G stated LPN-G notified DON-B and ADON right away because LPN-G was very concerned how R606 would have gotten the bruised and swollen right eye. LPN-G stated that R606 is combative a lot. LPN-G is not aware of anytime that R606 has rolled out of bed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 10:04 AM, Surveyor interviewed DON-B regarding R606's injury. DON-B stated that LPN-E worked on 8/20/24, and that LPN-E stated R606 slid off the mattress. DON-B stated LPN-E said LPN-E looked at R606 and saw nothing. DON-B confirmed that LPN-E did not do an assessment of R606 and did not report the incident to DON-B or NHA-A. DON-B stated DON-B obtained CNA-F's statement over the phone. CNA-F was the 1:1 assigned to R606 on 8/20/24. CNA-F informed DON-B that R606 was crawling around on the mat and did not slide off the mattress. DON-B does not know how LPN-E assumed that R606 slid off the mattress. Surveyor shared the concern with DON-B at this time that neither LPN-E or CNA-F reported an incident involving R606 which resulted in a bruised and swollen right eye, and both LPN-E and CNA-F provided conflicting statements. Surveyor shared that the facility did not obtain statements from LPN-E, CNA-F, or staff who had contact with R606 before the discovery of the bruised and swollen right eye of R606 DON-B shared that DON-B provided a re-education to LPN-E on 9/17/24. On 9/18/24, at 3:03 PM, Surveyor shared the concern with NHA-A and DON-B that R606's injury of unknown injury was not thoroughly investigated as evidenced by conflicting information of how the injury occurred as well as the facility did not obtain statements from all staff who worked with R606 prior to the discovery of the right bruised and swollen eye. It is not clear if R606 rolled off the mattress and obtained the injury or was crawling around on the mat and hit head on the bed frame. Surveyor also shared the concern that there is no assessment of the injury. No further information was provided by the facility at this time.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure 2 (R602 & R606) of 9 residents care plans were revised. * On 7/30/24 at 5:56 a.m. R602 was observed on the floor. The IDT (interdisciplinary team) determined an intervention of: If resident is awake offer resident to get up and dressed for the day. This intervention was not added to either R602's at risk for falls or had an actual fall care plan. * R606's care plan and Kardex were not individualized to address R606's care needs. Additionally, items on the comprehensive care plan were not included on the Kardex. R606's care plan was not updated with fall interventions including crawling on a mat. Findings include: The facility's policy titled, Careplan Standard Guideline with an effective date of 11/28/2017 documents under Procedure #6. The care plan is to be revised to reflect the current status of the resident and #7 The care plan will be reviewed throughout the resident's stay upon admission, quarterly and with changes in condition. 1.) R602's diagnoses include dementia. Care plans document: The resident is at risk for falls r/t (related to) weakness initiated 11/28/23 documents an intervention of Anticipate and meet the resident's needs. Initiated 11/28/23. The resident has had an actual fall with no injury, no minor injury, no serious injury care plan initiated 1/7/24 documents the following interventions: * Date and description of other interventions put in place after a fall: (specify). Initiated 1/7/24. * Continue interventions on the at-risk plan. Initiated 8/7/24. * For no apparent acute injury, determine and address causative factors of the fall. Initiated 8/7/24. * 8/22/24 fall Resident is to ambulate with staff and staff to encourage the utilization of walker. Initiated 8/22/24. The incident report for date of fall of 7/30/24, under conclusion documents Resident ambulating without assistance and wander (sic) into another resident's room where she fell on to the floor and sustained an injury. Resident was sent to the ED (emergency department) for evaluation, prior to been (sic) sent out resident received first aid at the facility. Resident appeared to be ready for the day ambulating without assistance naked but dry. (continued on next page)

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	525325	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention: If resident is awake offer resident to get up and get dressed for the day. On 9/18/24, at 12:22 p.m., Surveyor asked DON (Director of Nursing)-B following a Resident's fall who is responsible for updating the falls care plan. DON-B informed Surveyor following a fall the IDT (interdisciplinary team) comes up with an intervention. Surveyor informed DON-B following R602's fall on 7/30/24 the intervention was not added to R602's care plan. DON-B informed Surveyor the intervention should be on the care plan. On 9/18/24, at 3:18 p.m., during the end of the day meeting Surveyor informed NHA (Nursing Home Administrator)-A, DON-B, Regional Nurse-S and Regional Director of Clinical Operations-T regarding the above. No additional information was provided as to why R602's fall care plan was not revised after the fall on 7/30/24. 38829 2.) R606 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia, Anxiety Disorder, Epilepsy, Hemiplegia and Hemiparesis, and Paroxysmal Atrial Fibrillation. R606 has an activated Health Care Power of Attorney (HCPOA). R606's Admission Minimum Data Set (MDS) completed 8/13/24 documents R606 has both short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R606's MDS documents that R606 has fluctuating inattention and disorganized thinking is continuously present. R606's Patient Health Questionnaire (PHQ-9) documents minimal depression. R606 has physical behaviors 1-3 days and other behaviors 1-3 days that significantly put R606 at risk for physical illness/injury, interferes with cares, participation in activities and social interactions. R606 also demonstrates a rejection of cares and wandering 1-3 days. R606's MDS also documents that R606 has range of motion impairment on 1 side for both upper and lower extremities. R606 is dependent for tub/shower transfers and upper and lower body dressing. R606 requires partial/moderate assistance for rolling left and right and substantial/maximum assistance for chair/bed to chair transfer. R606 is dependent on tube feeding for nutrition. Surveyor reviewed R606's Kardex as of 9/18/24 which instructs Certified Nursing Assistants (CNAs) on how to best take care of R606. The following is documented: Safety *(R606) needs head of bed elevated 30-45 degrees during and thirty minutes after tube feed *9/3/24 fall new wheelchair for positioning properly *Striking out at staff, pulling at tube, cussing, laying on the mat next to bed, attempting to stand unassisted Skin *Wheelchair pressure reduction cushion (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R606's comprehensive care plan. The following is documented: -(R606) has potential to be physically aggressive towards staff and others due to poor impulse control due a diagnosis of cerebral infarction. -Initiated 8/15/24 -(R606) has potential post trauma ineffective coping due to near death experience.-Initiated 8/15/24 -(R606) is an elopement risk/wanderer due to behaviors and cognitive impairment-Initiated 8/12/24 -(R606) chooses to remove clothing, lie on floor and bed mat, and has been known to strike out at staff and pulls G-tube due to cerebral infarction and a diagnosis of vascular dementia-Initiated 8/15/24 -(R606) is at risk for falls due to confusion, gait/balance problems, unaware of safety needs, incontinence, and medication usage-Initiated 8/30/24 -- .bed in lowest position . Surveyor notes that lowest bed, mat on floor, elopement risk, laying/crawling on mat was not documented on R606's Kardex which instructs the CNAs on how best to take care of R606 as well as R606's comprehensive care plan was not updated with interventions for R606. Surveyor also notes that R606 has a continuous 1:1 which is not documented on R606's Kardex or comprehensive care plan. On 9/17/24, at 10:30 AM, Surveyor was observing R606 in R606's Broda chair. Surveyor spoke to (CNA)-JJ . CNA-JJ stated that R606 has a 1:1 for safety reasons. R606 thinks R606 can walk, but can't. We don't want (R606) to fall and injure self. R606 also has a 1:1 because R606 will pull on R606's feeding tube. CNA-JJ stated that R606 is a handful. On 9/18/24, at 10:04 AM, Surveyor was interviewing Director of Nursing (DON)-B regarding R606's black eye. DON-B stated that the intervention for the incident was to offer to get R606 up off the mat when agitated. Surveyor notes that this intervention was not documented on R606's Kardex or comprehensive care plan. On 9/18/24, at 10:19 AM, Surveyor interviewed the 1:1 staff for R606, CNA-KK. CNA-KK is agency but picks up a lot of hours. CNA-KK is not aware that R606 will crawl around on the mat. CNA-KK is aware that R606 may roll out of bed at night. Surveyor observed a mat propped up against the wall in R606's room and observed no padding on R606's bed. On 9/18/24, at 11:23 AM, Surveyor interviewed Unit Manager (UM)-H. UM-H stated that R606's bed should be in the lowest position, close to the mat. UM-H stated that R606 has not slept in a bed in a couple of years per family. UM-H stated to avoid increased agitation, it is best to keep R606 up as long as possible. UM-H confirmed there should be a mat on the floor when R606 is in bed. UM-H confirmed that any updates with interventions to R606's Kardex and comprehensive care plan is completed by UM-H. On 9/18/24, at 11:37 AM, Surveyor interviewed CNA-KK again. CNA-KK stated that if CNA-KK had never taken care of a Resident, CNA-KK would go to the Kardex to determine how to care for that Resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 12:31 PM, Surveyor reviewed with DON-B, R606's Kardex not being person-centered with specific interventions. DON-B agreed it is a problem and should have been updated. On 9/18/24, at 3:03 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and DON-B the concern that R606's Kardex and comprehensive care plan has not been revised with new interventions on how best to care for R606. No further information was provided by the facility at this time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on interview and record review the Facility did not ensure residents maintained acceptable parameters of nutritional status for 1 (R601) of 1 residents reviewed for weight loss. R601 sustained severe weight loss over a period of 7 months. The Physician was not notified, weight loss was not prescribed and no new interventions were implemented. Findings include: The Facility Policy titled, Nutritional Status Management last revised 4/2/2018, documents, in part: Purpose: It is the practice, in accordance with advanced directives to provide interventions to maintain, improve and respond to nutritional needs. Measures will be taken to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balances, unless the residents clinical condition demonstrates that this is not possible or resident preferences indicate otherwise . The interdisciplinary team together with the resident and/or resident representative will identify, evaluate risk factors and individualize interventions to meet the nutritional needs of the residents and determine through monitoring of health status the effectiveness . 6. Development and Implementation of individualized interventions based on interdisciplinary evaluations, resident and/or resident representative goals to promote the highest level of function and dignity which may include, but not limited to: *Encourage consumption of foods and fluids during meals . *Offer ethnic, cultural and religious food preferences *Provide food substitutions as needed . *Therapy evaluations and involvement *Determination of more frequent monitoring *Nutritional supplementation . *Liberalized diet . 8. Care planning: Must address, the extent possible, identified causes of impaired nutritional status, reflect the resident personal goals, preferences and identify specific interventions, timeframes and parameters for monitoring . The Facility Policy titled, Weight Monitoring Guideline last revised 7/1/2019, documents, in part: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: The facility measures and records weights to ensure accuracy and provide information for the evaluation of clinical status unless clinically contraindicated with physician justification. To provide guidance on timely consultation and weight parameters . Guideline . The Licensed Nurse . *Consult with the physician and dietician/designee with a confirmed 5% weight variances in 30 days and 10% in 6 months and/or as ordered by the physician with weight parameters . *Monitor weight reports produced inside PCC for significant changes and for gradual insidious changes that may indicate a risk factor for nutrition or hydration status and/or clinical condition. Dietician: *Review significant weight change reports daily for review and evaluation *Review weight reports at least weekly to ensure residents with weight variances of 5% in 30 days and 10% in 6 months are reviewed and evaluations for nutritional risk and timely interventions is completed. *Review weight reports for significant weight changes following the 7th of the month. Refer residents with significant weight changes to the NAR (nutrition at risk) committee for review. The Facility Policy titled, Therapeutic Diets last revised November 2015, documents, in part: Policy Interpretation and Implementation Mechanically altered diets, as well as diets modified for medical or nutritional needs, will be considered 'therapeutic diets.' Examples of therapeutic diets include . d. Altered consistency diet . 3. The resident has the right not to comply with therapeutic diets . 5. The Clinical Dietitian, nursing staff, and Attending Physician will review, along with other orders, the need for, and resident acceptance of, prescribed therapeutic diets . 10. The interdisciplinary team may liberalize the diet if the resident is losing weight, not eating well, or if he or she requests a liberalized diet. 11. If the resident or the resident's representative declines the recommended therapeutic diet, the interdisciplinary team will collaborate with the resident or representative to identify possible alternatives. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R601 was admitted to the facility on [DATE] and discharged on [DATE]. R601 admitted with diagnoses which include chronic obstructive pulmonary disease, type 2 diabetes (DM), phantom leg syndrome, and bipolar disorder. On R601's Quarterly Minimum Data Set (MDS) assessment, dated 6/6/2024, the Facility assessed R601 as having severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 02. R601 was assessed to have clear speech and be usually understood and to usually understand others. R601 has adequate hearing and vision. No behaviors were exhibited during the look back period. R601 is always incontinent of bowel and bladder. No swallowing disorders were noted, R601 was coded to have a mechanically altered diet. Upper extremities have no impairment and lower extremities have an impairment on one side. R601 has an activated Power of Attorney (POA). R601's care plan documents resident has alteration in nutrition/hydration r/t (related to) she is at risk for malnutrition MNA (mini nutritional assessment)=8 aeb (as evidenced by) weight loss x 3mo, decreased mobility and dx (diagnoses) dementia and depression. Receives Mech Soft/CCHO (consistent carbohydrate diet)/NAS (no added salt)/Glucerna 8oz 1x day appropriate secondary to difficulty chewing, dx DM, HTN (hypertension) and to prevent malnutrition. BMI (body mass index): WNL (within normal limits) for age. Date Initiated: 06/06/2024 Goals: The resident will tolerate diet texture without s/s aspiration of choking. Date Initiated: 12/12/2023 Target Date: 06/24/2024 R601 will maintain adequate nutritional status as evidenced by maintaining weight within 1-3# (pounds), no s/sx (signs/symptoms) of malnutrition, and consuming at least (50-75)% of at least (3) meals daily through review date. Date Initiated: 03/07/2024 Target Date: 06/24/2024 Interventions (in part): Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage the resident to comply. Explain consequences of refusal such as obesity, malnutrition, or other risk factors. Date Initiated: 03/07/2024 Monitor/record/report to MD PRN (as needed) s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, > (greater than) 5% in 1 month, >7.5% in 3 months, >10% in 6 months. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 03/07/2024 Provide food/fluids according to resident food preferences; No dislikes shared; Encourage adequate fluids intake. Date Initiated: 09/07/2021 Weigh at same time of day and record: monthly or as needed Date Initiated: 03/07/2024 R601's care plan documents The resident has an ADL (activities of daily living) self-care performance deficit. Date Initiated: 09/11/2020 Interventions (in part): -Dining: Resident is assisted with all meals Date Initiated: 09/11/2020 R601's care plan documents The resident is resistive to care at times and especially after visiting with family. Date Initiated: 03/01/2024 Goal: The resident will cooperate with care through next review date, Date Initiated: 03/01/2024, Target Date: 06/24/2024 Interventions: Allow the resident to make decisions about treatment regime, to provide sense of control. Date Initiated: 03/01/2024 Educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care. Date Initiated: 03/01/2024 Provide resident with opportunities for choice during care provision. Date Initiated: 03/01/2024 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24, at 8:10 AM, Surveyor reviewed R601's weights while residing in the Facility. Surveyor noted R601 had progressively lost weight from 1/23/2024 to the last weight taken on 8/4/2024. On 1/23/24 R601's documented weight was 180.8 pounds. On 4/9/24 R601's documented weight was 170.2 pounds. On 5/5/24 R601's documented weight was 164.8 pounds. On 7/4/24 R601's documented weight was 160.6 pounds. On 7/25/24 R601's documented weight was 176.4 pounds; this was a reweigh requested by the Dietician. On 8/4/24 R601's documented weight was 157 pounds. Surveyor notes a severe weight loss of 13.16% from 1/23/24 to 8/4/24 and a 2.24% weight loss from 7/4/2024 to 8/4/2024. A review of the electronic medical record revealed R601 was reviewed on 3/7/2024, 4/19/2024 and 5/11/2024 by the previous Facility dietician and summary progress notes were written. Surveyor noted all 3 progress notes state Physician was not consulted for weight gain/loss. April and May notes have that Resident has 6 month weight gain or loss 10% or greater see below. 6 month weight loss was unplanned. In April the note includes that Sig (significant) wt loss x 6 months, likely rt (related to) medical conditions including dementia, depression, diuretic use. Goal for wt maintenance. In May the note includes Sig wt loss x3 and 6 months, likely rt medical pmh (past medical history) including dementia, depression, diuretic use. Goal for wt Maintenance. Surveyor notes no new interventions were added to R601's plan of care to address this weight loss and that the dietician did not alert the physician per progress notes. On 9/18/2024, at 11:35am, Surveyor interviewed Dietician-N regarding R601's weight decline. Dietician-N stated that they just took over the account in July. They requested the resident be reweighed in July and it was done 7/25/2024. The Nutrition High Risk Note written by Dietician-N was referred to as the dietician's analysis of the reweight. On 7/26/2024, the dietician completed Nutrition High Risk Progress Note. The Assessment reads 73yo (year old) female significant for weight gain. 9.8%-1 month; weight 7/25 176.4#, 7/4 160.6# comparative wg (weight), 4/6 170.2, 1/23 180.8# . Diet rx: CCD NAS Mech soft thin liquids - SLP (speech language pathologist) downgrade diet to Mech soft 11/29/23 per staff and resident dislikes it. Family brings in food routinely to resident which is preferred. Meal intake noted as fair with 17/21 meal reported intake >50% past 14 days. Feeds self with set up/supv, resident is at health risk r/t behaviors d/t refusing meds, cares and resistive to staff, desires to make own choices. Continue with current orders at this review and f/up (follow up) weight with 16# change over past month, consider verify wgt. Further weight gain is not desired. The nutrition intervention listed is verify weight. For nutrition monitoring and evaluation F/up weight change is listed. Surveyor notes dietician is not acknowledging the weight loss due to the reweight being higher than the previous weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/2024, at 11:59am, Surveyor interviewed Dietician-N again and asked about the weight going down for R601. Dietician-N referred to R601's history back in March and April when weight was around 170 pounds which was lower than the reweight of 176, indicating weight gain. Surveyor pointed out that on the Nutrition High Risk Note, completed 7/25/2024, the intervention was to verify weight and that all the other weights since January were going down except the one reweight. Dietician-N stated this reweight was done at the end of the month and was waiting for the August weights to be posted to see if there was decline. Surveyor notes previous dietician was noting the weight decline and new dietician used a reweight that was not in line with other weights as basis of analysis. On 9/18/2024, at 11:35am, during interview with Dietician-N, Surveyor asked about residents with mechanical soft diets and was told the dietician visits residents and asks what their preferences are. Dietician-N told Surveyor how son brings in food that is not mechanical soft. Dietician-N stated there is always a substitute menu available called the alternative menu and meat on that can be ground up to be mechanical soft. Dietician-N stated the intervention of Glucerna supplement was added in December for R601. On 9/17/2024, at 10:50am, Surveyor interviewed Certified Nursing Assistant (CNA)-L and asked how R601 eats meals and was told R601 was dependent unless it was finger food, then ate on own. CNA-L also stated that R601 would refuse to eat sometimes or refuse help, then CNA-L would have to sit and watch R601 do it. When asked if R601 got choices in food selection, CNA-L replied no because of being mechanical soft diet. CNA-L did state that R601's son sometimes brought in food and would feed mom it in regular form. On 9/17/2024, at 10:53am, Surveyor interviewed Assistant Director of Nursing (ADON)-O and asked about R601 eating meals and was told R601 needed to be set up to eat, but nobody was required to watch while eating. ADON-O stated R601 was a mechanical soft diet. ADON-O also told Surveyor that son would come and state how R601 did not like the seasoning used at Facility and menu changes were discussed. Surveyor asked if R601 was offered choices and was told there were options available, and staff would talk to R601 about them. On 9/17/2024, at 10:56am, Surveyor interviewed CNA-M and was told R601's eating went both ways, sometimes would need help, other times not. CNA-M stated that R601 did not refuse to eat but would sleep a lot and when woke up would eat 100% of tray left for them. When Surveyor asked about alternative choices, CNA-M showed a list of alternative options available at meals. Surveyor asked if R601 could get these since on mechanical soft diet and was told yes, the kitchen cuts up the food to accommodate. On 9/18/2024, at 2:12pm, Surveyor interviewed Speech Therapist-R about R601's altered diet. Surveyor was told R601 was continually screened and that when the speech therapist was available would observe R601 eat the food brought in by son. From these observations it was determined R601 was not appropriate for an upgrade in food consistency. Speech Therapist-R also stated that the son was educated on what Mom should eat, also staff and son were educated to not feed R601 when sleepy. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed Referral to Rehab Services form provided by Facility which has section Therapy Follow-Up in which SLP is selected with Date of consult: 5/30/24. Form reads patient is able to feed self with meal tray set up. Patient was tolerating trial mechanical soft diet. Findings/observations are SLP recommends intermittent supervision due to lethargic behaviors. Staff should not attempt to feed patient when asleep. Surveyor notes that not to feed when sleepy was not implemented into R601's plan of care. Surveyor reviewed R601's Quarterly Minimum Data Set (MDS) assessment, dated 6/6/2024 and the Discharge MDS, dated [DATE]. For the question on weight loss of 5% or more in last month or loss of 10% or more in 6 months the answer was yes, not on physician-prescribed weight loss regimen on both MDS. Surveyor notes the weight loss was documented and not physician prescribed. On 9/18/2024, at 3:03 PM, during the end of day meeting, Surveyor let the Nursing Home Administrator-A, Director of Nursing-B, Regional Nurse-S and Regional Director of Clinical Operations-T know of the concern that R601 was not monitored to maintain acceptable parameters of nutritional status due to continued weight loss. No further information was provided at this time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not ensure 1 (R606) of 3 Residents reviewed who was receiving a psychotropic medication, was free from unnecessary medications. * R606 has a PRN (as needed) order for Ativan, an anti-anxiety medication that did not have a documented rationale in R606's medical record that indicated the duration for the PRN order beyond 14 days. Findings Include: The facility's policy 14 Day PRN Psychotropic Medication Guideline Effective 11/28/17 documents: .A psychotropic medication order with instructions for PRN dosing shall be discontinued after 14 days. For PRN non-antipsychotic psychotropic orders: The PRN order may be extended beyond 14 days if the prescriber believes it is appropriate to extend the order. The Prescriber must document the rationale for the extended treatment in the medical record and indicate a specific duration of therapy. The Director of Nursing (DON)-B or designee shall be responsible for ensuring the order discontinuation of any psychotropic medication with PRN dosing instructions on or before Day 14 of therapy. Guideline: Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record 1. PRN orders for psychotropic drugs are limited to 14 days 2. For non-antipsychotic orders: If the attending physician or prescribing practitioner believes that is is appropriate for the PRN order to be extended beyond 14 days, he/she should document their rational in the Resident's medical record and indicate the duration for the PRN order. 4. The facility does not utilize psychotropic medications to address behaviors without, first determining if there is a medical, physical, function, psychological, social or environment cause of the Resident's behaviors. Procedure -Prior to Day 14 of treatment, the DON-B/designee will contact prescriber to alert him/her of the imminent discontinuation of the PRN psychotropic medication order and will ask the prescriber to determine the patient's needs related to the psychotropic treatment (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R606 was admitted to the facility on [DATE] with diagnoses of Vascular Dementia, Anxiety Disorder, Epilepsy, Hemiplegia and Hemiparesis, and Paroxysmal Atrial Fibrillation. R606 has an activated Health Care Power of Attorney (HCPOA). R606's Admission Minimum Data Set (MDS) completed 8/13/24 documents R606 has both short and long term memory impairment and demonstrates severely impaired skills for daily decision making. R606's MDS documents that R606 has fluctuating inattention and disorganized thinking is continuously present. R606's Patient Health Questionnaire (PHQ-9) documents minimal depression. R606 has physical behaviors 1-3 days and other behaviors 1-3 days that significantly put R606 at risk for physical illness/injury, interferes with cares, participation in activities and social interactions. R606 also demonstrates a rejection of cares and wandering 1-3 days. R606's MDS also documents that R606 has range of motion impairment on 1 side for both upper and lower extremities. R606 is dependent for tub/shower transfers and upper and lower body dressing. R606 requires partial/moderate assistance for rolling left and right and substantial/maximum assistance for chair/bed to chair transfer. R606 is dependent on tube feeding for nutrition. R606's comprehensive care plan documents that R606 uses psychotropic medications due to behavior management for a diagnosis of dementia, adjustment disorder, and anxiety disorder which was initiated on 8/15/24. R606's current and discontinued physician orders document: On 8/14/24 Ativan 0.5 mg; 1 tablet as needed for behaviors, 2 times daily was ordered. On 9/2/24, the Ativan order was changed to 0.5 mg; 1 tablet as needed for behaviors, agitation, anxiety. Surveyor reviewed R606's Medication Administration Record (MAR) which indicate that the Ativan, as needed, was being administered to R606 on a regular basis. On 9/17/24, at 1:18 PM, Surveyor reviewed R606's electronic medical record (EMR) and could not locate any documentation for the rationale, stop date, or for how long to extend R606's PRN Ativan order. Surveyor was only able to locate an order written by Psychiatric Mental Health Nurse Practitioner (PMHNP)-I on 8/13/24 for the PRN Ativan as needed for anxiety (0.5 mg 2 times daily PRN). On 9/17/24, at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A and Director of Nursing (DON-B) that R606's EMR has no documentation of the rationale for R606's PRN Ativan and no documented stop date or documented end date. On 9/18/24, at 10:04 AM, DON-B is aware that there needs to be documentation for R606's PRN Ativan order that there is a reason, stop date, or indication as to why and when there is an end date. On 9/18/24, at 11:41 AM, DON-B informed Surveyor that DON-B is trying to get in contact with PMHNP-I for documentation of R606's PRN Ativan order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24, at 12:31 PM, Surveyor reviewed PMHNP-I psychiatric evaluation notes that had been forward to the facility. PMHNP-I evaluated R606 on 8/13/24, 8/20/24, 9/2/24, 9/10/24, and 9/17/24. PMHNP-I documents that R606 continues to have behaviors related to dementia. R606 is very restless, agitated, confused, resistive to cares, difficult to redirect, pulls on peg tube, climbs out of chair/bed, combative with staff, and yells out. PMHNP-I evaluations do not document a stop date for R606's PRN Ativan or an end date and then a re-evaluation prior to the 14 day end date to determine the continued need and use of the PRN Ativan order. Surveyor reviewed the psychiatric evaluation notes with DON-B who agreed there is no documented stop date or end date for the PRN Ativan to be re-evaluated. On 9/18/24, at 3:03 PM, Surveyor shared the concern with NHA-A and DON-B that there is no documented stop date or end date for R606's PRN Ativan to be re-evaluated prior to day 14. Surveyor shared the concern that R606's documented psychiatric evaluations were not available as part of R606's EMR to Surveyor prior to Surveyor request. On 9/26/24 the facility submitted additional information for review. Surveyor noted the original order sheet provided by the facility notes the start order for the PRN Ativan with no end date noted. Review of the submitted psychiatric NP sheets indicate the same descriptors of R606's behaviors and does not document any behavior trends that would explain the rationale for the medication. The psychiatric evaluations notes do not identify an end date for the PRN orders or further explanation to explain when R606 should receive the PRN Ativan after the Ativan also became a scheduled medication.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure 2 (R607 & R605) of 3 residents were free of significant medication errors. * R607 did not receive Lacosamide for seizures 11 times in July. In August R607 did not receive Lacosamide 2 times & Keppra 3000 mg one time. On 9/1/24 & 9/4/24 R607 did not receive the 7:00 a.m. dose of Divalproex Sodium 1500 mg. On 9/8/24 R607 did not receive the 7:00 a.m. dose of Keppra 3000 mg and on 9/9/24 R607 did not receive the 7:00 a.m. dose of Lacosamide 200 mg & Keppra 3000 mg. On 9/9/24 R607 was transferred to the hospital for seizures. On 9/10/24 R607 did not receive the 7:00 a.m. dose of Lacosamide 200 mg. * R605's physician order includes with an order date of 7/30/24 documents Clobazam oral tablet 10 mg (milligram) with directions to give one tablet by mouth two times a day for seizures. R605 did not receive Clobazam 13 times in August and 4 times in September. Findings include: The facility's policy titled, Administering Medications revised December 2012 under Policy Statement documents Medications shall be administered in a safe and timely manner, and as prescribed. Under Policy interpretation and Implementation #3 documents Medications must be administered in accordance with the orders, including any required time frame. 1.) R607's diagnoses includes epilepsy. The resident has a seizure disorder r/t (related to) head injury care plan initiated 10/28/22 documents the following interventions: * Give medications as ordered. Monitor/document for effectiveness and side effects. Initiated 10/28/22. * Monitor labs and report any sub therapeutic or toxic results to MD (medical doctor). Initiated 10/28/22. * Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Initiated 10/28/24. * Post Seizure Treatment: Turn on side with head back, hyper-extended to prevent aspiration. Keep airway open, After seizure take vital signs and neuro check, Monitor for aphasia, headache, altered LOC (level of consciousness), paralysis, weakness, pupillary changes. Initiated 10/28/22. * Seizure Documentation: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Initiated 10/28/22. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	* Seizure Precautions: Do not leave resident alone during a seizure, protect from injury, if resident is out of bed, help to the floor to prevent injury, remove or loosen tight clothing, don't attempt to restrain resident during seizure as this could make the convulsions more severe, protect from onlookers, draw curtains, etc. Initiated 10/28/22. The physician orders with an order date of 6/11/24 documents Keppra Oral Tablet 1000 mg (milligrams) with directions to give 3 tablet by mouth two times a day for seizure activity (3000 mg total). The physician orders with an order date of 6/11/24 documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total) and Give 3 tablet by mouth at bedtime for seizure (300 mg total). The physician orders with an order date of 9/3/24 documents Divalproex Sodium Oral Tablet Delayed Release 125 mg. Give 12 tablet by mouth two times a day for seizures. The July 2024 MAR (medication administration record) on 7/12/24 at 2100 (9:00 p.m.) for Lacosamide Oral Tablet 100 mg. Give 3 tablet by mouth at bedtime for seizure (300 mg total) is not checked & initialed as being administered. The July 2024 MAR on 7/13/24 at 0700 (7:00 a.m.) for Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total) is not checked & initial as being administered. The eMar (electronic medication administration record) dated 7/14/24, at 09:03 (9:03 a.m.), by LPN (Licensed Practical Nurse)-V documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). Awaiting delivery. The eMar note dated 7/20/24, at 10:30 a.m., by LPN-W documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). Only 1 tablet available - will call Pharm (pharmacy). The eMar note dated 7/20/24, at 20:07 (8:07 p.m.), by Med Tech-X documents Lacosamide Oral Tablet 100 mg. Give 3 tablet by mouth at bedtime for seizure (300 mg total). On order. The eMar note dated 7/21/24, at 14:47 (2:47 p.m.), by LPN-Y documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). Medication in route from pharmacy. The eMar note dated 7/21/24, at 20:23 (8:23 p.m.), by Med Tech-X documents Lacosamide Oral Tablet 100 mg. Give 3 tables by mouth at bedtime for seizure (300 mg total). On orders. The eMar note dated 7/22/24, at 8:07 a.m., by LPN-V documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). Awaiting delivery. The July 2024 MAR on 7/22/24, at 2100 (9:00 p.m.), for Lacosamide Oral Tablet 100 mg. Give 3 tablet by mouth at bedtime for seizure (300 mg total) is not checked & initialed as being administered. The eMar note dated 7/23/24, at 10:35 a.m., by LPN-Z documents Lacosamide Oral Tablet 100 mg Give 2 tablet by mouth in the morning for seizure (200 mg total). Not Available. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The July 2024 MAR on 7/28/24, at 2100 (9:00 p.m.), for Lacosamide Oral Tablet 100 mg. Give 3 tablet by mouth at bedtime for seizure (300 mg total) is not checked & initialed as being administered. The eMar note dated 8/12/24, at 9:03 a.m., by LPN-AA documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). Pharmacy is currently out of this medication. It will be delivered from [Pharmacy Name] 8/12/24. The eMar note dated 8/12/24, at 17:53 (5:53 p.m.), by Med Tech-X documents Keppra Oral Tablet 1000 mg. Give 3 tablet by mouth two times a day for Seizure Activity (3000 mg total). On order. The eMar note dated 8/12/24, at 21:46 (9:46 p.m.), by Med Tech-X documents Lacosamide Oral Tablet 100 mg. Give 3 tablet by mouth at bedtime for seizure (300 mg total). On order. The eMar note dated 9/1/24, at 17:47 (5:47 p.m.), by Med Tech-X documents Divalproex Sodium Oral Tablet Delayed Release 125 mg. Give 12 capsule by mouth two times a day for seizure. On order. The eMar note dated 9/4/24, at 10:01 a.m., by LPN-BB documents Divalproex Sodium Oral Tablet Delayed Release 125 mg. Give 12 capsule by mouth two times a day for seizure. On order. The eMar note dated 9/8/24, at 11:58 a.m., by RN (Registered Nurse)-CC documents Keppra Oral Tablet 1000 mg. Give 3 tablet by mouth two times a day for Seizure Activity (3000 mg total). 9/8/24: Medication not available. The nurses note dated 9/9/24, at 7:41 a.m., documents Writer was notified by roommate that resident was shaking. Resident had been given medication and had vitals taken 10 mins (minutes) prior vitals WNL (within normal limits). Resident turned to left side. Seizure lasted approximately 6 minutes. Writer notified [Name] NP (Nurse Practitioner) [Name] and received order to do neuro checks every hour for 4 hours. Vitals after seizure as followed BP (blood pressure) 127/62 pulse 116 temp (temperature) 98.3. Pupils equal and reactive. Resident returned to baseline. This nurses note was written by LPN-DD. The nurses note dated 9/9/24, at 8:26 a.m., documents Writer notified by wound nurse that resident was seizing. Resident had last been seen 15 mins prior for neuro check. Vitals WNL. Resident turned to left side. Seizure lasted approximately 6 minutes. Vitals taken after seizure BP 122/80 pulse 120 pupils equal and reactive spo2 97% room air respirations 16. Notified NP [Name] received order to send to hospital. [Name] ambulance called. Resident sent to [Name] hospital. POA (Power of Attorney) made aware. VM (voice mail) left for case manager. ADON (Assistant Director of Nursing) aware. This nurses note was written by LPN-DD. The eMar note dated 9/9/24, at 11:29 a.m., by LPN-DD documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). On order NP aware of missed dose. The eMar note dated 9/9/24, 11:34 a.m., by LPN-DD documents Keppra Oral Tablet 1000 mg. Give 3 tablet by mouth two times a day for Seizure Activity (3000 mg total). On order NP aware of missed dose. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The hospital ED triage note dated 9/9/24, at 9:50 a.m., documents Pt (patient) arrives via [Name] EMS (emergency medical services) coming from [Facility's name]. Pt (patient) has been out of seizure meds since Friday. Pt had seizure x2 today. Pt a+ox3 (alert and orientated times three) baseline, on RA (room air) baseline. Pt. awake and looking around answers yes/no questions. The hospital ED note dated 9/9/24, at 9:55 a.m., documents Pt. started seizing during triage. [Physician name] at bedside, airway protected. Pt with upper body shaking and right sided gaze. The hospital lab for Lacosamide (Vimpat) dated 9/9/24 at 10:09 a.m. has a result of 4.3 (reference range 10 to 20) and Keppra dated 9/9/24 at 10:09 a.m. has a result of <1.0 (reference range 6-20). The hospital neurology consult note dated 9/9/24 under History of Present Illness documents [R607's name] is a 65 Y (year) male with history of medically refractory epilepsy following TBI (traumatic brain injury) with ICH (intracerebral hemorrhage) s/p (status post) VPS (ventriculoperitoneal shunt) who presents with breakthrough seizure in the setting of medication regimen nonadherence. Unfortunately history limited as patient postictal at time of interview. On discussion with the ED (emergency department), he had been living in his group home and him (sic) and doing well when unfortunately he ran out of medications at the beginning of the weekend. He then went the next 2-3 days without his medications. Home regiment per chart review is Keppra 3000 mg BID (twice daily), Vimpat 300 mg BID, Depakote 1500 mg BID. He had 3 seizures total today and was given Keppra 4.5 g (gram) versed 4 mg x (times) 2. Per reprt (report), the facility had been out of medications all weekend so he has been at least 3 days without medication likely. The nurses note dated 9/9/24, at 16:21 (4:21 p.m.), documents MD (Medical Doctor) [Name] of [Name] Hospital contacted facility to obtain status of Keppra order r/t (related to) possible d/c (discharge) from hospital. Writer contacted [Name] pharmacy, pharmacy tech reported medication will be delivered on PM (evening) shift. Contacted MD [Name], provided update. This nurses note was written by LPN-EE. The nurses note dated 9/10/24, at 04:20 (4:20 a.m.), documents Resident returned from hospital to facility in stable condition transported via [Name] Ambulance. NNO (no new order) noted. Seizure medication arrived via pharmacy. This nurses note was written by LPN-FF. The eMar note dated 9/10/24, at 11:22 a.m., by LPN-AA documents Lacosamide Oral Tablet 100 mg. Give 2 tablet by mouth in the morning for seizure (200 mg total). Waiting on pharmacy [NAME] (delivery). No s/s (signs/symptoms) of distress. Vss (vital signs stable). On 9/18/24, at 9:14 a.m., Surveyor asked LPN-Q how medication is reordered in order for a resident not to run out of medication. LPN-Q explained they reorder on demand when there are 5 to 7 pills left or they get a normal cycle fill. Surveyor asked LPN-Q what she would do if there isn't a medication for a resident available. LPN-Q informed Surveyor she would go downstairs to contingency and would also call the pharmacy and ask if they can send out the medication. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 9/19/24, at 10:48 a.m., Surveyor asked DON (Director of Nursing)-B how residents medication are reordered. DON explained they have on demand or cycle fill. Surveyor informed DON-B there were multiple times when R607's Lacosamide and Keppra wasn't available. DON-B informed Surveyor Lacosamide is a narcotic and they have to order the medication on demand. DON-B informed Surveyor PCC (pointclickcare) will let them know when a script is needed. DON-B informed Surveyor when there are 5 to 7 pills they need to start reordering the medication. Surveyor asked DON-B if she could look into why R607 did not have Lacosamide and Keppra available multiple times and get back to Surveyor. On 9/19/24, at 12:03 p.m., DON-B provided Surveyor with delivery slips for R607's Lacosamide which showed the facility received this medication on 7/13/24 at 9:11 p.m., 7/26/24 at 2:25 p.m., and 9/10/24 at 1:51 p.m. No additional information was provided to Surveyor as to why R607 did not have Lacosamide & Keppra available to be administered per physician orders. On 9/19/24, at 1:20 p.m., Surveyor informed NHA (Nursing Home Administrator)-A, DON-B, Regional Nurse-S and Regional Director of Clinical Operations-T of the above. No additional information was provided as to why R607's seizure medication was not available. 49011 2.) R605 was admitted to the facility on [DATE] with diagnoses which include epilepsy, type 2 diabetes mellitus, and dementia. R605's Quarterly Minimum Data Set (MDS) with an assessment reference date of 7/19/2024 indicated R605 had a Brief Interview for Mental Status score of 10 (moderate cognitive impairment). R605 has an activated power of attorney. No behaviors were documented during the look back period of the assessment. R605's MDS showed that upper and lower extremities have no impairment. R605's care plan documents resident has a seizure disorder Date Initiated: 02/14/2024 Goal: The resident will be/remain free of seizure activity through review date. Date Initiated: 02/14/2024 Target Date: 07/01/2024 Interventions: Give medications as ordered. Monitor/document for effectiveness and side effects. Date Initiated: 02/14/2024 Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 02/14/2024 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	POST SEIZURE TREATMENT: Turn on side with head back, hyper-extended to prevent aspiration, Keep airway open, After seizure take vital signs and neuro check, Monitor for aphasia, headache, altered LOC, paralysis, weakness, pupillary changes. Date Initiated: 02/14/2024 SEIZURE DOCUMENTATION: location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity. Date Initiated: 02/14/2024 SEIZURE PRECAUTIONS: Do not leave resident alone during a seizure, Protect from injury, If resident is out of bed, help to the floor to prevent injury, Remove or loosen tight clothing, Don't attempt to restrain resident during a seizure as this could make the convulsions more severe, Protect from onlookers, draw curtain etc. Date Initiated: 02/14/2024 R605 has a physician order that started 7/30/2024 for Clobazam Oral Tablet 10mg, give one tablet by mouth two times a day for seizures. Surveyor reviewed R605's Medication Administration Record (MAR) and saw that Clobazam was not given 13 times in August and 4 times in September through the 14th. Surveyor notes this is 17 out of 90 opportunities that the medication was not given. On 9/18/24, at 9:08 AM, Surveyor interviewed Unit Manager (UM)-P and asked about the Clobazam medication not being given multiple times in August and September. The UM-P asked to look into the issue and get back to Surveyor. Later UM-P followed up with Surveyor and stated that the pills were in the Facility. The best guess is that nurses didn't know what the medication was. It is a narcotic so kept in the locked narcotic drawer. UM-P will do follow up training as one was a staff person and the others were agency that did not administer the medication. On 9/18/24, at 11:30 AM, Surveyor interviewed Director of Nursing (DON)-B about the missing administrations of Clobazam and was told the medication was on the cart in a locked box and figured staff didn't know to look there. On 9/18/2024, at 3:03 PM, during the end of day meeting, Surveyor let the Nursing Home Administrator-A, DON-B, Regional Nurse-S and Regional Director of Clinical Operations-T know of the concern that R605's Clobazam was not being administered regularly. No further information was provided as to why the facility did not ensure that R605 was free from this significant medication error.

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observation, interviews and record review the facility did not provide functional furniture appropriate to the resident's needs in each resident's room to attain or maintain his or her highest practicable level of independence and well-being, including a clean, comfortable mattress for 1 of 1 (R609) residents reviewed. R609 was not provided a comfortable mattress. Findings include: R609 admitted to the facility on [DATE] and has diagnoses that include Amyotrophic Lateral Sclerosis (ALS), Anxiety Disorder, Adjustment Disorder with Depression, Gastro-Esophageal Reflux Disease, Hypertension and Insomnia. R609's Admission Minimum Data Set (MDS) dated [DATE] documents: Mobility - roll left and right: The ability to roll from lying on back to left and right side and returning to lying on back on the bed - Dependent. R609's Braden dated 9/4/24 documents a score of 12, indicating high risk for pressure injuries. At present, R609 has no pressure injuries. On 9/17/24 at 9:00 AM, as Surveyor was walking in the hall, R609 asked to speak with Surveyor. Surveyor observed R609 sitting upright in a wheelchair with footrests and a high back which reclines. Surveyor observed soft blue arm rests on both sides and a blue cushion on the chair. R609 reported she complained to the facility that her bed was uncomfortable and asked for a new mattress. R609 reported she has been sleeping in her wheelchair because the facility has not provided a new mattress and she was told she can't have an air mattress because she doesn't have any wounds. R609 reported she has shared this concern with Assistant Nursing Home Administrator (ANHA)-U, but nothing has improved and she has not received a new mattress. R609 reports she is not comfortable sleeping in the chair and she can't move around at all because the space is narrow. Surveyor noted the wheelchair is narrow and does not allow room to shift from side to side. R609 reported she would prefer to sleep in a bed and would like to at least try an air mattress because the bed she has is way too uncomfortable. Surveyor reviewed a grievance filed by R609 dated 9/3/24. The grievance completed by ANHA-U documented: Describe the concern: Resident requested a recliner to sleep in; bed is not comfortable for her. Resolution Action Taken: How did we resolve the concern? 9/3/24 spoke with UM (Unit Manager) regarding bed/mattress - there are no other options available at this time; resident has no wounds to warrant air mattress. Explained this to resident who is accepting of explanation. Advised resident to discuss use of an air mattress with her MD (Medical Doctor). Date of resolution: 9/4/24. Followed up with resident who thanked me for the help and expressed her desire to be at home with significant other. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525325	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Estates Nursing and Rehab LLC	6735 W Bradley Rd Milwaukee, WI 53223

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 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:30 AM, Surveyor interviewed ANHA-U. Surveyor asked what did the facility do in regards to R609's complaint and request for a different mattress and why is it R609's responsibility to call the doctor to discuss use of an air mattress. ANHA-U stated: To be honest, I did talk with the UM and the Wound Care Nurse (Wound RN-Q). I wanted her to try the air mattress, but I was told she doesn't qualify for an air mattress because she doesn't have any wounds. Basically all our other mattresses are the same. We did have one we were going to try, but the bed control is on the rail and we can't use rails because they're a restraint. Surveyor asked if R609 was provided a special cushion for the wheelchair, since she sleeps in the chair. ANHA-U reported she did not think so. Surveyor advised ANHA-U R609 still has complaint that she has to sleep in her wheelchair because she does not have a comfortable bed available. Surveyor asked ANHA-U how she determined the grievance to be resolved. ANHA-U stated: Because I spoke with her and explained she couldn't have an air mattress because she doesn't have any wounds, and she accepted the explanation. Surveyor asked what choice did R609 have? AHNA-U stated: I guess none. I did try to get an air mattress for her but was told no. Surveyor asked if anyone at the facility called the doctor to inquire about an air mattress. ANHA-U stated: I don't think so, because she doesn't have any wounds. Surveyor asked why she advised R609 to call the doctor. AHNA-U stated: I just thought that might be an option so she could get one. On 9/18/24 at 11:45 AM, Surveyor observed R609 sitting in her wheelchair in the hall. Surveyor asked if she was still sleeping in her wheelchair. R609 stated: Yes, they said they have no other bed or mattress for me. R609 stated: It's horrible being in this all day and night, I can't move at all, I can't turn on my sides or anything because it's too narrow. My legs go numb sometimes and I think they get frustrated when I call so much to change position. I would love to still try an air mattress if you could get them to agree. Surveyor noted R609's current care plan does not document that R609's sleeps in her wheelchair. In fact, the care plan documents: The resident has actual for an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) ALS. Intervention - Bed Mobility: The resident uses bilateral enabler bars to maximize independence with turning and repositioning in bed - dated 8/16/24. On 9/18/24 at 3:00 PM the facility was advised of concern R609 filed a grievance that her bed is not comfortable. There is no evidence the facility attempted to replace the bed or mattress, thus R609 has been sleeping in her wheelchair. Nursing Home Administrator (NHA)-A reported the grievance was resolved because the resident did not complain about comfort, she reported the bed was broken and she has emails to prove it. Surveyor advised NHA-A the grievance R609 filed on 9/3/24 documents R609 requested a recliner to sleep in; bed is not comfortable for her. Surveyor was provided email chain between the facility and staff at Board of Aging & Long Term Care (BOALTC). BOALTC 8/30/24: I am writing on behalf of (R609). (R609) let me know she has been sleeping in her wheelchair because her bed is broken. She mentioned getting a more comfortable bed, but also indicated that even as she looks at other options she would like a bed to be able to sleep in. She was told one would be ordered but that was a while ago. She is unable to lay flat because she is aspirating. Surely there is another bed she can use for sleeping this weekend. (continued on next page)

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BOALTC 9/3/24: Good afternoon. I am sure my email got buried over the long weekend. I tried calling the facility and was disconnected after the gal answered. I am following up regarding (R609). She currently does not have a bed to sleep in, reports her hospital bed is broken and is sleeping in her wheelchair. I know you all must be very busy. If you are not able to assist me please let me know, and could you connect me with a Director of Nursing (DON) or Social Worker there who would be able to assist? Having a resident without a bed is a huge concern. Facility 9/3/24: In response to your concerns .(R609)'s bed is not broken, the foot board is out of its bracket. I placed a maintenance request for this to be corrected, which should be completed today. (R609) explained to me that she is sleeping in her chair due to her breathing issues and not being comfortable in her bed. She originally requested a recliner to sleep in; however, we do not have recliners here for residents to sleep in, which I explained to (R609). I suggested perhaps we could look into an air mattress for her. I stand corrected on that - after speaking with nursing staff, I now understand (R609) does not require the use of an air mattress, as she has zero wounds at this time. R609 filed a grievance on 9/3/24 requesting a recliner to sleep in; bed is not comfortable for her. There were no attempts to provide R609 a new bed or mattress for comfort which resulted in R609 resorting to sleeping in her wheelchair. On 9/26/24 the facility submitted additional information for review which included the grievance dated 9/3/24 and notes to indicate the facility is not obligated to provide a recliner or air mattress to R609. The note from the facility implies the Ombudsman from the BOALTC agreed with the facility's position it did not have to provide such items and the grievance was resolved. As noted above the Ombudsman shared with the facility F609 was not comfortable in the wheelchair she is presently sitting and sleeping in each day and wants a bed with a different mattress for comfort.