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	07/01/2024

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review the facility did not ensure resident was free from misappropriation of property for 1 (R64) of 1 residents reviewed for misappropriation. * R64 had eight (8) oxycodone tablets go missing when facility staff did not complete a shift change narcotic count on 6/10/2024. The facility did not thoroughly investigate the missing narcotic tablets and the investigation did not include a conclusion of where the missing 8 oxycodone tablets went. Findings include: The facility policy entitled Abuse, Neglect and Exploitation revised on 1/5/2024 documents It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent. Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. b. Establish policies to investigate any such allegations. 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. II. Employee Training A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. C. Training topics will include: (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Prohibiting and preventing all forms of abuse, neglect, misappropriation, of resident property, and exploitation. III. Prevention of Abuse, Neglect, and Exploitation- the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: . G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur. H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. V. Investigation of Alleged Abuse, Neglect, and Exploitation: . B. Written procedures for investigations include: . 4. Identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 6. Providing complete and through documentation of the investigation. 1.) R64 was admitted to the facility on [DATE] with a diagnosis that includes diabetes mellitus type 2, spinal stenosis, displaced comminuted fracture of right ankle anxiety disorder, vascular dementia, and major depressive disorder. R64's quarterly minimum data set (MDS) dated [DATE] indicated R64 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of 5. Section H of the MDS- Pain Management, documents that R64 is on a scheduled pain medication regimen, receives PRN (as needed) pain medications and has pain assessments conducted. At the time of the assessment, the facility documented R64 did not have pain at any time in the last five days of when the assessment was conducted. The facility self-report documents that on 6/10/2024 the 3rd shift licensed practical nurse (LPN)-AA left the facility at shift change before counting narcotics with the oncoming first shift LPN-BB. The report documents the medication cart keys were left on the med cart in the nurse's station. When LPN-NN arrived to the facility to start 1st shift, LPN-BB did not count the narcotics with another nurse before starting the shift. The medication narcotics were not counted until 6/10/2024 at shift change for second shift. It was documented that R64 was missing 8 oxycodone 5 mg tablets from the medication card. The facility then started an investigation. Surveyor noted that other staff that worked on 6/10/2024 were not interviewed as part of the investigation. The facility self-report did not document when LPN-BB arrived at the facility and started to pass medications from the medication cart. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2024, at 2:18 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked DON-B if other staff were interviewed regarding R64's missing narcotics on 6/10/2024. DON-B stated that LPN-BB left the medication cart keys on the medication cart in the medication room, and that no one had access to the medication room. DON-B stated that the facility reviewed video footage and could not substantiate the medication card was removed. Surveyor asked DON-B what the time frame was between LPN-AA leaving the facility and LPN-BB arriving to the facility and starting medication pass. DON-B informed Surveyor she would review the investigation and let Surveyor know. Surveyor then requested the time slips for LPN-AA and LPN-BB. On 6/27/2024, at 8:00 AM, Surveyor interviewed LPN-CC who stated any nursing would have access to the medication rooms. LPN-CC stated that medication counts can be done with any nursing staff if the prior shift nurse is unavailable to count the narcotics with. On 7/1/2024, at 2:09 PM, Surveyor shared concerns with DON-B regarding the self- report for R64's missing 8 Oxycodone 5 mg tablets and that no other staff was interviewed to determine if they knew anything about the missing medications. No additional information was provided as to why the facility did that R64 was free from misappropriation of property after eight (8) oxycodone tablets went missing.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42037 Based on record review, the facility did not properly complete a BID (Background Information Disclosure) form, DOJ (Department of Justice) form, and IBIS (Integrated Background Information System) form for 2 of 8 employees reviewed for the sufficient and competent staffing tasks. This has the potential to affect a pattern of residents whom may recieve care from both staff members. Findings include: On 6/27/24 at 8:11 AM, Surveyor reviewed CNA-KK's and Activity Aide-LL's employee files to validate that the facility completed a BID (Background Information Disclosure) form, DOJ (Department of Justice) form, and IBIS (Integrated Background Information System) form for upon hire and within the last 4 years. Surveyor noted: CNA-KK was hired by the facility on 11/6/23. The facility completed the following for CNA-KK: The BID was completed on 2/12/24. The DOJ was completed on 6/26/24. The IBIS was completed on 6/26/24 Surveyor noted the facility did not complete a BID, DOJ, and IBIS upon hiring CNA-KK. Activity Aide-LL was hired by the facility on 8/19/18. The facility completed the following for Activity Aide-LL: The BID was completed on 6/18/18. The DOJ was completed on 7/31/18. The IBIS was completed on 7/31/18. Surveyor noted the facility did not complete a BID, DOJ, and IBIS for Activity Aide-LL in the last 4 years. On 6/27/24 at 10:30 AM, Surveyor interviewed Human Resources (HR)-MM who has been in the position since July of 2023. HR-K states if an employee is hiredby the facility, a BID, DOJ, and IBIS is reviewed. HR-K states they are aware the BID, DOJ, and IBIS is to be completed every 4 years. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/24 at 10:00 AM, Surveyor shared concerns with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B regarding the facility not completing a BID, DOJ, and IBIS every for CNA-KK upon hire. Surveyor shared concerns with NHA-A and DON-B regarding the facility not completing a BID, DOJ and IBIS for Activity Aide-LL in the last 4 years. Surveyor asked NHA-A how often a BID, DOJ, and IBIS should be completed for employees. NHA-A reported that a BID, DOJ, and IBIS should be completed every 4 years for employees. No additional information was provided as to why the facility did not properly complete a BID (Background Information Disclosure) form, DOJ (Department of Justice) form, and IBIS (Integrated Background Information System) form for 2 staff members.

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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** 48391 Based on interview and record review the facility did not ensure 2 (R499 and R118) of 3 abuse allegations reviewed were reported to the State Agency. * On 4/16/2024, R499 filed a grievance indicating she did not receive care. R499 alleged she did not receive cares overnight on 4/16/2024. The facility did not report this allegation to the State Agency. * On 6/9/24, R188 was found with his hand down R73's pants. The facility failed to submit the initial self-report within the 2-hour timeframe for an allegation of sexual abuse to the state agency and the police were not notified of this allegation of sexual abuse until the next day. Findings include: The facility's policy Abuse, Neglect and Exploitation dated as last revised on 1/5/24 documents: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definition: Abuse means the willful infliction of injury, unreasonable, confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility will develop and implement written policies and procedures that: 1. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. 2. Establish policies and procedures to investigate any such allegations. Identification of Abuse, Neglect and Exploitation: 1. Failure to provide care needs such as feeding, bathing, dressing, turning and positioning. Investigation of Alleged Abuse, Neglect and Exploitation: 1. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Reporting/Response: 1. The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R499 was admitted to the facility on [DATE]. R499's diagnoses include encephalopathy, chronic obstructive pulmonary disorder, chronic kidney disease, gout, and osteoarthritis. R499's Admission MDS (Minimum Data Set) completed on 4/24/24 documents that R499 is incontinent of urine and bowel and requires substantial/maximal assistance with toileting and bathing. R499 was also documented as having a BIMS (Brief Interview for Mental Status) score of 15, indicating that R499 is cognitively intact. R499's care plan, dated 4/15/24, documents: ~ R499 has actual impairment to the skin integrity right buttock, left buttock, right groin, left groin related to Moisture Associated Skin Damage (MASD). Date initiated 4/15/24. Interventions include: 1. Evaluate and treat per physicians orders. Date initiated 4/15/24. 2. Evaluate R499 for signs and symptoms of possible infections. Date initiated 4/15/24. 3. Apply barrier cream per facility protocol to help protect skin from excess moisture. Date initiated 4/29/24. 4. Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Date initiated 4/29/24. 5. Educate R499/family/caregivers of causative factors and measures to prevent skin injury. Date initiated 4/29/24. 6. Follow facility protocols for treatment of injury. Date initiated 4/29/24. 7. Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to Medical Director (MD). Date initiated 4/29/24. 8. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date initiated 4/29/24. 9. Dietary consult as needed. Date initiated 4/23/24. 10. Encourage/assist with turning and reposition every 2-3 hours. Date initiated 4/23/24. 11. Monitor skin when providing cares, notify nurse of any changes in skin appearance. Date initiated 4/15/24. 12. Encourage good nutrition and hydration in order to promote healthier skin. Date initiated 4/23/24. ~ R499 has incontinence of bowel and bladder. Risk for skin breakdown and signs and symptoms of Urinary Tract Infections (UTI)s. Date initiated 4/15/24. Interventions include: 1. Provide skin care with each incontinent episode. Date initiated 4/16/24. 2. Clean peri-area with each incontinence episode. Date initiated 4/15/24. 3. Ensure R499 has the unobstructed path to the bathroom. Date initiated 4/23/24. 4. Monitor/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date initiated 4/23/24. ~ R499 has potential for Activities of Daily Living (ADL) self-care performance deficit related to generalized weakness and hospitalization for toxic encephalopathy and diverticulosis. Date initiated 4/15/24. Interventions include: 1. Bathing assist of one. Date initiated 4/15/24. 2. Bed mobility with moderate assist of one. Date initiated 4/17/24. 3. R499 is independent with dining and prefers to eat in room. Date initiated 4/17/24. 4. Dressing requires set up for upper body and moderate assist of one for lower body dressing. Date initiated 4/17/24. 5. R499 is independent with toileting. Date initiated 4/17/24. 6. R499 requires physical assistance with transfers. Date initiated 4/16/24. 7. Encourage R499 to use bell to call for assistance. Date initiated 4/15/24. 8. Monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Date initiated 4/15/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R499 has limited physical mobility. Date initiated 4/15/24. Interventions include: 1. R499 uses a wheelchair. Date initiated 4/15/24. 2. Provide supportive care, assistance with mobility as needed. Date initiated 4/15/24. ~ R499 has nutritional problem or potential nutritional problem related to diet restrictions. Interventions include: 1. Obtain and document weights per MD orders and facility protocol. Date initiated 4/16/24. 2. Explain and reinforce to the resident the importance of maintaining the diet ordered. Encourage R499 to comply. Explain consequences of refusal such as obesity, malnutrition, or other risk factors. Date initiated 4/16/24. 3. Monitor/record/report to MD PRN signs and symptoms of malnutrition: Emaciation, muscle wasting, significant weight loss. Date initiated 4/16/24. 4. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date initiated 4/16/24. 5. Provide and serve diet as ordered. Date initiated 4/16/24. 6. Provide, serve diet as ordered. Monitor intake and record every meal. Date initiated 4/16/25. 7. Registered Dietician (RD) to evaluate and make diet change recommendations PRN. Date initiated 4/16/24. 8. Weigh at same time of day and record: monthly or as needed. Date initiated 4/16/24. ~ R499 can be resistive to medications and meals at times. Date initiated 4/23/24. Interventions include: 1. Allow the resident to make decisions about treatment regime, to provide sense of control. Date initiated 4/23/24. 2. Educate R499/family/caregivers of the possible outcome(s) of not complying with treatment or care. Date initiated 4/23/24. 3. Provide R499 with opportunities for choice during care provision. Date initiated 4/23/24. On 6/26/24 at 7:55 AM, Surveyor reviewed the facility grievance log which included a grievance that was filed for R499 on 4/17/24. The grievance for R499 indicated there were care concerns on the night of 4/16/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24, at 1:26 AM, Surveyor interviewed Assistant Administrator-DD who stated she has been working with the facility for approximately 3 months and is new to the grievance process. Assistant Administrator-DD states she completes and investigates the grievances for the facility. Assistant Administrator-DD will receive grievances by staff, residents talking to her in person, or the grievance may be written on the grievance form and placed in the grievance box located outside her office. Surveyor asked Assistant Administrator-DD what the process is for grievances received. Assistant Administrator-DD states she will review the grievance and if she doesn't understand the grievance, she will go to the person filing the grievance for clarification. Assistant Administrator-DD states she will then talk with the resident listed on the grievance and start an investigation by talking with staff, nursing, unit manager, and reviews video cameras. Assistant Administrator-DD states she always keeps the manager of the department involved in the grievance informed. Assistant Administrator-DD states she received an anonymous grievance the morning of 4/17/24 for R499. The grievance stated R499 did not receive cares overnight on 4/16/24 and was not offered to be taken to the bathroom nor was she changed. Assistant Administrator-DD indicates she looked at the schedule to determine who worked R499's unit the night of 4/16/24. She then interviewed the Licensed Practical Nurse (LPN) and Certified Nursing Assistant (CNA) who was assigned to R499. Assistant Administrator-DD states she notified leadership and discussed the grievance in daily stand-up meetings. Assistant Administrator-DD reported she spoke with R499 on 4/22/24 to follow up on care concerns. Surveyor asked Assistant Administrator-DD why she didn't talk with R499 on 4/17/24, and Assistant Administrator-DD indicated she was new to the role and learning and that now starts with the residents as part of her investigation. Surveyor asked Assistant Administrator-DD if the care concern was reported to the state agency. Assistant Administrator-DD indicated the care concern was not reported to the state agency and notified Surveyor she is new and to the facility and the grievance process. On 7/1/24, at 8:14 AM, Surveyor interviewed DON- B who stated Assistant Administrator-DD is responsible for grievances within the facility. DON-B indicated she is notified of grievances within the facility and provided updates throughout the grievance process. DON-B stated she does not recall R499's grievance and care concerns filed on 4/16/24. DON-B stated she did not see a proper investigation into the care concern and was unaware if the allegation was reported to the state agency. Surveyor notified DON-B of concerns with the care concern not being reported to the state agency. Surveyor requested additional information if available. No additional information was provided as to why the facility did not report R499's care concern to the state agency. 20025 2.) Surveyor reviewed the facility's Abuse, Neglect and Exploitation policy dated 9/2020 with revised date of 1/5/24. The document indicates the following: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or (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 than 24 hours if the events that cause the allegation doe not involve abuse and do not result in serious bodily injury Surveyor reviewed facility self report regarding alleged sexual abuse. The investigation revealed that on 6/9/24 R188 was found with his hand down R73 pants. The NHA-A was made aware of the incident immediately. The initial self report was submitted on 6/10/24 at 1:35 p.m. to the state agency. The police were called for the allegation of sexual abuse on 6/10/24. On 6/27/24 at 9:58 a.m. Surveyor interviewed NHA-A regarding the reporting of the alleged sexual abuse. NHA-A stated she was made aware of the allegation on 6/9/24. DON-B called NHA-A to inform her of the allegation. NHA-A stated she was initially told R118 was found to be touching R73 inappropriately. NHA-A stated she was not aware of the details until 6/10/24 when she read Medication Technicians-R's statement dated 6/9/24. NHA-A stated that on 6/10/24, she made the initial reporting to the state agency and the police were called. On 7/1/24 at 11:30 a.m. Surveyor met with NHA-A and DON-B regarding concerns with R118. Surveyor expressed concern the initial facility self report was not submitted within the 2 hour timeframe for an allegation of sexual abuse and the police were not notified of this allegation of sexual abuse until the next day. No additional information was provided as to why the facility did not report the allegations of potential sexual abuse to the state agency within the required 2 hours timeframe.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on observation, interview and record review the facility failed to prevent further potential abuse for 1 (R118) of 2 residents reviewed. On 6/9/24, R118 was discovered with his hands down R73 pants. R118 and R73 are roommates. Med tech-R separated both residents and reported the incident immediately. The facility moved R73 to a different room and placed a different resident in the room with R118. NHA-A stated the reason for placing a different roommate with R118 is because the new roommate was more verbal and able to voice if R118 would touch him. R118's care plan was not updated to reflect the inappropriate sexual behavior. The facility did not have structured monitoring of R118 and no evidence of supervision of R118 after discovering his hands down R73 pants. The facility failed to prevent further potential abuse through supervision and structured monitoring which allowed R118 to act out sexually and touch R73 inappropriately. Findings include: Surveyor reviewed the facility's Abuse, Neglect and Exploitation policy dated 9/2020 with revision date of 1/5/24. The document includes: . III. Prevention of Abuse, Neglect and Exploitation A. Establishing a safe environment that supports, to the extend possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; . 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; . VI. Protection of Resident A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increase supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident (s) from the alleged perpetrator; E. Protection from retaliation; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Providing emotional support and counseling to the resident during and after the investigation, as needed; 1. R118 was admitted to the facility on [DATE] with diagnosis of dementia. R118 resides on unit 500, an alarmed all male unit, with a majority of the residents having dementia. R118 ambulates independently throughout the unit. The quarterly MDS (minimum data set) dated 4/10/24 indicates R118 has severe cognitive impairment. It also indicates R118 does not exhibit any verbal, physical or sexual behaviors. R73 was admitted to the facility on [DATE] with diagnosis of dementia. R73 resides on unit 500. R73 ambulates independently throughout the unit. The quarterly MDS dated [DATE] indicates R73 has severe cognitive impairment. The nurses note dated 6/9/24 at 16:07 (4:07 p.m.) documents, (R118) is being monitored for bx's (behaviors) due to abuse allegations. Residents' demeanor is within his normal baseline. No bx's noted this shift. Will continue to mx (monitor). Surveyor reviewed the facility's investigation into the abuse allegation. The self report documents the following: (R118) is an LTC resident who was admitted on [DATE]/2023. (R118) is an ad lib resident who walks the halls all day. He is very happy and likes to keep busy walking. (R73) is an LTC resident who was admitted on [DATE]. (R73) DOB (date of birth) is 02/23/1943, [AGE] year male. The residents BIMs is a 99 with dx of dementia. (R73) is an ad lib resident who walks the halls all day. He is very happy and likes to keep busy walking, same as (R118). (R118) and (R73) were roommates and walk the halls together daily. They will guide each other down the halls all day grabbing each other's hands at times to go a different way. (R118) has been observed rubbing (R73) back at times when they stand around. (R118) also rubs employees back or arms at times as well. (R118) is easily redirected. On Sunday June 9th 2024, it was reported to (DON-B) that (R118) was inappropriately touching(R73). They described it that (R118) was rubbing (R73) arm and back but was easily redirected. A little later (Med Tech-R) was passing medications and passed (R188) and (R73) room , and she seen (R118) and (R73) sitting on one bed and (R118) was reaching to put his hand down (R73) pants (which were lose fitting and the brief was seen), and she stopped (R118) and removed (R73) from the room. (DON-B) notified (NHA-A) and they agreed to call the POAs and have (R73) move to a different room and update the MDs. The POA's were notified and they were fine with the room change and the room changed happened after the incident happened. (DON-B) asked the employee to write a statement of what happened. (continued on next page)

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	525325	A. Building B. Wing	07/01/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After further investigation, (NHA-A) and (RNC-O) called (Med tech-R) who reported the incident to get her statement. We interviewed her and found that there was more to the incident than initially reported. (Med Tech-R) stated she put her statement under (DON-B) door which matched her interview over the phone. After the interviews and investigating further, we found out from (Med Tech-R) that not only (R118) had his hand in (R73) pants as if he was fixing his pants, he had his hand inside his brief. (Med Tech-R) removed (R118) hand from (R73) pants and removed (R118) from the room and reported it to the nurse. The Milwaukee police were called, MD was called with updates and no new orders, POA's were updated with the new findings. An initial self-report was submitted. The police came to the facility and tried to interview the two residents and were not able to get any answers from them. (R118) and (R73) had no idea of remembering what happened the night before. The CAD # is C2406100108. The psych NP was called to see (R118) and she will see him when she returns to the building. (R118) and (R73) are being monitored daily. Resident interviews were conducted on the 500 unit where (R118) and (R73) reside, no reports of any sexual abuse or touching inappropriately were noted. No other behaviors from either resident noted. This appears to be an isolated resident. Care plans were reviewed. The residents can walk the halls during awake hours but are not to be in a room alone with each other. Findings: Per (Med Tech-R) observed an inappropriate touching of a resident and stopped it immediately. It is unknown which resident initiated the actions. Neither resident was able to answer what happened with the incident. Neither was in any distress. No other employee has seen any inappropriate behavior with these two residents in the past. There is no negative effect on either resident currently. Both are at their baseline with no new behaviors and continuing with their daily routine of walking the halls. (R118) has been known to look after (R73) and other residents and it is unclear if he was trying to help (R73) with his loose/soiled brief. Since both residents are ambulatory, cameras were also reviewed, and no inappropriate sexual behaviors were noted from either one of those residents. Med Tech-R statement dated 6/9/24 reveal around 6:00 p.m. Med Tech-R observed R118 and R73 in their room. Med Tech-R observed R118 touch R73 on his chest. Med Tech-R indicate she stopped R118 and had him leave the room. Med Tech-R continues to indicate she continued with her medication pass and when she completed the pass she looked in on R118 and discovered him in his room with his hands inside R73 brief. Med Tech-R separated them and notified a nurse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In Med Tech-R statement she indicates she spoke with a CNA (not named) about R118 behavior. The CNA told Med Tech-R that R118 use to rub R73 hands or legs sometimes on night shift. Surveyor attempted to interview Med Tech-R but she did not return Surveyor's call. The investigation reveals R118 and R73 POAs were notified of the incident and agreed on a room change. On 6/9/24 R73 was moved to a different room and and R118 received a new roommate. On 6/10/24 the facility called the police and the police tried to interview R118 and R73 but neither resident were able to remember what happened the day before. On 6/12/24 Social Service Director spoke with R118 and R73 and both residents had no psychosocial distress and appeared to have baseline behavior. On 6/18/24 Psych Np assessed R118 and R73 and no changes were noted. The nurses notes document R118 behaviors daily and no unusual behaviors were noted. The medical record has no evidence R118 has had previous inappropriate sexual behaviors. The care plan does not address any behaviors beside wandering. Elopement care plan reads as follows: The resident is an elopement risk/wanderer r/t dementia with date initiate 2/10/2023. The interventions include -secure unit -staff aware of residents wander risk -Wander Alert Personal Safety device: Nurse note dated 6/17/2024 indicates R118 had no behaviors noted at this time. resident (R118) pacing hallway per his normal. Nurse note dated 6/19/2024 indicates R118 had no behavioral issues noted or reported doing shift. Resident (R118) received a shower and continues to walk the hallway. Nurses note dated 6/20/2024 indicates R118 paced back and forth for hours straight and @ 224 (2:24 a.m.) sat down in the middle of the hallway, which was witnessed, he then got of the floor and began pacing, I escorted him to his room and in Spanish asked him to sit down in which he complied and he laid down and covered him up and the resident is sleeping. Nurses note dated 6/25/2024 indicates resident (R118) continues to pace up and down hallway. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurses note dated 6/27/2024 indicates resident (R118) pacing up and down hallway redirected numerous times. On 6/27/24 at 9:47 a.m. Surveyor interviewed ADON (assistant director of nursing)- C regarding R118 behavior. ADON-C stated R118 has not had any sexual inappropriate behavior before 6/9/24. ADON-C stated R118 had been on the board to be monitored for his behavior. ADON-C stated R118 behavior has not changed. Surveyor asked ADON-C who is responsible for updating the care plan. ADON-C stated the interdisciplinary team discusses issues and the MDS nurse will update the care plan. ADON-C stated resident wanders the unit and at times wanders in other resident's room. ADON-C stated resident is redirected out of other resident's rooms. On 6/27/24 at 9:58 a.m. Surveyor interviewed NHA-A regarding the incident between R118 and R73. NHA-A stated on 6/9/24 she received a phone call from DON-B telling her R118 was witnessed touching R73 inappropriately. NHA-A stated R118 had no previous sexually inappropriate behavior. NHA-A stated R118 is like a father [NAME] trying to take care of other people but no inappropriate touching was observed in the past. NHA-A stated they moved R73 because they were afraid if they moved R118 from his room, R118 wouldn't remember his new room and wander back into the previous room he shared with R73. NHA-A stated because the unit is full they just switched roommates. NHA-A stated R118 has a roommate that is more alert and verbal and would voice if he was inappropriately touched. NHA-A stated when they talked with Med Tech-R her story changed from inside the brief to outside the brief. NHA-A stated R118 and R73 have not acted differently and continue to wander the unit. NHA-A stated the facility did not have any other interventions to keep other residents safe, other than monitoring R118. On 7/1/24 at 9:13 a.m. Surveyor interviewed LPN-EE regarding R118. LPN-EE stated she's been working on the unit for 2 months and has not seen R118 have any sexual inappropriate behavior. LPN-EE stated she had not heard of R118 having any past sexual inappropriate behavior. LPN-EE indicates R118 does wander the unit and will need to redirected from other people's room During the survey, on 6/24/24 and 6/26 Surveyor observed R118 wandering the unit and being redirected when he would wander into someone else's room. Facility staff did not engage R118 in any activities to divert his wandering behavior. On 7/1/24 at 11:30 a.m. Surveyor met with NHA-A and DON-B regarding concerns with R118. Surveyor expressed concern R118 does not have structured monitoring for his inappropriate sexual behavior, the care plan does not address the inappropriate sexual behavior or his behavior regarding non sexual touching of other people, the concern another resident was placed in the same room with R118 and the lack of supervision and safety concerns for other residents. Surveyor also expressed concern with the lack of structured activities for residents with dementia and wandering behavior. Surveyor expressed concern R118 care plan was not updated to reflect R118 behavior or interventions to assist with R118 wandering behavior. No additional information was provided as to why the facility failed to prevent further potential abuse through supervision and structured monitoring which allowed R118 to act out sexually and touch R73 inappropriately.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 21855 Based on record review and interview, the facility did not document in a resident's medical record the reason for a transfer to the hospital for 1 (R124) of 9 resident hospital transfers from the facility that were reviewed. * R124 was transferred to the hospital on 3/3/24. There is no documentation in the medical record, of reason and location of what hospital R124 was transferred to. Findings include: The facility's policy Change in a Resident's Condition or Status, dated as revised 11/2015 documents: 7. The Nurse Supervisor/ Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status 1.) R124 progress note by (Licensed Practical Nurse) LPN-N on 3/3/24, at 11:35 PM, states Writer received a call from Officer-V regarding the resident's wear about. Writer was told that the resident was found safe at their sister's house, after the resident left the hospital on foot. the Officer-V also stated that the resident had caught 3 buses from the hospital to arrive at their sister house. The Officer-V stated that he will transport the resident back to the facility. There is not documentation in R124 medical record of the reason for going out to the hospital and the hospital visit itself. On 6/27/24, at 3:46 PM, during the facility exit meeting, Surveyor shared the concerns with R124 transfer with (Regional Nurse Consultant) RNC-D after R124 called 911 themselves. (Nursing Home Administrator) NHA-A and RNC-D stated they would look for additional information and let Surveyor know. On 7/01/24, at 9:13 AM, RNC-D and NHA-A, provided Surveyor with a facility incident report. This report states it is not part of the medical record and is private and confidential. The report documents R124 called 911, went to the hospital, and left the hospital on their own. The report does not indicate why 911 was called or what hospital. There was no documentation of R124 transfer to the hospital on 3/3/24. No additional information was provided as to why the facility did not document in R124's medical record the reason for a transfer to the hospital on 3/3/24.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure residents received the required transfer notices, in writing, with a transfer from the facility. This was observed with 10 (R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81) of 10 resident transfer's reviewed. * R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81, were transferred from the facility to a hospital. There was no documentation in the medical record of receiving the notice requirements. Findings include: There is not a facility policy and procedure for the written transfer notice information. On 6/26/24, at 1:07 PM, Surveyor spoke with (Assistant Director of Nurses) ADON-C. ADON-C stated the written transfer notice information does not get sent with the resident transfer. The written transfer notices are part of the bed-hold form. That form is not sent with the resident. 1.) R31 medical record documents a hospital visit from 1/31/24 - 2/3/24. There is no information in the medical record they received the written transfer notice information. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R31 hospital transfer. On 6/27/24, there was no additional information provided as to why R31 did not get a writer transfer notice when transferred to the hospital on 1/31/24. 2.) R47 medical record documents a hospital stay's on 12/29/23 - 1/4/24; 3/15/24 - 3/18/24; 4/5/24 - 4/9/24. There is no information in the medical record they received the written transfer information. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R47 hospital transfer. On 6/27/24, there was no additional information provided as why R47 did not get a written transfer notice when transferred to the hospital on the above dates. 3.) R124 medical record documents a hospital visit from 9/14/23 - 9/17/23. There is no information in the medical record they received the written transfer information. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R124 hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24, there was no additional information provided as to why R124 did not get a written transfer notice on 9/14/23. 20025 4.) R106 nurses notes dated 6/22/24 documents R106 was sent to the hospital due to an unresponsive episode and seizure like activity. There is no evidence, in the medical record, of a transfer notice completed for R106. On 6/27/24 at 3:00 p.m. during the daily exit meeting with NHA-A and DON-B, Surveyor asked for the transfer notice for R106's transfer to the hospital on 6/22/24. As of 7/1/24 Surveyor did not receive any additional information regarding R106 transfer notice. 22692 5.) On 6/27/24 R81's medical record and it indicated R81 was transferred to the hospital on 10/23/23. R81's medical record did not include documentation that a transfer notice had been given to the resident and/or representative for the hospitalization . On 6/27/24 at 11:57 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated a transfer notice was not completed for R81 on 10/27/23 and should have been. On 6/27/24 at 3:00 PM, the above findings were shared with NHA-A and Director of Nursing-B. Additional information was requested if available. No further information was provided as to why R81 was not given a transfer notice on 10/27/23 when he was transferred to the hospital. 38253 6.) R110 was admitted to the facility on [DATE] with diagnoses of prostate cancer and anemia. R110 had an activated Power of Attorney (POA). On 4/18/2024, R110 was sent to the hospital and admitted with a diagnosis of anemia. No documentation was found of a transfer notice for R110's hospitalization on [DATE] being provided to R110 or R110's POA. On 6/26/2024 at 3:03 PM at the daily exit with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor shared the concern no documentation of a transfer notice was found that was provided to R110 or R110's POA. Surveyor requested a copy of the transfer notice for R110's hospitalization on [DATE]. On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024, but R110's transfer notice were not included in the copied documents. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interview, the facility did not ensure residents received the required bed-hold information, in writing, with a transfer from the facility. This was observed with 10 (R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81) of 10 resident transfer's reviewed. * R31, R47, R124, R106, R13, R15, R27, R64, R110 and R81, were transferred from the facility to a hospital. There was no documentation in the medical record of receiving the required bed-hold information. Findings include: The facility's policy and procedures for Bed-Hold and Return Guidelines, dated 4/25/29, documents: A. The facility will provide written information to the resident or resident representative before the resident is transferred to the hospital. On 6/26/24, at 1:07 PM, Surveyor spoke with (Assistant Director of Nurses) ADON-C. ADON-C stated the written Bed-Hold information notice does not get sent with the resident transfer. In morning report they will receive who was in the hospital. They then call, the resident/ representative, and provide the bed-hold information. The bed-hold information is not sent with the resident. 1.) R31 medical record documents a hospital visit from 1/31/24 - 2/3/24. There is no information in the medical record they received the written Bed-Hold notice. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R31 bed-hold information. On 6/27/24, at 7:30 AM, NHA-A provided a Bed-Hold notice, dated 2/2/24, of verbal notification. There was no additional information provided. 2.) R47 medical record documents a hospital stay's on 12/29/23 - 1/4/24; 3/15/24 - 3/18/24; 4/5/24 - 4/9/24. There is no information in the medical record they received the written Bed-Hold notice. On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R47 bed-hold's. On 6/27/24, at 7:30 AM, NHA-A provided a Bed-Hold notice, dated 12/29/23, of a verbal consent for a bed-hold. There was no additional information provided for any other transfer dates. 3.) R124 medical record documents a hospital visit from 9/14/23 - 9/17/23. There is no information in the medical record they received a Bed-Hold notice. R124 did return to the same room in the facility. (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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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24, at 3:00 PM, during the daily exit meeting with (Nursing Home Administrator) NHA-A, (Director of Nurses) DON-B and (Regional Nurse Consultant) RNC-D. Surveyor requested any addition information for R124 bed-hold. On 6/27/24 there was no additional information provided on why R124 did not recieve a bed hold notice on 9/14/23. 20025 4.) On 6/22/24, R106 was sent to the hospital due to an unresponsive episode and seizure like activity. There is no evidence, in the medical record, of a bed hold notice completed for R106. On 6/27/24 at 3:00 p.m. during the daily exit meeting with NHA-A and DON-B, Surveyor asked for the bed hold policy for R106's transfer to the hospital on 6/22/24. As of 7/1/24 Surveyor did not receive any additional information regarding why R106 did not recieve a bed hold notice on 6/22/24 when he was transfered to the hospital. 22692 5.) R81's medical record was transferred to the hospital on 10/23/23. R81's medical record did not include documentation that a bed hold notice had been given to the resident and/or representative for the hospitalization . On 6/27/24 at 11:57 AM, Nursing Home Adminstrator (NHA)-A was interviewed and indicated a bed hold notice was not completed for R81 on 10/27/23 and should have been. On 6/27/24 at 3:00 PM, the above findings were shared with NHA-A and Director of Nursing-B. Additional information was requested if available. No further information was provided as to why R81 was not given a bed hold notice on 10/27/23 when he was transferred to the hospital. 38253 6.) R110 was admitted to the facility on [DATE] with diagnoses of prostate cancer and anemia. R110 had an activated Power of Attorney (POA). On 4/18/2024, R110 was sent to the hospital and admitted with a diagnosis of anemia. No documentation was found of a bed hold notice for R110's hospitalization on [DATE] being provided to R110 or R110's POA. On 6/26/2024 at 3:03 PM at the daily exit with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor shared the concern no documentation of a bed hold notice was found that was provided to R110 or R110's POA. Surveyor requested a copy of the bed hold notice for R110's hospitalization on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024, but R110's bed hold notice was not included in the copied documents. On 6/27/2024 at 3:46 PM at the daily exit with NHA-A and DON-B, Surveyor shared R110's bed hold notice was not included in the documents received at the beginning of the day. NHA-A stated if the documentation was not in the folder provided at the beginning of the day from the information requested yesterday, then there is nothing in the resident record to provide. Surveyor verified with NHA-A that R110 did not have a bed hold notice provided to R110 or R110's POA on 4/18/2024. NHA-A stated that was correct. No further information was provided at that time. 42037 7.) R13's medical record documents R13 was hospitalized on [DATE], 3/13/24 and 4/21/24. Surveyor reviewed R13's medical record. Surveyor could not identify documentation in R13's medical record for completed bed hold policy information for hospitalization s on 1/28/24, 3/13/24 or 4/21/24. On 6/26/24, at 3:00 PM, during the daily exit meeting with NHA-A, DON-B and RNC-D, Surveyor requested completed bed hold policy information for R13's hospitalization s on 1/28/24, 3/13/24 and 4/21/24. On 6/27/24 at 9:00 AM, Surveyor followed up with NHA-A regarding R13's completed bed hold policy information for hospitalization s on 1/28/24, 3/13/24 and 4/21/24. No additional information was provided by the facility at this time. 8.) R15's medical record documents R15 was hospitalized on [DATE], 4/4/24 and 4/23/24. Surveyor reviewed R15's medical record. Surveyor could not identify documentation in R15's medical record for completed bed hold policy information for R15's hospitalization s on 2/25/24, 4/4/24 and 4/23/24. On 6/26/24, at 3:00 PM, during the daily exit meeting with NHA-A, DON-B and RNC-D, Surveyor requested completed bed hold policy information for R15's hospitalization s on 2/25/24, 4/4/24 and 4/23/24. On 6/27/24 at 9:00 AM, Surveyor followed up with NHA-A regarding R15's completed bed hold policy information on 2/25/24, 4/4/24 and 4/23/24. No additional information was provided by the facility at this time. 47094 9.) R64 was admitted to the facility on [DATE] with diagnoses of repeated falls, anxiety disorder, vascular dementia, major depressive disorder, and cerebral infarction. R64 had an activated Power of Attorney (POA). On 3/20/2024, R64 was transferred and admitted to the hospital. On 3/27/2024, R64 was transferred and admitted to the hospital. Surveyor reviewed R64's medical record and could not find any documentation that a bed hold had been given to R64 or R64's activated POA on 3/20/24 or 3/27/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/2024, at 3:303 PM, Surveyors requested transfer notices for residents from the nursing home administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor requested to see the bed holds for R64's hospitalization s for 3/20/2024 and 3/27/2024. On 6/27/2024, at 3:46 PM, Surveyors requested bed holds again for the residents. NHA-A and DON-B verified that they did not have transfer notices for the residents including R64's bed holds for R64's hospitalization s on 3/20/2024 and 3/27/2024. 10.) R27 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition, end stage renal disease with dependance on renal dialysis, anemia, mild cognitive impairment, and adult failure to thrive. R27 has a legal guardian. On 5/9/2024, R27 was transferred and admitted to the hospital. Surveyor reviewed R27's medical record and could not find any documentation that a bed hold had been given to R27 or R27's legal guardian. On 6/26/2024, at 3:303 PM, Surveyors requested bed holds for residents from the nursing home administrator (NHA)-A and Director of nursing (DON)-B. Surveyor requested to see the bed hold for R27's hospitalization for 5/9/2024. On 6/27/2024, at 3:46 PM, Surveyors requested bed holds again for the residents. NHA-A and DON-B verified that they did not have bed holds for the residents including R27's bed hold for R27's hospitalization on [DATE].

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on record review and interview, the facility did not ensure Preadmission Screening was completed or accurate for individuals with a mental disorder for 6 (R102, R140, R31, R47, R54, and R91) of 9 residents reviewed for PASARR (Preadmission Screening and Resident Review). *R102, R140, R31, R47, R54, and R91 had diagnoses mental disorders and medications to treat those disorders. A Level I PASARR should have triggered a Level II PASARR to be completed by the State Agency, but no Level II PASARRs were completed for these residents. Findings include: The facility policy and procedure entitled PASARR Guideline dated 11/28/2017 documents: PROCEDURE: 1. Admission and Readmission: a. The facility will participate in or complete a Level I screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. b. Based upon the Level I screen, if an individual is determined to meet the above criterion, the facility will not admit an individual, the facility will refer the potential admission to the State PASARR representative for the Level II screening process. On 6/26/2024 at 3:24 PM, Surveyor spoke with Admissions-G. Admissions-G has only been at the facility for a month. They are aware of the process of a PASARR Level I and Level II screen. They have been starting this process with new admissions. Admission-G did not have information about residents prior to them starting this position. 1.) R102 was admitted to the facility on [DATE] with diagnoses of anxiety disorder, major depressive disorder, and delusional disorders. R102 was taking antipsychotic and antidepressant medications to treat the mental disorders. On 4/17/2023 a Level I PASARR was partially completed, answering the questions in Section A, but leaving Sections B and C blank. The form indicated R102 was referred to the Screening Agency on 4/17/2023. No Level II PASARR was found in R102's medical record. On 6/26/2024 at 3:03 PM, at the daily exit with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor shared the concern no documentation of a Level II PASARR was found for R102. Surveyor requested a copy of the Level II PASARR for R102. On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024, but R102's Level II PASARR was not included in the copied documents. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/2024 at 3:46 PM, at the daily exit with NHA-A and DON-B, Surveyor shared R102's Level II PASARR was not included in the documents received at the beginning of the day. NHA-A stated if the documentation was not in the folder provided at the beginning of the day from the information requested yesterday, then there is nothing in the resident record to provide. Surveyor verified with NHA-A that R102 did not have a Level II PASARR completed. NHA-A stated that was correct. On 6/27/2024 a new Level I PASARR was scanned into R102's medical record with accurate information to have a Level II PASARR completed. No further information was provided at that time. 2.) R140 was admitted to the facility on [DATE] with diagnosis of major depressive disorder. R140 was taking an antidepressant to treat the depression. On 5/18/2024 a Level I PASARR was completed but did not have accurate information documented on the form; R110 was taking Sertraline on admission and that was not documented on the Level I PASARR. On 6/26/2024 at 3:03 PM at the daily exit with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor shared the concern no documentation of a Level II PASARR was found for R140. Surveyor requested a copy of the Level II PASARR for R140. On 6/27/2024 at 7:30 AM, Surveyor was provided a folder with copies of documents that had been requested on 6/26/2024, but R140's Level II PASARR was not included in the copied documents. On 6/27/2024 at 3:46 PM at the daily exit with NHA-A and DON-B, Surveyor shared R140's Level II PASARR was not included in the documents received at the beginning of the day. NHA-A stated if the documentation was not in the folder provided at the beginning of the day from the information requested yesterday, then there is nothing in the resident record to provide. Surveyor verified with NHA-A that R140 did not have a Level II PASARR completed. NHA-A stated that was correct. On 6/26/2024 a new Level I PASARR was scanned into R140's medical record with accurate information to have a Level II PASARR completed. No further information was provided at that time. 21855 3.) R31 was admitted to the facility on [DATE] and has diagnosis of schizophrenia and depression. R31 had a level I screen completed on 1/8/2018. There is not documentation the a level II screen was conducted. R31 had a Significant Change in Status MDS (minimum data set) assessment completed on 2/13/24. The section for the level II screen is not assessed. On 6/26/24, at 1:41 PM, Surveyor spoke with the MDS-H assessor. MDS-H indicated they did not see a level II screen in the medical record. On 6/26/24, at 3:24 PM, Surveyor spoke with Admissions-G. Admissions-G has only been at the facility for a month. They are aware of the process of a level I and level II screen. They have been starting this process with new admissions. Admission-G did not have information about residents, prior to, starting this position. On 6/27/24, at 3:36 PM, during the facility exit meeting Surveyor shared the level II screening concerns with (Nursing Home Administrator) NHA-A. No information was provided as to why R31 did not have a Level II PASARR completed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) R47 was admitted on [DATE] with a diagnosis of bipolar and depression. R47 had a level I screen conducted on 11/6/23. There is no documentation of a level II screen being conducted. R47 had an Admission MDS (minimum data set) assessment completed on 11/10/23. The section for the level II screen is not assessed. On 6/26/24, at 1:41 PM, Surveyor spoke with the MDS-H assessor. MDS-H indicated they did not see a level II screen in the medical record. On 6/26/24, at 3:24 PM, Surveyor spoke with Admissions-G. Admissions-G has only been at the facility for a month. They are aware of the process of a level I and level II screen. They have been starting this process with new admissions. Admission-G did not have information about residents, prior to, starting this position. On 6/27/24, at 3:36 PM, during the facility exit meeting, Surveyor shared the level II screening concerns with (Nursing Home Administrator) NHA-A.No information was provided as to why R47 did not have a Level II PASARR completed. 22692 5.) R91 was admitted to the facility on [DATE] and has diagnoses that included schizophrenia and bipolar disorder. On 06/26/24 R91's Preadmission Screen and Resident Review (PASRR) Level one screen dated 04/28/23 was reviewed and read: R91 is suspected of having a serious mental illness and was on the psychotropic medications Seroquel and Buspar. On 06/27/24 at 11:57 AM, Nursing Home Administrator (NHA)-A was interviewed and indicated a level 2 PASRR could not be found and one should have been completed. On 6/27/24 at 3:00 PM, NHA-A and Director of Nursing (DON)-B were informed of the above findings. No additional information was provided as to why R91's level 1 PASRR was not submitted for a level 2 PASRR screen. 6.) R54 was admitted to the facility on [DATE] and has diagnosis of Bipolar II Disorder and Major Depression Disorder. R54 had a level I screen completed on 09/22/2023. There is no documentation a level II screen was conducted. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/22/2023, The Facility completed a level I preadmission screen and resident review (PASRR) for R54. The form titled: Preadmission Screen and Resident Review (PASRR) Level I Screen, dated 09/22/2023, documents in part: Section A Questions regarding mental illness 1. Current Diagnosis does the person have a major mental disorder under the diagnostic and statistical manual of mental disorders, 3rd edition, revised (DSMIII-R) or DSM 5? 2. Medications within the past six months, has this person received psychotropic medications to treat symptoms or behaviors of a major mental disorder under the diagnostic and statistical manual of mental disorders, 3rd edition, revised (DSMIII-R) or DSM 5? Surveyor noted, box checked Yes for both questions 1 and 2. Surveyor noted in Section D titled: referring a person for a level II screen documents, if you have answered yes to any questions in section A and no to all of the exemptions listed in section B follow these instructions: contact the PASRR contractor to notify them that the person is being considered for admission. Forward a copy of the level one screen to the PASRR contractor (a copy must also be maintained by the nursing facility). The PASRR contractor will perform a level II determine if the person has a developmental disability and/or he's serious mental illness defined by the federal PASRR regulations . On 09/26/2023, R54 had an Admission Assessment MDS (minimum data set) completed and in the section titled: Preadmission Screening and Resident Review (PASRR) documents R54 was not evaluated by level II PASRR. On 11/21/2023, R54 had an Admission Assessment MDS (minimum data set) completed and in the section titled: Preadmission Screening and Resident Review (PASRR) documents R54 was not evaluated by level II PASRR. On 6/26/24, at 3:24 PM, Survey team member spoke with Admissions-G. Admissions-G has only been at the facility for one month. They are aware of the process of a level I and level II screen. They have been starting this process now with new admissions. Admission-G did not have information about residents, prior to, starting this position. On 6/27/24, at 3:36 PM, during the facility exit meeting Survey team shared the level II screening concerns with (Nursing Home Administrator) NHA-A. No additioanl information was provided as to why R54 did not have level II PASRR screen completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22692 Based on observation and staff interview the facility did not develop and implement a comprehensive person-centered care plan for 1 (R72) of 29 residents to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. *R72 was assessed to be at high risk for falls and only had one intervention on his care plan to prevent falls. Findings include: On 6/27/24 the facilities policy and procedure titled Care Plans-Comprehensive dated 10/10 was reviewed and documented: each residents comprehensive care plan after each assessment is designed to: Incorporate identified problem areas, incorporate risk factor identified with problem areas, reflect currently recognized of practice for problem areas and conditions. 1. R72 was admitted to the facility on [DATE] with diagnoses that included Anxiety and Degenerative Disease of the Nervous system. R72's annual Minimum Data Set (MDS) dated [DATE] was reviewed and indicated R72 had a Brief Score for Mental Status score of 3 which indicates severe cognitive deficit. The care area assessment for falls indicated R72 was not assessed for falls and did not trigger a care area assessment as it was not applicable. R72's fall assessment dated [DATE] was reviewed and indicated R72 scored a 13 (any score over 5 is considered high risk for falls). Risks for R72 to fall included confusion, incontinence, receiving anti-epileptic and benzodiazepine medication, and receiving 9 or more medications. None of these risk factors were included or R72's fall risk care plan. R72's care plan titled Fall Risk Care Plan related to generalized weakness with a start date of 2/13/23 and a last revision date of 2/13/23 was reviewed and only included the intervention of anticipate and meet the resident's needs. R72's medical record was reviewed and no falls could be found for R72 since R72's admission to the facility on [DATE]. On 7/1/14 at 2:10 PM, Surveyor interviewed Director of Nursing (DON)-B about R72's care plan. DON-B informed Surveyor that R72's care plan should have at least 3 interventions and is not comprehensive the way it is currently documented. DON-B indicated interventions like keeping R72's call light in reach should be added to his care plan. The above findings were shared with Administrator-A and DON-B at the daily exit meeting on 6/27/24. Additional information was requested if available. No further information was provided as to why R72 did not have a comprehensive care plan for falls.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38253 Based on interview and record review, the facility did not ensure comprehensive care plans were implemented and included participation by the resident or resident representative for 2 (R102 & R124) of 32 resident care plans reviewed. *R102 did not have any documented care conferences since admission on 4/15/2023 and did not have a care plan developed that included R102's preferences. *R124 did not have any care conferences to discuss discharge planning and the care plan was not revised after elopement attempts or refusals to take antidepressant medication. Findings include: The facility policy and procedure entitled Care Management Guideline undated documents: Guideline: Care Management is implemented when a qualifying change in condition occurs which require skilled services, interdisciplinary (IDT) collaboration, and timely proactive communication beyond the standard practices of communication established in the facility. Care Management is conducted upon admission or readmission from an acute setting. 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 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 -Meetings are scheduled in 20 minute increments at established times in the facility. The established times allow completion of the meeting within 48 hours of admission. -Admissions staff will explain the Care Management process to the patient and the patient representative and invite them to the Initial Care Management Meeting. Attendance may be either in person or by phone. -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, and estimated length of stay. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-IDT members should collaborate on evaluation findings prior to the Initial Care Management meeting whenever possible. 3. Initial Care Management Meeting Guideline: -Attendees: MDS or Nurse Designee/Therapy/SS/Patient and Patient Representative -The MDS staff of nursing designee will facilitate the meeting . -MDS staff or nursing designee documents the meeting utilizing the Care Management Evaluation. -The 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 complete. -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. The facility policy and procedure entitled Care Plan - Comprehensive from (C)2001 MED-PASS revised 10/2010 documents: Policy Interpretation and Implementation 1.Our facility's Care Planning/Interdisciplinary Team including the physician, Registered Nurse, nurse aide, member of food and nutrition services staff and/or other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident in coordination with the resident, his/her family or resident representative, develops and maintains a comprehensive persons-centered care plan consistent with resident rights for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes strengths, goals, life history and preferences, but is not limited to, the MDS. 3. Each resident's comprehensive care plan after each assessment including both the comprehensive and quarterly review assessments is designed to: a. Incorporate identified problem areas and goals for desired outcomes; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; (continued on next page)

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	525325	A. Building B. Wing	07/01/2024

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 - Some	On 7/1/2024 at 9:17 AM, Surveyor asked SW-P if SW-P was involved with R102's Care Conferences and if R102 had told Surveyor R102 requested to see a psychologist. SW-P stated no documentation was made of Care Conferences for R102. SW-P stated R102 sees a Psych Nurse Practitioner monthly or every other month for medication management. No additional information was provided at that time. 21855 2.) R124 was admitted on [DATE] due to a stroke. R124 (Power of Attorney for Healthcare) POA-HC was activated prior to admission. R124's Admission (minimum data set) MDS assessment completed on 5/22/23, indicates no wandering behavior with moderate cognitive impairment. R124 had verbalized they wanted to go home. R124 was moved to a alarmed unit on 12/1/24 due to R124 walking towards the sidewalk and away from the facility. On 3/3/24, R124 eloped from the hospital to her sister's house. There was no changes in the plan of care at that time of this elopement. On 5/14/24 the facility applied a wanderguard with no wandering/elopement assessment completed. The wanderguard was added as intervention however, there is not a plan of care for this device. R124 has been prescribed antidepressant medication. R124 does not want to take the medication. R124 isolates in their room and wants to go home. R124 progressed in cognition during their stay at the facility. R124 Annual MDS assessment, completed 3/20/24, shows no wandering behavior and no cognitive impairment. R124 requires set-up for activity of daily living and performs the tasks themselves. On 6/23/24 R124 verbalized they were being picked up and wanted to leave. The facility staff re-directed R124 back to their room. R124 then tied bed linens together and exited out their room window. R124 received bilateral ankle fracture requiring surgical intervention. There is not documentation of any care plan conferences with the resident, POA-HC and other disciplinary staff, to discuss R124 plan of care needs. This includes R124 verbalizations to be discharged , medication alternatives and cognitive status. On 6/27/24, at 1:58 PM, Surveyor spoke with (Social Worker) SW-P. SW-P stated they moved R124 upstairs to the alarmed unit. R124 was packing their bags, and verbalized, leaving the facility. SW-P stated R124 liked upstairs because it was more quite. R124 family would take them out for visits. R124 voiced they wanted to go home. The family was trying to work something out to bring R124 home. R124 was refusing their antidepressant medication. R124 stated they were not depressed and did not want medication. SW-P stated all staff do care planning. SW-P indicated they had talked to the POA-HC about discharge planning. SW-P has been waiting for the family to decide on discharge placement. R124 has a social service note, on 2/5/24, that states the POA-HC was called, message left, to discuss discharge planning. There was no additional documentation regarding discharge planning. R124 has a social service note, on 3/12/24, that states the POA-HC was called to schedule a care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24, at 3:46 PM, during the facility exit meeting, Surveyor shared concerns with (Nursing Home Administrator) NHA-A. R124 does not have documentation of care planning for elopements with desire to discharge home. On 7/01/24, at 9:06 AM, SW-P spoke with Surveyor. SW-P provided a care conference meeting form, dated 10/11/23, as a quarterly review. There was no other care plan conference's provided. On 7/01/24, 1:45 PM, Surveyor spoke with (Nurse Practitioner) NP-Q. NP-Q sees R124 weekly for psychiatric management. R124 does not feel they are depressed. They do want to take an antidepressant. They just want to go home. NP-Q stated they have not been asked to attend any care plan conferences or do any other assessments. No additional information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observation, interview and record review, the facility did not ensure 1 (R10) of 4 residents reviewed received ADLs (Activities of Daily Living) including personal hygiene per plan of care. *R10 was observed to be disheveled, having a strong body odor and untrimmed fingernails with a brown substance underneath R10's nails throughout the survey. Findings Include: R10 was admitted to the facility on [DATE] with diagnoses of cerebral vascular accident and left upper and lower extremity contractures. Surveyor reviewed R10's Quarterly MDS (Minimum Data Set) dated 5/15/24. R10 is rarely to never understood. R10 has limitations in range of motion to their left upper and lower extremities. R10 requires total assistance with personal hygiene and bathing. On 6/25/24 at 9:25 AM, Surveyor observed R10 in bed in a hospital gown. R10 was positioned on their back. R10 was non interviewable due to their cognitive status. R10 was noted to be disheveled with uncombed hair, body odor and untrimmed fingernails with a dark brown substance underneath fingernails On 6/25/24 at 11:15 AM, Surveyor observed R10 in bed in a hospital gown. R10 was positioned on their back. R10 was noted to be disheveled with uncombed hair, body odor and untrimmed fingernails with a dark brown substance underneath fingernails On 6/26/24 at 8:35 AM, Surveyor observed R10 in bed in a hospital gown. R10 was positioned on their right side. R10 was noted to be disheveled with uncombed hair, body odor and untrimmed fingernails with a dark brown substance underneath fingernails. R10's ADL care plan with an initiation date of 9/26/20 documents under the intervention for bathing section: bathing: physical assist of 2. R10's comprehensive care plan does not indicate how often R10 should receive baths or showers. R10's Kardex indicates that R10 should receive bathing on Thursdays. R10's behavior care plan with an initiation date of 4/7/21 reads: R10 has a behavior problem of refusal of cares related to refusing nail care. Care plan goal reads: R10 will show a decrease in negative behaviors by next review date. Care plan intervention dated 4/7/21 reads: anticipate and meet each of R10's needs. Surveyor noted R10's behavior care plan has not been updated since 1/11/22. Surveyor attempted to interview R10's assigned CNA (Certified Nursing Assistant) on 6/25/24 and 6/26/24. CNA declined to be interviewed by Surveyor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 10:30 AM, Surveyor requested bathing and therapy documentation for R10 . Facility provided Surveyor a form titled Referral to Rehab Services with a date of 4/12/24 for R10 reads the following: Bed rails .both sides .Hoyer at baseline, max (maximum assist) with all cares, able to feed self . Facility provided surveyor R10's skin and bath reports for June 2024. Surveyor reviewed R10's skin and bath reports for 6/6/24, 6/13/24 and 6/20/24. R10's skin and bath reports do not document any attempts at nail care for R10. On 6/27/24 at 8:20 AM, Surveyor interviewed NHA-A. Surveyor asked NHA-A how often comprehensive care plans should be updated. NHA-A responded that there should updates to care plans on at least a quarterly basis in accordance with MDS schedule and as needed Surveyor shared concern related to observations of R10's disheveled appearance, body odor and untrimmed fingernails with brown substance underneath. Surveyor shared concerns that there are no documented attempts to trim R10's nails during June 2024. Surveyor shared concerns that R10's ADL and behavior care plans are not being updated on a quarterly basis. No additional information was provided as to why the facility did not ensure R10 received ADLs (Activities of Daily Living) including personal hygiene per plan R10's care.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview and record review, the facility did not ensure that residents with pressure injuries received the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new pressure injuries from developing for 1 (R109) of 5 residents reviewed for pressure injuries. On 05/29/2024, R109 developed a Deep Tissue Injury (DTI) and did not receive the care and treatment necessary for the healing of a pressure injury. Findings include: The facility's policy, titled Skin Management Guideline with an implementation date of 11/28/2017, documents: An individualized plan of care will be developed upon admission, reviewed and updated quarterly and with a change in condition as needed. The plan of care will identify impairment and predicting factors. Interventions for prevention, removing and reducing predicting factors and treatment for skin may include: .Elevating heels: floating devices may vary, may include pillows and should be selected based on resident comfort and positioning needs. Inspection of skin daily with cares and weekly by a licensed nurse. B. Monitoring of skin integrity skin will be observed daily during cares by the nursing assistants. If any skin concerns are noted, they are to be reported to the licensed nurse. Weekly skin observation on the bath/shower day will be performed by a licensed nurse. If a skin concern is noted, refer to the skin and wound care formulary. The care plan for skin integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. The physician will be consulted with changes suggesting impairment in skin integrity. II. Treatment of pressure ulcers and lower extremity ulcers(arterial, [NAME], neuropathy/diabetic, or mixed) if a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: 1. Review the wound formulary for guidance 2. Consult with the physician/NP and resident representative 3. Notify a supervisor/designee as assigned .6. Reevaluate turning and repositioning interventions 8. Initiate Braden scale and initiate investigation process if new onset 9. Update the care plan for skin integrity and nursing assistant care cards with skin concern, appropriate risk factors turning intervals and interventions as appropriate. R109 was admitted to the facility on [DATE] with diagnoses to include traumatic spinal cord dysfunction, Paraplegia, and pressure ulcer of sacral region. R109's Admission Minimum Data Set (MDS), dated [DATE] documents the following: R109 has an indwelling urinary catheter, is at risk of pressure ulcers and was admitted to the facility with a stage 2 pressure ulcer. R109's MDS documents behaviors not exhibited in regard to rejections of care. R109 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R109 is cognitively intact. R109's functional limitation in range of motion indicates R109 has impairment on both sides of the lower extremity. R109's MDS Care Area Assessment (CAA) Summary documents Pressure Ulcer area triggered and addressed in R109's care plan. Surveyor reviewed the facility provided roster matrix, which documented that R109 has an unstageable pressure injury that was not present on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Survey reviewed R109's electronic health record and noted the following: R109's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2024 documents: Skin Checks Weekly - complete Skin Evaluation on admission and weekly, on assigned day, every evening shift, every Tuesday - Order Date - 02/22/2024 - Discontinue Date - 03/28/2024. Surveyor noted weekly skin checks were to be completed on 03/05/2024, 03/12/2024, 03/19/2024, and 03/26/2024. R109's MAR/TAR, documents that above weekly skin checks were not completed or documented as completed on any of the dates listed. R109's care plan on 03/26/2024 documents: R109 is choosing not to wear pressure relieving boots. However, Surveyor noted that R109's Quarterly MDS, dated [DATE], documents R109 does not exhibit behaviors related to rejection of care. On 03/27/2024, R109 was admitted to the hospital for Sepsis due to a Urinary Tract Infection (UTI) and discharged back to the facility on [DATE]. R109's Wound/Skin Specialist Consult dated 03/28/2024 documents: Coccyx with intact scar tissue, surrounded by hyperpigmented tissue. No open wounds to coccyx, sacrum, or buttocks at this time.Left lateral ankle with collapsing blister. Hyperpigmented with loose layer of epidermis. No open areas at this time. 3M barrier and protective heel mepilex applied for added protection. Heel lift boots reapplied, air mattress and bed extender ordered. Surveyor noted no assessment or interventions were documented as implemented by the facility for R109's left ankle after R109's readmission to the facility. Surveyor reviewed R109's MAR/TAR for April 2024 which documents: Skin Checks Weekly - complete Skin Evaluation in PCC on admission and weekly on assigned day every evening shift every Tue - Order Date 03/30/2024 1349 Surveyor noted that weekly skin checks were to be completed on 04/02/2024, 04/09/2024, 04/16/2024, 04/23/2024, and 04/30/2024. Weekly skin checks were not completed or documented on 04/02/2024, 04/16/2024, or 04/23/2024. Surveyor reviewed R109's MAR/TAR for May 2024 which documents in part: Skin Checks Weekly - complete Skin Evaluation in PCC on admission and weekly on assigned day every evening shift every Tue - Order Date - 03/30/2024 1349. Weekly skin checks were to be completed on 05/07/24, 05/14/24, 05/21/24, and 5/28/24. Surveyor noted skin checks were not completed or documented on 5/14/24, 5/21/24, or 5/28/24. Surveyor reviewed document titled Consultation/Clinic referral, dated 05/29/2024. Consultation/clinic referral documents: New diagnosis - Left ankle - deep tissue injury (DTI). Surveyor reviewed R109's MAR/TAR for June 2024 which documents in part: Skin Checks Weekly - complete Skin Evaluation in PCC on admission and weekly on assigned day every evening shift every Tue -Order Date - 03/30/2024 1349. Weekly skin checks were to be completed on 06/04/2024, 06/11/2024, 06/18/2024, and 06/25/2024. Surveyor noted skin checks were not completed or documented for any of the dates listed above. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 06/25/2024, Surveyor was unable to locate any assessment, physician orders, treatment plan, or care plan addressing R109's left ankle DTI. On 06/26/2024 at 09:30 AM, Surveyor requested 1 year of all wound notes, Nurse Practitioner notes, and care plan with revisions for R109 from NHA-A. On 06/26/2024 at 10:55 AM, RN-Y informed Surveyor that all wounds for R109 are resolved. Surveyor then requested last assessment of all healed wounds, last 3 months of skin/wound notes, and information related to 05/29/2024 wound consult note regarding DTI to left ankle. On 06/26/24, at 01:16 PM, Surveyor went to speak with RN-Y to request that Surveyor observe RN-Y assess R109's left ankle DTI. RN-Y informed Surveyor that he already assessed R109's left ankle DTI and states that R109 told RN-Y the wound has been there awhile. RN-Y provided Surveyor with a wound evaluation document, dated 06/26/2024, which documents in part: Pressure - Deep Tissue Injury Body Location: Left Lateral Acquired: In-house Acquired. The documented dimensions are as follows: Area - 2.8 cm (centimeters) Length - 2.43cm Width - 1.59cm. Surveyor asked wound RN-Y if Surveyor could watch wound care be performed the following day. Wound RN-Y stated that R109 receives wound care early in the morning around 04:00 AM. Surveyor planned with wound RN-Y to allow Surveyor to observe wound care the next day after 07:30 AM. On 06/27/2024, at 07:42 AM, Surveyor was informed that wound care had already been performed on R109 and stated R109 refused to allow Surveyor to observe wound care. Surveyor spoke with R109 shortly thereafter, R109 stated he was never asked if Surveyor could observe wound cares. R109 then attempted to show left ankle wound to Surveyor but was unable without assistance. Surveyor explained to R109 that Surveyor would attempt to observe wound care another time. On 07/01/2024, at 07:42 AM, Surveyor asked R109 if Surveyor could observe wound RN-Y perform wound cares, however R109 refused. The facility initiated a care plan dated 06/26/2024 that documents: The resident has actual impairment to skin integrity left lateral ankle r/t (related to) suspected deep tissue injury. The facility initiated orders on 06/26/2024 that document: Skin prep to left lateral ankle every day, one time a day for wound care. Surveyor noted that the facility did not assess or treat R109's left ankle DTI until time of 6/26/24. No further information was provided by the facility during survey.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observation, interview and record review, the facility did not assess the risk of entrapment and review the risk & benefits for 1 (R10) of 1 residents observed having bilateral half bed rails. Findings include: R10 was admitted to the facility on [DATE] with diagnoses of cerebral vascular accident and left upper and lower extremity contractures. Surveyor reviewed R10's Quarterly MDS (Minimum Data Set) dated 5/15/24. R10 is rarely to never understood. R10 has limitations in range of motion to their left upper and lower extremities. Surveyor reviewed R10s medical record including physician orders, progress notes, therapy notes, and comprehensive care plan. On 6/25/24 at 9:25 AM, Surveyor observed R10 in bed in a hospital gown. R10 was positioned on their back with 2 half bed rails up. R10 was non interviewable due to their cognitive status. On 6/25/24 at 11:15 AM, Surveyor observed R10 in bed in a hospital gown. R10 was positioned on their back with 2 half bed rails up. On 6/26/24 at 8:35 AM, Surveyor observed R10 in bed in a hospital gown. R10 was positioned on their right side with 2 half bed rails up. Surveyor reviewed R10s medical record including physician orders, assessments, progress notes, therapy notes, and comprehensive care plan. Surveyor could not identify a physician order for R10's half bed rails. Surveyor reviewed R10's comprehensive care plan. R10's comprehensive care plan did not address use of R10's half bed rails. Surveyor could not identify any assessment addressing R10's bed rail usage. On 6/26/24 at 10:30 AM, Surveyor requested therapy documentation for R10. Facility provided Surveyor a form titled Referral to Rehab Services with a date of 4/12/24 for R10 reads the following: Bed rails .both sides .Hoyer at baseline, max (maximum assist) with all cares, able to feed self .Findings/observations: does not use bed rails to assist with bed mobility. On 6/26/24 at 3:15 PM, during the daily exit meeting, Surveyor requested additional information from NHA (Nursing Home Administrator)-A for R10 including physician orders, comprehensive care plan and risk versus benefit information for R10's bilateral half bed rails and a bed rail policy. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 8:20 AM, Surveyor conducted interview with NHA-A. NHA-A told Surveyor that they were unable to find additional requested information related to R10's bilateral half bed rails including bed rail policy. Surveyor asked NHA-A if there should be a physician's order and comprehensive care plan in place for residents who require bed rails. NHA-A responded that there should be an bed rail assessment, physician orders and care plan in place for residents that require bed rails. Surveyor shared concerns related to observations of R10's bilateral half bed rails on 6/25/24 and 6/26/24 that were deemed to be unnecessary by therapy on 4/12/24. Surveyor shared concerns that R10 did not have a physician's order in place for bilateral half bed rails, a completed bed rail assessment or comprehensive care plan reflecting bed rail usage. No additional information was provided as to why the facility did not assess the risk of entrapment and review the risk & benefits for R10.

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on record review and interviews, the facility did not comprehensively provide medically related social services, to attain the highest psychosocial well-being, of a resident for 1 (R124) of 30 residents reviewed. *R124 verbalized, and attempted, to leave the facility to go home. The facility did not look at whether R124 still needed activation of power of attorney for health care and could, thus make own health decisions, did not look at alternatives to Sertraline, an antidepressant that R124 refused to take, did not look at discharge alternatives, and did not develop a plan of care for supervising R124 when agitated and expressing a desire to leave. On 6/23/24 R124 verbalized a desire to leave the facility and kept setting off alarms on the unit trying to leave, R124 was not permitted to do so. R124 then utilized their bed sheets to climb out a second-story window. This resulted in R124 falling and fracturing both of their ankles and a leg. The facility failure to provide comprehensive social services created a finding of immediate jeopardy that began on 6/23/24. Surveyor notified (Nursing Home Administrator) NHA-A of the immediate jeopardy on 7/1/24 at 1:33 PM. The facility removed the immediate jeopardy on 7/12/24. The deficient practice continues at an E (potential for harm pattern) as the facility implements their action plan. Findings include: Reassessment of need for Power of attorney R124 is a [AGE] year that was admitted on [DATE] due to a stroke. R124 has diagnoses of anxiety and depression. R124's POA-HC (Power of Attorney for Healthcare) was activated 3/30/23. R124's POA-HC was activated in a hospital setting due to delirium. R124 does not have a diagnosis of dementia or indications of ongoing delirium. R124's Admission MDS (minimum data set) assessment was completed on 5/22/23. The BIMS (Brief Interview for Mental Status) shows moderate cognitive impairment. R124's Annual MDS assessment was completed on 3/20/24. The BIMS shows no cognitive impairment. R124 requires set-up assist for activities of daily living. R124 is able to perform their own tasks. R124 had a BIMS (brief interview of mental status) completed on 6/20/24. This assessment documents no cognitive impairment. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Despite assessments showing no cognitive impairment, the facility did not reassess R124 to determine if the power of attorney should or could be deactivated and if R124 could be allowed to make their own health care decisions. On 7/01/24, at 01:45 PM, Surveyor spoke with (Nurse Practitioner) NP-Q. NP-Q stated they were not asked about deactivating the POA-HC status. On 6/26/24, at 11:21 AM, Surveyor spoke with (Social Worker) SW-P. SW-P stated they did not discuss any POA-HC de-activations. SW-P shared R124 did not ask for de-activation. Reassessment of antidepressant R124's Psychiatric Progress Note documents the following: - 3/12/24 (R124) is tolerating taking Sertraline 100 mg every day. This provider called and spoke with the POA-HC, to discuss medication changes, due to increased agitation. The POA-HC did not want to start or change any medication at this time. The POA-HC stated (R124) is upset because they want to come home. and needs to stay on the antidepressant. The POA-HC stated (R124) has had depression their whole life. -3/18/24 (R124's) Sertraline was increased to 125 mg every day for depression. This provider received a phone call from the POA-HC to discuss medications. The POA-HC felt (R124's) antidepressant could be increased due to (R124) feeling down. - 4/2/24 (R124) stated Does not want to take the antidepressant and does not think they need it. No change in Treatment Plan. - 4/9/24 4/17/24 (R124) stated Does not want to take the antidepressant and does not think they need it. No change in Treatment Plan. - 4/17/24 (R124) stated Does not want to take the antidepressant and does not think they need it. No change in Treatment Plan. -4/23/24 (R124) stated does not want to take the antidepressant and does not think they need it. The Treatment Plan (sic) this provider called the POA-HC about refusing the medication and throwing the pill out. (R124) isolates in their room with the lights out. The POA-HC stated they will talk with (R124). - 4/30/24 R124 stated does not want to take the antidepressant and does not think they need it. The Treatment Plan (sic) this provider called the POA-HC last week. They discussed (R124) refusing to take the antidepressant and throws the pill out. (R124) keeps isolating in their room and keeps the lights out. Discussed with facility staff to monitor (R124) taking their pills. The POA-HC stated they would talk with (R124). - 5/7/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) 2 weeks this provider spoke with the POA-HC. They discussed (R124) refusing medication most days and throwing it out. They talked about (R124) isolating in their room. The POA-HC will talk with (R124). The facility staff will monitor (R124) taking their medications. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-5/14/24 (R124) stated does not want the antidepressant, does not need it' and takes the antidepressant and throws it away. The Treatment Plan (sic) discussed with facility staff to monitor (R124) taking medications. - 5/21/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor (R124) taking their medications. - 5/29/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor (R124) taking their medications. - 6/4/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor R124 taking their medications. - 6/18/24 (R124) stated does not want to take the antidepressant, does not need it and takes the antidepressant and throws it away. The Treatment Plan (sic) facility staff to monitor R124 taking their medications. On 6/27/24, at 1:47 PM, Surveyor spoke with (Regional Nurse Consultant) RNC-O. RNC-O has overseen R124's unit the last few weeks. RNC-O stated R124 refused the Sertraline because they were not depressed. R124 stated they feel better and do not want the medication. RNC-O stated NP-Q comes in weekly. On 7/01/24, at 01:45 PM, Surveyor spoke with (nurse Practitioner) NP-Q, who took over R124's psych visits March 1st, at which time R124 was already on Sertraline 100 mg for a history of depression NP-Q stated R124 did not want to take the antidepressant and denied any anxiety or depression. R124 did mention they wanted to go home. NP-Q shared, a resident wanting to go home is a very common statement. NP-Q did talk with the POA-HC about going home. The POA-HC could not care for R124 at home. NP-Q did not do a cognitive or a living assessment. NP-Q was not involved in any Care Conferences to discuss R124's plan of care. NP-Q stated that R124 did not have suicidal thoughts or self-harm behaviors. R124 denied any negative behaviors. There was no collaboration to offer alternatives to antidepressant medication. Discharge planning R124 had 1 Care Conference on 10/11/23 for a Quarterly review. This included (Social Worker) SW-P and R124's POA-HC. The section for Discharge Plan states the resident will be long term care until an alternative and safe environment can be planned. There is no evidence the facility followed through on establishing an actual discharge plan and sought out an alternative and safe environment for R124 to discharge to. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R124 has a Social Worker note on 2/2/24 that states Family members wanted to take the resident home for the evening, but were unable to reach the POA-HC. They were not able to reach the POA-HC. The family was asking questions regarding POA-HC and how to get a new one. The Writer informed them the POA-HC is a legal document and they couldn't do anything. There is no evidence R124's cognitive status was reassessed to assist in establishing an individualized discharge plan. R124 was not in protective placement nor did R124 have a Guardianship. R124 wanted to go home and was not permitted to do so. R124 has a Social Worker note on 2/5/24 that states Writer left a message with the POA-HC to discuss discharge planning. There was no documented discharge planning process. R124 has a Social Worker note on 3/12/24 that states Writer called POA-HC to schedule a care plan conference. On 7/01/24, at 9:06 AM, Surveyor spoke with SW-P. SW-P stated the only care plan conference that was completed was on 10/11/23. Surveyor noted the only individuals present at that conference were SW-P and POA-HC. R124 was not included. On 6/26/24, at 11:21 AM, Surveyor spoke with SW-P about R124's typical day in the facility. SW-P stated R124 would just walk around the unit, and would try to leave, to go home. R124 was aware their daughter placed them here. R124 wanted to leave the facility to go home. There was discharge planning discussed with another family member. The POA-HC stated that family member was not home to supervise resident. They did not discuss any alternative placements for R124. R124's POA-HC was working on taking R124 home and has not secured that yet. When discussing the level of supervision provided to R124, SW-P shared R124 has never been on 1:1 (one on one) supervision at the facility. R124 will try to leave to go home and is easily redirected. SW-P stated R124 was determined to leave and go home. R124 was frustrated with their family taking so long to decide. On 7/01/24, at 9:13 AM, (Regional Nurse Consultant) (RNC)-D and (Nursing Home Administrator) NHA-A spoke to Surveyor. They shared R124's POA-HC did not have the ability to take R124 home. RNC-D and NHA-A stated R124 would not be safe to discharge on their own. R124 agreed to stay at the facility and liked their room upstairs. RNC-D is aware R124 does not take their antidepressant and has a history of depression. R124 wants to go home but is content with staying at the facility. There was no collaboration to offer alternatives to antidepressant medication, discharge planning, and cognitive status. Elopement risk R124's Wander/Elopement Risk Evaluations document the following: - Admission on 5/15/23, states there is no elopement history. There is no risk for elopement. - Quarterly on 8/17/23, states there is no elopement history. There is a risk to wander/elope. There are no behaviors triggered. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Re-Admission on 9/17/23, states there is no elopement history. There is no risk to wander/elopement. On 7/01/24, at 9:13 AM, RNC-D and NHA-A spoke to Surveyor. RNC-D stated that on 12/1/23 R124 was sitting outside the facility waiting for the POA-HC to pick them up. R124 decided to start walking from sitting outside. The facility treated it as an elopement just to be safe. They talked to R124 and the POA-HC to move R124 upstairs on the alarmed unit. This unit was also the dementia unit. R124's Wander/Elopement Risk Evaluations document the following: - (Untitled) on 12/4/23, states there is now a wander/elopement. (R124) does not accept placement, paces, attempt to exit facility, trying to find family and makes repetitive statements about going home. The Wander/Elopement Risk Care Plan added a secured unit and staff aware of wander risks. On 6/27/24, at 01:58 PM, Surveyor spoke with SW-P regarding R124's room change to a secured unit. SW-P stated R124 would pack their bags and voiced they wanted to leave. R124 agreed to move to the secured unit upstairs. The upstairs unit was quieter. R124's family would take them home to visit. R124 wanted to go home. R124 did not want to take any medication for depression. R124 would become anxious/ obsessive about leaving the facility. There is a phone for the residents to use on the unit. R124's POA-HC would be called at times to assist with redirection. SW-P shared R124 wanted to be alone even when they were on a different unit; R124 would sit by themselves. They were working with the POA-HC on going back home. R124's Wander/Elopement Risk Evaluations document the following: - Quarterly on 1/5/24, states is a wander/elopement history and risk. (R124) does not accept placement, paces, attempt to exit facility, trying to find family and makes repetitive statements about going home. The Wander/Elopement Risk Care Plan remains a secured unit, staff aware of wander risks. - Quarterly on 4/6/24, states is a wander/elopement history and risk. (R124) does not accept placement, paces, attempt to exit facility, trying to find family and makes repetitive statements about going home. The Wander/Elopement Risk Care Plan remains a secured unit, staff aware of wander risks. R124's plan of care states the resident is an elopement risk/wanderer with altered mental status. Date Initiated 08/17/2023, with a goal: resident's safety will be maintained through the review date of 9/15/2024. Interventions added: - Secured unit dated 12/04/2023. -Staff aware of resident's wander risk dated 8/17/2023. - WANDER ALERT Personal Safety Device: Right ankle dated 5/16/2024. R124's plan of care states - The resident wishes to return to the community. Date initiated 8/14/23, with a goal: the resident will verbalize an understanding of the discharge plan and describe the desired outcome, by the review date of 9/15/24. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/14/2024, at 9:32 PM R124's progress note by (Registered Nurse) RN-U states Resident did not try to leave unit all evening. Ate supper in their room. Writer placed a wander guard to resident's right ankle per order and resident did not refuse the placement. The wander guard was added to the plan of care as an intervention. There is not a correlating comprehensive assessment to determine the reason for this intervention/change in the plan of care. On 6/26/24, at 11:10 AM, Surveyor spoke with LPN-K. LPN-K is familiar with R124. LPN-K stated the wander guard was placed on R124 in May 2024 as a precaution. R124 had returned from a visit with the family and was agitated. R124 only attempted to leave through the alarmed doors and was easy to redirect. On 6/9/2024, at 10:23 PM R124's progress note by LPN-T states, At approximately 5:00 PM writer was in hallways and observed several Paramedics on unit. This writer was informed (R124) called 911 and stated they was (sic) having chest pain. (R124's) vital signs was (sic) taken and they were stable. This writer was informed resident would be transported to Hospital for Evaluation. POA-HC was informed and stated, this is not the first she done this (sic), am (sic) going to call this hospital to make sure they watch (R124). (R124) will escape. The facility did not send an escort to the hospital with R124. Surveyor noted R124 previously called 911 on 3/3/24 and left the hospital. R124 shows the cognitive ability to circumvent the alarmed doors on the unit by seeking 911 attention. This was demonstrated on 3/3/24 as well. On 6/26/24, at 11:30 AM, Surveyor spoke with Certified Nursing Assistant (CNA)-L. CNA-L worked the Day shift on 6/23/24. CNA-L stated the unit alarm was beeping towards the end of their shift. R124 stated someone was picking them up. CNA-L shared R124's family would sometimes take them out. R124 was always redirected when the doors alarms went off. R124 did not ever get to the elevators. CNA-L shared R124 preferred to stay in their room including eating in their room. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/23/24, at 11:49 PM R124's progress note by (Licensed Practical Nurse) LPN-E documents beginning of shift (R124) was anxious but easily redirected by PM staff. (R124) did not display further anxious behavior. (R124) was in good spirits for a while but (R124) did get upset later because (R124's) daughter wasn't answering the phone when (R124) was calling their daughter but (R124) didn't display any abnormal behaviors from that. (R124) tolerated meds well and ate 100% supper and (R124) was compliant with staff with directives. During the evening at approximately 2015 (8:15 pm) the two (Certified Nursing Assistants) CNAs came to writer while writer on the hall passing meds and asked writer would writer speak with (R124) regarding refusal to allow them to put bed linen on the bed. Writer approached (R124) and writer asked (R124) did (R124) refuse linen on their bed to the CNAs. (R124) stated No I didn't refuse, I do want linen on my bed. Staff then put linen on (R124's) bed after writer spoke with (R124). (R124) still showed no further behavior. CNAs put (R124's) roommate in bed then when CNAs were done (R124) was noticed by CNA assisting on their bed. Writer continued to pass meds Writer finished med pass at 2030 (8:30 pm) and came to check with med tech regarding a resident's issue on unit 600 When writer was checking on another resident's medication that is when writer was notified that (R124) had climbed out window and was outside sitting on buttocks talking to other staff that found (R124) outside on ground. Writer and the 2 CNAs inside building noticed (R124) had took (sic) the window out the frame (sic) and tied sheets together in knots and tied the sheets to the bed and climbed out the window with the sheets hanging out the window in knots. (R124) was being assessed immediately by the staff that were nurses outside. Writer then came out to further assess. Ambulance called and present and assessed (R124) head to toe. (R124) c/o (complained of) right lower leg pain to writer and ambulance. Daughter notified and aware of above findings Director of Nurses (DON-B) notified and (NHA-A) notified of above findings (Nurse Practitioner) NP notified and updated NP and daughter aware of resident going to hospital for further evaluation. On 6/27/24, at 11:42 AM, Surveyor spoke with CNA-J who worked the shift R124 exited through the window. CNA-J stated R124 made knots tying the sheets together. CNA-J is not sure where they got the bed sheets from. R124 was setting off the unit door alarms wanting to go home during the shift. They were redirected back to their room. CNA-J shared R124 typically does not come out of their room. After supper they had no linen on their bed. R124 did not want their bed made. CNA-J told the floor nurse R124 did not want their bed made. Then R124 stated they could make their own bed. R124 was provided bed sheets. There were pictures obtained of the bed sheets out the window. There were bed sheets on the bed. CNA-J thought R124 did not show any different behavior before the discovery outside. On 6/27/24, at 12:58 PM, Surveyor spoke with CNA-I who worked the evening shift on 6/23/24. CNA-I stated R124 was dressed, with their jacket on, trying to go out the unit door. R124 stated they wanted to go home. R124's family was not answering the phone. R124 was getting frustrated about not getting a hold of their daughter. CNA-I stated around 7:30 - 8:00 PM they were assisting R124's roommate to bed. They noticed R124 had no sheets on their bed. They offered to make their bed and she said no. They told the floor nurse about the sheets. The nurse talked to R124 about the bed sheets. CNA-I brought the bed linen in the room. R124 stated they will make their own bed. About 30 - 40 minutes later they heard from other staff that R124 fell outside. CNA-I stated R124 took the window out and tied the sheets together from the bed frame. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/27/24, at 03:26 PM, Surveyor spoke with LPN-E. LPN-E worked the evening shift on 6/23/24. LPN-E is from an Agency and 6/23/24 was their 1st time working on the unit. LPN-E shared they relied on the 2 CNAs who were regular staff. R124 talked to the CNAs and wanted their daughter to answer the phone. LPN-E found out later R124's daughter was supposed to pick them up. The CNAs told LPN-E that the resident typically stayed in their room. LPN-E stated that when R124 paces or gets angry it means they want to leave. LPN-E stated R124 was doing that before this happened. R124 was on the 24-hour board, because the Day shift noted they were anxious. LPN-E was told they should watch the unit doors - staff said resident is anxious; watch the doors. LPN-E shared another staff told LPN-E that there was a resident on the ground. They went into R124's room and they noticed the sheets through the window. LPN-E stepped on the window glass pane that was laying on the floor. LPN-E thought the glass was pushed out and did not see it. LPN-E did not expect R124 to go through a window, The staff indicated to just keep an eye on the doors and R124 typically stayed in their room alone with the door closed. On 6/27/24, at 3:46 PM, during the daily exit meeting, Surveyor notified NHA-A and RNC-D concerns with R124. R124 did not have any comprehensive assessments/root cause analysis completed after leaving the hospital on 3/3/24 to determine R124's care needs. R124 took 3 different buses to get to their sister's house. There was not a plan of care to determine supervision needs when expressing to leave. A wander guard was placed on 5/14/24 with no correlating assessment. There was not an individualized plan of care to address R124's desire to leave the facility and the consequent behaviors of leaving or trying to leave the facility and repeatedly verbalizing wanting to go home. There was not a comprehensive assessment or plan of care to direct discharge from the facility. The facility did not provide interdisciplinary care to address medication needs, discharge requests and anxious behaviors. There was no documentation of alternatives for discharge to the community. There was not documentation or discussions for de-activating the POA. R124 performed their own cares and determined what medications they wanted to take. The facility's failure to provide medically related social services to R124 to address her desire to live at home, to assess R124's ability to make her own decisions and direct her care led to R124 to experience increased anxiety, isolation, and behaviors to convey her desire to leave. This created a situation of immediate jeopardy for R124 that resulted in R124 taking the extreme action of tying bed sheets together and removing a window to leave the facility from the second floor resulting in her falling to the ground and sustaining bilateral ankle fractures and a broken leg. The facility removed the immediate jeopardy on 7/12/24 when they implemented the following action plan: 1. R124 sent out to hospital 2. MD and POA notified. 3. Complete investigation with full RCA (root cause analysis). 4. All interviewable residents who have a BIM score 9 and above who scored high risk for Elopement and express desire to leave the facility while showing any signs and symptoms of anxiety and depression may have the potential to be affected by this alleged deficient practice. (continued on next page)

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F 0745 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Check resident's wanderguard device and ensure it is functioning properly. 6. Check all wanderguards and wanderguard/alarm doors for functionality 7. Education provided to Social Service staff on Medical Social Services, Discharge Planning, Care Conference and POA activation. 8. Staff educated on Wandering and Elopement, and Behavior Monitoring. 9. All interviewable residents who have a BIM score 9 and above who scored high risk for Elopement and express desire to leave the facility while showing any signs and symptoms of anxiety and depression will be also assessed for psycho-social well-being abuse/neglect evaluation. Care plans will be reviewed and updated as needed. Care conferences addressing discharge planning will be scheduled for those who express desire to leave. 10. All interviewable residents who have a BIM score 9 and above who scored high risk for Elopement and express desire to leave the facility while showing any signs and symptoms of anxiety and depression will be reviewed by DON/designee to ensure accurate, appropriate plan of care in place. 11. Elopement and wandering binders were reviewed and updated as needed. 12. Residents who are not-interviewable are upset, anxious, and need increased supervision will be put on 24-hour board and monitored closely. 13. DON or designee will conduct audits to ensure care conferences were scheduled and held to discuss discharge planning on people who desire to leave once a week for 4 weeks. Bring results to QAPI and readdress and adjust the plan as needed. Ad hoc education to be provided as immediately as possible when indicated. 14. Audits will be reviewed at the monthly QAPI meeting to determine trends or patterns of concern and/or if further education is needed until substantial compliance has been achieved. No additional information was provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary medication for 1 (R54) of 2 Residents reviewed. * R54 received an antibiotic but did not meet the facility's criteria for the administration of the antibiotic. R54 also did not receive final dose of an antibiotic after returning to the facility from the hospital. Findings include: R54's diagnosis includes acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), asthma and sleep apnea. On 06/08/2024, R54 was admitted to the hospital and discharged on [DATE]. Per R54's Patient Discharge Summary, R54 discharge diagnoses documents, Acute hypoxic/hypercapnic respiratory failure 2/2 COPD exacerbation. R54's Discharge Medication List documents, continue these medications which have changed azithromycin 250 mg (milligrams) tablet Take 1 tablet (250 mg total) by mouth daily for 1 dose. Surveyor noted no orders documented on R54's Medication Administration Record (MAR) for R54 to receive azithromycin after returning from the hospital. R54 did not receive the medication. Surveyor reviewed NP-HH note dated 06/11/2024 which documents in part, R54 Continues to be on Zithromax until tomorrow and prednisone taper. Will start levofloxacin 750 mg daily x 7 days per pulmonology recommendation.Contingency Plan: Stat CBC, CMP and chest xray. Duonebs Q4 scheduled and albuterol Q4 prn. Start Prednisone 40 mg daily x 5 days. Doxycycline 100 mg BID x 5 days. Consider Levaquin 750 mg PO daily per review of chest xray. Send to ER if in respiratory distress per GOC. Contingency Plan: Stat labs and chest xray. Prednisone 40 mg daily x 5 days. Abx if indicated. R54 was started on an antibiotic, levofloxacin 750 mg. First dose given on 06/11/2024 at 10:00 am, per R54's MAR. Surveyor noted that R54 did not receive a chest x-ray or labs before receiving the antibiotic. On 06/27/24, at 10:09 AM, Surveyor spoke with NP-HH via phone. Surveyor asked NP-HH what a contingency plan is for residents and asked specifically regarding R54's contingency plan. NP-HH stated that x-rays and labs were not preformed prior to antibiotic therapy due to R54 enrolling in hospice services. NP-HH stated she would not be able to answer any specific questions unless Surveyor put them in writing. Surveyor thanked NP-HH for her time. receive final dose of an antibiotic after returning to the facility from the hospital. On 06/27/24, at 11:09 AM, Surveyor spoke with IP-F who stated, R54 did not meet criteria for antibiotic therapy, but IP-F will reach back out to NP-HH and look for documentation regarding risk/benefit, criteria used for prescribed therapy. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/24, at 11:19 AM, IP-F informed Surveyor she spoke to NP-HH who stated R54 was treated prophylactically due to the recommendation from pulmonology on 06/04/2024 prior to R54's hospitalization . No information was provided as to why R54 received an antibiotic without meeting the facility's infection control criteria. No additional information was provided as to why facility did not ensure R54's drug regimen was free from unnecessary medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47094 Based on interview and record review, the facility did not ensure coordination of care and the hospice communication process was followed for 1 (R119) of 4 residents reviewed for hospice services. The facility did not ensure hospice required documentation was maintained in R119's medical record. The facility did not have R119's hospice plan of care with the delineation of hospice's responsibilities and services provided, and communication process between the facility and hospice. Findings include: Surveyor reviewed the Nursing Facility Services Agreement with [hospice company] with the effective date of 7/20/2023. The agreement documents: . In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions: . 2. Responsibilities of the facility: (d) Coordination of Care: (i) General- Facility shall participate in any meetings, when requested, for the coordination, supervision, and evaluation by hospice of the provision of facility services. Hospice and facility shall communicate with one another regularly and as needed, via phone, fax, email, and/or in person, for each particular hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of hospice patients are being met 24 hours per day. (ii) Design of Plan of Care- In accordance with applicable federal and state laws and regulations, facility shall coordinate with hospice in developing a plan of care for each hospice patient. Hospice retains primary responsibility for development of the plan of care. 1.) R119 was admitted to the facility on [DATE] and has diagnoses that include end stage renal disease, Dementia, anxiety disorder, respiratory failure, encephalopathy, and atrial fibrillation. R119's Quarterly Minimum Data Set (MDS) dated [DATE] indicated R119 had severely impaired cognition with a brief interview for mental status (BIMS) score of 3. The MDS documents that R119 requires extensive assist with 1 staff member for toileting, bathing and transferring with a Hoyer lift and 2 staff members, and moderate assist with 1 staff member for personal hygiene and dressing. R119 was admitted to the facility with hospice services. Surveyor reviewed R119's hospice binder and noted the plan of care was last reviewed on 1/3/2024 and did not contain documentation of a schedule of hospice interdisciplinary team (IDT) visits. Surveyor observed the pages in R119's hospice binder pages were wet and cockled and the writing was blotched in some areas making it difficult to read. Surveyor reviewed R119's medical record and noted the facility did not initiate a comprehensive hospice care plan. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/2024, at 8:53 AM, Surveyor interviewed assistant director of nursing (ADON)-C regarding R119's hospice services. ADON-C informed Surveyor that she does not typically cover R119's unit or work with R119's hospice company and referred Surveyor to speak with regional nurse consultant (RNC)-O. Surveyor asked RNC-O about R119's hospice services to which RNC-O stated she not sure about R119's hospice services. Surveyor showed ADON-C and RNC-O R119's hospice binder and pointed out the care plan was last reviewed on 1/3/2024, there were not IDT progress notes, and the binder pages were all wet and blotched. RNC-O stated RNC-O never looks in the hospice binder and was unsure of how communication happened between the facility and hospice. ADON-C stated usually hospice will put notes in the binders, but ADON-C was not familiar with R119's hospice company. On 7/1/2024, at 9:00 AM, Surveyor interviewed licensed practical nurse (LPN)-K who stated R119's hospice nurse and hospice certified nursing assistant (CNA) make sure to report with nursing before hospice staff leave the facility and update facility staff on any concerns or cares that were completed during the visit. Surveyor asked how that information was documented. LPN-K stated that hospice staff write on their tablets and not sure what happens after that. Surveyor asked LPN-K if the hospice staff documented any information on the facility medical records or in the hospice binder for R119. LPN-K stated LPN-K does not look in the hospice binder so she was not sure, but that the hospice staff does not document on the medical record for R119. Surveyor asked how hospice communication is communicated to facility staff. LPN-K stated that it is all verbal communication. Surveyor asked how it gets documented what hospice staff did or what concerns hospice has for R119. LPN-K stated through shift report. Surveyor noted that when looking through R119's medical record, Surveyor did not locate any documentation from hospice or facility staff regarding R119's Hospice IDT visits. On 7/1/2024, at 9:13 AM, Surveyor interviewed Social Worker (SW)-P who stated the facility meets with hospice services quarterly for IDT meetings and any updates from hospice services gets sent to nursing and should be put in R119's hospice binder. Surveyor asked where communication from IDT visits with R119 would be located so it is accessible for facility staff to view. SW-P stated any communication from hospice IDT visits should be in point click care (PCC, healthcare software) for facility staff to review. On 7/1/2024, at 1:42 PM, Surveyor shared concerns with DON-B that R119 did not have a comprehensive care plan for hospice services, there was not hospice IDT visit documentation available for facility staff, and R119's hospice binder had a care plan from 1/3/2024 and had wet pages where the writing was blotched. DON-B stated DON-B does not go into the hospice binders and would look into how nursing staff and facility staff are documenting communications. DON-B stated that R119 should have a comprehensive care plan for hospice especially since she was admitted to the facility on hospice services. No additional information was provided as to why the facility did not ensure coordination of care and the hospice communication process was followed for R119.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 21855 Based on observations, interviews and record review, the facility did not establish and maintain an infection prevention and control program based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. This deficient practice has the potential to affect all 148 residents. The facility's Water Management Plan (WMP) was not based on current standards of practice and did not: ~Reflect changes in program members. ~Include water management team members who were knowledgeable about the facility's water system. ~Identify control measures based on where Legionella could grow and spread and identify how to monitor the control measures and risks. ~Identify acceptable ranges of control limits (temperature ranges) and corrective actions to take when control limits are not met. The Facility's Infection and Control Program Surveillance did not have: ~ monthly infection percentage rates for each infection type. ~urinary tract infections (UTI) separated into catheter associated and non-catheter associated UTIs. ~surveillance documentation for October 2023, November 2023 and December 2023. ~ documentation for interventions implemented for UTI percentage increase. The Facility did not implement Enhanced Barrier Precautions (EBP) for residents requiring EBP as recommended by the Center for Disease Control (CDC) and per the Facility's policy. The Facility's laundry was observed to have: ~ washers coated in a white, brown crusty matter. ~water dripping from the ceiling. ~ water on the floor. ~ grease on the floor. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 6/24/21 CDC Toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities to include: 1. Establish a water management program team 2. Describe the building water systems using text and flow diagrams 3. Identify areas where Legionella could grow and spread 4. Decide where control measures should be applied and how to monitor them 5. Establish ways to intervene when control limits are not met 6. Make sure the program is running as designed and is effective 7. Document and communicate all the activities The CDC toolkit identifies locations in a buildings water system where Legionella can grow and spread to include but not limited to: ~Hot and cold-water storage tanks ~Water heaters ~Water Filters ~Electronic and manual faucets ~Aerators ~Shower heads and hoses ~Pipes, valves, and fittings ~Infrequently used equipment including eye wash stations. ~Ice machines ~Hot tubs Control Measures: Determine Locations Where control measures must be applied and maintained to stay in established control limits. Water Management Plan (WMP) not consistent with current standards of practice: The Facility's Policy, titled: Infection Prevention and Control Program, with a last revision date of 07/25/2023, documents in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy explanation and compliance guidelines: 16. Water management: a. A water management program has been established as part of the overall infection prevention control program. b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. c. The maintenance director serves as the leader of the water management program. The Facility's policy, titled: Legionella Surveillance Policy, with an implementation date of 10/24/2022 and no last reviewed date, documents in part: Policy: it is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. Policy explanation and compliance guidelines: 1. Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems. 2. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies. 5. Primary prevention strategies: c. Physical controls: i. Cooling towers and portable water system shall be routinely maintained. ii. At risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations. iii. Non potable water systems shall be routinely cleaned and disinfected. iv. Nebulization devices shall be filled only with sterile fluid (e.g., sterile water or aerosol medication). d. Temperature controls: i. Cold water shall be stored and distributed below 68 degrees Fahrenheit. ii. Hot water shall be stored above 140 degrees Fahrenheit and circulated at a minimum return temperature of 124 degrees Fahrenheit. On 06/27/2024, at 09:36 AM, Surveyor reviewed the Facility's WMP with MA-W. Surveyor noted Nursing Home Administrator (NHA) information listed in the WMP was not current and the Infection Preventionist (IP) was not listed as part of the WMP team. Surveyor noted the Facility's WMP did not identify and include any control measures, control measure limits or ways to intervene when control limits are not met. MA-W informed Surveyor that control measures are not written down formally. MA-W states some tasks related to the WMP are done as maintenance tasks and are documented in the Facility's electronic system. Surveyor requested MA-W to provide relevant tasks associated with the Facility's WMP control measures. On 06/27/2024, at 03:19 PM, Surveyor requested the electronic system documentation for Maintenance tasks, related to the Facility's WMP, from NHA-A. Surveyor encouraged NHA-A to have the documents available for Surveyor to review on Monday when the Survey team returns to the Facility. On 07/01/2024, at 09:52 AM, MA-W provided Surveyor with documentation, titled: Logbook Report for eye wash stations and water temperatures. Surveyor reviewed the Facility's Logbook Report record, titled: Water Systems: Inspect eye wash stations. Last 24 months. Surveyor noted three areas listed for the locations of eye wash stations and noted pass documented under each location. Surveyor noted there to be no documentation of the frequency eye wash stations are to be inspected, control limits or ways to intervene when control limits are not met. Surveyor reviewed the Facility's Logbook Report record, titled: Water Temps: test and log the hot water temperatures. Surveyor noted no documentation of control limits for hot water or ways to intervene if control limits are not met. MA-W was not able to provide any further Maintenance task logs/records for the WMP control measures at time of survey. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Infection and Control Program Surveillance: The Facility's Policy, titled: Infection Prevention and Control Program, with a last revision date of 07/25/2023, documents in part: 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting. investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under contractual agreement based upon a facility assessment and accepted national standards. On 06/26/2024, at 09:38 AM, Surveyor reviewed the Facility's infection control binder and noted surveillance logs missing for April 2023 through December 2023. Surveyor requested IP-F to provide dates of surveillance and line lists from time of last survey, April 2023 to current. On 06/26/2024, at 01:37 PM, IP-F informed Surveyor that IP began working at the Facility three months ago and would need to ask management for documents from April 2023 through December 2023. On 07/01/2024, at 08:16 AM, IP-F provided Surveyor with surveillance logs/line list for April 2023, May 2023, June 2023, July 2023, August 2023, and September 2023. IP-F stated no documents can be found for October 2023, November 2023 and December 2023. All provided documents did not include separate calculated percentages for monitoring of each infection type and identification of infection increases and implementation of interventions for increased infection rates. Surveyor noted an overall infection increase among residents as documented for the following: April 2023 to May 2023- 36% increase in infections. May 2023 to June 2023- 102.94% increase in infections. August 2023 to September 2023- 119% increase in infections. No information provided for October 2023, November 2023 and December 2023. Surveyor noted the most recent surveillance data, as of March 2024, have all UTIs in one category labeled GU. Surveyor noted for the category labeled GU, April 2024 to May 2024 had an increase in infection rate of 29.62%. No documentation provided at time of survey to show the Facility addressed and implemented interventions for this increased infection rate. EBP: The Facility's Policy, titled: Enhanced Barrier Precautions, with an implementation date of 04/01/2024, documents in part: (continued on next page)

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	525325	A. Building B. Wing	07/01/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Policy: it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Definitions: enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves used during high contact resident care activities. Policy explanation and compliance guidelines: 1. Prompt recognition of need: . c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high contact care activities. 2. Initiation of enhanced barrier precautions: a. The facility will have the discretion and using E BP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDR O that is not currently targeted by CDC. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g. Chronic wounds such as pressure ulcers, diabetic foot ulcers, surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of enhanced barrier precautions: a. Make gowns and gloves available immediately near or outside of the residence room. Note: face protection may also be needed if performing activity with risk of splash or spray. d. Position a trash can inside the resident's room and near the exit for discarding PPE after removal prior to exit of the room or before printing care for another resident in the same room. On 06/25/2024, at 10:06 AM, Surveyor was conducting initial interviews and observations on unit 300. Surveyor noted R109 to not have any precaution signs on or by R109s door. While speaking with R109, R109 disclosed to surveyor that R109 has a catheter, recently had a UTI and is being seen by the wound clinic. On 06/25/2024, at 09:44 AM, Surveyor was conducting initial interviews and observations on unit 300. Surveyor spoke with R11 who stated R11 has an implanted catheter for draining urine from R11's right kidney. Surveyor noted there was no EBP sign on R11's door, and no PPE outside R11s door. On 06/25/2024, at 12:22 PM, EBP sign and Personal Protective Equipment (PPE) now on/outside of R109's door. Paper on PPE cart documents, EBP-foley No further EBP signs or PPE were placed on unit 300 during survey. On 06/26/2024, at 01:53 PM, Surveyor spoke with IP-F regarding EBP. IP stated EBP is for any res that has an abnormal opening to body, wound(s), and any opening that would put resident at an increased risk for infection. Surveyor asked IP-F if there are any residents on EBP in the facility. IP-F stated the facility does not have enough trash bins to put everyone who meets criteria on EBP. IP stated only residents with foley catheters have EBP in place due to lack of bins. IP stated admin is aware of issue. Surveyor was provided with email documents. Email documents documents, IP-F sent out an email that included NHA-A, DON-B, ADON-C, MD-X, MA-W, and RN-D regarding the need for isolation and trash bins on 04/05/2024. It is documented that the Facility conducted an audit and concluded the Facility needs 160 trash bins and 80 isolation bins. On 04/29/2024, its documented that NHA-A did not have any luck with the Facility's supplier for trash bins. No further information was provided at time of survey. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Laundry: environmental On 06/26/2024, at 10:58 AM, Surveyor toured the laundry area with EVS-Z. Surveyor noted two washers, both covered in a white, brown crusty matter. EVS-Z informed Surveyor that cleaning and maintaining of the washer is responsibility of maintenance and laundry attendant. Surveyor also noted water dripped from the ceiling onto Surveyors head. Surveyor noted water to be pooling under and to the side of the washer designated for residents personal clothing. In the dryer room, Surveyor noted there to be lint covering the floor behind the 3 dryers. In the same room, across from the dryers approximately 2 feet away from a dryer, there were 2 caution wet floor signs with a towel covering a yellow/brown substance. EVS-Z informed Surveyor that is from the grease tank that is leaking. EVS-Z stated maintenance is aware and waiting for the part to fix it. On 06/26/2024, at 11:29 AM, MA-W arrived in the laundry area. MA-W explained to Surveyor that the water dripping from the ceiling in the laundry area is from condensation. MA-W informed Surveyor that the residents' personal items washing machine has been leaking for about 1 week. Surveyor asked MA-W about the leaking grease tank by the dryers. MA-W stated that they have been unable to fix the grease tank because the tank needs to be emptied before they can change the part that is broken. MA-W stated they do not have a contract service to empty the tank due to contractor needing payment upfront. MA-W stated grease tank issue has been going on for several weeks. On 06/27/2024, at 03:19 PM, Surveyor requested the electronic system documentation for Maintenance tasks related to the washer and dryers. Surveyor was provided documents titled: Logbook documentation. Surveyor reviewed logbook documentation for Laundry: Check washers and Laundry: Check dryers marked done on 06/07/2024 by MA-W, and documents in part the following: Washers: - inspect for water leak - check for cleanliness The facility did not establish and maintain an infection prevention and control program based upon current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable diseases and infections. 2.) On 6/25/24 at 09:20 AM, Surveyor observed R33 in their bed. R33 stated they have a wound on their bottom. They have had this wound for a long time. There was no indication R33 was on enhanced barrier precautions for the wound. R33 has a physician order on 6/14/24 for wound care to the sacrum. There is not a physician order for enhanced barrier precautions. On 6/26/24, at 12:41 PM, Surveyor observed R33 in bed. R33 stated there wound treatment was completed today. There is no indicators for enhanced barrier precautions for the wound. 20025 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.) On 6/27/24 at 7:51 a.m., Surveyor observed pressure injury treatment for R33. R33 had a pressure injury and was not placed in enhanced barrier precaution. Surveyor observed Wound RN-Y and Wound RN-GG perform the pressure injury treatment. Wound RN-Y and Wound RN-GG did not wear PPE (personal protective equipment) necessary for R33 who should be in enhanced barrier precaution based on the pressure injury. No additional information was provided.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 49845 Based on observation, interview, and record review the facility did not maintain mechanical and/or electrical equipment in safe operating condition. Surveyor observed the following: * A leaking, full grease tank from the kitchen next to the dryers in the laundry area. * Dryer vent with copious amounts of lint. * Washer for residents personal clothing leaking water. This deficient practice has the potential to affect all 148 residents residing in the facility. Findings include: On 06/26/24 11:31 AM, Surveyor observed towels and 2 caution wet signs on the floor in the dryer room. Surveyor was informed by Maintenance Assistant (MA)-W the kitchen grease trap tank is leaking as a result of staff hitting the pipe with carts. MA-W informed Surveyor that the tank needs to be emptied before it can be fixed, and that they are unable to get this fixed as the contractor requires immediate payment. MA-W stated this has been known for several weeks. On 06/26/24, at 12:00 PM, Surveyor asked MD-X about the grease tank leaking. MD-X stated he is calling around to get quotes and find a different company to get it cleaned out. Surveyor attempted to observe the facility's outside dryer vent, but it was located on the roof. Life Safety Engineer was able to view the Facility's outdoor dryer vent and took pictures of findings. Life Safety Engineer informed Surveyor that the outside vent had about 1 inch of accumulative debris covering the vent. The facility's maintenance task log, titled: Dryers, documents, lint removed from exhaust ducts. The log documents this task was competed on 06/07/2024 by MA-W. The facility's maintenance task log, titled: Washers, documents in part, Inspect for water leaks. The log documents this task was competed on 06/07/2024 by MA-W. On 06/26/24, at 11:31 AM, MA-W informed Surveyor that the leak on the residents personal washing machine has been going on for about 1 week and that the facility is working on getting it repaired. On 07/01/24, at 08:44 AM, Surveyor informed Nursing Home Administrator (NHA)-A of above concerns. No additional information was provided as to why the facility did not maintain mechanical and/or electrical equipment in safe operating condition.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 36161 Based on interview and record review, the facility did not ensure that facility staff received required Quality Assessment and Performance Improvement (QAPI) program training for 2 of 5 sampled Certified Nursing Assistants (CNAs). This has the potential to affect the148 Residents who reside at the facility and have the potential to receive care from both CNAs. Findings Include: On 07/12/24 at 3:16 PM, Surveyor reviewed CNA-II and CNA-JJ's completed trainings for the past year and noted there was no documentation that CNA-II and CNA-JJ's received wertraining on the facility's QAPI program which outlined and informed staff of the elements and goals of the facility's QAPI program. On 7/12/24 at 4:02 PM, Surveyor requested documentation from NHA (Nursing Home Administrator)-A for CNA-II and CNA-JJ that included training of the facility's QAPI program which outlined and informed staff of the elements and goals of the facility's QAPI program. On 7/12/24 at 4:05 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-II and CNA-JJ with the mandatory QAPI training. NHA-A informed Surveyor the facility was working on providing QAPI training to all CNAs. No additional information was provided as to why the facility did ensure that CNA-II and CNA-JJ received the required Quality Assessment and Performance Improvement program training.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 36161 Based on interview and record review, the facility did not ensure that 2 of 5 sampled Certified Nursing Assistants (CNAs received annual training on the facility's compliance and ethics program. This has the potential to affect the148 Residents who reside at the facility and have the potential to receive care from both CNAs. Findings Include: On 07/12/24 at 3:16 PM, Surveyor reviewed CNA-II and CNA-JJ's completed trainings for the past year and noted there was no documentation that CNA-II and CNA-JJ's received training of the facility's compliance and ethics program. On 7/12/24 at 4:02 PM, Surveyor requested documentation from NHA (Nursing Home Administrator)-A for CNA-II and CNA-JJ that included training of the facility's compliance and ethics program. On 7/12/24 at 4:05 PM, Nursing Home Administrator (NHA)-A confirmed the facility has not provided CNA-II and CNA-JJ with the facility's compliance and ethics program. NHA-A informed Surveyor the facility was working on providing training on the facility's compliance and ethics program to all CNAs. No additional information was provided as to why the facility did ensure that CNA-II and CNA-JJ received the required training on the facility's compliance and ethics program.