STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525333	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watertown Health Care Center	121 Hospital Dr Watertown, WI 53098

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on observation, interview, and record review, the facility did not ensure a dignified existence and self-determination in choices which affected 1 of 9 resident (R4) out of a total sample of 9 residents. R4 voiced concerns that she was forced to wear a nightgown because she had no clean clothes. As evidenced by: R4 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Kidney Disease, Type II Diabetes with Diabetic Neuropathy, Dehydration, Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Wasting and Atrophy, Unsteadiness on feet, Weakness. R4's admission Minimum Data Set (MDS) with a target date of 7/18/24, indicates, in part: Brief Interview of Mental Status (BIMS) of 14, indicating cognitively intact. On 8/6/24 at 9:34 AM, Surveyor observed R4 sitting in a wheelchair in her room, dressed in a nightgown. R4 expressed concerns to Surveyor that she had no clean clothes, that they were all in the laundry. R4 stated that she stays in her room because it makes her uncomfortable to be out in common areas with others while dressed in her nightgown. R4 indicated that staff tell her it is okay to wear her nightgown out of her room, but for her it is not okay. R4 told Surveyor that she eats in her room and won't go to activities without wearing regular clothes. R4 stated, I feel foolish sitting here in my nightgown. Surveyor observed that R4 had no clean clothes hanging in her closet except one sweater. On 8/7/24 at 9:16 AM, Surveyor observed R4's closet had 6 pairs of clean shorts and 3 clean tops hanging in her closet. R4 was not in her room at this time. On 8/7/24 at 10:18 AM, Surveyor interviewed R4 who stated she had been at therapy earlier. Surveyor observed R4 to be dressed in clean clothes. R4 stated that she might go to activities now that she had clean clothes. R4 confirmed that not having clean clothes had been an ongoing issue since she was admitted to the facility. R4 stated that she feels much better today in her own clothes. R4 stated she doesn't feel like she has any dignity when forced to wear a nightgown. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 10:39 AM, Surveyor interviewed CNA I who stated she has never seen R4 come out of her room except to go to therapy. On 8/7/24 at 10:43 AM, Surveyor interviewed CNA F who stated that R4 stays mostly in her room but that she does come out for therapy. CNA F said that she offers to take R4 to the dining room for meals or to activities, but that R4 always refuses. CNA F stated that R4 told her that she is embarrassed to not have clothes to wear. R4's dignity is important to her, which includes wearing her own clothes and not a nightgown. The facility's failure to ensure that R4's choice to dress in her own clothes was honored resulted in R4's embarrassment and loss of dignity. R4 has remained isolated to her room and declined social activities and communal dining since admission due to her lack of clean clothes and choices not being honored.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice when experiencing a change of condition for 1 of 3 sampled residents (R1). On [DATE], R1 experienced a change in condition exhibiting as shortness of breath and critically low oxygenation. The facility failed to recognize the change of condition as a medical emergency, complete a comprehensive cardiorespiratory data collection, and consult with the RN which resulted in a delay of treatment. LPN E's (Licensed Practical Nurse) failure to recognize a change of condition, complete a comprehensive cardiorespiratory data collection, and consult with the RN resulted in a delay of treatment and created a finding of Immediate Jeopardy (IJ) beginning on [DATE]. On [DATE] at 2:15 PM, NHA A (Nursing Home Administrator) was informed of the IJ. The IJ was removed on [DATE] when the facility recognized the IJ and implemented an immediate action plan. The IJ was corrected on [DATE]. This is evidenced by: The facility policy titled Notification of Changes Policy dated [DATE], states in part: Policy: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate .Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative , and the resident's physician, to ensure best outcomes of care for the resident DEFINITIONS Significant change in status - deterioration in health, mental or psychosocial status in life threatening conditions or clinical complications Significant alteration in treatment - A need to alter treatment significantly. A significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. OBJECTIVE OF THE NOTIFICATION OF CHANGE POLICY The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to the resident's condition .to the parties who will make decisions about care, treatment, and preferences to address the changes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	OVERVIEW OF COMPONENTS OF THE POLICY 1. Requirements for notification of resident, the resident representative, and their physician . 2) A significant change in the resident's physical, mental, or psychosocial status. (i) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications . Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions to or discontinuation of treatments . PROCEDURE FOR NOTIFICATION OF CHANGES FOR RESIDENT PURPOSE The facility shall promptly notify the resident and/or the resident representative and his or her physician or delegate of changes in the resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences. PROCEDURE 1. The nurse will immediately notify the resident, resident's physician, and the resident representative(s) for the following (list is not all inclusive): . b. A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complication. c. A need to alter treatment significantly a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment. d. A decision to transfer or discharge the resident from the facility . 3. Document the notification and record any new orders in the resident's medical record . 7. Communicate the changes to the rest of the care team and inform the supervisor . According to Wisconsin Statutes N 6.04 Standards of practice for licensed practical nurses. (1) Performance of acts in basic patient situations. In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a provider: (a) Accept only patient care assignments which the L.P.N. is competent to perform. (b) Provide basic nursing care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(c) Record nursing care given and report to the appropriate person changes in the condition of a patient. (d) Consult with a provider in cases where an L.P.N. knows or should know a delegated act may harm a patient. (e) Perform the following other acts when applicable: 1. Assist with the collection of data. 2. Assist with the development and revision of a nursing care plan. 3. Reinforce the teaching provided by an R.N. provider and provide basic health care instruction. 4. Participate with other health team members in meeting basic patient needs. (2) Performance of acts in complex patient situations. In the performance of acts in complex patient situations the L.P.N. shall do all of the following: (a) Meet standards under sub. (1) under the general supervision of an R.N., physician, podiatrist, dentist or optometrist. (b) Perform delegated acts beyond basic nursing care under the direct supervision of an R.N. or provider. An L.P.N. shall, upon request of the board, provide documentation of his or her nursing education, training or experience which prepares the L.P.N. to competently perform these assignments. R1 was admitted to the facility on [DATE] with diagnoses to include chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with (acute) exacerbation (COPD) and dependence on supplemental oxygen. R1's Minimum Data Set (MDS) with an assessment date of [DATE] includes the following: Brief Interview of Mental Status (BIMS) assessment score of 14 indicating R1 is cognitively intact. Section J1100 C. Shortness of breath or trouble breathing when lying flat was marked. J1400 Prognosis. Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? 'No' was marked. O0110 Special Treatments, Procedures, and Programs C1. Oxygen therapy while a resident was marked. R1's physician orders included the following: DNR (Do Not Resuscitate) start date [DATE]. Q4 (every 4 hours) vital signs every 4 hours start date [DATE]. Continuous Oxygen via NC (Nasal Cannula) 3L (3 Liters) every shift start date [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Albuterol Sulfate Inhalation Nebulization Solution (2.5MG/3ML) 0.083%v (Albuterol Sulfate) 1 vial inhale orally via nebulizer three times a day for COPD exacerbation start date [DATE]. Mometasone Furo-Formoterol Fum Inhalation Aerosol ,d+[DATE] MCG/ACT 2 puff inhale orally at bedtime for COPD start date [DATE]. Mometasone Furo-Formoterol Fum Inhalation Aerosol ,d+[DATE] MCG/ACT 2 puff inhale orally one time a day for COPD start date [DATE]. Spiriva HandiHaler Inhalation Capsule 18MCG 1 puff inhale orally one time a day for COPD rinse mouth after use start date [DATE] R1's comprehensive care plan Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, Chronic Hypoxic Respiratory failure. Oxygen Dependent. Dated [DATE] has goals of Patient will have adequate gas exchange as evidenced by no adventitious breath sounds, absence of respiratory distress, and absence of shortness of breath. Patient will remain free of exacerbation of COPD. Interventions include Observe labs, response to medication and treatments. Administer oxygen as needed per Physician order. Monitory oxygen saturations on room and and/or oxygen. Monitor oxygen flow rate and response. Elevate HOB (Head of Bed) to alleviate shortness of breath. Monitory cough and effectiveness of inhaler/nebulizer. Notify practitioner if symptoms worsen or do not resolve. R1's Progress Notes written by LPN E (Licensed Practical Nurse) include the following: [DATE] 10:56 (AM) Note Text: At 0725 (7:25AM) res (R1) was on call light requesting a boost due to SOB (Shortness of Breath) because she was to [sic] low. Writer went to get an aide to assist, and res was repositioned, and HOB (Head of Bed) was raised. After that writer went to get res nebulizer (a device for producing a fine spray of liquid for inhaling a medication) meds (medication) and ran that with mask (a face mask used to administer medication via a nebulizer). And writer also gave the res an inhaler. Res breathing was labored. Checked res POX (Pulse Oximetry, a noninvasive method for monitoring blood oxygen saturation) and it was 62% on oxygen at 3L (Liters) via NC (Nasal Cannula), writer increased oxygen to 4L. Writer came back in a little while and rechecked res POX and it had gone up to 69% but writer had CNA (Certified Nursing Assistant) get res a mask (a face mask to administer oxygen) and it was applied to the res instead of the NC. Res was responsive at that time. Writer rechecked POX and it was at 72%. Res was responsive at that time. Writer went back soon after this to recheck res POX and at that time res noted to have her eyes rolling up and not responding to verbal but did have a slight response to touch. POX was down to 54% on mask so writer went and called EMS (Emergency Medical Services) to come for resident. Writer went back into res room and stayed there with res until EMS arrived. Res was not really responsive then and was pale in color and had labored breathing but when writer went and held res hand res did respond to it. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to Lippincott Nursing 2024 King, [NAME] E. RN, C, ACNP, ANP, PhD. How do I choose a supplemental oxygen delivery device? Nursing 33(12):p 32, [DATE] states in part; perform a more complete physical assessment. Besides the patients SPO2 (blood oxygen level), note the respiratory rate, quality of breath sounds, use of intercostal muscle (muscles around ribs, if noting intercostal muscle use the patient is working hard to breath), presence of mottling (bluish color of skin), heart rate and any cardiac arrhythmias. The nasal canula is most appropriate for patients experincing minimal respiratory distress. The flow rates rate from 1 to 6 liters. Like the nasal canula the face mask mixes oygen with room air but can provide higher oxygen concentration and higher flow rates (5 to 10 Liters). To prevent carbon dioxide accumulating in the mask, maintain an oxygen flow rate of at least 5 liters/minute. Of note, despite R1's significant respiratory history and R1's presentation LPN E did not listen to R1's lungs or complete a full respiratory review of R1. At no time did LPN E consult with a RN regarding R1; instead LPN E left R1's room despite R1 showing increased respiratory distress as evidenced by low O2 sats and labored breathing. Additionally, LPN E chose to use an oxygen mask with a low oxygen delivery of 4 liters per mask which would have increased the carbon dioxide accumalation in the mask making breathing more difficult for R1 and furthering R1's respiratory distress. EMS report dated [DATE] includes the following information: Clinical Impression: Primary Impression: Acute Respiratory Distress. Onset Time: 07:00 (AM) [DATE]. Chief Complaint: Respiratory distress. Duration: 2 hours. Signs & Symptoms: Acute respiratory distress (Primary), Slowness and poor responsiveness. Initial Patient Acuity: Critical (Red) Vital Signs: Time 09:08 (AM) BP (Blood pressure) Blank. Pulse Blank. RR (Respiratory Rate) 10 R. SPO2 (Oxygen Saturation) 70 Rm. (on room air) Time 09:13 (AM) BP ,d+[DATE]. Pulse 111. RR 12 R. SPO2 93 Ox. Flow Chart: Time: 09:09 (AM). Treatment: Oxygen. Description: Device: Non-Re-breather Mask (NRB); Flow Rate; 15 lpm; Patient Response: Improved; Successful; Complications: None; Medical Control: Protocol (Standing Order) Time 09:13 (AM). Treatment: Oxygen. Description: Device: Bag Valve Mask (BVM); Flow Rate: 15 lpm; Patient Response: Improved; Successful; Complication: None; Medical Control: Protocol (Standing Order) Assessments Time 09:08 (AM) Mental Status - Slowness and poor responsiveness. Skin - Cold, Cyanotic (bluish or purplish discoloration due to deficient oxygenation). Eyes - Left: Non-Reactive, right: non-reactive. Extremities: Cyanotic extremities. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Narrative: [Ambulance Number] was dispatched to a nursing home for difficulty breathing. [Ambulance Number] responded emergent and arrived on scene without incident. On arrival EMS crew was met at the front door by facility staff and escorted to pt's (R1) room. On contact pt was [age] GCS 7 (Glasgow Coma Scale indicating severe traumatic brain injury requiring immediate emergency care) laying upright in bed with an oxy (oxygen) mask on. Pt had shallow respirations and was cyanotic in the extremities. Pt's eyes were moving on initial contact. Nursing home staff state she has a history of pulmonary failure and started to have acute difficulty breathing around 0700 (7:00AM) this morning, which has not improved with their treatments of oxygen and a nebulizer. Nursing home staff state that her initial spO2 was 60% on a 2 LPM NC (liters per minute/via nasal canula), spO2 at time of EMS contact 71% on oxy mask @6 LPM. Nursing home state they obtained an automated blood pressure of ,d+[DATE] prior to EMS arrival. EMS unable to obtain with monitor, radial pulse was weak. EMS was presented with a valid DNR for the pt, as well as med list indicating the pt was on blood thinners. Unable to obtain stroke scale due to pt's GCS. Pt slide sheet transferred over to stretcher and a NRB was applied @15 LPM. Pt moved via stretcher to [Ambulance Number]. In [Ambulance Number] a 4-lead was applied showing a tachy sinus arrhythmia (an irregular and faster than normal heart rate). SpO2 remained at 69% on NRB (Non-rebreather/face mask), BVM (Bag Valve Mask-device used to deliver ventilation to patient) ventilation started due to shallow respirations, raising the spO2 to 93%. Pt began to increase ventilatory effort following BVM, however it was noted that her eyes were now fixed. [Ambulance Number] started emergent transport to hospital. Enroute BVM was continued with spO2 remaining above 90%. BP obtained enroute was ,d+[DATE]. [Ambulance Number] arrived at [ER Name] without incident and pt was moved via stretcher to ER room [ROOM NUMBER] where she was slide sheet transferred to bed. Care, report, and DNR (Do Not Resuscitate) paperwork transferred to RN. [Ambulance Number] cleared [ER name] following decon (decontamination). Level of Service: Advanced Life Support Incident Times: Call Received 09:01:04 Dispatched 09:01:13 En Route 09:01:44 On Scene 09:05:29 At Patient 09:07:00 Depart Scene 09:14:16 At Destination (Hospital ER) 09:15:45 Pt. Transferred 09:17:16 [DATE] 10:52 (AM) Note Text: Res left via EMS around 0914 (9:14AM). ER (emergency room) updated on res going over there for evaluation at 0916 (9:16AM) and son [Name] updated that res was going to the ER due to low oxygen sats (Oxygen Saturation) at 0918 (9:18AM). [Name] NP (Nurse Practitioner) consulted regarding res low POX and low BP (Blood Pressure) and high pulse, send to ER. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospital Emergency Department report dated [DATE] includes the following: Date of service [DATE]. Chief complaint: Difficulty breathing. Unable to obtain history r/t (related to): Other - Patient nonverbal due to critical nature presentation. Comments: .presents to the emergency room by ambulance for evaluation of respiratory distress which did not respond to a breathing treatment at the nursing home . When she was brought into the emergency department the patient was being bag (manual ventilation) and she was having agonal respirations (a distinct and abnormal pattern of breathing) she did have a palpable pulse, but she did not have any other signs of life she was not responding to needlestick or questioning . General Appearance: other - Patient is not responding to stimulation or verbal communication . Eyes: Bilateral: Other - The right pupil is blown left pupil is 6 mm but not responding Respiratory: Other - Decreased air movement only noted with bagging. Neuro/Psych: Other - On arrival patient had a blown pupil on the right. She was not responding to verbal communication she was not responding to tactile stimulation or needlestick. Medical Decision Making: Summary of care: Patient presents with agonal respirations and appeared to be at end of life. She is a DNR. I spoke to the son who has power of attorney and comfort care measures were started. Patient was given intravenous morphine Zofran and lorazepam. Shortly after arrival patient lost all signs of life. She had no palpable pulse no cardiac sounds and no respiratory effort. No neurologic function. Clinical course as noted above after speaking with the son since she is a DNR comfort measures were started the patient expired at 9:55 a.m. [DATE] 11:14 (AM) Note Text: At 1000 (10:00AM) received call from [Name] ER that res was pronounced dead at 0955 (9:55AM). [Name of practitioner] NP was consulted regarding res pronounced dead after phone call from ER. [DATE] 11:16 (AM) Note Text: [Name] DON was updated at 1045 (10:45AM) regarding res passing at [Name] ER. On [DATE] at 9:49 AM, Surveyor interviewed PO D (Police Officer - Detective). PO D indicated the facility contacted the police and reported the incident as possible neglect due to the delay in treatment. PO D indicated she spoke with the medical examiner in charge of R1's case. PO D indicated there was an autopsy which revealed preliminary cause of death as COPD, emphysema, and lung disease. PO D and medical examiner discussed the case, and it was said that being deprived of adequate oxygenation might be a contributing factor for the cause of death. On [DATE] at 10:26 AM, Surveyor interviewed NP C (Nurse Practitioner). NP C indicated she was not made aware of R1's change in condition until after R1 was sent to the ER which was almost 2 hours after the change in condition started. NP C stated she had ordered vital signs every four hours for R1 because of R1's condition. NP C indicated R1 had no reserve due to end stage COPD. NP C indicated the first oxygen saturation of 62% was a critical value and R1 should have been sent to the ER immediately. NP C indicated she does not believe the situation was handled correctly. NP C indicated staff should have called 911 then attempted other interventions like the inhaler or nebulizer as they waited for EMS to arrive. NP C agreed being deprived of adequate oxygen for that long could have been a contributing factor to R1's death. NP C indicated it is her expectation that any critical values in vital signs need an immediate phone call to the provider. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:06 PM, Surveyor interviewed DON B (Director of Nursing). DON B indicated R1 had a hospice consult on [DATE] but declined hospice services. DON B indicated she was notified of R1's death on [DATE]. DON B indicated on [DATE], LPN E did not give details of what happened that lead to R1 being sent to the hospital and passing. On [DATE], after reviewing LPN E's documentation, DON B suspended LPN E and started an investigation. DON B indicated she would have expected LPN E to call the NP and send R1 to the hospital for a pulse oximetry reading of 62%. DON B indicated LPN E did delay treatment for R1. On [DATE] at 8:40 AM, Surveyor interviewed LPN E. LPN E indicated the following: At 7:30 AM R1 had her light on and needed a boost up in bed because she was short of breath. LPN E left the room to get a CNA on a different hallway. They returned and boosted R1 up in bed. After they boosted R1, LPN E went to her cart to get a nebulizer treatment that took about 15 minutes to run. LPN E also grabbed an inhaler for R1 and brought in a pulse oximeter. LPN E checked R1's O2 sats (oxygen saturation) and it was 62% on 3L. LPN E turned the oxygen up to 4L at that time. LPN E left the room and came back a little later and rechecked R1's O2 sats. It was 69%. LPN E then had a CNA get an oxygen mask and change it out with the nasal cannula. LPN E then came back a little later and R1's O2 sats was 72%. LPN E left R1's room and returned to her medication cart. LPN E prepared another resident's medications and went to administer that resident's medications to them. Then LPN E went back to R1 to recheck O2 sats which was now at 52%. LPN E ran out of the room and called 911. LPN E returned to R1's room and waited for EMS to arrive. Upon EMS arrival, LPN E gave EMS report then left the room. LPN E then escorted EMS out of the building. LPN E then called ER to give them report on R1 being sent there and called R1's son. Surveyor asked LPN E when she first took an O2 sats reading for R1. LPN E indicated she checked R1's O2 sats for the first time after boosting R1 and administering the nebulizer and inhaler. LPN E indicated R1 was a DNR and R1's O2 sats were going up slowly. LPN E indicated in hindsight LPN E would have done things way different. LPN E indicated she would have called 911 after the first O2 reading of 62%. On [DATE] at approximately 7:30 AM, R1 complained of shortness of breath. R1's O2 sats were not obtained for approximately 20 minutes. R1's O2 sats at that time was critically low at 62% and remained low. The facility did not notify the provider. The facility called 911 at 9:01AM, approximately 1.5 hours after the facility noted the change in condition. R1 expired at 9:55AM. The facility's failure to recognize a change of condition complete a comprehensive cardiorespiratory data collection and consult with the RN resulted in a delay of treatment creating a finding and immediately notify the physician created a finding of IJ which was removed, on [DATE], when the facility implemented the following action plan: Investigation initiated. Police notified. Nurse suspended. Chart review completed. Hospital notes reviewed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff statements obtained. Like resident statements obtained Skin assessments completed on residents with BIMS of 12 or less. Audit completed on all change in conditions within the last week to ensure RN (Registered Nurse) assessment completed and Nurse Practitioner was updated timely. Audit completed on oxygen use orders. Audit completed on all vital signs to determine if there were any missed vital signs or abnormal vital signs. Review of all nursing competencies Review of crash carts Audit of Code status Audits daily x (for) 30 days for change in condition, appropriate assessments, vital signs completed, any new orders completed, place d on 24-hour board, and continued follow up. Respiratory assessments reviewed or completed on residents with Respiratory diagnosis. [NAME] Clinical Consulting educated the QAPI (Quality Assurance and Performance Improvement) committee on notifications/investigations that must begin off-hours for any death or unusual event. Education completed for all licensed staff and CNA's. Recognition of change in condition with post test O2 orders with post test Following MD orders and MD notification MD and RN notification Vital signs and Baseline vital signs with post test Education completed for all staff. Change in condition. Reporting to nursing any changes Abuse, Neglect, Misappropriation

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation, interview, and record review, the facility did not ensure that the resident's environment remains as free of accident hazards as is possible and did not ensure resident's care plans are up to date for 1 of 3 residents (R3) reviewed for accidents. R3 fell on [DATE], sustaining a laceration under his left eye that required stitches. This is evidenced by: The facility's Policy and Procedure entitled Falls Management Process dated 1/10/24 documents the following in part: .12. The nurse will determine the most appropriate intervention, implement, and update care plan . The facility's Policy and Procedure entitled Comprehensive Care Plan dated 3/1/23 documents the following in part: .3. The comprehensive care plan will describe, at a minimum, the following .f. Resident specific interventions that reflect the resident's needs and preferences .8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. R3 is a short-term rehab resident admitted to the facility with the following diagnoses: intraspinal abscess and granuloma, MRSA (methicillin-resistant Staphylococcus aureus), type 2 diabetes mellitus, muscle wasting, cystitis, MSSA (Methicillin-Sensitive Staphylococcus aureus), cognitive communication deficit, fall in shower or empty bathtub, acute metabolic acidosis, sepsis due to MSSA, and fusion of spine-cervical region. R3's Fall Risk Evaluations document the following: 4/25/24 - score of 12 4/27/24 - score of 17 5/15/24 - score of 18 6/1/24 - score of 17 8/4/24 - score of 8 A score of 10 or higher indicates the resident is at high risk for falls. R3's Care Plan documents the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Focus: 4/25/24 At risk for falls related to: History of falls, New environment, Use of medication; Goal: No Fall related injuries; Interventions: Keep personal items within reach, Keep environment well-lit and free of clutter, Gait belt with transfers, Encourage rest periods if feeling fatigued, Encourage participation in activities to improve strength or balance, Clear and monitor environmental obstacles (tubing, cords, etc.), Call light and personal items available and in easy reach or provide reacher, Activity Programming - exercises, TV programs 5/1/2024 Grip socks to be donned when shoes are not worn. 5/15/2024 Sign hung in room and bathroom to remind resident to call for assistance. 5/20/2024 Resident to be offered assistance with toileting Q2hrs (every 2 hours) while awake. 6/17/2024 Resident to be offered toileting after lunch daily. 8/6/2024 8/3-Resident to be offered Q2hrs toileting throughout the NOC (Night shift) R3's Certified Nursing Assistant (CNA) Care Plan documents the following: -Resident is to be offered assistance with toileting needs Q2hr while awake. -Resident is to be offered toileting assistance following lunch daily. -Resident to be offered Q2hrs toileting throughout the NOC. Of note, the following interventions were not on the CNA Care Plan - Sign hung in resident's room and bathroom to call for assistance and - Larger Dycem (non-slip material) to seat of wheelchair. R3's Fall Reports document the following: 5/9/24 - Notified by PT (Physical Therapy) that resident had a witnessed fall and did not hit his head. Per PT, safety education provided. No injury. PT witnessed resident fall in front of sink just before making it to his wheelchair. DON (Director of Nursing), MD (Medical Doctor), POA (Power of Attorney) notified. RCA (Root Cause Analysis) trying to get out of bed to go to the bathroom. Intervention - Sign hung in resident's room and bathroom to call for assistance. R3's dates of falls in correlation with when fall interventions were added to the care plan: Fall 5/9/24, Intervention - Sign hung in resident's room and bathroom to call for assistance. Sign hung in room and bathroom to remind resident to call for assistance added to Care Plan 5/15/2024. This is six (6) days after this fall. On 8/7/24 at 12:56 PM, Surveyor entered R3's room with his permission. There were no signs in R3's room or bathroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5/15/24 - Staff outside room heard ow! sound came from the room. Went in room and saw resident on buttocks, leaning to right side, right arm extended to floor and left arm in lap, feet on floor, knees bent up toward ceiling. Resident began to move about and stood up from floor with help from writer and social worker. Resident sat in chair. VS (Vital Signs). Neuro (Neurological) check complete. Skin assessment/assessment for injury. NP (Nurse Practitioner), DON, RR (Resident Representative) notified. RCA - R3 I lost my footing when I tried to get to the bathroom. I know I'm supposed to ask for help, but I didn't want to bother anyone. Intervention - Resident is to be offered assistance with toileting needs Q2hr while awake. R3's dates of falls in correlation with when fall interventions were added to the care plan: Fall 5/15/24, Intervention - Resident is to be offered assistance with toileting needs Q2hr while awake. Resident to be offered assistance with toileting Q2hrs while awake added to Care Plan 5/20/2024. This is five (5) days after this fall. 5/21/24 - Alerted by CNA that resident had fallen. Found on floor, resting on buttocks in front of wheelchair. Assessed for injury and pain. VS = 100.2 (dressed in multiple top layers and room is very hot in temperature). Follow-up temp = 98.8. Neuro checks assessed. Grip socks on, not incontinent. DON, MD, Family notified. RCA - I slid out of wheelchair and lowered myself onto my buttocks. Intervention - larger dycem to seat of wheelchair. R3's dates of falls in correlation with when fall interventions were added to the care plan: Fall 5/21/24, Intervention - Larger Dycem to seat of wheelchair. This intervention was not added to the Care Plan. On 8/7/24 at 12:56 PM, Surveyor entered R3's room with his permission. Surveyor asked R3 if he was sitting on a non-slip mat, R3 wasn't sure. There was no Dycem noted on top of wheelchair cushion. On 8/7/24 at 1:05 PM, Surveyor interviewed CNA/Med Tech I (Medication Technician). Surveyor asked CNA/Med Tech I what R3's fall interventions are? CNA/Med Tech I stated keeping bed low, trip hazards out of way, door open, and table away from bed. Surveyor asked CNA/Med Tech I if R3 was sitting on Dycem. CNA/Med Tech I said unsure. Surveyor asked CNA/Med Tech I if she could look with Surveyor if R3 was sitting on Dycem. CNA/Med Tech I had R3 pick up his legs so she could look and feel under his thighs and lean forward to see under his buttocks; there was not Dycem in place. 6/1/24 - Resident found on the floor in the bathroom. Resident on coccyx, back to the wall, arms at sides, feet flat on floor, knees bent toward chest. ROM WNL (Range of Motion Within Normal Limits). VSS (Vital Signs Stable). Skin assessment. Neuro check. DON, NP, family notified. RCA - R3 I did not fall on the floor. I don't know why everyone says I fell . I stood up, my knees got weak, and I sat myself on the floor. I know, but I didn't want to wait. Intervention - resident is to be offered toileting assistance following lunch daily. R3's dates of falls in correlation with when fall interventions were added to the care plan: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall 6/1/24, Intervention - Resident is to be offered toileting assistance following lunch daily. Resident to be offered toileting after lunch daily added to Care Plan 6/17/2024. This is 16 days after this fall. 8/3/24 - Resident was sitting on toilet, naked from the waist down, no shoes or socks on feet. Resident had blood coming from small laceration to left lateral eye. There were large areas of urine in front of end table and closet. Wheelchair was at bedside with brakes locked, call light attached to bedsheets and in view accessibility. RCA - R3 stated he didn't know if he could make it to toilet without having an accident. He stated that he fell off his bed but didn't know what he hit his face on. Resident stated he was fine and didn't need to go to hospital. Neuro checks initiated. VS. MD, NM (Nurse Manager), family notified. While notifying MD, swelling under R3's left eye became more significant, and MD requested he be sent to ER (emergency room) for evaluation. Intervention - Resident to be offered Q2hrs toileting throughout the NOC. R3's ER paperwork documents the following: -Traumatic hematoma of left orbit, laceration of face, right hip pain, fall. -Pt (Patient) presents with left periorbital hematoma and laceration. Pt was trying to get up to use the bathroom and fell hitting his left side of face on his nightstand. Pt denies LOC (Loss of Consciousness). Pt is unable to open his left eye. Pt has severe swelling to left periorbital hematoma. Pt is on warfarin (anticoagulant - medication that inhibits the coagulation (the action of a liquid changing to a solid or semi-solid state)). Pt denies nausea, vomiting, CP (Chest Pain), SOB (Shortness of Breath), cold symptoms, weakness, and dizziness. Pt C/O (complained of) of 6/10 left facial pain. Pt's speech is clear. -3 stitches to laceration below left eye. R3's dates of falls in correlation with when fall interventions were added to the care plan: Fall 8/3/24, Intervention - Resident to be offered Q2hrs toileting throughout the NOC. Resident to be offered Q2hrs toileting throughout the NOC added to Care Plan 8/6/2024. This is 3 days after this fall. On 8/7/24 at 12:58 PM, Surveyor interviewed CNA F (Certified Nursing Assistant). Surveyor asked CNA F what R3's fall interventions are. CNA F stated keep door open, nothing next to bed, and to encourage him to call for assistance. Surveyor asked CNA F if R3 was sitting on Dycem, CNA F said not sure about that. It is important to note that CNA F did not say anything about toileting R3. On 8/7/24 at 1:03 PM, Surveyor interviewed CNA J. Surveyor asked CNA J what R3's fall interventions are. CNA J stated for him to call for assist, door open, and verbal encouragement to use call light. Surveyor asked CNA J if R3 was sitting on Dycem, CNA J replied don't know for sure on that. It is important to note that CNA J did not say anything about toileting R3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/7/24 at 1:22 PM, Surveyor interviewed RN/UM K (Registered Nurse/Unit Manager). Surveyor asked RN/UM K how the fall interventions get on the care plan. RN/UM K stated, I enter them daily or on Monday if over a weekend and I'm not here. Surveyor asked RN/UM K how the CNAs know the fall interventions. RN/UM K replied they are written on 24-hour board, the Nurses should be giving them verbally in report, and they are on the CNA Care Plan. Surveyor asked RN/UM K where is R3's Dycem supposed to be? RN/UM K stated between him and the wheelchair cushion. Surveyor asked RN/UM K should all the fall interventions be in place, RN/UM K said yes. Surveyor asked RN/UM K should all fall interventions be on the Care Plan and CNA Care Plan, RN/UM K replied yes. Surveyor told RN/UM K that R3 doesn't have any signs in his room or bathroom, R3 is not sitting on any Dycem, and none of the staff on R3's unit brought up toileting as part of his fall interventions. RN/UM K said R3 must have taken the signs down again. On 8/7/24 at 3:21 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect all fall interventions to be in place, DON B stated yes. Surveyor asked DON B would you expect all fall interventions to be on the Care Plan, DON B responded yes. Surveyor asked DON B would you expect all fall interventions to be on the CNA Care Plan, DON B said yes. Surveyor asked DON B if an intervention is removed by the resident what should occur? DON B replied we should come up with a different intervention. Surveyor showed DON B R3's CNA Care Plan that Surveyor viewed on computer prior to speaking with staff and compared it to the printed copy given after speaking with staff. The two documents did not match. The document pulled up on the computer did not include the Sign hung in room and bathroom to remind resident to call for assistance. Surveyor asked DON B if she had any idea why the paper copy of CNA Care Plan and computer copy of CNA Care Plan didn't match, DON B said I'm not sure.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on observation, interview, and record review, the facility failed to assess and provide appropriate treatment and services to achieve and maintain as much normal bowel and bladder function as possible for 2 of 4 sampled residents (R) (R4 and R2) reviewed with a bladder and bowel decline. R4 is being cited at severity level 3 (actual harm). R2 is being cited at severity level 2 (potential for more than minimal harm). R4 was continent of bowel and bladder prior to admission. R4 had a decline in bowel and bladder continence from 7/15/24 to present. R4 was assessed by the facility as continent on admission on 7/15/24 and currently is frequently incontinent of bladder and bowel. The facility failed to implement measures to improve R4's bowel and bladder continence and failed to update R4's care plan or establish a toileting program in an effort to restore R4's bowel and bladder continence. R2 had a decline in bowel and bladder continence from 6/20/24 to the present. R2 was continent of bowel and bladder on admission. R2 has had a decline in bowel and bladder continence since admission and is now incontinent of bowel and bladder. The facility failed to update R2's care plan and failed to establish a toileting program to restore R2's bowel and bladder function. This is evidenced by: The facility's policy, Incontinence, with an effective date of 3/26/23 and no revision/review dates noted states in part . The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence . The facility's policy, Comprehensive Care Plan, with an effective date of 3/1/23 and no revision/review dates noted; states in part: .The comprehensive care plan will describe, at a minimum, the following: (3)(a) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . (6) The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . Example 1: R4 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Kidney Disease, Type II Diabetes with Diabetic Neuropathy, Dehydration, Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Wasting and Atrophy, Unsteadiness on feet, Weakness. R4's admission Minimum Data Set (MDS) with a target date of 7/18/24, indicates in part: Brief Interview of Mental Status (BIMS) of 14, indicating cognitively intact. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	R4's Elimination charting indicates R4 was of continent bladder and bowel elimination on 7/15/24 and 7/16/24. R4's Elimination charting beginning on 7/17/24, indicates 3 continent voiding episodes and 54 incontinent episodes for bladder. R4's elimination charting beginning on 7/17/24 indicates all 34 bowel episodes as incontinent. There is no evidence in R4's medical record that the facility assessed R4 or implemented a plan including a bowel and bladder toileting plan to assist R4 in achieving or restoring bowel and bladder continence. There is no evidence the facility attempted to complete a bowel and bladder diary, implement interventions such as a bedside commode, frequent toileting to aid R4 in maintaining or regaining bowel and bladder continence. On 8/7/24 at 10:18 AM, Surveyor interviewed R4 who stated she had been continent before she came to the facility but has been incontinent the entire time since admission. R4 indicated that at first staff assisted her to the commode, but that was stopped, and the commode removed by therapy because she was always soiled by the time staff came to help her. R4 stated that she has to urinate approximately every 30 minutes, and that she can't wait that long for staff to come and assist her. R4 also confirmed that she was continent of bowel at home but has been incontinent of bowel since being in the facility. R4 stated she never had problems with continence before coming to the facility. On 8/6/24 at 9:34 AM, Surveyor observed R4 sitting in a wheelchair in her room, dressed in a nightgown. R4 expressed concerns to Surveyor that she had no clean clothes, that they were all in the laundry. R4 stated that she stays in her room because it makes her uncomfortable to be out in common areas with others while dressed in her nightgown. R4 indicated that staff tell her it is okay to wear her nightgown out of her room, but for her it is not okay. R4 told Surveyor that she eats in her room and won't go to activities without wearing regular clothes. R4 stated, I feel foolish sitting here in my nightgown. Surveyor observed that R4 had no clean clothes hanging in her closet except one sweater. R4 stated she has no clean clothes because she frequently soils herself. On 8/7/24 at 10:18 AM, Surveyor interviewed R4 who stated she had been at therapy earlier. Surveyor observed R4 to be dressed in clean clothes. R4 stated that she might go to activities now that she had clean clothes. R4 confirmed that not having clean clothes had been an ongoing issue since she was admitted to the facility. R4 stated that she feels much better today in her own clothes. R4 stated she doesn't feel like she has any dignity when forced to wear a nightgown. On 8/7/24 at 10:39 AM, Surveyor interviewed CNA I who stated she has never seen R4 come out of her room except to go to therapy. On 8/7/24 at 10:43 AM, Surveyor interviewed CNA F who stated that R4 stays mostly in her room but that she does come out for therapy. CNA F said that she offers to take R4 to the dining room for meals or to activities, but that R4 always refuses. CNA F stated that R4 told her that she is embarrassed to not have clothes to wear. R4's admission MDS with a target date of 7/18/24 indicates, in part: Section GG - Functional Abilities: Substantial/Maximum Assist - helper does more than half the effort for Toileting Hygiene. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Toilet transfer - not attempted due to medical conditions or safety concerns. Section H - Bladder and Bowel: Urinary Toileting Program: Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? Code 0 is entered, meaning: No. Bowel Toileting Program: Is a toileting program currently being used to manage the resident's bowel incontinence? Code 0 is entered, meaning: No. Urinary Continence: Code 2 is entered, meaning: Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Bowel Continence: Code 2 is entered, meaning: Frequently incontinent (7 or more episodes of bowel incontinence, but at least one episode of continent voiding). R4's Care Plan contains no focus or goals related to toileting or incontinence. A Focus of Physical functioning deficit related to: Mobility impairment, Self-care impairment was initiated on 7/15/24. Goal: I will improve my current level of physical functioning was initiated on 7/15/24. Intervention: Toileting Extensive assistance of one with bed pan was initiated on 7/15/24. Of note: R4's Care Plan did not contain a focus, goal, or interventions related to incontinence or aims to improve or maintain bladder or bowel functioning. R4's Certified Nursing Assistant (CNA) Kardex printed 8/7/24 states in part: Elimination/Toileting. B&B Bladder Elimination . Of note: R4's CNA Kardex gives no indication of her continence status or the way in which she is to be toileted. On 8/6/24 at 9:23 AM, Surveyor interviewed R4 who stated that she is dependent upon staff for all Activities of Daily Living (ADLs). R4 stated that she cannot do things by herself. R4 stated she needs assistance with a mechanical lift and staff to get up to use the bathroom. R4 indicated that she is always incontinent, sitting in a wet brief and wet clothes because she sometimes has to wait 1-2 hours for assistance. R4 stated this happens every day. R4 stated it, Makes me feel degraded that I have to sit here an hour and half in my pee. I feel like nothing more than an animal. On 8/7/24 at 12:50 PM, Surveyor interviewed DOR L (Director of Rehabilitation) who confirmed that R4 was incontinent, and that they have encouraged her to do a two-hour toileting schedule, which would include sitting on the toilet every two hours even if she did not need to relieve herself at that moment. DOR L stated that the commode had been removed from R4's room because it was a bariatric commode and was needed for another resident who was larger. DOR L stated that R4 is able to get on and off the toilet with a mechanical lift and staff assistance and does not require a bedside commode. On 8/7/24 at 1:04 PM, Surveyor interviewed CNA J who stated that R4 has always been incontinent to her knowledge, and that R4 utilizes her call light for staff to change her, not use the commode or toilet. CNA J stated she was not aware of a toileting program for R4. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 8/7/24 at 1:22 PM, Surveyor interviewed RN/UM K (Registered Nurse/Unit Manager) who indicated that there is no bowel and bladder diary or training program for R4. On 8/7/24 at 2:38 PM, Surveyor interviewed CNA M who stated that R4 is always incontinent. CNA M stated she was unaware of a toileting program for R4. CNA M stated that she uses the CNA Kardex for information on how to care for the residents, including what their toileting needs are. CNA M indicated that there is a form in the nursing station, hanging on the wall, that states if a resident has a change in their toileting or transferring needs. On 8/7/24 at 2:43 PM, Surveyor interviewed RN N (Registered Nurse) who stated that whenever there is a change or therapy makes a new recommendation, it is indicated on a Rehab Recommendation to Nursing form and hung in the nursing station. RN N stated that therapy will also give a verbal report to nursing of any changes, who in turn gives a verbal report to the caregiver staff. RN N stated that it is his expectation that the CNAs check the forms to be apprised of any changes in resident status. RN N showed Surveyor an example of the Rehab Recommendation to Nursing form but confirmed that there was no such form in the nursing station for R4. On 8/7/24 at 2:46 PM, Surveyor interviewed DOR L, who stated that there was no written order or form completed for R4 to start a bladder training program, but that she had told R4 verbally. DOR L confirmed that the Rehab Recommendation to Nursing form is how changes in resident care are communicated to staff. Example 2: R2 was admitted to the facility on [DATE] with diagnoses that include, in part: Muscle Wasting and Atrophy, Morbid Obesity, Coronary Artery Disease, Cardiac Arrest, Retention of Urine, Unsteadiness of Feet, Need for Assistance with Personal Care. R2's admission Minimum Data Set (MDS) with a target date of 6/27/24, indicates, in part: Brief Interview of Mental Status (BIMS) of 15, indicating cognitively intact. R2's admission MDS with a target date of 6/27/24 indicates, in part: Section GG - Functional Abilities: Dependent - helper does all of the effort for Toileting Hygiene. Toilet transfer - not attempted due to medical conditions or safety concerns. Section H - Bladder and Bowel: Urinary Toileting Program: Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? Code 0 is entered, meaning: No. Bowel Toileting Program: Is a toileting program currently being used to manage the resident's bowel incontinence? Code 0 is entered, meaning: No. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Urinary Continence: Code 9 is entered, meaning: Not rated, resident has a catheter, urinary ostomy, or no urine output for the past 7 days. Bowel Continence: Code 2 is entered, meaning: Frequently incontinent (7 or more episodes of bowel incontinence, but at least one episode of continent voiding). Of note, R2's indwelling foley catheter was discontinued on 7/2/24. R2's Care Plan contains no focus or goals related to toileting or incontinence. A Focus of Physical functioning deficit related to: Mobility impairment, Self-care impairment was initiated on 6/20/24. Goal: I will improve my current level of physical functioning was initiated on 6/20/24. Intervention: Toileting Dependent Assistance of two was initiated on 6/20/24. A Focus of Needs pain management and monitoring related to low back pain, advanced distention of urinary bladder was initiated on 6/20/24. Goal: Evaluate need for bowel management regimen was initiated on 6/20/24. A Focus of Urinary Tract Infection, potential or actual was initiated on 7/7/24. Intervention: Monitor bowel pattern and evaluate need for bowel management regimen was initiated on 7/7/24. A Focus of Alteration in elimination of bowel and bladder due to Indwelling Urinary Catheter was initiated on 6/20/24 and discontinued on 7/2/24. Goal: I will have a soft formed bowel movement at least every three days initiated on 6/20/24. Intervention: Monitor bowel status frequency initiated on 6/20/24. Of note: R2's Care Plan did not contain a focus, goal, or interventions related to incontinence or aims to improve or maintain bowel functioning. R2's CNA Kardex printed on 8/7/24 states in part: Elimination/Toileting. B&B Bladder Elimination .) Of note: R2's CNA Kardex gives no indication of his continence status or the way in which he is to be toileted. R2's elimination charting beginning on 7/9/24, indicates 60 continent voiding episodes and 24 incontinent episodes for bladder. R2's elimination charting, beginning on 7/9/24, indicates 9 continent episodes of bowel and 28 incontinent episodes for bowel. On 8/6/24 at 9:38 AM, Surveyor observed R2 in his room in his bed wearing a hospital gown, no brief, and entire groin area was exposed and covered in stool that appeared to be quite dry. R2 stated that he had pressed his call button at approximately 8:00 AM and no one had come in yet to assist him with getting cleaned up. R2 stated I've been sitting in my s**t for over an hour. At this point, R2 terminated the interview by telling Surveyor to find another resident to answer questions. R2 stated, I'm not in a good mood right now. I need to get out of this place. I will crawl home if I have to. On 8/7/24 at 1:01 PM, Surveyor interviewed CNA F who stated she didn't know if R2 was continent at admission and was not aware of any changes or decline in his continent status. On 8/7/24 at 1:22 PM, Surveyor interviewed RN/UM K who indicated that there is no bowel and bladder diary or training program for R2. On 8/7/24 at 2:38 PM, Surveyor interviewed CNA M who indicated that R2 was sometimes incontinent and sometimes continent. CNA M was unaware if this was a change of status since admission. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 8/7/24 at 3:12 PM, Surveyor interviewed DON B (Director of Nursing) who stated that bowel and bladder assessments are completed for residents upon admission, and if there is a noted change in resident continence, they will do a three-day bowel and bladder diary. DON B stated that the bowel and bladder diary will be completed for three days, then quarterly, and again with any change of condition that affects their continence status. DON B confirmed that a bowel and bladder diary had not been completed for R4 or R2. DON B stated that if a resident was incontinent, this should be indicated on their care plan with person-centered focus and interventions. DON B confirmed that R4 and R2 did not have a focus or interventions for incontinence. DON B stated that changes in continence status and toileting needs would be indicated on the CNA Kardex and communicated to staff with an alert on the POC (Point of Care) dashboard. DON B stated it was her expectation that the CNA Kardex would have detailed information on how the staff were to assist the residents with toileting. DON B confirmed that the CNA Kardex for R4 and R2 did not have any detailed information for bowel and bladder elimination. The facility failed to implement a robust care plan for residents, implement person-centered goals and interventions, and complete ongoing bowel and bladder assessments, which resulted in a failure to recognize and prevent resident's functional decline in continent status.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This affected 4 of 4 halls and has the potential to affect all 72 residents (R) residing at the facility. R5, R7, R9, R4, and R2 voiced concerns regarding not having enough staff to meet their basic needs. Residents also voiced long call light wait times. Facility staff stated there are tasks that they are not able to get done due to not having enough staff per shift. Evidenced by: The Facility Assessment Tool, dated, 8/18/17, states, in part: .Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents .The purpose of the assessment is to determine what resources are necessary to care for residents .The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require . Example 1: R5 was admitted to the facility on [DATE] with diagnoses including heart failure, respiratory failure, anxiety disorder, major depressive disorder, chronic pain, and muscle wasting. R5's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/22/24, indicates R5 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R5 is cognitively intact. R5 is her own person. On 8/6/24 at 11:20 AM, R5 indicated she often has to wait over an hour for her call light to be answered. R5 indicated she has reported this concern. R5 indicated the facility is short staffed. R5 indicated the staff that are here are very busy, stating they aren't just sitting around. R5 indicated, Money has become the bottom line and not good care. This is the feeling I get now. Example 2: R7 was admitted to the facility on [DATE] with diagnoses including respiratory failure, kidney disease, muscle weakness, difficulty in walking, unsteadiness on feet, and weakness. R7's most recent MDS with ARD of 6/14/24, indicates R7 has a BIMS score of 15 indicating R7 is cognitively intact. R7 is his own person. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/7/24 at 8:39 AM, R7 indicated there are not enough staff at the facility. R7 stated, I am laying in my piss and crap often because there is not enough staff. R7 indicated call light wait times are often an hour to an hour and a half before staff are able to answer. R7 indicated staffing and not having enough staff working is the main problem at the facility. R7 indicated staff know this is a problem and he has reported this. R7 stated, I want to get out of here. Example 3: R9 was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes, respiratory failure, depression, anxiety disorder, and pneumonia. R9's most recent MDS with ARD of 2/14/24, indicates R9 has a BIMS score of 11 indicating R9 is moderately cognitively impaired. R9 is her own person. On 8/7/24 at 10:40 AM, R9 indicated call light wait times are an area of concern. R9 indicated this morning she had to wait an hour and a half before staff could change her because she had a bowel movement. R9 indicated call light times depend on the time of the day. R9 indicated this morning her call light had been on for a half an hour, staff came in her room and turned call light off, and said they were really busy and would be back. R9 indicated an hour later staff came back and assisted her with ADLs (Activities of Daily Living). R9 indicated staff are working hard, but there is not enough staff to get everything done. On 8/7/24 at 9:10 AM, CNA O (Certified Nursing Assistant) indicated there are times CNA O is not able to get to all tasks because of staffing and not having enough staff working per shift. CNA O indicated she is not always able to get to all residents to assist them in washing up and brushing their teeth. On 8/7/24 at 1:10 PM, Scheduler P indicated staffing is based on census and acuity of residents. Scheduler P indicated the facility is doing a full sweep to determine if more staff are needed. On 8/7/24 at 3:13 PM, DON B (Director of Nursing) indicated typically nursing is 1 nurse down each hallway and 7 total CNAs. DON B indicated staffing is based on the census. DON B indicated an acceptable call light wait time is 15-20 minutes. DON B indicated an hour to an hour and a half wait time is not acceptable. DON B indicated understanding on the staffing concerns and staff not getting tasks done. The facility failed to ensure that sufficient nursing staff was provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 50285 Example 4: R4 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Kidney Disease, Type II Diabetes with Diabetic Neuropathy, Dehydration, Major Depressive Disorder, Generalized Anxiety Disorder, Muscle Wasting and Atrophy, Unsteadiness on feet, and Weakness. R4's admission Minimum Data Set (MDS) with a target date of 7/18/24, indicates, in part: Brief Interview of Mental Status (BIMS) of 14, indicating cognitively intact. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R4's Kardex states, in part: .Personal Hygiene extensive assistance of 1 . Transfer Dependent assistance of two with EZ stand lift . R4's Comprehensive Care Plan, dated 7/15/24, states, in part: .Focus: I have a physical functioning deficit related to mobility impairment, self-care. Goal: I will improve my current level of physical functioning. Interventions: Personal Hygiene extensive assistance of 1 .Transfer Dependent assistance of two with EZ stand lift . On 8/6/24 at 9:23 AM, Surveyor interviewed R4, who stated, It's terrible here. There is too much work for these girls. They can't keep up with the demands. R4 indicated that she can't do things by herself and requires assistance from staff and a mechanical lift. R4 stated that at times she has to wait 1-2 hours to be changed, and that this happens almost every day. R4 said that if she puts on her call light at the end of shift time, she will always have to wait 30 minutes or more. R4 stated that she is always sitting in wetness due to incontinence, and states, It makes me feel so degraded that I have to sit here an hour and a half in my pee. I feel like nothing more than an animal. R4 states that she told the staff that came in to assist her that it was ridiculous that she had to wait that long. Example 5: R2 was admitted to the facility on [DATE] with diagnoses that include, in part: Muscle Wasting and Atrophy, Morbid Obesity, Coronary Artery Disease, Cardiac Arrest, Retention of Urine, Unsteadiness of Feet, and Need for Assistance with Personal Care. R2's admission Minimum Data Set (MDS) with a target date of 6/27/24, indicates in part: Brief Interview of Mental Status (BIMS) of 15, indicating cognitively intact. R2's Kardex states, in part: .Personal Hygiene dependent assistance of 2 . Transfer assistance of 2 with Hoyer lift . R2's Comprehensive Care Plan, dated 6/20/24, states, in part: .Focus: I have a physical functioning deficit related to mobility impairment, self-care. Goal: I will improve my current level of physical functioning. Interventions: Personal Hygiene dependent assistance of 2 .Transfer assistance of 2 with Hoyer lift . On 8/6/24 at 9:38 AM, Surveyor observed R2 in his room in his bed wearing a hospital gown, no brief, and his entire groin area was exposed and covered in stool that appeared to be quite dry. R2 stated that he had pressed his call button at approximately 8:00 AM and no one had come in yet to assist him with getting cleaned up. Surveyor observed that R2's call light was not lit when she entered the room. R2 stated that sometimes staff come in and turn the call light off without helping him. R2 indicated that it seemed to be taking the staff longer and longer to respond to call lights. R2 admitted that he required staff assistance for all ADLs (Activities of Daily Living) including mobility and personal hygiene. R2 stated, I've been sitting in my shit for over an hour. I need to get out of this place. I will crawl home if I have to. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/6/24 at 10:45 AM, Surveyor interviewed CNA H who indicated that R2 had been soiled and she assisted in cleaning him up just now. CNA H indicated that she will turn the call light off when she enters the room, even if she has to leave the room to go find additional staff. CNA H stated that she does not need to leave the light on, because she never forgets to go back. Surveyor pointed out that R2 had pushed his call light at 8:00 AM and said that a staff member had come in and shut it off. CNA H stated she had not shut the light off, and this time was the first time she had interacted with R2 on this day. On 8/6/24 at 10:29 AM, Surveyor interviewed CNA G. CNA G indicated there is not enough time each day to get everything done and meet the residents' needs. CNA G stated that she can't get to residents' showers and cares are not being done because there is not enough staff. CNA G stated this happens all the time, every day. CNA G said that she had talked to the Scheduler about her concerns of being short-staffed. CNA G admitted that they are short staffed at the facility, especially after mealtimes, and when staff must assist the residents who smoke to go outside several times per shift. On 8/7/24 at 8:32 AM, Surveyor interviewed CNA I who stated sometimes they are short-staffed, and she is not able to get things done. CNA I indicated that this happens 2-3 times per week, and that residents have to wait longer for help. CNA I stated that she has brought her concerns to management and the Scheduler. On 8/7/24 at 8:40 AM, Surveyor interviewed CNA F. CNA F stated there are not enough staff to get things done, at least twice a week. CNA F stated that charting doesn't always get done and that she gets behind on call lights, resulting in residents having to wait longer than normal. CNA F indicated that residents get frustrated when having to wait, especially to use the bathroom. CNA F said a lot of the CNAs have brought this concern to management and told them that they need more help to care for the residents, but they are told that the census doesn't meet the need for more help. On 8/7/24 at 8:46 AM, Surveyor interviewed CNA J who stated she feels like there is not enough staff and it makes it hard to answer all the call lights when they are short-staffed. CNA J stated that there is a lack of care to the residents when there is not enough staff, and that it makes the residents angry sometimes when they have to wait. CNA J indicated that they are short-staffed at least three times a week. CNA J stated that she has brought her concern up to management, and it is discussed at every staff meeting, but there has been no resolution.