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	11/14/2024

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** 44552 Based on interview and record review, the facility did not ensure residents were treated with respect and dignity and cared for in a manner to enhance their quality of life for 1 (R5) of 3 residents reviewed for resident rights. R5 voiced concern with staff not assisting her out of bed after using the bed pan. R5 indicated the interactions with staff make her feel like a child. R5 was admitted to the facility on [DATE] with a diagnoses including stroke, anxiety disorder, major depressive disorder, pain, adult psychological abuse, kidney failure, muscle wasting, vascular disease, and need for assistance with personal cares. R5 most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/8/24, indicates R5 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R5 is cognitively intact. R5 is own person. R5's Comprehensive Care Plan, states, in part; .Focus R5 has a physical functioning deficit related to left side hemiparesis. Date initiated: 2/16/23 .Toileting: R5 uses the bedpan with assist of one for toileting . Transfer: dependent using Hoyer lift with assist of 2 . On 11/4/24 at 11:37AM, R5 indicated R5 uses a bed pan and often will need to urinate around 2pm daily. R5 indicated once she lays down to use the bed pan in the afternoon, staff will often tell her she can't get back up and to just stay down for the rest of the day. R5 indicated this happens often and R5 believes this has been reported as a concern. R5 indicated R5 will try to hold her urine so she doesn't have to lay down. R5 indicated this makes her feel like a child. R5 indicated staff will say, we aren't playing the up and down game. R5 indicated she has lived too long to be made to feel like a child. On 11/6/24 at 8:32AM, RN V (Registered Nurse) indicated R5 has voiced concerns with staff telling her she has to stay in bed after using the bedpan. RN V indicated the expectation is if a resident wants to get back up after using the bed pan that is their right to get back up. (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 11/6/24 at 9:15AM, CNA Z (Certified Nursing Assistant) indicated R5 will use the bed pan around 2pm every day. CNA Z indicated she has heard R5's concern with not being assisted back up after using the bed pan around 2pm. CNA Z indicated around 2pm is shift change so AM staff may assist R5 in getting on the bed pan and then PM shift would be the staff to assist in getting R5 back up. CNA Z indicated a resident should be able to get back up and telling a resident she can't is not ok. On 11/6/24 at 10:38AM, CNA Y (Certified Nursing Assistant) indicated she is aware of R5 voicing concern with not being assisted in getting back up after using the bed pan and that R5 will ask to use the bed pan around 2pm. CNA Y indicated some staff tell her no and that she's in for the night. CNA Y indicated this frustrates R5. On 11/6/24 at 11:26AM, LPN N (Licensed Practical Nurse) indicated she is aware of R5's concern with PM staff assisting her back up after using bed pan. LPN N indicated the expectation is if a resident wants to get up staff should assist them in doing so. On 11/6/24 at 2:56PM, CNA X (Certified Nursing Assistant) indicated R5 has voiced concerns regarding staff assisting her in getting back up after using bed pan. CNA X indicated staff should assist resident in getting up if resident wants to get up. On 11/7/24 at 8:25AM, NHA A (Nursing Home Administrator) and DSS W (Director of Social Services) indicated it is expected that staff assist resident if they want to get up after using the bed pan. NHA A and DSS W indicated they will discuss with R5 what she would like her daily schedule to look like and update care plan. The facility failed to ensure all residents are treated with dignity and respect.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on observation, interview, and record review, the facility did not ensure that self-administration of medications was determined to be clinically appropriate for 1 of 1 supplemental residents (R1) investigated for self administration of medication. Surveyor observed R1 to have medication at bedside. R1 did not have a self-administration of medication assessment completed. Evidenced by: The facility policy, entitled, Resident Self Administration Medication, dated 3/1/20, states, in part: .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.2. Resident's preference will be documented on the appropriate form and placed in the medical record. 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; . g. The resident's ability to ensure that medication is stored safely and securely.7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. Example 1 R1 admitted to the facility on [DATE] with diagnoses which include, in part: heart failure, unspecified; chronic pain syndrome; and anxiety disorder. R1's MDS (Minimum Data Set) dated 10/22/24, indicates BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 is cognitively intact. R1's Self-Administration of Medication assessment, dated 11/5/24 4:50PM, states, in part: 1. Capable of storing medications in a secure location-marked Fully capable.5. Capable of administering eye drops/ointments-marked Fully capable.12. Capable of administering nasal sprays or drops-marked N/A (Not Applicable). On 11/5/24 at 3:35 PM, RN O (Registered Nurse) stated that R1 self administers eye drop, Restasis. Surveyor observed multiple single dose vials of Restasis on R1's bedside table. On 11/6/24 at 8:40 AM, Surveyor observed Fluticasone nasal spray, Afrin nasal spray, Restasis eye drops, and artificial tears on bedside table while observing medication administration task with LPN N (licensed practical nurse). Surveyor asked R1 if facility staff had spoken with R1 about self-administration of medication and safe medication storage. R1 stated no. LPN N stated that medications for self-administration needed to be locked when in a resident room. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 11:13 AM, Surveyor interviewed DON B (Director of Nursing) who indicated that residents are allowed to self-administer medications if they have the appropriate assessment and are deemed safe. DON B indicated that the assessment needs to be done prior to the resident self-administering medications. DON B indicated that self-administered medications kept in a resident's room are to be stored in a locked drawer or a lock box. (Important to note the Self-Administration of Medication assessment for R1 was dated/timed after observation of medication at bedside and RN stating that R1 self administers. Medications were observed sitting on over the bed table at resident's bedside. There was no lock box for medication storage.)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on interview and record review, the facility did not ensure grievances were documented and thoroughly resolved for 2 of 23 sampled residents (R5 and R29.) R5 voiced concern regarding staff not assisting her in getting back up after she uses the bed pan. R5 indicated this makes her feel like a child and staff will say, We aren't playing the up and down game. R29 voiced a concern regarding being left on the commode and filed a grievance. Staff did not follow-up with R29 regarding the resolution of the grievance. Evidenced by: The facility policy Grievances dated 3/1/19, states in part: .The facility will ensure prompt resolution to all grievances, keeping the resident and the resident representative informed throughout the investigation and resolution process .G. Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority .As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated . Example 1: R5 was admitted to the facility on [DATE] with a diagnoses including stroke, anxiety disorder, major depressive disorder, pain, adult psychological abuse, kidney failure, muscle wasting, vascular disease, and need for assistance with personal cares. R5's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/8/24, indicates R5 has a BIMS (Brief Interview for Mental Status) score of 15 indicating R5 is cognitively intact. R5 is own person. R5's Comprehensive Care Plan states in part: .Focus R5 has a physical functioning deficit related to left side hemiparesis. Date initiated: 2/16/23 .Toileting: R5 uses the bedpan with assist of one for toileting .Transfer: dependent using Hoyer lift with assist of 2 . On 11/4/24 at 11:37AM, R5 indicated she uses a bed pan and often will need to urinate around 2pm daily. R5 indicated once she lays down to use the bed pan in the afternoon, staff will often tell her she can't get back up and to just stay down for the rest of the day. R5 indicated this happens often and R5 believes this has been reported as a concern. R5 indicated she will try to hold urine so she doesn't have to lay down. R5 indicated this makes her feel like a child. R5 indicated staff will say, We aren't playing the up and down game. R5 indicated she has lived too long to be made to feel like a child. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/24 at 8:32AM, RN V (Registered Nurse) indicated R5 has voiced concerns with staff telling her she has to stay in bed after using the bedpan. RN V indicated she tells residents to ask for her if they are having concerns or any issues. RN V indicated the expectation is if a resident wants to get back up after using the bed pan that is their right to get back up. RN V indicated that R5 now uses a Hoyer lift and requires two staff so that takes more time and staffing is a concern. RN V indicated RN V does follow through and will assist residents in filing grievances. RN V did not assist R5 in filing a grievance regarding this concern. On 11/6/24 at 8:46AM, CNA AA (Certified Nursing Assistant) indicated R5 uses a bed pan with assist of staff for toileting needs. On 11/6/24 at 9:15AM, CNA Z (Certified Nursing Assistant) indicated R5 will use the bed pan around 2pm every day. CNA Z indicated she has heard R5's concern with not being assisted back up after using the bed pan around 2pm. CNA Z indicated around 2pm is shift change so AM staff may assist R5 in getting on the bed pan and then PM shift would be the staff to assist in getting back up. CNA Z indicated she typically works AM shifts. CNA Z indicated resident should be able to get back up and telling resident she can't is not ok. CNA Z indicated R5 requires more assistance now since she uses a Hoyer lift with assistance from two staff so this may be the reason why staff are not getting her back up. On 11/6/24 at 10:38AM, CNA Y (Certified Nursing Assistant) indicated she is aware of R5 voicing concern with not being assisted in getting back up after using the bed pan and that R5 will ask to use the bed pan around 2pm. CNA Y indicated some staff tell her no and that she's in for the night. CNA Y indicated this frustrates R5 and CNA Y does not know if it was reported as a grievance. On 11/6/24 at 11:24AM, Med Tech U (Medication Technician) indicated R5 uses bed pan with assistance from staff. On 11/6/24 at 11:26AM, LPN N (Licensed Practical Nurse) indicated she is aware of R5's concern with PM staff assisting her back up after using bed pan. LPN N indicated the expectation is if a resident wants to get up staff should assist them in doing so. LPN N indicated she is unsure if a grievance was filed. On 11/6/24 at 2:56PM, CNA X (Certified Nursing Assistant) indicated R5 has voiced concerns regarding agency staff and assisting her in getting back up after using bed pan. CNA X indicated staff should assist resident in getting up if resident wants to get up. On 11/6/24 at 3:08PM, CNA I (Certified Nursing Assistant) indicated R5 has voiced concerns with agency staff being rude. CNA I indicated CNA I works PM shifts and has seen the issue where R5 is in bed all day, not dressed, and is soaking wet when CNA I comes in for shift. CNA I indicated staff will say there wasn't enough staff on the day shift so they couldn't get to R5. CNA I indicated she sees this occur usually twice a week and is not sure if this was filed as a grievance. On 11/4/24 at 11:37AM Surveyor interviewed R5 regarding concerns with being let in bed wet or not getting dressed. R5 denied these concerns, R5 stated her concern was only regarding getting back up after she uses the bedpan. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 8:25AM, NHA A (Nursing Home Administrator) and DSS W (Director of Social Services) indicated R5's concern with staff assisting in getting back up after using bed pan should have been documented as a grievance. DSS W indicated she will follow up with R5. The facility failed to ensure all grievances were documented and thoroughly resolved. 49434 Example 2: R29 was admitted to the facility on [DATE] with diagnoses that include in part: encounter for orthopedic aftercare, chronic obstructive pulmonary disease, type 2 diabetes mellitus, congestive heart failure, partial traumatic amputation of right foot, and acute osteomyelitis, right ankle and foot. R29's most recent Quarterly Minimum Data Set (MDS) with a target date of 9/6/24, documents a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates the resident is cognitively intact. Section GG indicates R29 is dependent on staff for toileting hygiene, sit to stand, chair/bed-to-chair transfer, and toilet transfer (the ability to safely get on and off a toilet or commode.) On 11/4/24 at 1:24 PM, Surveyor interviewed R29. R29 stated her overall stay has been good, however she filed a grievance around two weekends ago because CNA X (Certified Nursing Assistant) left her on the commode for two hours. R29 stated she has not heard back. On 11/4/24 at 3:44 PM, Surveyor reviewed grievance log from October 2024. R29 had an entry from 10/21/24, that was incomplete. Surveyor notes no resolution listed, no notification date listed, and no staff was assigned as investigator on the log. On 11/4/24 at 3:46 PM, Surveyor requested all documentation regarding this grievance from NHA A (Nursing Home Administrator). On 11/4/24 at 4:02 PM, Surveyor interviewed DSS W (Director of Social Services). Surveyor asked DSS W to explain the grievance process. DSS W stated anybody can file a grievance, sometimes people write them out, but they all get turned into me, then get passed onto the manager of the unit that applies to the grievance, the result is then turned back into me in 5 days. Surveyor asked DSS W what she does if a concern is suspected to be neglect. DSS W stated that the grievance immediately goes to DON B and NHA A to see if it needs to be reported to the State Agency. Surveyor asked DSS W who is responsible for notifying the resident of the outcome of a grievance. DSS W stated the investigating staff member, but she will if that staff member has not. Surveyor asked DSS W if she recalls the grievance filed by R29 on 10/21/24. DSS W stated R29 reported that a CNA left her on the commode for 30 minutes. DSS W investigated, and CNA reported it was 20 minutes as she was assisting another resident at the time. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 4:16 PM, Surveyor interviewed NHA A. Surveyor asked NHA A to describe the grievance process. NHA A stated grievances are first turned into DSS W, and the grievances are brought right to NHA A or DON B (Director of Nursing) depending on the time and if they are reportable or not. The clinical team or department is notified, depending on the complaint. Surveyor asked NHA A who notifies the resident about the outcome of the grievance. NHA A stated the department that handled the grievance or DSS W. DSS W doesn't finish the grievance until it is completely resolved. Surveyor asked NHA A what she would do if she suspected a grievance involved allegations of neglect. NHA A stated she would report it to the state and investigate. Surveyor asked NHA A if she recalled the grievance made by R29 on 10/21/24. NHA A recalled the grievance being discussed in their Stand up meeting and it involved R29 being left on the commode for around 30 minutes waiting for assistance. NHA A also stated she believes NM H (Nurse Manager) conducted this investigation. NHA A recalled that NM H was out sick, but called CNA X and DSS W completed the rest of the investigation. On 11/4/24 at 4:26 PM, Surveyor interviewed NM H. Surveyor asked NM H to describe the grievance process. NM H stated DSS W receives grievances then distributes them to the appropriate department, that department investigates the grievances than returns the grievance to DSS W when completed. Surveyor asks what NM H does with grievances she suspects to be neglect. NM H stated these grievances go right to NHA A for reporting and investigation. Surveyor asked NM H if she recalls the grievance filed by R29 on 10/21/24. NM H stated R29 filed a grievance stating she had to wait around 20-30 minutes to get off the commode. NM H stated she interviewed CNA X and CNA X reported to her that from start to finish R29 was on the commode for around 20 minutes. On 11/5/24 at 2:14 PM, Surveyor reviewed documents provided by NHA A regarding the investigation of the grievance. Documentation corroborates staff statements regarding R29's wait time to be around 20-30 minutes. A call light audit was also conducted 10/22/24-10/25/24 with no pertinent findings. Surveyor requested copy of grievance log. On 11/7/24 at 8:34 AM, Surveyor interviewed NHA A and DSS W. Surveyor showed NHA A and DSS W the log that now had an investigator name and a resolution listed, where before it was blank. Surveyor asked NHA A when the grievance log was filled in as Surveyor had timestamped and recorded previous observation. NHA A confirms the log was filled in recently. Surveyor asked NHA A if residents should be notified of the outcome of their grievance. NHA A stated, yes.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments were coded correctly for 2 of 20 residents (R76 and R10) reviewed for MDS accuracy. R76's MDS assessment indicated that R76 discharged due to being deceased while R76 discharged home to the community. R10's Minimum Data Set (MDS) assessment did not indicate R10 had a gradual dose reduction (GDR) on her [DATE] MDS. Evidenced by: Example 1 R76 admitted to the facility on [DATE] after a fall at home. She had the following diagnoses severe sepsis secondary to a urinary tract infection from e. coli bacteria. R76's admission assessment, signed [DATE], indicates R76 admitted to the facility for a short-term rehab stay. R76's discharge summary, dated [DATE], includes Patient will be discharged home. She will be provided a 30-day supply of medications. Patient to follow up with primary care provider within 2 weeks and follow up with nephrology. Patient is understanding and agreeable . R76's MDS, with ARD (Assessment Reference Date) of [DATE], indicates R76 discharged from the skilled nursing facility, her return was not anticipated, and this was an unplanned discharge due to deceased status. (It is important to note R76 discharged to the community, but her MDS indicates R76 is deceased .) On [DATE] at 8:49 AM DON B (Director of Nursing) and Corporate RN C (Registered Nurse) indicated R76 discharged home to the community. Surveyor, DON B, and Corporate RN C reviewed R76's MDS section A. DON B stated, We should not have marked deceased . We will have to do an addendum. We will re-educate the staff who filled this section out. On [DATE] at 9:01 AM MDS Coordinator NN indicated the facility staff who completed this section should not have marked deceased and an addendum needs to be made. 49436 Example 2 R10 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, dementia with psychotic disturbance, and anxiety disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's quarterly MDS (Minimum Data Set) dated [DATE], question section N0450 B: Has a gradual dose reduction been attempted is marked NO, indicating a GDR (Gradual Dose Reduction) has not been attempted. Section N0450 C: Date of last attempted GDR: was not answered. On [DATE], R10's Risperdal oral tablet 0.5 mg was reduced from four times a day to three times a day. R10's physician orders dated [DATE] include Risperdal oral tablet 0.5mg three times a day. On [DATE] at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) regarding the MDS process. DON B indicated the facility follows the Resident Assessment Instrument (RAI) Manual for completing the MDS. DON B indicated the [DATE] quarterly MDS should have been completed correctly to include R10's GDR that was completed on [DATE].

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on observation, interview, and medical record review, facility staff did not provide care and treatment in accordance with professional standards of practice for 2 of 22 sampled residents (R56 and R68). Surveyor observed R56's Medtronic to be unplugged rendering it unable to transmit data timely to the cardiac clinic that monitors R56's pacemaker. R68 was not weighed daily per physician order. Evidenced by: The facility policy, Weight Monitoring, no date, states, in part; .Based on resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range .5. A weight monitoring schedule will be developed upon admission for all residents: .d. If clinically indicated- monitor weight daily . Example 1 R56 admitted to the facility on [DATE] with diagnoses including presence of cardiac pacemaker. On 11/4/24 at 2:04 PM facility staff unplugged R56's Medtronic/pacemaker monitoring system from a power strip that laid alongside R56's bed. On 11/5/24 at 11:58 AM during an interview R56 indicated his Medtronic has been unplugged since yesterday. R56 indicated the unit transmits data to the cardiology clinic and needs to be plugged in at all times. On 11/5/24 at 12:00 PM RN JJ (Registered Nurse) and DM R (Dietary Manager) indicated the machine is unplugged and it should be plugged in at all times. RN JJ and DM R indicated R56's care plan did not contain goals or interventions related to R56's Medtronic and it should. RN JJ indicated she could not locate a physician order related to the Medtronic either. On 11/7/24 at 9:49 AM Surveyor completed a phone interview with RN KK, RN KK works at the cardiology clinic. RN KK indicated R56's machine is to be plugged in all the time to transmit data to the clinic that is monitoring R56's pacemaker. RN KK indicated if the machine is not plugged in, the clinic will not be alerted if R56 has a cardiac event. On 11/7/24 at 10:31 AM R56 stated, It sits by my bed and is supposed to be plugged in all the time. It reads my Pacemaker. (continued on next page)

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Watertown Health Care Center	121 Hospital Dr Watertown, WI 53098

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/7/24 at 10:32 AM LPN F (Licensed Practicing Nurse) and RN H indicated R56's Medtronic should always be plugged in so data can be transmitted to the cardiology clinic that is monitoring R56's pacemaker. RN H indicated she thinks if it is plugged back in the data will still transmit from the time it was unplugged, but the data would not transmit timely. LPN F indicated if an event occurs during the time the machine is unplugged the clinic would have no way of being alerted. On 11/7/24 at 10:34 AM CNA MM (Certified Nursing Assistant) indicated she is unsure if R56's Medtronic should always be plugged in. CNA MM indicated things like this should be on R56's care plan so everyone knows that it needs to be plugged in. On 11/7/24 at 10:44 AM Corporate RN C and NHA A (Nursing Home Administrator) indicated R56's care plan should contain goals and interventions related to his Medtronic and it should be plugged in all the time as data can't transmit timely without the machine being plugged in. 44552 Example 2 R68 was admitted to the facility on [DATE] with a diagnoses including fracture with routine healing, pulmonary disease, unsteadiness on feet, panic disorder, and congestive heart failure. R68's order states, in part; .daily weight every shift for CHF (congestive heart failure) update MD if weight gain 3lbs .start 8/30/24 . Surveyor reviewed R68's daily weights. R68 was missing 9 daily weights for the month of October 2024. On 11/7/24 at 11:57AM, RN BB (Registered Nurse) indicated R68 gets a lot of visitors daily. R68 will tell staff that he doesn't want to get weighed at that specific moment because family may be visiting. RN BB indicated staff may forget to come back and weigh him or there may be a shift change and it doesn't get communicated that it still needs to get done. RN BB indicated she will remind staff to weigh residents and the expectation is if a resident has an order for daily weights that it is done daily. On 11/7/24 at 12:05PM, DON B (Director of Nursing) indicated if a resident has an order for a daily weight the expectation is that the weight is done daily. DON B indicated if a resident was to refuse then that refusal should be documented. DON B indicated understanding regarding R68's missing weights.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49436 Based on observation, interview, and record review, the facility failed to ensure residents (R) received adequate supervision to prevent accidents for 2 of 2 sampled residents (R57 and R56) and 3 supplemental residents (R36, R63, and R35) reviewed for the charging of their electric wheelchairs. R57's electric wheelchair was plugged in and charging in his room. R35's electric wheelchair was in her room along with her charging cord for her electric wheelchair. Surveyor observed R56's power wheelchair charger plugged into the wall in room. Surveyor observed R36's power wheelchair charger plugged into the wall in room. Surveyor observed R63's power wheelchair charger plugged into the wall in room. This is evidenced by: The facility policy Electric Wheelchair Policy, implements 3/8/20, states, in part: Due to the potential for fire or explosion, all electric wheelchairs will be recharged in an area which is not used by the residents for sleeping and which has no oxygen in the vicinity. Example 1 On 11/5/24 at 11:34 AM, Surveyor observed R57's electric wheelchair plugged in and charging in his room. Example 2 On 11/5/24 at 3:14 PM, Surveyor observed R35's electric wheelchair in her room. The electric wheelchair charging cord was plugged into the wall in her room, although the cord was not plugged into the wheelchair. On 11/4/24 at 2:11 PM, Surveyor interviewed CNA K (Certified Nursing Assistant) about where the facility charges the residents electric wheelchairs. CNA K stated staff charge the residents' electric wheelchairs in their rooms. CNA K stated she was uncertain if the electric wheelchairs should be charged in the residents' rooms or not. On 11/4/24 at 2:15 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) about where the facility charges the residents electric wheelchairs. LPN F stated the facility charges the electric wheelchairs in the residents' rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/24 at 2:16 PM, Surveyor interviewed DON B (Director of Nursing) about where the facility charges the residents electric wheelchairs. DON B indicated the electric wheelchairs should be charged in the big room by the shower room on the north wing. DON B indicated they should not be charged in the resident's room because of the batteries. 38882 Example 3 R36 admitted to the facility on [DATE] with Multiple Sclerosis. R36 utilizes a power wheelchair for mobility. On 11/4/24 at 2:00 PM Surveyor observed R36's power wheelchair charging unit to be plugged into an outlet in his bedroom. During an interview COTA HH (Certified Occupational Therapy Assistant) indicated there are at least 4 electric wheelchairs in the house and the staff charge them in each of the residents' rooms. On 11/4/24 at 2:02 PM R36 stated, They charge it in my room, pointing out the charger unit connected to the outlet in his room. On 11/4/24 at 2:12 PM CNA II (Certified Nursing Assistant) indicated the facility charges all of the power wheelchairs in the resident's rooms. CNA II indicated he was not sure if the facility should charge the power wheelchairs inside of resident rooms, stating No one ever talked to me about where they are supposed to charge them. On 11/4/24 2:16 PM DON B (Director of Nursing) indicated power wheelchairs should not be charging in resident rooms. On 11/4/24 at 2:24 PM INHA D (Interim Nursing Home Administrator) indicated power wheelchairs are not supposed to be being charged in resident rooms and they need to be behind a fire safe door. Example 4 R56 admitted to the facility on [DATE]. R56 utilizes a power wheelchair for mobility. On 11/4/24 at 2:00 PM during an interview COTA HH indicated there are at least 4 electric wheelchairs in the house and the staff charge them in each of the residents' rooms. On 11/04/24 at 2:04 PM R56 stated, They charge it in the bathroom. Surveyor observed R56's power wheelchair charging system to be connected to an outlet in R56's bathroom. On 11/4/24 at 2:12 PM CNA II indicated the facility charges all the power wheelchairs in the resident's rooms. CNA II indicated he was not sure if the facility should charge the power wheelchairs inside of resident rooms, stating No one ever talked to me about where they are supposed to charge them. On 11/4/24 02:16 PM DON B indicated power wheelchairs should not be charging in resident rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/4/24 at 2:24 PM INHA D indicated power wheelchairs are not supposed to be being charged in resident rooms and they need to be behind a fire safe door. Example 5 R63 admitted to the facility on [DATE]. R63 utilizes a power wheelchair for mobility. On 11/4/24 at 2:00 PM during an interview COTA HH indicated there are at least 4 electric wheelchairs in the house and the staff charge them in each of the residents' rooms. On 11/4/24 at 2:08 PM Surveyor observed R63's power wheelchair's charging unit to be plugged into the wall in his bedroom. R63 stated, I charge it right in my room, as he pointed to the outlet with the charger connected. On 11/4/24 at 2:12 PM CNA II indicated the facility charges all the power wheelchairs in the resident's rooms. CNA II indicated he was not sure if the facility should charge the power wheelchairs inside of resident rooms, stating No one ever talked to me about where they are supposed to charge them. On 11/4/24 02:16 PM DON B indicated power wheelchairs should not be charging in resident rooms. On 11/4/24 at 2:24 PM INHA D indicated power wheelchairs are not supposed to be being charged in resident rooms and they need to be behind a fire safe door.

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434 Based on interview and record review, the facility did not ensure that parenteral medications were administered consistent with professional standards of nursing practice for 1 of 1 resident (R29) reviewed for parenteral medications. R29 was readmitted to the facility on [DATE] with a midline for IV (intravenous) antibiotic treatment following a diagnosis of sepsis secondary to urinary tract infection with E. coli bacteremia (bacteria in the blood). On 7/27/24, LPN P (Licensed Practical Nurse) attempted to flush the midline and was unable to, noting that some of the normal saline ran down R29's arm. LPN P reported this to RN O (Registered Nurse) around 2:20 PM on 7/27/24. RN O did not complete an immediate assessment and when he did complete an assessment, he found the line to appear infiltrated (catheter delivering fluid into tissues instead of the vein). RN O attempted to remove the catheter without a physician order, and the midline broke, retaining a piece of catheter in R29's left arm. R29 was then sent to the emergency room at 11:30 PM that night, 9 hours after the initial concern was raised by LPN P. R29 was found to have a 10 cm (centimeter) length of catheter retained in her upper arm that required a surgical procedure to remove it. After several failed attempted procedures and a long referral process, R29 finally had the catheter removed on 10/7/24. The facility's failure to monitor and document monitoring of the midline site, to measure and record the measurement of the midline, to notify the provider following LPN P's concern of the midline not flushing, to complete a timely RN assessment following notification of a problem with the midline, and conduct removal procedures according to policy and current standards of practice caused R29 to retain 10 centimeters of midline catheter within her brachial vein. This put R29 at risk for pulmonary embolism (blockage of lung vessels by the catheter), stroke, or death. This created a finding of Immediate Jeopardy beginning on 7/27/24. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the finding of Immediate Jeopardy on 11/11/24 at 1:23 PM. The immediacy was removed on 11/13/24 and continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan. This is evidenced by: The facility policy titled, Intravenous Therapy, dated 10/1/22, states in part: .Compliance Guidelines: . 8. IV sites are changed every seventy-two (72) hours unless otherwise ordered by the physician, if the site becomes infiltrated, or if the resident exhibits signs and symptoms of phlebitis. 9. In the event an IV is left in place longer than seventy-two hours, IV site care will be done every twenty-four (24) hours . 13. IV sites are checked every shift or as per facility policy and PRN (as needed) for signs and symptoms of infection or inflammation .14. The nurse will assess for associated risks due to IV fluid administration such as: a. infiltration b. bruising c. embolism (air or blood) d. phlebitis . 15. IV documentation is recorded in the nurses' notes and/or Medication Administration Record. 16. The nurse will notify the practitioner to assess the need for continuation of the catheter if not being used for IV fluids or medication and will discontinue as per the practitioner's order . (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled, Midline Catheter Flushing-Lock-Removal, dated 11/28/23, states in part: Policy: It is the policy of this facility to ensure that midline catheters are flushed, locked and removed consistent with current standards of practice . Compliance Guidelines: . 2. Midline catheters will be flushed and aspirated for blood return prior to each infusion to assess catheter and functionality and prevent complications . 5. The catheter will be locked after the final flush to prevent catheter occlusion if used intermittently. If it is a multilumen catheter, all lumens must be flushed regularly . 7. The facility will use a flush such as a heparin flush solution or preservative-free normal saline solution to lock the catheter as per facility protocol. 8. Syringes no smaller than 10 mL (milliliters) should be used when assessing patency to avoid catheter damage . 10. Midline catheter removal will be performed by the practitioner or nurse in accordance with facility policy and your state's nurse practice act. 11 . Obtain a physician's order for removal. Removal: 1. Verify the physician's orders . 6. Place resident in sitting or recumbent position. 7. Carefully remove the dressing and dispose in appropriate receptacle. 8. Remove stabilization device or sutures, if present . 10. Hold sterile gauze over insertion site and with dominant hand remove the catheter using gentle, even pressure . 11. Have the resident perform the Valsalva maneuver unless contraindicated, or exhale as the last segment of the catheter is withdrawn to prevent an air embolism. 12. Apply pressure to the site with gauze for about 30 seconds or hemostasis is achieved. 13. Apply a petroleum-based ointment to the exit site and cover with an occlusive gauze dressing or a transparent semipermeable dressing for at least 24 hours. 14. Label the dressing with date and initials. 15. Encourage resident to lie flat or reclining for at least 30 minutes to reduce risk for air embolism. 16. Inspect the catheter to ensure that the tip is intact and not damaged and entire length of catheter has been removed . 20. Document the procedure . According to the National Library of Medicine, midline peripheral catheters have a large catheter (16-18 gauge) that allows for rapid infusions. Midline catheters are typically inserted into the basilic, cephalic, or brachial veins of the upper arm with the proximal tip placed near the level of the axilla (armpit). They are much longer and inserted deeper than a peripheral IV (intravenous access), but do not extend into a central vessel, so are not considered a central line. (Source: https://www.ncbi.nlm.nih.gov/books/NBK594499/) According to the Center for Disease Control and Prevention's (CDC) recommendation for catheter education, training, and staffing, healthcare personnel should be educated regarding maintenance of intravascular catheters. Periodic assessment of knowledge of and adherence to guidelines for all personnel involved in the insertion and maintenance of intravascular catheters should be conducted. Additionally, designate only trained personnel who demonstrate competence for the insertion and maintenance of peripheral and central intravascular catheters. The CDC also recommends evaluation of the catheter insertion site daily by palpation to discern tenderness and by inspection. They also recommend removal of peripheral venous catheters if the patient develops signs of phlebitis (vein inflammation), infection, or a malfunctioning catheter, along with promptly removing any intravascular catheter that is no longer essential. The CDC's recommendations for dressings include not submerging the catheter site in water. (Source: https://www.cdc.gov/infection-control/hcp/intravascular-catheter-related-infections/summary-recommendations.html) R29 was admitted to the facility on [DATE], with diagnoses that include, in part: encounter for orthopedic aftercare, chronic obstructive pulmonary disease, type 2 diabetes mellitus, congestive heart failure, partial traumatic amputation of right foot, and acute osteomyelitis, right ankle and foot. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R29's most recent Quarterly Minimum Data Set (MDS) with a target date of 9/6/24, documents a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates the resident is cognitively intact. On 7/17/24, R29's Hospital Discharge paperwork states that she was admitted for sepsis secondary to a urinary tract infection with E. coli bacteremia. While in the hospital, the resident had a midline placed in her left upper arm for antibiotic administration. On 7/20/24, R29 was discharged from the hospital and readmitted to the facility with the midline in place for continued antibiotic administration. NP FF (Nurse Practitioner) wrote a note with a date of service of 7/21/24 with an assessment and plan for history of UTI (urinary tract infection) and sepsis is to continue meropenem (antibiotic) for a total of a five-day course and to monitor for any signs of infection recurrence or complications. R29's Physician Orders for July 2024, state in part: Ertapenem Sodium Injection Solution Reconstituted 1 GM (Gram) (Ertapenem Sodium) Use 1 vial intravenously in the morning for E. coli in blood (bacteremia) for 55 days Give intravenous via midline in LUE (Left Upper Extremity) Heparin Sod (Sodium) Lock Flush Intravenous Solution (Heparin Sodium (Porcine) Lock Flush) Use 5 cc (cubic centimeters) intravenously one time a day for Midline Left AC (antecubital space, space inside of elbow) Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) Use 10 ml intravenously every day shift for Flush Midline before and after IV ABT (Antibiotic) administration. (Of note: The Medication Administration Record (MAR) and Treatment Administration Record (TAR) from July 2024, contains no documentation or orders regarding dressing changes, midline site assessment, measurement, or monitoring.) R29's Comprehensive Care Plan states in part: Focus: Potential for infection/complication r/t (related to): IV use for ABO (antibiotic) for bacteremia. Date initiated: 7/22/24. Goal: Will be free from signs and symptoms of infection. Date initiated: 7/23/24. Target Date: 12/10/24. Interventions: Administer IV fluids/medications per MD (medical doctor) order, Change IV tubing, dressings, and caps according to line type change schedule in IV order set or more frequently as needed. Monitor for infiltration. Monitor IV site for s/s (signs and symptoms) of infection: redness, inflammation, drainage, irritation to the vein. Notify physician of any abnormalities. PICC. All interventions initiated on 7/22/24. (Of note: The care plan lists the wrong catheter type and does not include basic midline site care such as protecting the Tegaderm or bandage when showering, changing the dressing, or maintaining a measurement of how long the catheter is from the site.) (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NP FF wrote a note with a date of service of 7/22/24 that states R29 reported midline IV site discomfort. The assessment and plan for the IV site discomfort is to continue to use the midline as it flushes without resistance and no erythema or swelling is present, monitor the site for any signs of infection or complications, provide patient education on proper care of the midline site. R29's Medication Administration Record indicates she was administered her prescribed Ertapenem (antibiotic) as ordered from 7/21/24 to 7/25/24. On 7/25/24 at 00:30 (12:30 AM), a progress note was written by LPN CC which states: Res (resident) continues to receive IV abt (antibiotic) as ordered for bacteremia. No adverse reaction noted. (Of note: No progress notes regarding resident's midline are written on 7/26/24) On 7/27/24 at 14:24 (2:24 PM), a progress note was written by LPN P which states: Writer went in to flush res (resident) mid line. Res mentioned that it might not flush, because last flush res had had went back down arm. Writer attempted a flush with scant amount of NS (normal saline) but NS just rolled down res arm instead. Writer updated [Name] RN O to assess IV. (Of note: There are no notes written about the previous flush attempt where the midline was not working correctly and the saline ran down R29's arm.) On 11/7/24 at 1:50 PM, Surveyor interviewed LPN P. LPN P indicated she was working on 7/27/24, but no longer works at this facility. LPN P stated that she gave report to RN O about 2:20 PM, regarding the midline not flushing. LPN P stated she can't remember any additional information about the incident. On 7/27/24 at 23:34 (11:34 PM), a progress note was written by RN O which states: Writer started process of removing midline from resident. Upon removal of dressing and assessment of skin, unable to locate midline lumen insertion point. Writer determines midline has broken off into vein, coinciding with earlier reports from dayshift LPN P [Name] that midline did not flush. Area cleansed, dressed with gauze and tape. On 11/6/24 at 4:35 PM, Surveyor interviewed RN O. RN O described the standard of practice for both administering IV medication and removing a midline. Surveyor asked RN O what R29's midline site looked like when he entered the room. RN O states that it looked swollen and bruised and appeared to be infiltrated, and that he was going to remove it. As he pulled the Tegaderm off, the catheter broke and some of the catheter was still in R29's skin. Surveyor asked RN O if he received any education or training from the facility prior to caring for R29's midline. RN O stated no. Surveyor asked RN O if he completed any competency checks prior to caring for R29's midline. RN O stated no. On 11/7/24 at 3:00 PM, Surveyor interviewed RN O for the second time. Surveyor asked RN O if he had obtained an order to remove the midline. RN O indicated he would never remove a midline without an order. Surveyor asked RN O who he obtained the order from. RN O stated he doesn't remember. Surveyor asked RN O if he obtained a telephone or verbal order, should that order have been transcribed into the electronic medical record. RN O stated yes, but that he was too busy trying to transfer R29 to the emergency department. Surveyor asked RN O what he did after the Tegaderm was removed and the piece had broken off. RN O indicated he covered the site with a 4x4 sterile gauze and tape and notified the provider immediately. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Of note: LPN P reported to RN O around 2:20 PM that R29's midline was not flushing. R29 was not assessed, provider was not notified, and R29 was not sent out until around 11:30 PM, 9 hours after discovery of the problem. Additionally, there is no record of an order being given to remove the midline.) On 7/27/24 at 23:32 (11:32 PM), a triage note was written by RN DD, who is employed by an outside hospital. This note states: The patient comes from [Facility Name] after the nurse was removing her midline and part of it was missing. The patient brought the external piece of the midline and states the internal part is still in her. The patient denies any pain to that area of her arm. On 7/28/24, an x-ray was taken confirming 10 cm of a linear radiopaque density is found in R29's left upper extremity. On 7/28/24 at 01:41 (1:41 AM), a note was written by DO (Doctor of Osteopathic Medicine) EE, who is also employed by an outside hospital. This note states in part: . She had a midline catheter placed so that she could complete her course of meropenem at home for her E coli bacteremia. This was stopped however yesterday when the catheter was flushed her arm swelled up. Then today the hub of the catheter broke off without the rest of the catheter coming with it. She presented today with x-ray findings of the catheter still in her arm. This note also indicates that DO EE attempted a sterile procedure utilizing local anesthesia to numb the area and an ultrasound to visualize the catheter. DO EE made an incision down to the brachial arterial sheath but was unable to identify the catheter in the brachial vein, and due to the risk to the brachial artery had to stop the procedure. On 7/28/24 at 03:53 (3:53 AM), hospital documentation shows R29 was transferred from one hospital to another outside hospital for further care and treatment. R29's discharge paperwork from the second outside hospital indicates that she was admitted from 7/28/24 to 7/30/24. Discharge diagnosis includes in part: vascular catheter issue s/p (status post) IR (interventional radiology) attempt to retrieve, which was unsuccessful. The hospital course indicates R29 reported that her midline had been flushing ok up until Friday (7/26/24) when the flush went all over. R29 also reported her midline seemed to flush fine on Thursday (7/25/24). Additionally, R29 reported that the line was to be discontinued yesterday (7/27/24) but when the RN took the band aid off, it was broken. Under the section labeled ED Course, it states in part: . IR attempted to retrieve under sedation, but unsuccessful. Per IR, she will need upper arm brachial exposure in the event of phlebitis or infection to perform a venotomy and removal of the catheter. The catheter will be very unlikely to [sic] move due to the thrombosed vein. Plan to keep in place and monitor for phlebitis or infection. Would recommend no IVs or BPs (blood pressures) to LUE (left upper extremity) . NP FF wrote a note with a date of service of 8/13/24. This note indicates an Assessment & Plan for left upper extremity pain and PICC line remnants [sic] of scheduling an appointment for vascular surgery to remove the remaining catheter and to continue to monitor the site for any signs of infection, erythema, discharge, swelling, or discoloration. NP GG's note from 10/7/24, indicates that R29 had the catheter removed on this date. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/7/24 at 10:40 AM, Surveyor interviewed NP FF. Surveyor asked if NP FF assessed and flushed the midline herself. NP FF stated she assessed the site but did not flush the midline. Surveyor asked NP FF if she gave an order to remove the midline. NP FF stated, I'm 100% sure someone did. Surveyor asked NP FF if she would expect staff to conduct dressing changes. NP FF indicated once every seven days or when soiled. Surveyor asked NP FF if she would expect staff to be doing measurements of the line to ensure the line wasn't migrating, which is current standard of practice. NP FF indicated she would not expect staff to measure the external line. Surveyor asked NP FF if she expects staff to document things like dressing changes or removal of the midline. NP FF stated she doesn't speak to staff expectations at the facility. On 11/7/24 at 11:57 AM, Surveyor interviewed R29. Surveyor asked R29 what her experience was like throughout this process. R29 indicated that initially she was ok since things were getting taken care of, however after she returned from the second outside hospital, she was experiencing a lot of pain and discomfort. She also indicated that this pain was worse than her normal chronic pain due to the unpredictability of pain occurrence. R29 described not knowing what kind of action or motion caused the pain so she was always surprised when it started hurting which made it worse. Surveyors requested all training, education, and competency records for all LPNs and RNs working in the facility for the past year. LPN CC last received training on managing intravenous devices on 10/5/24. A description of this training was obtained from the facility, and it does review vascular access devices, care of vascular access devices, and risks of vascular access devices. Documentation does not list any other dates this training was completed. Also of note, the facility provided a document titled, Medication Administration Competency Test that is undated. Surveyor notes only two questions that could be applicable specifically to midlines or central venous catheters and asks about heparin locks and using the SASH flushing method (Flush Saline, administer medications, Flush Saline, Administer Heparin). LPN CC has the question regarding heparin locks marked incorrect. Surveyor also notes these questions contradict each other, as the SASH method requires a heparin lock following each infusion, whereas the correct answer indicated for the heparin lock question requires this to only be done one time per day. Additionally, several documents titled, Licensed Nurse Competency were provided to Surveyor with the most recent date 2/24/24. Under the section titled, Medication Management, there are many topics including one titled, IV Therapy; no further specifics are listed, especially pertaining to midlines. No documentation of competency checks was provided regarding care of a resident with a midline. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN P last received training on managing intravenous devices on 4/18/24. A description of this training was obtained from the facility, and it does review vascular access devices, care of vascular access devices, and risks of vascular access devices. Also of note, the facility provided a document titled, Medication Administration Competency Test that is dated 12/3/19. Surveyor notes only two questions that could be applicable specifically to midlines or central venous catheters and asks about heparin locks and using the SASH flushing method. LPN CC has the question regarding heparin locks marked incorrect. Surveyor also notes these questions contradict each other, as the SASH method requires a heparin lock following each infusion, whereas the correct answer indicated for the heparin lock question requires this to only be done one time per day. Additionally, several documents titled Licensed Nurse Competency were provided to Surveyor with the most recent dated 12/8/23. Under the section titled Medication Management, there are many topics including one titled IV Therapy; no further specifics are listed, especially pertaining to midlines. No documentation of competency checks was provided regarding care of a resident with a midline. (Of note: According to the Wisconsin Nurse Practice Act, N6.03(1), LPNs may only accept patient care assignments which the LPN is competent to perform and perform delegated acts beyond basic nursing care under the direct supervision of an R.N. or provider.) RN O also has a document titled Licensed Nurse Competency dated 8/2 with no year listed. Under the section titled, Medication Management, there are many topics including one titled, IV Therapy. RN O's records came with an undated guideline titled IV Competency without any facility designation or markings. This document contains topics related to vascular access devices, maintenance, dressing changes, and midline removal. No names, signatures, dates, or competency checks are listed on this document. There is no indication if or when this information was provided to RN O. The facility did not provide Surveyor with any documentation of competency checks regarding care of a resident with a midline for RN O. The facility provided Surveyor with an additional 17 Licensed Nurse Competency documents with the same notation under the section titled, Medication Management, there are many topics including one titled IV Therapy. Of these 17 documents, 14 had only the month and day documented, with no year. One additional Education/Training sheet was provided to Surveyor with 6 RNs, the DON (Director of Nursing), and one LPN listed that is dated 8/1/24. The IV Therapy policy is attached that is described above. However, the Midline Catheter Flushing-Lock-Removal policy is not. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/7/24 at 10:10 AM, Surveyor interviewed LPN N. Surveyor asked LPN N what her responsibilities were for the care of a resident with a midline. LPN N stated she flushes the midline, observes and monitors for signs of infection and pain, and makes sure everything is intact. Surveyor asked LPN N if she does dressing changes. LPN N stated, no, only the RNs do dressing changes. Surveyor asked LPN N what she would do if she noticed anything abnormal with the midline. LPN N stated she would call for another LPN/RN immediately. Surveyor asked what LPN N would do if she noticed there was bleeding, redness, or swelling at the site. LPN N stated, notify the nurse manager as soon as possible and notify the physician. Surveyor asked LPN N if she every completed a competency check for midlines. LPN N stated yes, I believe so, it was a long time ago. Surveyor asked LPN N how she knew how much fluid to flush into the midline. LPN N stated she would check the order. Surveyor asked LPN N what she looks for as she flushes a midline. LPN N stated to make sure it's flushing, if it's not blocked, and that the cap is on securely. Surveyor asked what LPN N would do if she noticed the midline was leaking. LPN N stated she would call the Nurse Practitioner, get the nurse manager to get the dressing off and check the line. Surveyor asked LPN N how she would know how long the line should be. LPN N stated the line should be measured with some documentation of how long it's supposed to be. On 11/7/24 at 10:13 AM, Surveyor interviewed RN BB. Surveyor asked RN BB how she cares for a resident with a midline. RN BB stated she monitors the site and line for signs and symptoms of infection, keeps the site clean, conducts sterile dressing changes, and makes sure the lines and dressing stay in place. Surveyor asked RN BB how she knows when the midline needs to be flushed. RN BB stated she flushed the line before and after medications, and once a shift with a heparin lock. Surveyor asked RN BB how she conducts dressing changes. RN BB stated that this is a sterile process, so sterile gloves and masks need to be worn, the site should be cleaned, and measurements should be made of the line. Surveyor asked RN BB how she knows when to do dressing changes. RN BB stated by physician order. Surveyor asked RN BB how she knows when to remove the midline. RN BB stated by physician order. Surveyor asked what RN BB would do if she found that the midline was leaking. RN BB stated she would contact the Nurse Practitioner and [Company Name] if the midline needs to be replaced. Surveyor asked RN BB if she has ever had a competency check related specifically to midlines. RN BB stated yes. Surveyor asked RN BB, who was working on R29's unit at the time of interview, if she recalled the incident with R29's midline. RN BB stated she does, and that she took care of the midline during the week on the day shift and did not notice any issues with the midline. Surveyor asked RN BB if she recalled the measurements for R29's midline, as they were not documented. RN BB stated she does not recall, but the measurements should be charted and believes this midline had the measurement markings directly on the midline. Surveyor asked RN BB how she delegates care of midlines to LPNs. RN BB stated she does not delegate this task and prefers to care for her resident's midlines herself. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/7/24 at 10:31 AM, Surveyor interviewed LPN F. Surveyor asked LPN F what she can do to care for a midline. LPN F stated she can't do anything with it unless they have a grenade (small ball of medication that is attached to the midline that self-administers medication). Surveyor asked LPN F if she can flush midlines. LPN F stated that she can. Surveyor asked LPN F how she knows when she's supposed to flush the line. LPN F stated she would check the order in the medication administration record. Surveyor asked LPN F how dressing changes are completed. LPN F stated that RNs do dressing changes. Surveyor asked LPN F what she would do if she noticed something different with the midline. LPN F stated she would get the RN as soon as possible to observe the site. Surveyor asked LPN F if she received any education from the facility on IVs. LPN F stated she received training on grenades. LPN F also stated they showed her how to flush and hook up the grenade with a return demonstration. LPN F stated that she has been agency staff at this facility for two years and prior to that was regular staff. LPN F estimates her last IV training to be around four years ago and said that she has not received additional training since coming back as agency staff around two years ago. Surveyor asked LPN F what she would do if she attempted to flush a line and met resistance. LPN F stated she would talk to the RN about it. On 11/7/24 at 2:50 PM, Surveyor interviewed LPN E. Surveyor asked LPN E what she does to care for midlines. LPN E stated she can't change dressings, but she can flush them and start IV medication. LPN E noted she is in school to become an RN and has documentation to show she has completed an IV therapy class in school. Surveyor asked LPN E what she checks for when caring for a resident with a midline. LPN E stated she would look for signs and symptoms of infection and that the dressing is intact. LPN E stated she would clean the port or remove the cap cover to use the line. LPN E also notes she has seen one with clamps but it's been months since she had a resident with a midline. Surveyor asked LPN E what she would do if she met resistance while trying to flush a midline. LPN E stated she would replace the cap and get a nurse manager. Surveyor asked LPN E if she would remove the midline. LPN E stated no, she is not allowed to do that and there should be an order to remove the midline. Surveyor asked LPN E if she has completed a competency check for caring for residents with a midline. LPN E stated she cannot remember, she believes it is on the [Name] outside training and that they have come around with the steps before. Surveyor asked what LPN E would do if the midline was broken or falls apart. LPN E stated she would go get the nurse manager. Surveyor asked LPN E what she would do if the midline is leaking. LPN E stated she would stop flushing and get the nurse manager as the line is probably dislodged. Surveyor asked LPN E how she knows what to flush and how much. LPN E stated she would check the order in the electronic medical record. Surveyor asked LPN E if she had ever attended a skills fair. LPN E stated no. On 11/7/24 at 2:54 PM, Surveyor interviewed LPN LL. Surveyor asked what LPN LL does to care for midlines. LPN LL stated he does not care for them, he has the RN care for them. Surveyor asked LPN LL if he monitors anything with the midline. LPN LL stated he monitors the site and dressing and if something doesn't look right he tells the RN and informs DON B. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/7/24 at 4:24 PM, Surveyor interviewed DON B. Surveyor asked DON B to describe the issue that occurred in July with R29's midline. DON B stated, we had an order to remove the midline, RN O removed it and realized it wasn't intact. R29 was sent out to the hospital and eventually transferred to a second hospital. R29 returned to the facility with the catheter still in her arm due to second outside hospital being unable to remove it. The facility then made referrals to get R29 the care she needed. Surveyor asked DON B if RN O had received a telephone or verbal order to remove the midline and if the order should have been transcribed into the electronic medical record. DON B stated she would have expected it to be transcribed. DON B also added that she would expect some sort of progress note or change of condition note regarding this event. Surveyor asked DON B if a midline could ever be removed without an order. DON B stated no. Surveyor asked DON B if she was aware there was no order in the electronic medical record to remove the midline. DON B stated no. Surveyor asked DON B what she would expect staff to monitor for in residents who come to the facility with a midline in place. DON B indicated she would expect staff to monitor the insertion site for infection, redness, swelling, pain, and when the line is removed to check to make sure the catheter is intact. Surveyor asked DON B if she would expect staff to notify a provider if a midline was leaking. DON B stated yes. Surveyor asked DON B what she would expect to happen after LPN P notified RN O of the midline not flushing. DON B indicated she would expect an LPN to get an RN to assess the line immediately and to notify the Nurse Practitioner right away. Surveyor asked DON B how often she expects dressing changes to be conducted. DON B stated weekly. Surveyor asked DON B where Surveyor could find that documented. DON B stated, in the TAR (Treatment Administration Record). DON B added that this comes in as an order and an RN is expected to add this into the TAR. Surveyor asked DON B when she expects midlines to be measured. DON B stated during dressing changes. Surveyor asked DON B if she expects dressing changes to be documented. DON B stated yes. Surveyor asked DON B if any competency checks were conducted prior to staff managing R29's midline. DON B stated they do competency checks yearly, so after a year they would, but otherwise no. Surveyor ask [TRUNCATED]

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility failed to ensure the medication regimen was free from unnecessary medications for 1 of 5 residents (R10) reviewed for unnecessary medications. R10 does not have a timely Abnormal Involuntary Movement Scale (AIMS) test. This is evidenced by: The facility policy Use of Psychotropic Med implemented 4/24/24, states, in part: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . Psychotropic drugs include, but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics . Residents who receive an antipsychotic medication will have an AIMS test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN (As Needed) or as per facility policy. R10 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, dementia with psychotic disturbance, and anxiety disorder. R10's physician orders dated 11/7/24 include Risperdal (an antipsychotic medication) 0.5 mg three times a day for Mood disturbance related to dementia. R10 had an AIMS test completed on 10/2/23. Of note, the AIMS test was completed over 1 year ago and R10 should have had at least 3 quarterly assessments in the last year. On 11/7/24 at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) regarding AIMS testing. DON B indicated AIMS test should be completed per policy. DON B indicated R10's AIMS test was not completed per policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on observation, interview, and record review, the facility did not ensure that it was free of medication error rates of 5% or greater. There were 2 errors out of 31 opportunities that affected 1 out of 3 residents (R1) included in the medication pass task, which resulted in an error rate of 6.45%. LPN N (Licensed Practical Nurse) did not prime R1's insulin pens before administration. (Of note, if insulin pens are not primed the resident may not receive the correct dose of insulin.) This is evidenced by: The facility policy entitled, Medication Administration, dated 3/1/19, states, in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . (Of note, the facility policy did not contain information on priming of insulin pens) The facility policy entitled, Medication Errors, dated 3/1/19, states, in part: .1. The facility shall ensure medications will be administered as follows: .b. Per manufacturer's specifications regarding the preparation, and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services. 2. The facility must ensure that is free of medication error rates of 5% or greater as well as significant medication events. Manufacturer's recommendations for administration of Fiasp, from the manufacturer's website (https://www.novomedlink.com/diabetes/products/treatments/fiasp/dosing-and-administration/administration-options.html) notes in part: .Priming your FIASP FlexTouch Pen Step 7: Turn the dose selector to select 2 units. Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0:. The 0 must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. If you still do not see a drop of insulin, change the needle, and repeat steps 7 to 9. Selecting your dose: Step 10: Check to make sure the dose selector is set at 0. Turn the dose selector to select the number of units you need to inject. R1's Physician Orders state, in part: Fiasp PenFill Subcutaneous Solution Cartridge 100 UNIT/ML (insulin Aspart (with Niacinamide) Inject 20 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS. May use insulin lispro kwikpen until supply is out. Fiasp PenFill Subcutaneous Solution Cartridge 100 UNIT/ML Inject as per sliding scale: if 151-200=2; 201-250=4; 251-300=6; 301-350=8; 351-400=10; 401-450=12; update MD (medical doctor) if BG (blood glucose) <70 (less than 70) or >451 (greater than 451) per [NAME] NP, subcutaneously with meals related to Type 2 Diabetes Mellitus with unspecified complications. May use insulin lispro kwikpen until supply is out. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin Glargine Subcutaneous Solution Pen-Injector 100 UNIT/ML Inject 50 unit subcutaneously every morning and at bedtime for diabetes hold if BG (blood glucose) under 150 or NPO (nothing by mouth) On 11/6/24 at 8:40 AM, Surveyor observed LPN N prepare Fiasp (short acting insulin) and Insulin glargine (long-acting insulin) pens for R1. LPN N applied a needle to Fiasp pen and dialed the pen to 28 units (20-unit initial dose plus 8 units for blood glucose of 332). LPN N applied needle to Insulin glargine pen and dialed the pen to 50 units. LPN N gathered supplies and the dosed pens and turned from cart to proceed into R1's room. Surveyor stopped LPN and asked if the pens were ready for administration. LPN N stated yes. Surveyor asked if anything else needed to be done to the pens prior to administration. LPN N stated no. Surveyor asked if anything need to be done regarding the needle prior to administration. LPN N stated no. Surveyor asked if insulin pens need to be primed prior to administration to ensure proper dosing. LPN N stated that the Fiasp did not, then stated that the insulin glargine did need to be primed. Surveyor asked if either pen had been primed. LPN N stated no. Surveyor asked if all insulin pens need to be primed prior to dialing the dose for administration. LPN N stated yes. On 11/6/24 at 11:13 AM, Surveyor interviewed DON B (Director of Nursing) and asked about procedure for administering insulin via pen. DON B stated that order needs to be verified, blood sugar needs to be checked, needle needs to be applied and pen needs to be primed. Surveyor asked if nurses are expected to prime insulin pens prior to administration of insulin. DON B stated yes.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49434 Based on interview, and record review, the facility did not ensure residents are free of significant medication errors for 1 of 1 resident's (R329). R329 had an order for Novolin 70/30 FlexPen (Insulin) and Metoprolol Tartrate 25 MG (Lowers blood pressure), that was not administered on 10/12/24 and 10/13/24, missing a total of two doses of his daily insulin and four doses of his blood pressure medication. This is evidenced by: The facility policy titled, Medication Administration, dated 3/1/19, states in part: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Policy Explanation and Guidelines: . 8. Obtain and record vital signs, when applicable or per physician orders . 10. Review MAR (Medication Administration Record) to identify medication to be administered . 14. Administer medication as ordered in accordance with manufacturer specifications . 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR . 19. Report and document any adverse side effects or refusals. 20. Correct any discrepancies and report to nurse manager. The facility policy titled, Medication Error, dated 3/1/19, states in part: . Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders . 4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with prescriber's order. Examples include, but not limited to: . ii. Medication omission . R329 was admitted to the facility 10/11/24 and has diagnosis that include in part: fracture of superior rim of left pubis (pelvic fracture), paroxysmal atrial fibrillation, type 2 diabetes mellitus with proliferative diabetic retinopathy, legal blindness, and essential (primary) hypertension. R329's Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/16/24, indicated that R329 has a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating that he is cognitively intact. R329's Physician Orders state in part: Novolin 70/30 FlexPen (70-30) 100 UNIT/ML (units per milliliter) Suspension pen-injector Inject 28 unit subcutaneously one time a day for T2DM (type 2 diabetes mellitus) Order Date: 10/12/24. Metoprolol Tartrate 25 MG (milligram) Tablet Give 1 tablet by mouth two times a day for HTN (hypertension) hold if SBP (systolic blood pressure) <110 Pulse <60 Order Date: 10/12/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R329's Medication Administration Record (MAR) indicates staff did not administer Novolin 70/30 as ordered on 10/12/24 and 10/13/24. The MAR contains blank spaces for both entries signifying that no dose was administered. R329's MAR indicates staff did not administer Metoprolol Tartrate as ordered on 10/12/24 at 8:00 AM and 6:00 PM, and on 10/13/24 at 8:00 AM and 6:00 PM. The MAR contains blank spaces for both entries signifying that no dose was administered. These omissions resulted in six significant medication errors. Of note: R329 had his blood glucose level checked once on 10/11/24. On 11/5/24 at 10:21 AM, Surveyor interviewed R329. R329 states that he did not receive his insulin for his first two days at the facility. On 11/7/24 at 10:50 AM, Surveyor interviewed RN BB (Registered Nurse). RN BB states she has been working at the facility since March 2024, and always works the day shift on R329's unit. Surveyor asked RN BB when blood sugar should be checked. RN BB stated as ordered, before meals, and before administering insulin. Surveyor asked RN BB if R329 ever refused medications or blood sugar checks. RN BB states, no. On 11/7/24 at 4:24 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when should blood sugar be checked. DON B states, before giving insulin and according to physician orders. Surveyor asked DON B if blood sugars should be checked while administering insulin. DON B states, yes. Surveyor asked DON B what the blank spaces indicate on the MAR. DON B states, it means the medication wasn't signed out. Surveyor asked DON B if medications should be administered according to physician order. DON B states, yes. Surveyor reviewed the missing medications. DON B states she is aware of the issue and investigated the issue finding the order was not transcribed appropriately into the electronic medical record, so the order wasn't available to administer. DON B states she provided verbal education to LPN QQ, who was found to be responsible for the error by the facility. Surveyor asked DON B if she educated all nursing staff to ensure this issue did not reoccur, DON B stated she did not. Surveyor asked DON B if R329's medication should have been administered as ordered. DON B states, yes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation, interview and policy review the facility did not ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles, including appropriate accessory and cautionary instructions and the expiration date when applicable, this affected 2 of 2 medication rooms, 1 of 2 medication carts and 1 of 2 residents who self-administer medication (R32). Surveyor observed the following: An insulin pen with no labeling. A vial of Tuberculin solution without an open date or expiration date. Three bottles of expired liquid Tylenol. One bottle of expired Enulose. Three bottles of expired Gerimox. Surveyor observed R32 to have medication in an unlocked drawer at R32's bedside. R32 stated the medication had never been locked up for safety while stored in her room. This is evidenced by: The Facility's Policy and Procedure entitled Labeling of Medications and Biologicals dated [DATE], documents in part: 1. All medications and biological will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices .4. Labels for individual drug containers must include a. The resident's name; b. The prescribing physician's name; c. The medication name (generic and/or brand name); d. The prescribed dose, strength, and quantity of the medication; e. The prescription number (if applicable); f. The date the drug was dispensed; g. Appropriate instructions and precautions (such as shake well, take with meals, do not crush, special storage instructions); h. The expiration date when applicable; i. The route of administration .6. Labels for each floor/unit's stock medications must include .c. The expiration date when applicable .7. Labels for over-the-counter (OTC) medications must include .c. The expiration date when applicable .8. Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle-punctured), b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, entitled, Resident Self Administration Medication, dated [DATE], states, in part: .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.2. Resident's preference will be documented on the appropriate form and placed in the medical record. 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; . g. The resident's ability to ensure that medication is stored safely and securely.7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. Example 1 The 100-wing medication cart had one Fiasp flex touch pen (aspart insulin pen) that had no resident name and no open date. The was insulin pen was open and appears to be full. On [DATE] at 11:46 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F if she knew whose insulin pen this was, LPN F said there is only one resident down the 100 wing that gets that insulin, and he has a full pen with an open date of [DATE]. Surveyor asked LPN F what is missing from the insulin pen, LPN F stated it should have a name, open date and it should not be in the medication cart unlabeled. Example 2 Medication rooms contained the following: 1 vial of Tuberculin purified protein derivative diluted /aplisol 5/TU0.1ml (milliliters) that had no open date on it, the vial was dispensed date of [DATE]. 3 bottles of liquid Tylenol with expiration dates of ,d+[DATE]. 1 bottle Enulose (lactulose solution usp) 10g(grams)/15ml with expiration date of ,d+[DATE]. 3 bottles of Gerimox regular strength antacid/antigas bottle with expiration date of ,d+[DATE]. On [DATE] at 11:51 AM, Surveyor interviewed LPN E. Surveyor asked LPN E if there was an open date on the Tuberculin vial, LPN E stated no, there is not one on there. Surveyor asked LPN E if she knew when vial was opened, LPN E said she doesn't know when it was opened, but it should have an open date. Surveyor asked LPN E if an expired medication should be in the medication storage room, LPN E replied they should not be in the OTC (over the counter) storage. LPN E took the medications to be disposed of. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:07 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B who is responsible for stocking the OTC medications, DON B explained that their central supply staff stocks it and is supposed to go through dates. Surveyor asked DON B how the OTC medications should be stocked, DON B said FiFo (first in, first out), new medications go to the back and older ones stay in the front and expired ones get destroyed. Surveyor asked DON B how should medication dating and labeling be done, DON B stated when opened put open date on it. Surveyor asked DON B what about for insulin pens, DON B said if you open it, you date it, should have label with resident name and open date on all medications in the cart. 50228 Example 3 R32 admitted to the facility on [DATE], with diagnoses that include, in part: other chronic pancreatitis, pseudocyst of pancreas, personal history of other diseases of the digestive system. R32's MDS (Minimum Data Set), dated [DATE], indicates BIMS (Brief Interview of Mental Status) score of 15, indicating R32 is cognitively intact. On [DATE] at 8:34 AM, Surveyor observed resident taking Creon (a prescription medication used to treat pancreatic insufficiency) out of her bedside cabinet, top drawer. LPN N (Licensed Practical Nurse) indicated that the medication was supposed to be locked in a lock box/bag and would need to be removed from R32's room. R32 indicated that staff had never discussed the need to keep medication locked up. On [DATE] at 11:13 AM, Surveyor interviewed DON B (Director of Nursing), DON B indicated that self-administered medications kept in a resident's room are to be stored in a locked drawer or a lock box.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and policy review, the facility did not ensure that all residents receive food at a palatable temperature for 1 of 4 hallways and 1 of 1 test trays. Residents voiced concerns with receiving hot foods cold. Surveyor requested test tray. Hot foods temped cold and cold foods temped warm. R39 and R32 stated the food is cold. Evidenced by: The facility policy, Record of Food Temperatures, with no date, states, in part; .2. Hot foods will be held at 135 degrees or greater .11. No food will be served that does not meet the food code standard temperatures . Example 1 On 11/5/24 at 11:40AM, Surveyor requested a meal tray down the 100 hallway. Pork with gravy temped at 114.2 F, potatoes 124.7 F, and red juice temped at 50.1 F. Hot foods were cold and drink was warm. On 11/6/24 at 4:58PM, DM R (Dietary Manager) indicated DM R completes weekly audits on room meal trays. DM R indicated the food temperatures really depend on the resident's personal preference. DM R indicated understanding when Surveyor shared the food temperatures from the meal tray and resident voices regarding hot foods served cold and cold foods served hot. DM R indicated the facility does have the bottom plate for the hot plates, but they are not using them because the bottom plate makes it more difficult for residents to be able to eat if they are eating in their beds. 50228 Example 2 R39's MDS (Minimum Data Set) dated 9/19/24, indicates R39 has BIMS (Brief Interview for Mental Status) score of 15, indicating R39 is cognitively intact. On 11/5/24 at 9:54 AM, Surveyor interviewed R39 during initial screening. R39 indicated that food is cold when receiving meal trays in room. Example 3 R32's MDS dated [DATE] indicates R32 has a BIMS score of 15, indicating R32 is cognitively intact. On 11/5/24 at 10:37 AM, Surveyor interviewed R32 during initial screening. R32 indicated that food is cold when receiving meal trays in room.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38882 Based on interview and record review, the facility did not implement an established process of assessing a resident's cognitive ability to understand an arbitration agreement before obtaining a signature for residents; and did not ensure the staff responsible for the arbitration agreement had complete understanding of an arbitration agreement and was able to thoroughly explain the agreement for complete resident/reasonable party understanding. This deficient practice had the potential to affect all 71 residents who resided in the facility and went through the admission process as arbitration agreements is part of the facility's admission process. R25, R12, R128, R129 and R72's resident representative voiced concerns regarding not fully understanding the arbitration agreement they signed upon admission to the facility. R25, R128, and R129 indicated they wanted to revoke their arbitration agreement. RR OO indicated the arbitration agreement was not explained to him fully and he would not have wanted to sign the agreement if he knew he was signing away constitutional rights to use the judicial system to resolve disputes with the facility. Evidenced by: Facility policy, titled Binding Arbitration Agreement, dated 10/1/22, includes: The facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, this facility. Arbitration is a private process where disputing parties agree that one or several other individuals can make a decision about the dispute after receiving evidence and hearing arguments . binding arbitration is a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final can be enforced by a court and can only be appealed on very narrow grounds. Judicial proceeding is any action by a judge formally before the court including trials, hearings, petitions, or other matters . when explaining the arbitration agreement the facility shall explicitly inform the resident or his representative of his or her right not to sign the agreement as a condition of admission . Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands . ensure a resident or his or her representative acknowledges that he or she understands the agreement . the agreement must: provide for the selection of a neutral arbitrator agreed upon by both parties . provide for selection of a venue that is convenient to both parties . explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it . explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission . the agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials . (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Alternative dispute Resolution Agreement form, dated 3/2020, includes: arbitration is a method of resolving disputes without the substantial time and expense of using the judicial system. Disputes resolved through arbitration generally resolve more quickly than disputes resolved through civil litigation, which generally takes years to complete. By avoiding the judicial system many costs are eliminated. There are charges and fees involved in arbitration, but an arbitration hearing will generally resolve a dispute sooner and at less cost than a trial. It is important to understand however that there is only a limited right to appeal an arbitration award. Unless there is evidence of fraud on the part of the arbitrator or a serious procedural defect, an arbitration award will be final. Of course, the facility also agrees to be bound by the arbitrator's decision. This alternate dispute resolution agreement is optional. Admission to the facility is not conditional on the residents willingness to enter into this agreement. By signing this alternate dispute resolution agreement, you are giving up your constitutional right to a jury or court trial . if this agreement has been read on behalf of the resident by an authorized representative or agent of the resident the representative or agent has explained to the resident, to the extent of the resident's capability to understand such explanation, the nature of this agreement and its essential terms. The resident understands that he or she has the right to seek legal counsel concerning this agreement; the execution of this agreement is not a precondition to admission expedited admission or the furnishing of medical services to the resident buy the facility; and this alternative dispute resolution agreement may be revoked by providing notice to the facility from the resident within 10 days of signature. If not revoked within 30 days this agreement shall remain in effect for all care and services rendered at the facility, even if such care and services are rendered following the residents discharge and re admission to the facility . Facility's admission welcome packet includes an arbitration agreement with 28 pages. Example 1 R25 admitted to the facility on [DATE]. On 11/07/24 at 3:36 PM R25 and Surveyor reviewed R25's signed arbitration agreement, dated 10/8/24. R25 stated, I probably signed it with all the other paperwork. I do not want this. Can you fix it? Example 2 R12 admitted to the facility on [DATE]. On 11/07/24 at 3:30 PM R12 and Surveyor reviewed R12's signed arbitration agreement, dated 9/20/24. R12 stated, I signed a bunch of things. I am sure I signed it. Wish they did that on a different day than the day they do all admission papers. R12 indicated she did not fully understand what she was signing at the time. Example 3 R128 admitted to the facility on [DATE]. On 11/07/24 at 3:25 PM R128 and Surveyor reviewed R128's signed Arbitration agreement, dated 10/4/24. R128 stated, I would not want that signed. R128 indicated she did not understand what the form was for, and it was presented to her with all her admission paperwork. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 4 R129 admitted to the facility on [DATE]. On 11/07/24 04:29 PM during an interview R129 stated, They did not explain it to me. I would not sign that. Surveyor and R129 reviewed the last paragraph of the agreement and R129 stated, I would like it revoked. Example 5 R72 admitted to the facility on [DATE] and has an activated power of attorney. On 11/11/24 at 2:21 PM during a phone interview RR OO (Resident Representative) indicated he is R72's activated power of attorney. RR OO indicated he was not fully aware of the arbitration agreement that he had signed, stating, It was well hidden amongst all the other paperwork. I know we are past the 30 days. Thank you. I will look for this in the future. On 11/07/24 at 3:44 PM Admissions Coordinator PP stated, I go through the agreement with all new admissions. Surveyor asked Admissions Coordinator PP to explain what the arbitration agreement is as if she was explaining it to a new admitting resident. Admissions Coordinator PP stated, It is about their rights to use the grievance process. They can talk to anyone here about concerns that they have, and we will resolve the concerns. Surveyor asked if Admission Coordinator PP explained to new admissions that if the resident signs the form, they forfeit their constitutional rights to use the judicial system to resolve disputes they may have with the facility. Admissions Coordinator PP indicated she was unaware that the form meant that. Surveyor and Admissions Coordinator PP reviewed paragraph one of the arbitration agreement together including: Arbitration is a method of resolving disputes without substantial time and expenses of using the judicial system . By signing this alternative Dispute Resolution agreement you are giving up your constitutional right to a jury or court trial. Surveyor asked Admission Coordinator PP if there was a timeframe the residents had to back out of the agreement. Admissions Coordinator PP indicated she was unsure. Surveyor and Admissions Coordinator PP reviewed the last paragraph of the arbitration agreement together including: . this Alternative Dispute Resolution may be revoked by providing notice to the facility within 10 days of signature. If not revoked within 30 days, this agreement shall remain in effect for all care and services rendered at the facility. On 11/7/24 at 4:44 PM INHA D (Interim Nursing Home Administrator) and Corporate RN C (Registered Nurse) indicated Admissions Coordinator PP should understand and be able to explain the binding arbitration agreement to new residents upon admission. INHA D indicated residents do not have to sign the agreement to admit and they have 30 days to revoke the agreement after it is signed.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation, interview, and record review, the facility does not have an effective infection control program to control the spread of infectious disease, in this case COVID-19; this has the potential to affect all 71 residents residing at the facility. Staff were observed going in and out of COVID positive rooms without appropriate PPE (Personal Protective Equipment). Staff were observed exiting COVID positive room with PPE on and doffing PPE in the hallway. Staff were observed not using source control. Staff were working with COVID symptoms and not tested . Facility is not utilizing dedicated equipment in COVID positive resident rooms. Privacy curtains are not being pulled between COVID positive and COVID negative residents. Staff were observed working with a COVID positive resident and then with same PPE about to work with a resident who was COVID negative. Observations of COVID positive residents smoking outside with non-COVID positive residents and not six feet apart. Food cart was left with the door open in front of a COVID positive resident room, the resident was sitting in the doorway of the room and coughing without using cough etiquette. The facility did not offer residents the most recent COVID-19 vaccine. The facility did not offer residents antiviral (drug or treatment effective against viruses) medication. The facility's failure to ensure appropriate infection control practices are in place and followed during a COVID-19 outbreak, created a finding of immediate jeopardy that began on 11/4/24. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 11/11/24 at 1:23 PM. The immediate jeopardy was removed on 11/11/24, however, the deficient practice continues at a scope/severity of F (potential for more than minimal harm/widespread) as evidenced by the following: The facility did not have complete water management control measure documentation. Poor hand hygiene was observed with wound care and medication administration. This is evidenced by: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Policy and Procedure titled Infection Prevention and Control Program dated 10/1/22, documents in part: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines .4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies .5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC (Center for Disease Control and Prevention) guidelines. b. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. c. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines . The facility's Policy and Procedure titled Infection Outbreak and Response dated 10/1/22, documents in part: .Outbreak generally refers to the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time .2. Implementation of infection control measures: a. Symptomatic employees will be screened by the Infection Preventionist, or designee, and referred to appropriate medical provider. c. Standard precautions will be emphasized. Transmission-based precautions will be implements as indicated for the particular organism . The facility's COVID-19 Outbreak timeline documents the following: On 10/25/24, there was one resident with a cough, he tested positive for COVID. The facility updated his care plan, started COVID monitoring, tested residents on south side, and staff on that side of facility to test every two days. On 10/27/24, all residents on south side of facility were tested , all were negative. On 10/28/24, R63 tested positive on the south side of the facility. On 10/29/24, R329 and R37 tested positive on the north side of the facility and R14, R36, R24, and R64 tested positive on the south side of the facility. NM H (Nurse Manager) and LPN E (Licensed Practical Nurse) tested positive on this date as well. The facility identified this as an outbreak, hung signage on front door, initiated use of well-fitting mask throughout facility, updated care plans, started COVID monitoring, dietary began utilizing disposable dishware for positive residents, Activities distanced residents as needed, Therapy saw positive resident last, housekeeping increased their cleaning of high touch areas (light switches, door knobs, door frames, and handrails), testing for all staff and residents to be done every 2 days, families and providers updated, and updated Public Health. On 10/30/24, CNA I (Certified Nursing Assistant) tested positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/31/24, R130, R330, and R49 tested positive on the north side of the facility and R67, R66, and R26 tested positive on the south side of the facility. BOM RR (Business Office Manager) and SLP SS (Speech/Language Pathologist) tested positive on this date. On 11/2/24, R56 tested positive on the north side of the facility and R2 and R18 tested positive on the south side of the facility. On 11/3/24, R48 tested positive on the south side of the facility. On 11/4/24, R34 tested positive on the south side of the facility and LPN J tested positive. On 11/6/24, all residents tested , all negative, first round of no new positives. Staff Line List documents the following: On 10/2/24, LPN J (Licensed Practical Nurse) is listed as having a headache/migraine. There is no documentation that a COVID test was completed. On 10/4/24, NM H (Nurse Manager) is listed as having a headache. There is no documentation that a COVID test was completed. On 10/29/24, NM H tested positive for COVID, line list documents that symptoms started 10/25/24. NM H's punch detail documents that she worked 10/25/24 and 10/28/24, eight hours each day with a COVID positive test result on 10/29/24. On 10/29/24, LPN E tested positive for COVID, the staff line list documents that symptoms started on 10/27/24. LPN E's punch detail documents that she worked 10/29/24 the beginning half of the shift with COVID positive result on 10/29/24. On 10/30/24, CNA I (Certified Nursing Assistant) tested positive for COVID, the staff line list documents that symptoms started 10/29/24. CNA I's punch detail documents that she worked on 10/29/24 with COVID positive result on 10/30/24. On 11/4/24 at 11:56 AM, Surveyor observed CNA K enter R64's room. On the wall outside R64's room was an infection control sign indicating COVID precautions for R64's room. The infection control sign indicated staff should wear eye protection, N95 mask, gown, and gloves when entering the room. CNA K was wearing a surgical mask, gown, and gloves. On 11/4/24 at 12:00 PM, Surveyor interviewed CNA K regarding the required PPE (Personal Protective Equipment) when entering a COVID positive room. CNA K read the infection control sign outside the door indicating she should wear eye protection, N95 mask, gown, and gloves when entering the room. Surveyor asked CNA K if she should have put on eye protection and an N95 mask prior to entering the room. CNA K indicated she should have applied the appropriate PPE but did not. On 11/4/24 at 11:56 AM, Surveyor observed CNA L enter R67's room. On the wall outside R67's room was an infection control sign indicating COVID precautions for R67's room. The infection control sign indicated staff should wear eye protection, N95 mask, gown, and gloves when entering the room. CNA L was wearing a surgical mask, gown, and gloves. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/4/24 at 12:00 PM, Surveyor interviewed CNA L regarding the required PPE when entering a COVID positive room. CNA L read the infection control sign outside the door indicating he should wear eye protection, N95 mask, gown, and gloves when entering the room. Surveyor asked CNA L if he should have put on eye protection and an N95 mask prior to entering the room. CNA L indicated he should have applied the appropriate PPE but did not. On 11/4/24 at 2:02 PM, Surveyor observed CNA T (Certified Nursing Assistant) don (put on) 2 surgical masks and an N95 over the top of the surgical masks, a gown, and gloves. Then CNA T entered R14's room to assist R14 who was COVID positive. (It is important to note CNA T did not don eye protection and had on a total of 3 masks.) On 11/4/24 at 12:00 PM, Surveyor observed R36 watching TV with the room curtain divider pulled back. R36 is COVID positive and R36's roommate, R30, is not. On 11/4/24 at 2:56PM, CNA T (Certified Nursing Assistant) answered the call light for R30. Surveyor observed CNA T put on gown, gloves, and a face shield. Surveyor observed CNA T wear a surgical facemask and enter R30's room. CNA T walked past R36's side of the room. R36 is R30's roommate and is COVID positive. CNA T came out of the room and still had the surgical facemask on. Surveyor asked who CNA T assisted. CNA T indicated she answered call light for R30 and R30 is not COVID positive. CNA T indicated she puts on the full PPE for precaution since R30's roommate is COVID positive. CNA T indicated if she was assisting someone who is COVID positive she will don all PPE, gown, gloves, face shield, 2 surgical face masks, and 1 N95. CNA T indicated she wears the 3 face masks for extra protection. CNA T indicated staff are constantly reminding R36 to keep his facemask above his nose when he is out in common areas. On 11/4/24 at 12:11 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) regarding appropriate PPE for COVID positive rooms. LPN F indicated staff should wear eye protection, N95 mask, gown, and gloves when entering a COVID positive room. On 11/7/24 at 3:21 PM, Surveyor interviewed DON B (Director of Nursing) regarding appropriate PPE for COVID positive rooms. DON B indicated staff should wear eye protection, N95 mask, gown, and gloves when entering a COVID positive room. DON B was aware of Surveyor's observations of CNA K (Certified Nursing Assistant,) CNA L, and CNA T. DON B indicated the CNAs should have worn eye protection and an N95 mask when entering the COVID positive rooms. On 11/4/24 at 2:02 PM, Surveyors observed 5 residents smoking in a circle outside. Residents were not 6 feet apart and two of the residents were positive for COVID. On 11/07/24 05:51 PM, Surveyor interviewed DON B (Director of Nursing) regarding COVID positive residents going outside to smoke. DON B indicated COVID positive residents should go out to smoke separately but if the COVID positive residents go outside to smoke with COVID negative residents, then they should stay 6 feet apart. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/5/24 at 11:32 AM, Surveyor observed two staff members bring a meal tray cart onto the 200 unit. The cart was placed within six feet of the door to the right of R49's room who was COVID positive. At the time, R49 was sitting in his wheelchair in the threshold of his doorway, not wearing a mask, and actively coughing. Staff members were passing trays and leaving the tray cart door open at this time. On 11/5/24 at 11:39 AM, Surveyor observed the tray cart moved from the right to the left of R49's room. The tray cart was still within six feet of the resident, and at this time within arm's reach. R49 remained in the threshold of his doorway and was still actively coughing without a mask. On 11/5/24 at 11:41 AM, DSS W (Director of Social Services) came onto the unit and moved the tray cart down to the other end of the hall away from R49. On 11/5/24 at 11:43 AM, Surveyor observed DSS W exit R330's room, who was COVID positive, still wearing all her PPE. Surveyor observed DSS W doff all her PPE in the hallway and dispose of her PPE in the medication cart trash can. On 11/5/24 at 11:54 AM, Surveyor interviewed DSS W. Surveyor asked DSS W if she was passing trays on the 200 hall. DSS W stated yes. Surveyor asked DSS W if she passed a tray to R330's room who is on special isolation precautions for COVID. DSS W stated yes. Surveyor asked DSS W if she walked out of the room with all her PPE on. DSS W stated yes. Surveyor asked DSS W if she should have doffed her PPE prior to exiting R330's room. DSS W stated yes. On 11/6/24 at 8:05 AM, Surveyor observed LPN N (Licensed Practical Nurse) leave R56's bedside, go into the resident's bathroom, remove gloves, cleanse hands, and don new gloves. R56 is COVID positive. LPN N then walked to R56's roommate's side of the room, past the privacy curtain. Surveyor intervened as LPN N passed around the corner of R56's roommate's bed and asked LPN N to come to the doorway. Surveyor asked LPN N if she was going to see R56's roommate. LPN N stated yes. Surveyor asked why LPN N was wearing PPE in the room. LPN N stated that R56 has COVID and is on precautions. Surveyor asked if PPE worn with a COVID positive resident could be worn with another resident. LPN N stated no. LPN N removed the PPE, cleansed hands, and went to the medication cart. LPN N pushed the medication cart to the next room down the hall and opened the medication cart and began preparing medications. Surveyor asked if any PPE was required to be worn by staff while in the hallways of the building due to the COVID outbreak. LPN N stated yes, a surgical mask. Surveyor asked LPN N if she was wearing a mask at the present time. LPN N took a mask from the isolation cart in the hallway and applied the mask. On 11/7/24 at 8:24 AM, Surveyor interviewed DON B (Director of Nursing) who indicated that the preferred order to see residents sharing a room is to see the resident without COVID first, then remove PPE, cleanse hands, apply new PPE, then see the COVID positive resident. DON B stated that after seeing a COVID positive resident, PPE must be removed and hand hygiene must be performed. DON B stated that a surgical mask needs to be worn by staff in the building while there is a COVID outbreak. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/5/24 at 4:47 PM, Surveyor interviewed HLS Q (Housekeeping and Laundry Supervisor). Surveyor asked HLS Q if the cleaning products they use are good for COVID; HLS Q stated yes. Surveyor asked HLS Q what surfaces are they cleaning with these products; HLS Q said all high touch areas (doorknobs, light switches, doorframes, handrails). Surveyor asked HLS Q if cleaning changed once there was a COVID outbreak; HLS Q stated yes, we increased cleaning of high touch areas by one time per day (already being done three times per day regularly). On 11/6/24 at 3:08 PM, Surveyor interviewed LPN/IP G (Licensed Practical Nurse/Infection Preventionist). Surveyor asked LPN/IP G once the facility had a positive COVID resident in the building, were residents who declined the vaccine to use a mask; LPN/IP G stated all residents were encouraged to wear a mask. Surveyor asked LPN/IP G if there was consultation about beginning an antiviral medication; LPN/IP G said she had spoken to their Medical Director prior to this outbreak and the medical director didn't seem to want to go there. Surveyor asked LPN/IP G if masks are being offered to residents when the residents are out of their rooms; LPN/IP G stated yes, not all residents are compliant. Surveyor asked LPN/IP G what PPE is to be worn in COVID positive rooms, LPN/IP G replied gown, gloves, N95, and eye protection. Surveyor asked LPN/IP G what PPE is to be worn throughout the facility when not in a COVID positive room; LPN/IP G said a well-fitting mask (surgical mask). Surveyor asked LPN/IP G if it is acceptable to wear two surgical masks with an N95 over the top, LPN/IP G stated no. On 11/7/24 at 11:32 AM, Surveyor interviewed LPN/IP G again. Surveyor asked LPN/IP G if COVID boosters/vaccines have been offered, LPN/IP G explained they offer, on admission, then for the next three days if they refuse, if still refused then offered quarterly. Surveyor asked LPN/IP G if NM H had symptoms that started 10/25/24, should she have tested on [DATE]? LPN/IP G stated yes, she should have. LPN/IP G stated she was unsure if she had access to testing. Surveyor asked LPN/IP G if she didn't have access to testing 10/25/24, should she have tested on [DATE] before working; LPN/IP G said yes. On 11/7/24 at 4:36 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B when would you expect a staff member to test for COVID if they have symptoms? DON B said when the symptoms start. Surveyor asked DON B if she would expect staff to be working if they have COVID symptoms; DON B stated no, they should test before they work. The facility's failure to ensure appropriate infection control practices are in place and followed during a COVID-19 outbreak created a reasonable expectation of serious outcome resulting in a finding of immediate jeopardy. The facility removed the immediate jeopardy on 11/11/24 when the facility completed the following: ~A record review was completed on all residents to ensure no unreported signs and symptoms of infection were present. ~An audit was completed on all residents COVID-19 vaccination status with vaccines offered if appropriate. ~All staff had a competency completed on DONNing and DOFFing PPE as well as hand hygiene and will be completed prior to next shift worked. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	~All staff were educated on the appropriate use of PPE on all types of precautions and COVID specific precautions to include donning gown, gloves, mask, and eye protection when entering COVID positive rooms, and removing PPE prior to leaving the resident room. ~Education also included not wearing a surgical mask under a N95 and that surgical masks are to be worn in the halls during a COVID outbreak. ~All staff were education on appropriate hand hygiene. ~All nursing staff were educated on offering Antiviral medications for residents with a positive COVID result and offering the most recent COVID vaccines. ~All staff were educated on the use of privacy curtains in positive COVID rooms as well as disinfecting equipment and doffing PPE after working with a COVID positive resident. ~All staff were educated on taking COVID positive smoking residents out separately than non-positive smoking residents. ~All staff were educated on dining carts cannot be left open during meal tray pass in the hallways. ~All staff were educated on testing for COVID prior to working if symptoms are present. Education will be completed prior to next shift worked. ~Infection Control and vaccines policy and procedures were reviewed with no updates at this time. ~DON or designee will audit 5 residents weekly x8 weeks to ensure residents are up to date with current COVID-19 vaccinations. ~DON or designee will audit 5 employees weekly x8 weeks to ensure appropriate DONNing/DOFFing PPE, privacy curtains are being closed in a COVID positive room and appropriate hand hygiene is being completed. ~Dietary Manager or designee will complete 5 observations weekly x8 weeks to ensure dining carts are being closed during meal tray pass in the hallways. ~SSD or designee will complete 5 observations weekly x8 weeks to ensure COVID positive residents are being taken out after non COVID residents have finished smoking. ~Audits will be reported and reviewed to QAPI for further direction. Example 2: The facility is lacking documentation on the water management control measures. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Policy and Procedure titled Infection Prevention and Control Program dated 10/1/22, documents in part: .16. Water Management .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 Water Management Plan has multiple control measures in it that are to be tested on a regular basis. Testing/documentation of testing of these control measures are in place until May or July. On 11/7/24 at 3:30 PM, Surveyor interviewed AIT S (Administrator in Training). Surveyor asked AIT S why the documentation for the control measures stop in either May or July? AIT S explained that the facility has been without a full-time Maintenance Director since July, they do have Maintenance from other facilities or their Corporate Office covering but the documentation has not been completed. 49436 Example 3: The facility policy Hand Hygiene not dated, states in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . Staff will perform hand hygiene when indicated, using proper technique consistent with the accepted standards of practice. On 11/6/24 at 9:30 AM, Surveyor observed RN M (Registered Nurse) perform wound care for R43. During the observation, RN M removed the old dressing from R43's left lower leg. R43 has two separate wounds on her left leg, one on the posterior (back) left calf and one on the anterior (front) left leg. RN M washed and dried the posterior wound then proceeded to wash and dry the anterior wound. It is important to note, RN M did not perform hand hygiene in between caring for the two separate wounds. On 11/6/24 at 9:39 AM, Surveyor interviewed RN M regarding hand hygiene during wound care. RN M indicated since the two wounds on R43 were in different locations, she should have treated the wounds separately. RN M indicated she should have performed hand hygiene after treating the posterior left calf wound before proceeding to the anterior left leg wound. On 11/6/24 at 9:39 AM, Surveyor interviewed DON B (Director of Nursing) regarding hand hygiene during wound care. DON B indicated the two wounds on the left leg should have been treated separately. DON B indicated RN M should have performed hand hygiene after treating the posterior left calf wound before treating the anterior left leg wound. 50228 Example 4: LPN N did not remove gloves and cleanse hands following administration of insulin. LPN N contaminated a medication cup with her finger. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/6/24 at 9:20 AM, Surveyor observed LPN N performing medication administration. LPN N donned gloves and administered insulin to R32. Following the medication administration, LPN N touched the following with her contaminated gloves: R32's door and the medication cart. LPN N then removed and disposed of gloves. LPN N touched computer keyboard and med cart drawer following removal of gloves. Surveyor intervened and asked LPN N if there was anything that should be done following administration of insulin. LPN N stated that gloves should have been removed and hands sanitized prior to touching any items. LPN N went on to take R32's oral medications from the medication cart. LPN N picked up a medication cup and flipped it upright by placing her index finger inside the cup. LPN N then placed a medication card onto the cup and positioned the card to dispense the medication into the cup. Surveyor asked LPN N where medication cups should be touched by staff. LPN N stated on the outside near the bottom. Surveyor asked if it is ok to touch inside the cup. LPN N stated no. On 11/6/24 at 11:13 AM, Surveyor interviewed DON B (Director of Nursing) who indicated that gloves are to be removed and hand hygiene performed following insulin administration and prior to touching other things. DON B indicated that medication cups are to be handled from the outside and fingers are not to touch the inside of the cup.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 38725 Based on interview and record review the facility did not ensure that their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use was in place for 2 supplemental residents (R64 and R35). R64 was treated with an antibiotic when she didn't meet the facility's standard of practice (McGeer). R35 was treated with an antibiotic when she didn't meet the facility's standard of practice. This is evidenced by: The Facility's Policy and Procedure entitled Antibiotic Stewardship Program undated, documents in part: .4. The program includes antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols: i. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR (Situation, Background, Assessment, and Recommendation) form prior to notifying the physician. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility use McGeer Criteria to define infections. iv. Criteria specific to each state are used to determine whether or not to treat an infection with antibiotics . Example 1 Per McGeer Criteria for Long Term Care Surveillance Definitions for Infections Updated 2012: Cellulitis/soft tissue/wound: At least 1 criteria must be present: Pus present at a wound, skin, or soft tissue site and/or New or increasing presence of at least 4 of the following sub criteria: Heat at the affected site, Redness at the affected site, Swelling at the affected site, Tenderness or pain at the affected site, Serous drainage at the affected site. The following was on the September resident line list: R64, 9/11/24, cellulitis, S/Sx (signs and symptoms) warmth, redness, and swelling. R64's Infection Surveillance Data Collection tool documents in part: Dated 9/11/24 .New or increasing presence of 4 or more of the following Cellulitis .heat at site, redness at site, swelling at site .Meets minimum criteria for an infection yes . R64's physician orders include the following: Cephalexin 500 mg (milligrams) by mouth every 6 hours for cellulitis for 5 days (9/11/24-9/16/24). On 11/6/24 at 3:08 PM, Surveyor interviewed LPN/IP G (Licensed Practical Nurse/Infection Preventionist). Surveyor asked LPN/IP G if R64's symptoms meet McGeer Criteria, LPN/IP G stated no, you must have 4 symptoms. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided additional information for this example. The provided documentation is R64's pain levels. R64 has pain scores of 3-6 from 9/2/24-9/5/24 and then pain scores of 2-7 9/9/24-9/28/24. It is not clear that this pain was related to this cellulitis encounter. Example 2 Per McGeer Criteria for Long Term Care Surveillance Definitions for Infections Updated 2012: Pneumonia: MUST HAVE: Chest x-ray demonstrating pneumonia, probable pneumonia, or new infiltrate. AND MUST HAVE at least 1 of the following- New or increased cough, 02 (oxygen) sat<94% or < 3% baseline, pleuritic chest pain, fever (see CC table 2), New or increased sputum production, New or changed lung exam abnormalities, respiratory rate. (>25/minute), MUST HAVE at least 1: Constitutional Criteria (Fever, ADL, Mental change) Table 2: Definitions for Constitutional Criteria in Residents of Long-Term Care Facilities (LTCFs) Fever- 1. Single oral temperature >100 F OR 2. Repeated oral temperatures >99 F OR 3. Single temperature >2 F over baseline from any site (oral, tympanic, axillary) Leukocytosis- 1. Neutrophilia (>14,000 leukocytes/mm3) (cells per cubic millimeter) OR 2. Left shift (>6% bands or 1,500 bands/mm3) Acute change in mental status from baseline- All criteria must be present: 1. Acute onset (Evidence of acute change in resident's mental status from baseline) 2. Fluctuating course (Behavior fluctuating: e.g., coming and going or changing in severity during the assessment) 3. Inattention (Resident has difficulty focusing attention: e.g., unable to keep track of discussion or easily distracted) 4. Either disorganized thinking or altered level of consciousness a. disorganized thinking (Resident's thinking is incoherent: e.g., rambling conversation, unclear flow of ideas, unpredictable switches in subject) OR b. Altered level of consciousness (Resident's level of consciousness is described as different from baseline: e.g. , hyperalert, sleepy, drowsy, difficult to arouse, nonresponsive) Acute functional decline- 1. A new 3-point increase in total activities of daily living (ADL) score (range, 0-28) from baseline, based on the following 7 ADL items, each scored from 0 (independent) to 4 (total dependence) Bed mobility, Transfer, Locomotion within LTCF, Dressing, Toilet use, Personal hygiene Eating. The following was on the October resident line list: R35, 10/5/24, pneumonia, S/Sx cough. It is important to note that there was no chest x-ray completed at this time. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R35's Infection Surveillance Data Collection tool documents in part: Dated 10/5/24 .Criteria 1. Must have chest x-ray demonstrating pneumonia or presence of infiltrate AND Criteria 2. Must have at least 1 of the following (constitutional criterion) fever, leukocytosis, acute change in mental status from baseline or acute functional decline AND Criteria 3. Must have at least 1 of the following (respiratory sub criteria Respiratory/Pneumonia .cough .Describe constitutional criteria box .Meets minimum criteria for an infection yes . It is important to note that the box for the constitutional criteria was blank. R35's physician orders include the following: Amoxicillin-Pot Clavulanate 875-125 mg give 1 tablet by mouth every 12 hours for PNA (pneumonia) for 10 days (10/5/24-10/15/24). On 11/6/24 at 3:08 PM, Surveyor interviewed LPN/IP G. Surveyor asked LPN/IP G if R35's symptoms meet McGeer Criteria, LPN/IP G stated no. The facility provided additional information for this example. The provided documentation is R35's Infection Surveillance Data Collection tool dated 9/20/24 that has the same documentation recorded as above for 10/5/24 except the constitutional criteria box says PNA. The facility also provided R35's chest x-ray dated 9/20/24, it documents the following results: .1. Cardiomegaly (enlarged heart), 2. Left moderate pleural effusion. Further evaluation with clinical correlation and possible follow-up imaging is recommended . Of note, this chest x-ray is not indicative of pneumonia.