STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER: Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE: N7135 Rocky Knoll Parkway Plymouth, WI 53073	

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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 - Some	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** 49010 Based on observation and resident and staff interview, the facility did not maintain dignity for 7 residents (R) (R29, R5, R45, R50, R18, R34, and R10) of 7 residents who required dining assistance. R29, R5, R45, R50, R18, R34, and R10 required assistance with dining. During the lunch meal on 3/3/25 and the breakfast meal on 3/4/25, staff did not sit down while feeding R29, R5, R45, R50, R18, R34, and R10. Findings include: From 3/3/25 to 3/5/25, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety, and functional quadriplegia. R29's Minimum Data Set (MDS) assessment, dated 1/16/25, indicated R29 was rarely or never understood From 3/3/25 to 3/5/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including severe dementia with anxiety, epilepsy, and functional quadriplegia. R5's MDS assessment, dated 2/13/25, indicated R5 was rarely or never understood. From 3/3/25 to 3/5/25, Surveyor reviewed R45's medical record. R45 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, dementia, dysphagia, and weakness. R45's MDS assessment, dated 12/5/24, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R45 had moderately impaired cognition. From 3/3/25 to 3/5/25, Surveyor reviewed R50's medical record. R50 was admitted to the facility on [DATE] and had diagnoses including vascular dementia, epilepsy, and memory deficit following a stroke. R50's MDS assessment, dated 12/19/24, had a BIMS score of 2 out of 15 which indicated R50 had severely impaired cognition. From 3/3/25 to 3/5/25, Surveyor reviewed R18's medical record. R18 was admitted to the facility on [DATE] and had diagnoses including anxiety, disorientation, mild cognitive impairment, and left side paralysis following a stroke. R18's MDS assessment, dated 12/16/24, had a BIMS score of 15 out of 15 which indicated R15 was not cognitively impaired. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	From 3/3/25 to 3/5/25, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, anxiety, and diverticulosis. R34's MDS assessment, dated 12/12/24, had a BIMS score of 9 out of 15 which indicated R34 had moderately impaired cognition. From 3/3/25 to 3/5/25, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including Huntington's chorea, Parkinson's disease, dementia, epilepsy, dysphagia (difficulty swallowing), and functional quadriplegia. R10's MDS assessment, dated 1/2/25, indicated R10 was rarely or never understood. On 3/3/25 at 12:10 PM, Surveyor observed 21 residents in the second floor main dining room during the lunch meal and noted the following: ~ At 12:32 PM, Surveyor observed Certified Nursing Assistant (CNA)-R feed R29. CNA-R sat next to R29 for approximately two minutes then fed R29 while standing. Surveyor noted a staff who was assisting R5 had to step away. CNA-R continued to stand and feed R29 and R5. ~ At 12:44 PM, Surveyor observed CNA-S stand while feeding R45 and R50. CNA-S fed R45 a bite of food and then fed R50 a bite of food. Surveyor noted two other staff feeding residents at the same table were seated while feeding the residents. On 3/3/25 at 12:40 PM, Surveyor interviewed CNA-R who indicated CNA-R was an agency staff who worked at the facility for two months. CNA-R indicated it is a regular practice to stand while feeding residents. On 3/3/25 at 12:44 PM, Surveyor interviewed CNA-S while CNA-S was feeding R45 and R50. CNA-S indicated CNA-S had worked at the facility for [AGE] years and it was typical to stand and feed residents. CNA-S indicated CNA-S usually feeds two residents at a time. On 3/4/25 at 8:04 AM, Surveyor observed 23 residents in the second floor main dining room during the breakfast meal and noted the following: ~ At 8:46 AM, Surveyor observed Registered Nurse Manager (RNM)-K stand and feed R29. Surveyor offered a chair to RNM-K, however, RNM-K continued to stand and feed R29. RNM-K then left R29 to assist others with obtaining items, including clothing protectors. At 8:53 AM, Surveyor observed RNM-K sit down and feed R29. At 9:02 AM, RNM-K stood up to feed R29. At 9:04 AM, RNM-K left and CNA-L finished feeding R29 while standing. ~ At 9:05 AM, Surveyor observed a staff standing while feeding R18 and R5. The staff alternated between feeding R18 and R5 bites of food. On 3/4/25 at 9:06 AM, Surveyor interviewed CNA-L who was feeding R29. Surveyor noted five staff standing and feeding residents in the dining room. CNA-L indicated staff stand while feeding residents because it is easier than getting up and down. On 3/4/25 at 9:08 AM, Surveyor interviewed CNA-M who was standing and feeding R34. CNA-M confirmed CNA-M usually stands while feeding residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/4/25 at 9:09 AM, Surveyor interviewed CNA-R who was standing and feeding R10 and R45 at the same time. CNA-R confirmed CNA-R usually stands while feeding residents. CNA-R indicated CNA-R often feeds two residents at a time because the residents eat slowly and there is time to do so. On 3/5/25 at 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should not stand while feeding residents. DON-B stated staff should sit and be at eye level with the resident they are feeding. DON-B indicated staff should be aware of and follow the facility's expectations for serving food and assisting residents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure a physician was notified of a change in condition for 1 resident (R) (R93) of 7 sampled residents. On 1/1/25, R93 had a low blood pressure reading of 84/43 mmHg (millimeters of mercury). R93's physician was not notified. Findings include: The facility's Notification of Change policy, revised 2/2025, indicates: Communication within the Interdisciplinary Team (IDT), resident .and Medical Doctor is maintained. A facility should immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is .a significant change in the resident's physical, mental or psychosocial status (that is a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment .Physician notification should occur when a resident experiences symptoms such as chest pain, loss of consciousness, or other signs or symptoms of heart attack or stroke that may signify a significant change . From 3/3/25 to 3/5/25, Surveyor reviewed R93's medical record. R93 was admitted to the facility on [DATE] and had diagnoses including acute and chronic respiratory failure with hypoxia (low levels of body oxygen), chronic obstructive pulmonary disease and hypertensive heart disease with heart failure. R93's Minimum Data Set (MDS) assessment, dated 1/21/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R93 was not cognitively impaired. R93 had a court-appointed Guardian who was responsible for R93's healthcare decisions. R93's medical record indicated R93 was transferred to the hospital on 10/10/24 due to low blood pressure and returned to the facility on [DATE]. R93 had an order (dated 10/15/24) to call R93's primary care provider for systolic blood pressure (top number) (SBP) less than 85 or greater than 175. R93's medical record indicated R93's blood pressure was 84/43 mmHg on 1/1/25 at 8:25 AM. R93's medical record did indicate staff updated R93's physician in accordance with the physician's order. On 3/4/25 at 1:20 PM, Surveyor requested documentation that R93's physician was updated on 1/1/25. Director of Nursing (DON)-B was unable to provide documentation and indicated the physician should have been updated per R93's order.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not provide privacy during medication administration for 2 residents (R) (R17 and R228) of 5 sampled residents. On 3/4/25, Licensed Practical Nurse (LPN)-C lifted the back of R17's shirt and lowered the back of R17's pants to administer a lidocaine patch in the dining room. On 3/4/25, LPN-C administered insulin to R228 in the hallway. Findings include: The National Institutes of Health (NIH) National Library of Medicine article Maintaining Patients' Dignity During Clinical Care: A Qualitative Interview Study (November 2, 2010) indicates: In Western countries, measures to maintain dignity in patients' care include maintaining privacy of the body, providing spatial privacy. 1. From 3/3/25 to 3/5/25, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had diagnoses including heart failure, atrial fibrillation, idiopathic pulmonary fibrosis, and presence of a cardiac pacemaker. R17's Minimum Data Set (MDS) assessment, dated 2/11/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R17 had severely impaired cognition. On 3/4/25 at 8:39 AM, Surveyor observed LPN-C administer medication to residents in the second floor dining area. Surveyor observed LPN-C pull up the back of R17's shirt and partially pull down R17's pants. LPN-C then applied a patch to R17's backside. Surveyor noted there were 22 others residents and various staff in the dining room at the time. On 3/4/25 at 8:41 AM, Surveyor interviewed LPN-C who indicated LPN-C applied a Lidocaine patch on R17's lower back. LPN-C indicated LPN-C probably should not have administered the patch in the dining room in front of others due to privacy. On 3/4/25 at 11:19 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated it was not appropriate to lift or lower R17's clothing in the dining room to administer a patch. DON-B indicated the patch should have been applied in the privacy of R17's room. 45943 2. On 3/4/25 at 8:05 AM, Surveyor observed LPN-C administer Basaglar and Humulin insulin to R228 in the hallway. LPN-C lifted up R228's shirt and administered the insulin in R228's abdomen. Surveyor noted there were residents and staff in the hallway at the time. On 3/4/25 at 11:18 AM, Surveyor interviewed DON-B who indicated it was not appropriate to lift R228's clothing in the hallway to administer insulin. DON-B indicated staff should have administered the insulin injections in the privacy of R228's room.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure the Ombudsman was notified of emergency room (ER) or hospital transfers for 6 residents (R) (R23, R36, R56, R91, R93 and R99) of 7 residents reviewed for hospitalization . The Long-Term Care Ombudsman was not notified of ER or hospital transfers for R23, R36, R56, R91, R93, and R99. In addition, the facility did not have a process in place to notify the Ombudsman of ER or hospital transfers. Findings include: The facility's Notice of Transfer, Bed Hold Notice and Return to Facility policy, dated 10/2024, did not include a statement regarding Ombudsman notification. 1. From 3/3/25 to 3/5/25, Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE]. R23's medical record indicated R23 was transferred to the ER or hospital on the following dates: ~ On 9/21/24, R23 had a change in condition and was transferred to the hospital. ~ On 9/25/24, R23 was transferred to the ER. ~ On 9/26/24, R23 was transferred to the ER. ~ On 10/24/24, R23 had a change in condition and was transferred to the hospital. ~ On 12/16/24, R23 was transferred to the ER. Surveyor reviewed the facility's September, October, and December 2024 Ombudsman Notification for transfers/discharges which did not include R23's hospital or ER transfers. 2. From 3/3/25 to 3/5/25, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE]. R36's medical record indicated R36 had a changed in condition on 9/6/24 and was transferred to the ER. Surveyor reviewed the facility's September 2024 Ombudsman Notification for transfers/discharges which did not include R36's ER transfer. 3. From 3/3/25 to 3/5/25, Surveyor reviewed R56's medical record. R56 was admitted to the facility on [DATE]. R56's medical record indicated R56 had a change in condition on 9/10/24 and was transferred to the hospital. Surveyor reviewed the facility's September 2024 Ombudsman Notification for transfers/discharges which did not include R56's hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. From 3/3/25 to 3/5/25, Surveyor reviewed R91's medical record. R91 was admitted to the facility on [DATE]. R91's medical record indicated R91 had a change in condition on 1/7/25 and was transferred to the hospital. Surveyor reviewed the facility's January 2025 Ombudsman Notification for transfers/discharges which did not include R91's hospital transfer. 5. From 3/3/25 to 3/5/25, Surveyor reviewed R93's medical record. R93 was admitted to the facility on [DATE]. R93's medical record indicated R91 had a change in condition on 10/10/24 and was transferred to the hospital. Surveyor reviewed the facility's October 2024 Ombudsman Notification for transfers/discharges which did not include R93's hospital transfer. 6. From 3/3/25 to 3/5/25, Surveyor reviewed R99's medical record. R99 was admitted to the facility on [DATE]. R99's medical record indicated R99 had a change in condition on 1/2/25 and was transferred to the hospital. Surveyor reviewed the facility's January 2025 Ombudsman Notification for transfers/discharges which did not include R99's hospital transfer. On 3/5/25 at 11:38 AM, Surveyor interviewed Director of Nursing (DON)-B who stated nursing staff issue the Notice of Transfer at the time of transfer and Health Information (HI) follows up to ensure the facility has the documentation. DON-B was uncertain about Ombudsman notification. On 3/5/25 at 12:09 PM, Surveyor interviewed Heath Information Director (HID)-D who stated HID-D sends a monthly report generated from the electronic medical record to the Ombudsman. HID-D confirmed ER and hospital transfers are not included in the list HID-D sends to the Ombudsman.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure 3 residents (R) (R13, R36, and R38) of 7 sampled residents met the PASRR (Pre-Admission Screening and Resident Review) requirements. R13 was prescribed Abilify (an antipsychotic medication) on 1/5/23. A new PASRR Level II Screen was not completed. R36 had a positive PASRR Level 1 Screen upon admission and remained at the facility beyond the 30 day exemption period. A Level II Screen was not completed until 3/4/25. R38 had a negative PASRR Level I Screen upon admission. A Level II Screen was not completed when R38 received a qualifying diagnosis and was prescribed medication. Findings include: The facility's Preadmission Screen and Resident Review (PASRR) policy, revised February 2025, indicates: . All persons seeking admission to a nursing facility must receive a Level I Screen prior to admission. If a person is suspected of having a serious mental illness or a developmental disability, they will require a Level II Screen. The Level II Screen will determine if the resident is appropriate for nursing facility placement and if the resident needs specialized services or specialized psychiatric rehabilitative services to address his/her disability needs .If the resident remains in the facility longer than 30 days, the facility will screen the individual using the state's Level I Screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASRR evaluation and determination. If an individual who enters the facility as an exemption is later found to require more than 30 days of skilled nursing care, the state mental health or intellectual disability authority will conduct a Level II review within 40 calendar days of admission .The facility must notify the state mental health authority of significant changes in residents .Referral to the state mental health authority should be made as soon as the criteria indicative of a significant change are evident. Examples of such changes include, but are not limited to: A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms, a resident with behavioral, psychiatric, or mood-related symptoms that have not responded to ongoing treatment, a resident who experiences an improved medical condition such that the residents' plan of care or placement recommendations may require medications, a resident whose significant change is physical, but has behavior, psychiatric, or mood-related symptoms, or cognitive abilities that may influence adjustment to an altered pattern of daily, a resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination .The Social Worker will monitor for significant changes, include new medications and diagnoses . (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. From 3/3/25 to 3/5/25, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including bipolar disorder, chronic generalized disorder, major depressive disorder, and post-traumatic stress disorder. R13's Minimum Data Set (MDS) assessment, dated 2/13/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R13 had moderately impaired cognition. Surveyor noted a PASRR Level I Screen for R13 was last completed on 10/11/16. R13's medical record indicated R13 was prescribed Abilify 5 milligrams for bipolar disorder on 1/5/23 as indicated on R13's signed medication consent form. R13's medical record did not indicate the facility completed an updated PASRR Level II Screen. On 3/5/25 at 10:09 AM, Surveyor interviewed Social Worker (SW)-E who verified R13's Abilify consent was signed on 1/5/23 and R13's last Level II Screen was completed in 2016. SW-E indicated a PASRR Level II Screen should have been sent in when Abilify was prescribed and started on 1/5/23. 2. From 3/3/25 to 3/5/25, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. R36's MDS assessment, dated 1/23/25, had a BIMS score of 15 out of 15 which indicated R36 was not cognitively impaired. A PASRR Level II Screen was scanned on 3/3/25. No previous Level II Screen was noted. On 3/4/25 at 3:22 PM, Surveyor interviewed Assistant Administrator (AA)-AA who indicated a PASRR Level II Screen was not sent in when R36 was admitted because R36 was supposed to have a short-term stay. After it was determined that R36 would remain beyond 30 days, the facility did not send for a Level II Screen. AA-AA confirmed a Level II Screen was submitted on 3/4/25 at 10:44 AM. On 3/5/25 at 9:50 AM, Surveyor interviewed SW-E who indicated a PASRR Level I Screen is completed prior to admission and will indicate a 30 day exemption. If a resident remains in the facility beyond 30 days, the facility will send for a Level II Screen. SW-E indicated the Level II Screen is sent right away when the facility becomes aware the resident will stay in the facility for long-term care. SW-E indicated the facility knew R36 would stay long-term in April or May of 2024. SW-E confirmed R36's Level II Screen was not sent in until 3/4/25. 45943 3. From 3/3/25 to 3/5/25, Surveyor reviewed R38's medical record. R38 was admitted to the facility on [DATE]. On 1/4/19, R38 was not suspected of having a mental illness and was not prescribed psychotropic medication. R38's medical record contained a PASRR Level I Screen, dated 9/10/21, that indicated R38 had a serious mental illness and was prescribed Zoloft (the Level I Screen did not include a diagnosis for Zoloft). A PASRR Level II Screen, dated 9/14/21, indicated R38 did not need specialized services. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24, R38 was diagnosed with anxiety. On 7/18/24, R38 had a diagnosis of dementia with severe anxiety. R38 was prescribed buspirone HCL 15 milligrams (mg) 1 tablet by mouth two times a day for anxiety on 11/8/24. R38 was also prescribed Lorazepam 0.5 mg 1 tablet by mouth one time a day for anxiety/restlessness on 2/13/25. A PASRR Level II Screen was not completed following the additional diagnoses and medications. On 3/5/25 at 10:02 AM, Surveyor interviewed SW-E who verified a PASRR Level II Screen was not completed when R38 was diagnosed with anxiety and when buspirone was prescribed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51044 Based on staff and resident interview and record review, the facility did not ensure the necessary care and services were provided to prevent pressure injuries from developing and/or promote healing for 1 resident (R) (R376) of 2 sampled residents. R376 had an unstageable pressure injury on the middle spine. The facility did not assess the wound and implement wound orders according to the facility's policy. In addition, staff did not ensure R376's wound treatment was completed as ordered and R376's care plan did not contain goals or interventions for treatment. Findings include: The facility's Wound and Treatment policy, revised 12/2024, indicates: Rocky [NAME] strives to ensure that a resident entering the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates unavoidable skin breakdown. Residents with pressure injuries receive necessary treatment and services, consistent with professional stands of practice, to promote healing, prevent infection, and prevent new ulcers from developing .Skin integrity assessments are completed by a licensed nurse as soon as possible upon admission and within 8 hours, as soon as possible upon readmission but within 8 hours, and then weekly thereafter and as needed .1) The resident's skin is to be assessed from head to toe for any skin integrity impairments .5) Skin integrity impairments are to be monitored and care planned. 6) Interventions are to be implemented and care planned. 7) All interventions are to be communicated to staff members .2) Effective prevention and treatment is based upon consistently providing routine and individualized interventions. 3) Based upon the assessment and the resident's clinical condition, choices and identified needs, basic or routine care could include .a. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); .c. Provide appropriate, pressure-redistributing, support surfaces; .e. Maintain or improve nutrition and hydration status, where feasible .1) Repositioning or relieving constant pressure is a common, effective intervention for an individual with a pressure injury or who is at risk of developing one. 2) Assessment of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. a) Such plans are addressed in the comprehensive care plan consistent with the resident's need and goals. b) Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning as the resident is unable to make small movements on their own that would help to relieve prolonged pressure to one area .Infections: . Since bacteria reside in non-viable tissue, debridement of the tissue and wound cleansing are important to reduce bacteria and avoid adverse outcomes such as sepsis. The facility's Baseline Care Plan policy, revised 12/2024, indicates: A baseline care plan will be developed and implemented for each resident within 48 hours of admission .The baseline care plan is intended to promote continuity of care .and safeguard against adverse events that are most likely to occur right after admission .1. The baseline care plan .provides instructions for the provision of effective and person-centered care to each resident .and must include as a minimum the following information: A. Physician orders .F. Initial goals based on admission orders and the resident's stated goals. G. Instructions needed to provide effective and person-centered care. H. Address the resident's health and safety concerns to prevent decline or injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE N7135 Rocky Knoll Parkway Plymouth, WI 53073	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25, Surveyor reviewed R376's medical record. R376 was admitted to the facility on [DATE] post hospitalization for chronic compression fractures. R376 was transferred to the hospital on 2/24/25 and readmitted to the facility on [DATE]. R376 had diagnoses including diabetes mellitus with other diabetic kidney complication and atrial fibrillation. R376's Minimum Data Set (MDS) assessment, dated 2/24/25, indicated R376 had an unhealed unstageable pressure injury. The MDS assessments for R376's admissions on 2/21/25 and 2/28/25 did not contain information regarding R376's cognitive status, mobility, or skin. R376 did not have a care plan that indicated R376 had a pressure injury. A skin assessment, dated 2/21/25 at 2:04 PM, indicated R376 had an unstageable pressure injury on the mid-back that measured 2.3 centimeters (cm) (length) x 2 cm (width) x 0.1 cm (depth) with 100% slough in the wound bed. R376's medical record indicated R376 was admitted to the hospital on 2/24/25 for acute metabolic encephalopathy likely secondary to sepsis with bacteremia. R376 returned to the facility on [DATE]. R376's hospital discharge instructions contained the following: Low Back Wound Care Instructions: Every day remove the old bandage and wash the wound well with a mild soap and water, rinse and pat dry. Low Back: Apply a nickel-thick amount of Santyl to the wound bed followed by a dry cover dressing. You may apply a foam pad or callus pad around the wound to help off load pressure. A hospital inpatient wound care consult note indicated R376 was seen by a wound care Nurse Practitioner (NP) on 2/25/25 for lower back ulceration. A skin assessment, dated 3/1/25 at 1:39 PM, indicated R376 had a pressure injury on the mid-spine that was 2.5 cm (length) x 2 cm (width) x 0.1 cm (depth) with slough in the wound bed. (R376's medical record did not contain a wound assessment or a wound care order from 2/28/25 when R376 was readmitted from the hospital.) R376's March 2025 treatment administration record (TAR) contained the following order (dated 3/1/25): Mid back: Cleanse wound with wound cleanser. Apply skin prep to surrounding area and apply petroleum dressing covered with border foam daily. One time a day. The TAR indicated R376's dressing change was completed on 3/2/25 and 3/4/25 but did not indicate R376's dressing was changed on 3/1/25 or 3/3/25. On 3/5/25 at 10:18 AM, Surveyor interviewed R376 who stated R376 was given a new cushion earlier that day to put behind R376's back. R376 indicated R376's wound dressing was not changed daily. On 3/5/25 at 10:35 AM, Surveyor interviewed Registered Nurse (RN)-W who indicated R376 had a pressure injury on the mid-back. RN-W indicated RN-W completed R376's wound treatment earlier that day with a physician. RN-W stated R376's wound care order was changed due to continued slough in the wound bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 12:03 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated orders from the hospital are transcribed upon admission and should start immediately. DON-B indicated when a resident is admitted to the facility a skin assessment and wound care are completed on the day of admission. Unless an order states not to remove a dressing, DON-B indicated the resident's wound is assessed, a new treatment is applied, and there is follow up by the wound nurse. DON-B indicated wounds and interventions are care planned within 48 hours of admission and care plans should include interventions to alleviate pressure. In addition, DON-B indicated staff should complete and document daily wound treatments.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff and resident interview, and record review, the facility did not ensure 1 resident (R) (R43) of 1 sampled resident received the necessary care and services for oxygen therapy. R43's oxygen order did not specify the flow rate. On 3/4/25, R43 was observed without oxygen. In addition, R43's plan of care did not indicate R43 used continuous oxygen. Findings include: The facility's Respiratory Care Policy, revised 9/20/24, indicates: A resident who needs respiratory care .is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences .Oxygen Therapy: .iii. For a resident receiving oxygen therapy, the resident's record must reflect ongoing assessment of the resident's respiratory status, response to oxygen therapy and include at a minimum, the attending practitioner's orders and indication for use .iv. The resident's care plan should identify the interventions for oxygen therapy based upon the resident's assessment and orders, such as but not limited to: .2. When to administer, such as continuous or intermittent and/or when to discontinue; 3. Equipment settings for the prescribed flow rates . The facility's Comprehensive Care Plan Policy dated 12/2024, indicates: To ensure a comprehensive person-centered care plan is developed and implemented for each resident based on their individual needs . that includes measurable objectives and time frames to meet his or her preferences and goals and address the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .The comprehensive care plan must describe the following: a. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . A Nursing Assistant Care Plan (Certified Nursing Assistant (CNA) Kardex) will be maintained for each resident. The care plan will be updated by licensed staff with the input of nursing assistants .3. Changes will be highlighted on the care plan .4. The licensed nurse will update the care plan in the electronic medical record . 5. Care plans will be updated quarterly and as needed . From 3/3/25 to 3/5/25, Surveyor reviewed R43's medical record. R43 was admitted to the facility on [DATE] and had diagnoses including pulmonary fibrosis, interstitial pulmonary disease, eosinophilic asthma, dependence on supplemental oxygen, congestive heart failure, and presence of cardiac pacemaker. R43's Minimum Data Set (MDS) assessment, dated 1/23/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R43 was not cognitively impaired. On 3/4/25 at 8:01 AM, Surveyor observed R43 in the hallway near the nurses' station outside the second floor dining room. Surveyor heard R43 ask if someone could hook up R43's oxygen. Surveyor observed R43 ask a second time when Licensed Practical Nurse (LPN)-C walked by. R43 had on a nasal cannula and was holding the end of the oxygen tubing in R43's hand. LPN-C walked around the back of R43's wheelchair and connected the tubing to a portable oxygen concentrator on the back of the wheelchair. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 8:02 AM, Surveyor interviewed R43 who indicated R43 had to go to the nurses' station to have R43's oxygen hooked up because staff who got R43 ready for breakfast did not connect the oxygen. R43 could not identify the staff who did not attach the oxygen tubing. R43 indicated R43 was without oxygen for approximately five minutes and it was not the first time it occurred. R43 indicated R43 was not short of breath. On 3/4/25 at 1:10 PM, Surveyor interviewed LPN-C who indicated R43 needs oxygen on at all times. LPN-C confirmed LPN-C attached the tubing when R43 asked for assistance. LPN-C did not know which staff got R43 ready that morning. On 3/5/25 at 10:42 AM, Surveyor interviewed LPN-C who indicated oxygen specifications for R43 should be on R43's medication administration record (MAR), care plan, and Kardex (an abbreviated care plan used by nursing staff) on the back of R43's door. On 3/5/25 at 10:46 AM, Surveyor interviewed Registered Nurse (RN)-Z who indicted R43's MAR or treatment administration record (TAR) should contain R43's oxygen flow needs and track oxygen saturation levels. R43's medical record contained an order, dated 4/24/24, for oxygen via nasal cannula to keep oxygen saturation above 90%. The order did not specify the oxygen level or flow (via liters per minute) rate. Staff documented R43's oxygen saturation level each shift on the MAR. A second oxygen order, dated 4/25/24, indicated it was okay to provide oxygen at 2 liters via nasal cannula for emergent situations and update the Medical Doctor (MD) if initiated (use only if has no other orders for oxygen). Since R43 had an oxygen order from 4/24/24 the as needed order from 4/25/24 would not have been used. A care plan, initiated 7/14/23, indicated R43 had the potential for altered respiratory status and difficulty breathing and contained interventions to watch for signs and symptoms of respiratory distress. The care plan did not mention R43's oxygen therapy. R43's plan of care mentioned oxygen at 2 liters while ambulating in the hallway under a restorative program (initiated 3/30/22). R43 did not have a care plan for continuous oxygen use. On 3/5/25, Surveyor noted R43's Kardex did not include oxygen use. The Kardex contained an intervention for oxygen at 2 liters while ambulating in the hallway under a restorative program. The Kardex did not indicate R43 used continuous oxygen. On 3/5/25 at 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated R43 was on oxygen therapy. DON-B indicated a resident's care plan should be up-to-date with the resident's needs so staff know how to care for the resident. DON-B confirmed a resident who uses oxygen should have a care plan for oxygen therapy including how many liters per minute the resident requires. DON-B indicated the resident's Kardex should also indicate the resident's oxygen needs. DON-B indicated an assessment should be completed with any changes and the care plan and the Kardex should be updated accordingly. On 3/5/25 at 1:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated a resident's care plan and Kardex should be updated with new diagnoses, cares, and treatment orders. NHA-A indicated a resident's care plan and Kardex should be updated within 24 hours and a care plan should be initiated right away.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not ensure medications were labeled and stored appropriately for 2 residents (R) (R43 and R228) of 6 sampled residents. This practice had the potential to affect more than 4 of the 134 residents residing in the facility. On 3/3/25, two bags of unidentified and unsecured medications were observed in R43's room. During observations of medication administration, staff left a tray of medication unattended on top of the medication cart. Findings include: The facility's Self Administration of Medication Policy, dated 12/2024, indicates: .2. A resident may only self-administer medications and/or have medications left at the bedside after the Interdisciplinary Team (IDT) has determined which medications may be self-administered. 3. When determining if self-administration is clinically appropriate for a resident, the IDT should at a minimum consider the following: a. If the medications are appropriate and safe for self-administration and/or to leave at the bedside .g. The resident's ability to ensure the medication is stored safely and securely. 4. Appropriate notation of these determinations is documented in the resident's medical record and care plan. 5. An order for self-administration of medication and or to leave medications at the bedside must be obtained from the attending physician. The facility's Medication Storage in the Facility Policy, revised January 2018, indicates: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication .Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access. The facility's Bedside Medication Storage Policy, revised January 2018, indicates: Bedside medication storage is permitted for residents who wish to self-administer medication, upon the written order of the prescriber, and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team. 1. From 3/3/25 to 3/5/25, Surveyor reviewed R43's medical record. R43 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, pulmonary fibrosis, eosinophilic asthma, Parkinsonism, congestive heart failure, and presence of cardiac pacemaker. R43's Minimum Data Set (MDS) assessment, dated 1/23/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R43 was not cognitively impaired. On 3/3/25 at 1:56 PM, Surveyor knocked on R43's door and peered in R43's room in an attempt to interview R43. R43 did not appear to be in the room. Surveyor observed two gallon size or larger clear plastic bags (one was open) on a table in R43's room that was visible from the doorway. Surveyor noted the bags contained unidentified medications with what appeared to be pharmacy labels. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

R43's medical record contained a self-administration of medication assessment dated [DATE]. The assessment indicated R43 was able to demonstrate secure storage of medication kept in R43's room (keep key, lock and unlock medication box/drawer).

Surveyor attempted to locate R43 on at least two occasions on 3/3/25 and at least three occasions on 3/4/25.

On 3/4/25, Surveyor requested self-administration of medication and bedside medication storage orders for R43. Surveyor received a self-administration order, dated 2/5/25, for fluticasone propionate nasal suspension (a nasal spray) and fluticasone-salmeterol inhalation aerosol powder. In addition, an order dated 2/6/25 indicated R43 could self-administer insulin with staff supervision.

On 3/4/25, Surveyor reviewed R43's medication administration record (MAR) which contained the following orders:

~ Fluticasone propionate nasal suspension 50 mcg/act (micrograms per actuation) two sprays in each nostril once daily for nasal congestion. Unsupervised self-administration. (Start date: 4/23/24).

~ Fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act inhale 1 puff two times daily for shortness of breath and wheezing. Unsupervised self-administration. (Start date: 4/22/24).

~ Sodium chloride nasal solution 0.65 % (saline). One spray in each nostril four times daily for nasal dryness/congestion. Unsupervised self-administration. (Start date: 4/22/24).

~ Sodium chloride nasal solution 0.65 % (saline). One spray in each nostril every 2 hours as needed for dry nasal cavity. Unsupervised self-administration. (Start date: 4/22/24).

On 3/4/25 at 1:33 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated a resident should have a self-administration of medication order and assessment completed prior to being able to self-administer medication. DON-B also indicated medications should be stored in a locked area. When asked the protocol if a resident does not secure their medication, DON-B indicated staff should reevaluate the resident to ensure the resident meets the criteria to self-administer medication. DON-B indicated the resident should be reeducated and the medication should be secured.

On 3/4/25 at 1:53 PM, Surveyor interviewed Medication Assistant (MA)-Y who indicated MA-Y was not able to administer R43's medication because R43 was not in the facility. Surveyor and MA-Y then entered R43's room and observed two bags of medication on a table. The following medications were observed in the bags:

~ Nystop powder

~ Diclofenac sodium gel 1%

~ Three containers of clobetasol propionate topical solution .05%

~ Lidocaine topical ointment

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ Two containers of fluocinonide 0.05% ~ Bacitracin ointment 500 ~ Two containers (one almost empty) of triamcinolone acetonide cream .1% ~ Two containers of ketoconazole shampoo 2% ~ Dermaklenz wound cleanser (house stock) ~ Sciatiflex (no pharmacy label) ~ Hempvana pain relief cream (no pharmacy label) ~ Iodosorb (no pharmacy label) After the medications were identified, Surveyor asked if R43 cleansed R43's wounds with wound cleanser. MA-Y replied, Your guess is as good as mine. When Surveyor asked if the medications should be secured or locked, MA-Y indicated MA-Y believed the medications should be locked because a resident could have access to the medications if they wandered into R43's room. On 3/4/25 at 2:41 PM, Surveyor interviewed DON-B who indicated R43 is able to administer R43's insulin in front of staff. DON-B indicated the medications in R43's room should be secured or locked even if they are self-administered. DON-B verified unsecured medications pose a safety issue because they're accessible to other residents. DON-B indicated R43 is not adhering to protocol by not securing the medications and will need to be evaluated again. DON-B looked at R43's medication and self-administration orders with Surveyor and indicated there should be an order for each medication R43 is assessed as able to self-administer. DON-B indicated the facility's self-administration of medication policy needed to tweaked regarding securing/locking medications. 45943 2. On 3/4/25 from 8:03 AM to 8:44 AM, Surveyor observed LPN-C intermittently leave a tray of medication unattended on top of the medication cart in the hallway while LPN-C passed medication. The tray contained a bottle of Florajen 15 billion live cultures/capsule (stock supply) and R228's insulins (a bottle of insulin glargine 100 units/milliliter (ml), a Humulin R U-500 insulin Kwik pen (500 units/ml), and a pre-filled syringe of Basaglar insulin (100 units/ml)). During that time, Surveyor observed residents in the hallway near the medication cart. On 3/4/25 at 8:44 AM, Surveyor interviewed LPN-C who indicated LPN-C did not usually leave medication on top of the medication cart. On 3/4/25 at 11:18 AM Surveyor interviewed DON-B who indicated medications should not be left on top of the medication cart for resident safety.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not ensure food was stored, prepared, and served in a sanitary manner. This practice had the potential to affect all 134 residents residing in the facility. Staff did not store or date food in a manner to ensure food safety. Staff did not follow safe food cooling protocols. Staff did not adhere to temperature requirements when testing parts per million (PPM) of the sanitizing solution. Staff did appropriately process clean dishes and did not maintain dishwasher temperature testing strips. Staff did not follow microwave safe heating procedures. Staff did not consistently wear hair restraints in the kitchen and while serving food. Staff did not perform proper hand hygiene prior to applying and removing gloves and while preparing and serving food. Findings include: Food Labeling/Storage: The facility's Food Storage Policy, revised September 2024, indicates: All products are correctly stored in appropriate areas .2. The Director of Dining Services or Designee will ensure food is clearly marked, dated, labeled, and discarded in accordance with the Food and Drug Administration (FDA) Food Code . The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 Celsius (C) (41 Fahrenheit (F)) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an initial tour of the kitchen that began at 9:26 AM on 3/3/25, Surveyor and Director of Dining Services (DDS)-H observed the following items: Cooler: ~ A container of cottage cheese with an open date of 2/23 (per DDS-H) and no use-by date ~ A container of cheese spread with an open date of 2/19 (per DDS-H) and no use-by date ~ A container of sour cream with an open date of 2/28 (per DDS-H) and no use-by date ~ A package of ham with an open date of 2/28 (per DDS-H) and no use-by date ~ A package of cheddar cheese with an open date of 1/28 (per DDS-H) and no use-by date ~ A package of sliced American cheese with an open date of 2/26 (per DDS-H) and no use-by date ~ A container of cooked noodles with a made date of 2/28 (per DDS-H) of 2/28 and no use-by date ~ A container of cooked burgers with a made date of 2/28 (per DDS-H) of 2/28 and no use-by date ~ A container of egg salad with a made date of 3/1 (per DDS-H) and no use-by date ~ A container of cooked chicken breast with a made date of 3/1 (per DDS-H) and no use-by date ~ A container of cooked corn chip chicken with a made date of 3/1 (per DDS-H) and no use-by date ~ A container of cooked cube steak with a made date of 3/1 (per DDS-H) and no use-by date ~ A container of cooked macaroni and cheese with a made date of 3/1 (per DDS-H) and no use-by date ~ Two containers of fruit with made dates of 3/3 (per DDS-H) and no use-by dates ~ Two containers of cooked hard boiled eggs with made dates of 2/26 (per DDS-H) and no use-by dates ~ A container of cooked fish with a made date of 2/28 (per DDS-H) and no use-by date. ~ A container of Italian pasta with a made date of 2/28 (per DDS-H) and no use-by date ~ A container of cooked egg bites with a made date of 3/3 (per DDS-H) and no use-by date ~ A container of cooked green beans with a made date of 3/2 (per DDS-H) and no use-by date ~ A container of ham with a made date of 3/2 (per DDS-H) and no use-by date ~ A container labeled eggs with a made date of 3/2 (per DDS-H) and no use-by date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER: Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE: N7135 Rocky Knoll Parkway Plymouth, WI 53073	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ An unlabeled container of washed and separated grapes (per DDS-H) with no prepared or use-by dates ~ A unlabeled container of sliced summer sausage with an open date of 2/28 (per DDS-H) and no use-by date ~ Two unlabeled peanut butter and jelly sandwiches with made dates of 2/28 (per DDS-H) and no use-by dates ~ An unlabeled container of cut strawberries with a prepared date of 2/28 (per DDS-H) and no use-by date Freezer: ~ Three open and unlabeled packages of waffles (per DDS-H). One package had an open date of 2/9 (per DDS-H) and no use-by date. The other two packages had no open or use-by dates. ~ Four containers labeled soft bite meat with no made or use-by dates ~ An unsealed box of gluten-free snickerdoodle cookie dough that was open to air with no open or use-by dates ~ Eight unlabeled pieces of gluten-free cornbread with made dates of 1/23 (per DDS-H) and no use-by dates ~ Two containers of gluten-free banana french toast with no made or use-by dates ~ Eight unlabeled gluten-free muffins (per DDS-H) with no made or use-by dates ~ An unlabeled package of pepperoni with an open date of 2/13 (per DDS-H) and no use-by date ~ An unlabeled package of sausage patties with an open date of 2/4 (per DDS-H) and no use-by date Dry Storage: ~ A package of strawberry Jell-O with an open date of 2/13 (per DDS-H) and no use-by date ~ A package Cherry Jell-O with an open date of 2/7 (per DDS-H) and no use-by date ~ A package of cheesecake filling with an open date of 2/16 (per DDS-H) and no use-by date ~ A package of baking powder with an open date of 2/17/25 (per DDS-H) and no use-by date ~ A package of powdered sugar with an open date of 2/28 (per DDS-H) and no use-by date ~ A package of fettuccine noodles with an open date of 2/12 (per DDS-H) and no use-by date ~ A package of elbow noodles with an open date of 3/1 (per DDS-H) and no use-by date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ A package of cheese sauce mix with an open date of 1/18 (per DDS-H) and no use-by date ~ A package of chicken gravy with an open date of 3/1 (per DDS-H) and no use-by date ~ A container of fried onions with an open date of 3/1 (per DDS-H) and no use-by date ~ A package of Cheerios with an open date of 2/17 (per DDS-H) of 2/17 and no use-by date ~ A package of [NAME] Puffs with an open date of 2/26 (per DDS-H) and no use-by date ~ A package of Corn Flakes with an open date of 3/3 (per DDS-H) and no use-by date ~ A package of [NAME] Krispies with an open date of 2/28 (per DDS-H) and no use-by date ~ A container of brown sugar with an open date of 2/19 (per DDS-H) and no use-by date ~ A container of dry thickener with an open date of 2/26/25 and no use-by date ~ A container of taco seasoning with an open date of 1/22/25 (per DDS-H) and no use-by date ~ A package of herb seasoning with an open date of 10/4/24 (per DDS-H) and no use-by date ~ An unlabeled package of Fruit Loops with an open date of 2/28 (per DDS-H) and no use-by date On 3/4/25 at 7:48 AM, Surveyor noted the following additional items: Cooler: ~ A container of beef dated 3/3 with no use-by date ~ A container of sliced beets dated 3/3 with no use-by date ~ A container of cooked bacon dated 3/3 with no use-by date Dry Storage: ~ A container of brown sugar dated 3/4 with no use-by date ~ A bulk container of flour dated 8/7/24 with no use-by date ~ A bulk container of sugar dated 2/13/25 with no-use by date ~ A bulk container of panko dated 6/28/24 with no use-by date ~ An unlabeled container of an unknown item dated 8/6/24 with no use-by date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an initial kitchen tour that began at 9:26 AM on 3/3/25, Surveyor interviewed DDS-H who indicated DDS-H did not know the use-by dates for the open items in the dry storage area. DDS-H observed the items in the walk-in cooler and indicated DDS-H did not know the expiration dates for many of the undated items but believed they were one month or the expiration date on the package. DDS-H indicated staff should use stickers for the items with use-by dates. DDS-H indicated staff should label all items in the freezer so they can be identified and ensure they have use-by dates. DDS-H stated, I think the use-by date is our biggest issue. On 3/4/25 at 9:32 AM, Surveyor interviewed [NAME] (CK)-P who stated the unidentified item in the bulk container should be labeled with the item's name. CK-P then labeled the bulk container panko. CK-P indicated CK-P did not put the item in the container but knew it was panko. CK-P indicated CK-P did not know the use-by dates of the containers of panko that were dated 6/28/24 and 8/6/24. Cooling Temperatures: The 2022 FDA Food Code documents at 3-501.14 Cooling: (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. (B) Time/temperature control for safety food shall be cooled within 4 hours to 5 C (41 F) or less. The 2022 FDA Food Code documents at section 3-501.15 Cooling Methods: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of food being cooled: (1) Placing the food in shallow pans; (2) Separating the food into smaller or thinner portions; (3) Using rapid cooling equipment; (4) Stirring the food in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. The facility's General HACCP Guidelines for Food Safety policy, dated 2021, indicates: .5. Essentials of Cooling: A. Cool from 135 F to 70 F in 2 hours and from 70 F to 41 in 4 hours (not to exceed 6 hours). During an initial kitchen tour that began at 9:26 AM on 3/3/25, Surveyor observed the facility's food cooling logs with DDS-H. Surveyor noted a water damaged food cooling log near the three-compartment sink did not contain any documentation. DDS-H showed Surveyor a second cooling log posted on the cook's cooler which also did not contain any documentation. During an initial kitchen tour that began at 9:26 AM on 3/3/25, Surveyor interviewed DDS-H who stated the water damaged cooling log near the three-compartment sink most likely hadn't been used in a while. After viewing the second blank cooling log, DDS-H indicated cooks should use the cooling logs for all cooked food put in the coolers and freezers. DDS-H looked though folders in DDS-H's office but was unable to find the cooling logs. DDS-H indicated there should be cooling logs. Surveyor noted the following items in the cooler that were not on a cooling log: ~ A container of cooked chicken breast dated 3/1 ~ A container of cooked corn chip chicken dated 3/1 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~ A container of cooked cube steak dated 3/1 ~ A container of cooked macaroni and cheese dated 3/1 ~ Two containers of cooked hard boiled eggs dated 2/26 ~ A container of cooked fish dated 2/28 ~ A container of Italian pasta dated 2/28 ~ A container of cooked egg bites dated 3/3 ~ A container of cooked green beans dated 3/2 ~ A container of cooked ham dated 3/2 ~ A container of cooked eggs dated 3/2 On 3/4/25 at 7:48 AM, Surveyor noted the cooling log by the three-compartment sink was still blank and the cooling log on the cook's cooler door had an entry for beef made on 3/3. Surveyor noted the following new items in the cook's cooler that were not on the cooling log: ~ A container of sliced beets dated 3/3 ~ A container of cooked bacon dated 3/3 On 3/4/25 at 10:17 AM, Surveyor interviewed DDS-H who indicated DDS-H had not found the January and February 2025 cooling logs. On 3/4/25 at 3:26 PM, Surveyor received the January and February 2025 cooling logs from DDS-H who indicated a coworker had the logs. Surveyor reviewed the cooling logs and noted the only item on the cooling log from the list above was fish sticks from 2/28. Surveyor noted the eight pieces of gluten-free cornbread dated 1/23 from the initial kitchen tour were not on the January 2025 cooling log. Sanitizing Solution: The 2022 FDA Food Code documents at 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization-Temperature, pH, Concentration, and Hardness: A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under 7-204.11 Sanitizers, Criteria, shall be used in accordance with the Environmental Protection Agency (EPA)-registered label use instructions. The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an initial kitchen tour that began at 9:26 AM on 3/3/25, Surveyor observed red sanitizing buckets in the kitchen and a quat sanitizer testing log posted near the three-compartment sink. Surveyor noted the testing log contained two entries (one dated 2/7 and another dated 3/3) and there was no column for testing the temperature of the sanitizing solution. Surveyor observed a quat sanitizer poster on the wall that indicated the testing solution should be between 65 and 75 degrees Fahrenheit. After testing the temperature of the water, the Hydrion test strip should be dipped in the sanitizing solution for 10 seconds to determine the PPM. During an initial kitchen tour that began at 9:26 AM on 3/3/25, Surveyor interviewed DDS-H who indicated the sanitizing buckets were tested on ce per shift with Hydrion test strips. DDS-H stated DDS-H does not test the temperature of the sanitizing solution and just uses the test strips to record the PPM. DDS-H indicated staff should follow the quat sanitizer testing poster which indicated appropriate sanitization was 150-400 PPM for the sanitizing buckets and for manually washed cookware, dishes, and utensils. Surveyor noted the Hydrion quaternary test strip package indicated the sanitizing solution should be between 65 and 75 degrees F at the time of testing. DDS-H indicated staff should test the sanitizing solution more often than what is on the log. DDS-H indicated DDS-H would look for more testing logs. On 3/4/25 at 7:34 AM, Surveyor interviewed CK-T who indicated CK-T uses sanitizing buckets every day and changes them as often as every hour if particles were in the water. CK-T indicated CK-T does not always test the sanitizing solution and sometimes only documents the first test. CK-T could not explain why there were no entries on the log that indicated CK-T had tested the sanitizing solution. On 3/4/25 at 10:17 AM, Surveyor interviewed DDS-H who indicated DDS-H could not locate the February 2025 sanitizing log. On 3/4/25 at 3:26 PM, Surveyor received the February 2025 sanitizing log. DDS-H indicated a coworker had the log which was recently recovered. Surveyor reviewed the log and noted the majority of days contained only one entry and indicated the temperature of the sanitizing solution was not tested . In addition, seven of the twenty eight days in the month did not contain an entry Dishwashing: The 2022 FDA Food Code documents at 4-302.13 Temperature Measuring Devices, Manual Warewashing: Water temperature is critical to sanitization in warewashing operations. This is particularly true if the sanitizer being used is hot water. The effectiveness of cleaners and chemical sanitizers is also determined by the temperature of the water used. A temperature measuring device is essential to monitor manual warewashing and ensure sanitization. Effective mechanical hot water sanitization occurs when the surface temperatures of utensils passing through the warewashing machine meet or exceed the required 71 C (160 F). Parameters such as water temperature, rinse pressure, and time determine whether the appropriate surface temperature is achieved. Although the Food Code requires integral temperature measuring devices and a pressure gauge for hot water mechanical warewashers, the measurements displayed by these devices may not always be sufficient to determine that the surface temperatures of utensils are reaching 71 C (160 F). The regular use of irreversible registering temperature indicators provides a simple method to verify that the hot water mechanical sanitizing operation is effective in achieving a utensil surface temperature of 71 C (160 F). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Food Code documents at 3-401.12 Microwave Cooking: The rapid increase in food temperature resulting from microwave heating does not provide the same cumulative time and temperature relationship necessary for the destruction of microorganisms as do conventional cooking methods. In order to achieve comparable lethality, the food must attain a temperature of 74 degrees C (165 degrees F) in all parts of the food. Since cold spots may exist in food cooking in a microwave oven, it is critical to measure the food temperature at multiple sites when the food is removed from the oven and then allow the food to stand covered for two minutes post microwave heating to allow thermal equalization and exposure. Although some microwave ovens are designed and engineered to deliver energy more evenly to the food than others, the important factor is to measure and ensure that the final temperature reaches 74 degrees C (165 degrees F) throughout the food. On 3/3/25 at 12:27 PM, Surveyor observed DA-I microwave a bowl of soup for 2 minutes. When the microwave cycle was complete, DA-I served the steaming soup to a resident. DA-I did not stir the soup, let the soup stand for two minutes after heating, or temp the soup before serving it. On 3/4/25 at 8:24 AM, Surveyor observed DA-I microwave a bowl of soup for 2 minutes. DA-I stopped the cycle 14 seconds early and served the steaming soup to a resident. DA-I did not stir the soup, let the soup stand for two minutes after heating, or temp the soup before serving it. On 3/4/25 at 9:13 AM, Surveyor interviewed DA-I who indicated DA-I did not temp the soup on 3/3/25 or 3/4/25 because DA-I did not have a thermometer. Hair Restraints: The 2022 FDA Food Code documents at 2-402.11 Hair Restraint Effectiveness: (A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils and linens, and unwrapped single service and single-use articles. The facility's Personal Adherence to Sanitary Procedures policy, dated 10/2005, indicates: .2. Hair is to be completely restrained .i. Wear hair bonnet covering all hair. ii. Keep hair off collar and neck . On 3/3/25 at 12:10 PM, Surveyor observed Dietary Assistant (DAS)-J prepare food in the main kitchen. DAS-J then transported the food and began serving the food in the second floor dining room and unit kitchen. DAS-J wore a hair restraint but did not wear a beard restraint. Surveyor noted DAS-J's beard stuck out approximately two inches from the sides and bottom of a surgical mask. On 3/4/25 at 7:57 AM, Surveyor observed DA-I prepare a food cart in the main kitchen for the second floor dining room. Surveyor noted DA-I's hair restraint did not cover approximately three to four inches of hair on the back and sides of DA-I's head. DA-I also served food in the dining room and second floor kitchen without DA-I's hair fully restrained. On 3/4/25 at 8:52 AM, Surveyor noted DAS-J's hair restraint did not fully cover DAS-J's hair. Surveyor also noted DAS-J was not wearing a beard restraint and DAS-J's beard stuck out of the sides and bottom of a surgical mask. DAS-J served food in the dining room and second floor kitchen without DAS-J's hair and beard fully restrained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/4/25 at 9:13 AM, Surveyor interviewed DAS-J and DA-I regarding hair and beard restraints. DAS-J indicated DAS-J did not know DAS-J needed to wear a beard restraint and did not know where to find one. DA-I indicated DA-I knew DA-I's hair should be fully covered, however, DA-I was in a rush that morning. On 3/4/25 at 9:20 AM, Surveyor observed DAS-J and DA-I in the main kitchen. Surveyor noted DAS-J was not wearing a beard restraint and DA-I's hair restraint did not fully cover the back of DA-I's hair. On 3/4/25 at 9:43 AM, Surveyor interviewed DDS-H who indicated staffs' hair should be fully covered while preparing and serving food. DDS-H indicated staff with facial hair should wear a beard restraint. Hand Hygiene: The 2022 FDA Food Code documents at 2-301.14: Food Employees shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles. The 2022 FDA Food Code documents at 3-301.11 Preventing Contamination From Hands: (A) Food employees shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. The facility's Personal Adherence to Sanitary Procedures policy, dated 10/2005, indicates: All dietary employees will practice optimal personal hygiene at all times to minimize contamination of food and/or residents in accordance with food service department procedures as follows: .A. Clean hands: i. Before handling or serving food; ii. After using the toilet; iii. After handling soiled dishes, rags, mops, or garbage; iv. After sneezing or blowing nose; v. After taking a break, eating a meal, or smoking; vi. After touching face and hair; vii. After returning to kitchen area from any other area . On 3/4/25 at 8:24 AM, Surveyor observed DA-I serve breakfast from a steam table in the second floor kitchen/dining room with gloved hands. DA-I served food to twenty three residents, opened a can of soup, multiple drawers and various condiment packets, and picked up dishes, food covers, and toast from the toaster with the same gloved hands. Surveyor noted also observed DA-I remove bread from the toaster, spread butter and condiments on the bread, and serve it directly to residents. On 3/4/25 at 9:00 AM, Surveyor observed DA-I answer a phone in the second floor dining room with gloved hands. DA-I then hung up the phone and removed gloves. DA-I did not complete hand hygiene before donning a clean pair of gloves and continued with breakfast service. On 3/4/25 at 9:20 AM, Surveyor observed DA-I and DAS-J enter the main kitchen from the second floor dining room. Neither DA-I or DAS-J completed hand hygiene before they began kitchen tasks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/4/25 at 10:17 AM, Surveyor interviewed DDS-H who indicated DDS-H expects staff to know and follow the facility's hand hygiene and glove use policies. DDS-H indicated staff should change gloves prior to and after switching tasks and before applying new gloves. On 3/5/25 at 1:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A expects dietary staff to be aware of and follow the FDA Food Code and the facility's policies regarding food prep, food storage, food serving, hand hygiene, and food temperatures.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Knoll Health Care	N7135 Rocky Knoll Parkway Plymouth, WI 53073

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49010

Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 4 residents (R) (R17, R55, R89, and R116) of 4 sampled residents.

On 3/4/25, Licensed Practical Nurse (LPN)-C dropped a pill on the floor in the dining room and then administered the medication to R17.

During multiple care observations on 3/3/25, staff did not follow enhanced barrier precautions (EBP) for R55.

During an observation of care on 3/3/25, Certified Nursing Assistant (CNA)-F removed soiled gloves and did not wash or sanitize hands before touching R89 and objects in R89's environment.

During a wound care observation on 3/5/25, staff did not follow EBP precautions for R116.

Findings include:

The facility's Hand Washing/Hand Hygiene Policy revised 11/2024, indicates: Hand washing/Hand hygiene is regarded by this facility as the single most important means of preventing the spread of infection .Hand hygiene: A general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub .All personnel shall follow our established hand washing/hand hygiene procedures to prevent the spread of infection and disease to residents, staff, and visitors .The use of gloves does not replace hand washing/hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.

The facility's Enhanced Barrier Precautions policy, revised 4/2024, indicates: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities . c. Each resident requiring enhanced barrier precautions will have a picture of a laminated gown hanging on the outside of their door and will have enhanced barrier precaution signage and gowns inside the room .2. b. Enhanced barrier precautions will be initiated for residents with any of the following: .i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with an MDRO. ii. Infection or colonization with a Centers for Disease Control and Prevention (CDC)-targeted MDRO when contact precautions do not otherwise apply .4. High-contact resident care activities include: a. bathing, dressing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes), wound care (any chronic skin opening requiring a dressing) .

(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. From 3/3/25 to 3/5/25, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had diagnoses including pulmonary hypertension due to heart disease, atrial fibrillation, idiopathic pulmonary fibrosis, history of heart attacks, and presence of a cardiac pacemaker. R17's Minimum Data Set (MDS) assessment, dated 2/11/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R17 had severely impaired cognition. On 3/4/25 at 8:39 AM, Surveyor observed LPN-C administer medication to residents in the second floor dining room. Surveyor observed LPN-C drop a pill on the floor under a dining table during medication administration for R17. LPN-C then picked up the pill off the floor and administered the pill to R17. On 3/4/25 at 8:41 AM, Surveyor interviewed LPN-C who verified LPN-C dropped one of R17's medications on the floor. LPN-C stated the medication was losartan and confirmed LPN-C picked up the pill off the floor and administered it to R17. LPN-C indicated R17 did not have a problem with taking the medication after it was on the floor. LPN-C verified LPN-C should not administer a medication that fell on the floor and should have disposed of the pill and administered another one. On 3/4/25 at 11:19 AM and 11:50 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should not administer medication in the dining room and should not administer medication that fell on the floor. DON-B stated if a medication falls on the floor, staff should destroy the medication and administer another one. DON-B indicated staff should follow the facility's medication pass and infection control procedures. 2. From 3/3/25 to 3/5/25, Surveyor reviewed R55's medical record. R55 was admitted to the facility on [DATE] and had diagnoses including calculus in bladder, calculus of kidney, artificial openings of urinary tract, benign prostatic hyperplasia with lower urinary tract symptoms, and history of urinary tract infections. R55's MDS assessment, dated 12/19/24, had a BIMS score of 9 out of 15 which indicated R55 had moderately impaired cognition. On 3/3/25 at 1:11 PM, Surveyor observed Occupational Therapist (OT)-X enter R55's room. When R55 stated R55 needed to have a bowel movement, OT-X brought R55 to the bathroom and continued cares behind the door. OT-X did not wear a gown and gloves when OT-X entered the bathroom with R55. Surveyor noted there was a picture of a gown outside the door to R55's room but no EBP sign inside R55's room. On 3/3/25 at 1:18 PM, Surveyor observed OT-X exit R55's room with a clear plastic garbage bag. Surveyor noted the bag contained soiled wipes but no gown. Surveyor observed OT-X sanitize hands, exit the room, and carry the bag down the hall without gloves. On 3/3/25 at 1:18 PM, Surveyor interviewed OT-X who indicated OT-X wore gloves when OT-X assisted R55 in the bathroom but not a gown. OT-X indicated OT-X did not have to wear a gown because OT-X assisted R55 with a bowel movement and not catheter care. OT-X indicated OT-X was going to assist R55 with a transfer. On 3/3/25 at 1:20 PM, Surveyor observed OT-X reenter R55's room. OT-X placed a gait belt on R55 and assisted R55 to a standing position. OT-X encouraged R55 to ambulate several steps to a recliner and assisted R55 with sitting in the recliner. OT-X did not wear a gown or gloves while providing assistance. OT-X then sanitized hands and exited R55's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/3/25 at 1:47 PM, Surveyor noted R55's door was closed and heard talking in the room. A short time later, Surveyor observed CNA-S exit the room and noted CNA-S was not wearing PPE and did not have anything in CNA-S' hands. On 3/3/25 at 1:47 PM, Surveyor interviewed CNA-S who indicated CNA-S emptied R55's catheter bag and wore gloves but no gown. CNA-S indicated the gowns in the room were for changing R55's bandages and were not needed to empty a catheter bag. On 3/3/25, Surveyor reviewed R55's plan of care and noted R55 did not have a care plan for EBP. Surveyor observed a Kardex on the back of R55's door that indicated Ensure Enhanced Barrier Precautions (EBP) (gloves and gown) are adhered to for all high-contact cares. On 3/5/25 at 11:50 AM, Surveyor interviewed DON-B who indicated a resident on EBP should have an EBP care plan. DON-B indicated a resident's plan of care should be updated with EBP information within 24 hours of initiating EBP. DON-B indicated staff should be aware of and follow infection control measures for residents with catheters. On 3/5/25 at 1:29 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated EBP should be on a resident's care plan within 24 hours of initiation. NHA-A also indicated staff should be aware of and follow infection control policies. 45943 3. On 3/3/25 at 10:56 AM, Surveyor observed CNA-F and CNA-G transfer R89 to the toilet via EZ Stand lift. CNA-F and CNA-G donned gloves prior to the transfer. CNA-F removed R89's soiled brief which contained a moderate amount of urine. CNA-F and CNA-G removed gloves, completed hand hygiene, and donned clean gloves. CNA-F put a clean brief between R89's legs and wiped R89's peri-rectal area. CNA-F removed soiled gloves but did not wash or sanitize hands before touching the clean brief and R89's clothing. CNA-F then completed hand hygiene. On 3/3/25 at 11:07 AM, Surveyor interviewed CNA-F who verified CNA-F should have completed hand hygiene after removing soiled gloves. On 3/4/25 at 11:22 AM, Surveyor interviewed DON-B who verified staff should complete hand hygiene when gloves are removed and prior to touching other items. 45942 4. From 3/3/25 to 3/5/25, Surveyor reviewed R116's medical record. R116 was admitted to the facility on [DATE] and had diagnoses including pressure ulcer of left heel (stage 3), anemia, and vitamin D deficiency. R116's MDS assessment, dated 12/19/24, had a BIMS score of 9 out of 15 which indicated R116 had moderately impaired cognition. R116 had an activated Power of Attorney (POA). On 3/3/25 at approximately 10:15 AM, Surveyor noted there was no EBP sign inside R116's room or picture of a gown outside R116's room to indicate EBP was required. On 3/5/25 at 10:32 AM, Surveyor interviewed Infection Preventionist (IP)-V who indicated R116 was not on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 10:42 AM, Surveyor observed IP-V and Registered Nurse (RN)-BB complete wound care for R116's bilateral heel pressure injuries without adhering to EBP precautions. On 3/5/25 at 11:02 AM, Surveyor interviewed IP-V who indicated the facility determined R116's pressure injuries would heal within a time frame that would not be considered a chronic wound. IP-V indicated only chronic wounds required EBP precautions. IP-V indicated if the facility anticipates a wound is not going to heal, EBP is implemented. IP-V was unsure the time frame in which R116's pressure injuries would heal. IP-V verified IP-V and RN-BB did not implement EBP or don personal protective equipment (PPE) in accordance with EBP when wound care was completed for R116. On 3/5/25 at 1:34 PM, Surveyor interviewed NHA-A who indicated residents with chronic pressure injuries should be placed on EBP. On 3/5/25 at 1:45 PM, Surveyor interviewed DON-B who indicated pressure injuries are considered chronic wounds and residents with chronic wounds should be placed on EBP.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51044 Based on staff interview and record review, the facility did not implement their antibiotic stewardship program and monitor antibiotic use for 1 resident (R) (R115) of 3 sampled residents. R115 was prescribed a prophylactic antibiotic. R115's medical record did not indicate the prophylactic antibiotic was routinely assessed. In addition, the facility's infection surveillance log for antibiotic use contained inaccurate documentation for continued appropriate use of an antibiotic for R115. Findings include: The facility's Antibiotic Stewardship Policy, revised 2/2025, indicates: .Residents placed on antibiotics will be reviewed by the Infection Control Preventionist, Director of Nursing (DON), or Designee. The facility's Antibiotic Stewardship Program, revised 10/2022, indicates: .Tracking: Monitor antibiotic use and outcome(s) from antibiotic use Provide regular feedback on antibiotic use and resistance to prescribers, nursing staff, other relevant staff, and quarterly to the Quality Assurance and Performance Improvement (QAPI) committee .Infection Preventionist (IP): The IP will be responsible for surveillance, infection definition based on standards of practice, education, tracking, data management, analysis of data, communication with .Medical Director and Consult Pharmacist and ongoing system review. On 3/5/25, Surveyor reviewed R115's medical record. R115 was initially admitted to the facility on [DATE] following hospitalization for a left hip fracture and Clostridium difficile. R115 was prescribed vancomycin (an antibiotic) 1 tablet 4 times daily for 10 days for suspected Clostridium difficile due to loose stools on 9/5/24. R115's stool tested positive for Clostridium difficile toxin on 9/6/24. R115 was discharged from the facility on 10/1/24. R115 was readmitted to the facility on [DATE] post hospitalization for a right lower leg fracture and enterocolitis due to Clostridium difficile. Additional diagnoses for R115 included sepsis, diarrhea, bacteriuria, and history of urinary tract infections (UTIs). R115's Minimum Data Set (MDS) assessment, dated 2/17/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R115 was not cognitively impaired. Upon admission on 12/31/24, R115 had an order for prophylactic vancomycin. R115 was last seen by an infectious disease physician on 1/15/25 who indicated to continue use of prophylactic vancomycin. The facility's last documented communication with the physician regarding the risks versus benefits of continued prophylactic antibiotic treatment was on 1/15/25. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25, R115 was diagnosed with a UTI. Bactrim (an antibiotic) was started on 2/28/25. Documentation on the facility's monthly infection surveillance log, dated 2/24/25, indicated R115 did not meet the criteria for a UTI and was asymptomatic. R115's urinary analysis (UA) contained greater than 100,000 colony-forming units (CFUs) of E. coli. According to McGeer's criteria (a set of clinical guidelines used by the facility for infection surveillance that focuses on identifying potential infections and guiding antibiotic stewardship to assess antibiotic use), an infection is indicated when a UA contains 100,000 CFUs per millimeter or greater of E coli bacteria. Bactrim was continued for seven days. On 3/4/25 at 11:14 AM, Surveyor interviewed Infection Preventionist (IP)-V and Registered Nurse (RN)-U regarding the facility's infection prevention and control program. IP-V indicated IP-V was responsible for the infection prevention and control program since May of 2024. Surveyor reviewed the facility's policies and procedures, including infection surveillance logs that listed residents and infectious processes and the use of antibiotics. IP-V indicated IP-V used McGeer's criteria as a standard of practice for antibiotic stewardship. RN-U indicated R115 was seen by an infectious disease physician for prophylactic antibiotic use. RN-U stated IP-V updates the physician if a resident does not meet McGeer's criteria. RN-U stated R115 had an order for prophylactic vancomycin so IP-V did not follow R115's antibiotic use. RN-U indicated IP-V is responsible for following up with the physician regarding antibiotic use each month and documenting the follow-up. On 3/5/25 at 1:00 PM, Surveyor shared with Director of Nursing (DON)-B the concern that R115 was prescribed a prophylactic antibiotic without documentation of continued surveillance. DON-B indicated it is IP-V's responsibility to track long-term antibiotic use and indicated IP-V is provided a monthly pharmacy report of all residents on antibiotics. DON-B stated the list should remind IP-V to review residents on antibiotics. DON-B indicated DON B was unsure how IP-V tracked the use of long-term antibiotics. On 3/5/25 at 4:55 PM, Surveyor interviewed IP-V regarding IP-V's responsibilities related to prophylactic antibiotic use. IP-V stated it is IP-V's responsibility to contact the physician monthly and ask if an antibiotic is still appropriate. IP-V indicated contact with the physician should be documented in the resident's medical record. Surveyor noted the last documentation of prophylactic antibiotic use for R115 was in January of 2025.