STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 38725 Based on interview and record review, the facility did not ensure that resident(s) and/or their families have the right to voice grievances to the facility, and the facility must make prompt efforts to resolve any grievances the resident may have for 1 of 6 residents (R3) reviewed for grievances out of a total sample of 11. R3's family voiced concerns to the facility that were not filed as grievances and the facility did not have evidence of following up. This is evidenced by: The facility's policy and procedure entitled Grievance dated 3/1/23 documents, in part: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Prompt efforts to resolve include facility acknowledgement of a complaint/grievance and actively working toward resolution of that complaint/grievance .1. The Grievance Official is responsible for overseeing the grievance process .9. Procedure .b. The staff member receiving the grievance will record the nature and specifics of the grievances on the designated grievance form, or assist the resident or family member to complete the form .c. Forward the grievance form to the Grievance Official as soon as practicable. D. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions on the grievance form. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances . R3 had no grievances documented on the Facility's Grievance logs. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FM T (Family Member) provided Surveyor with the following email to the facility's Social Worker, dated 5/2/24 with eight different areas, it documented, in part: .1. The necessity and urgency of this meeting has not been communicated effectively to (R3) and her family. Can we get a clear understanding as to the purpose and intent of the meeting? Particularly since (R3) is currently at facility for the treatment of the stage 4 wound on her sacrum not cancer. And it was not communicated to any of us by the facility staff regarding any concerns of her cancer diagnosis or treatment. 2. Is it protocol for the facility staff to call the personal medical staff of a resident and set up a meeting prior to the resident's and/or personal representative knowledge? The lack of transparency in this regard is concerning. 3. Can this meeting be scheduled at a more convenient time for all involved? Anytime after 10 am is more convenient for us as it takes us 1.5 hours to travel from (city name) and 1.0 hour to travel from (city name). Also, (R3s) Insurance team are unavailable to participate in the meeting on that day as well. It's important to (R3) that she had adequate support present, so that she can make the most well-informed decision regarding her care. 4. In trying to reach the Nurse Practitioner .at the number provided it was noted that she was not located at the clinic but rather various nursing homes .And, that there was not an available phone number to be provided. Can you please have her give me a call directly? 5. As directed, I called R3's Cancer Physician .to see if the teleconference meeting could be rescheduled. In speaking with the nurse, she noted that there wasn't a scheduled teleconference scheduled for tomorrow in the system. Therefore, nothing could be rescheduled pertaining to the aforementioned teleconference. 6. (R3) does have a teleconference appointment scheduled next week for May 7, 2024, at 4:00 pm with her Cancer Physician that was previous scheduled at her las appointment. At that time, she will be discussing her current status of health, how it relates to her cancer diagnosis and how to move forward with any possible treatment. 7. There are some immediate concerns regarding the current UTI (Urinary Tract Infection) diagnosis that mom is currently receiving treatment for. The lack of urine output and concern for her diet have been discussed. (R3) has increased her fluid intake as well as has been eating food that her family brings in and drinking the Ensure Max that is being provided. 8. Per our meeting with the Facility Administrator, Director of Nursing, and Assistant Director of Nursing, there will be weekly updates regarding (R3's) progress, so that all parties involved can have a clear understanding of her status. The first update is to be provided Friday, May 3, 2024, as this would provide enough time for the facility staff to review and compile the Medical Doctor's notes for said weekly update. If there are any comments or concerns regarding the above synopsis please do not hesitate to contact me . Email response FM T received from the facility's Social Worker was dated 5/2/24 at 7:10 PM, which indicates the meeting for 5/3/24 can be at 11 AM, that she will contact the NP to figure out how FM T can communicate with her, apologizes for late response, and states [the] rest will be addressed at meeting. It is important to note, that there is not a grievance form filled out, no documentation of any follow up or a resolution related to the concerns relayed to the facility Social Worker by FM T. On 6/13/24 at 1:45 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if she had any grievances for R3, NHA A said, Not that I know of. Surveyor asked NHA A if all grievances should be on the grievance log, NHA A stated yes. Surveyor asked NHA A if all grievances should have followed up related to the concerns, NHA A replied yes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure that 1 of 11 residents (R1) reviewed for Activities of Daily Living (ADL) received the necessary services to maintain personal hygiene. R1 voiced concern that R1 did not receive showers as scheduled. R1 voiced concern that R1 does not receive assistance with oral care, and has not had a toothbrush since admission to the facility. Evidenced by: The facility policy titled, Bathing a Resident, with no date, states, in part; .It is the practice of this facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. The facility policy titled, Oral Care, with no date, states, in part; .It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases . R1 was admitted to the facility on [DATE] with diagnoses including diabetes, obesity, hypertension, anxiety disorder, abscess of tendon sheath/left lower leg, major depressive disorder, and attention-deficit hyperactivity disorder. R1's Kardex states, in part; .ADL's, Dressing assistance of 1 .Personal Hygiene assistance of 1 . R1's Comprehensive Care Plan, states, in part; .Focus: I have a physical functioning deficit related to: mobility impairment, self care impairment due to weakness, leg abscess, IV tubing, physical limitations, and need for staff assistance 5/15/24 .Goal: I will improve my current level of physical functioning .Interventions: Personal Hygiene assistance of 1 . R1's active orders states, in part; .Shower to be completed every Weds evening shift refusal of shower to be documented in progress note by the nurse. Collect and sign shower sheet 5/20/24 . R1's shower documentation since admission, states, in part; .5/29/24 substantial/max assistance, 6/5/24 partial/moderate assistance, and 6/12/24 not applicable . R1's Oral Hygiene documentation since admission to current, states, in part; .5/15/24 partial/moderate assistance checked once that day, from 5/16/24-5/23/24 set up or clean up assistance needed checked once per day, 5/24/24 set up or clean up assistance needed checked twice, 5/25/24 set up or clean up assistance checked once that day, 5/26/24 and 5/27/24 set up or clean up assistance needed checked twice both days, 5/28/24 set up or clean up assistance checked once, 5/29/24 checked twice substantial/max assistance, 5/30/24 set up or clean up assistance needed checked twice, 5/31/24 set up or clean up assistance checked once, 6/1/24 independent checked once, 6/2/24-6/4/24 checked twice daily independent, 6/5/25 set up or clean up assistance checked twice, 6/6/24-6/12/24 independent checked once daily . (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 3:00 PM, R1 stated, I think I am becoming institutionalized by being here (living at the facility). R1 indicated there is not enough staff to meet resident basic needs. R1 indicated I haven't brushed my teeth in days .since I got here. R1 indicated R1 does not have a toothbrush. Surveyor observed R1 to be in need of oral care. R1 indicated staff have never asked if R1 needs assistance to brush her teeth. R1 indicated she had asked for a toothbrush when she was first admitted to the facility and still does not have one. R1 indicated she does need assistance with showers and personal hygiene. R1 indicated when R1 was first admitted she went many days without a shower. It is important to note R1 was admitted to the facility 5/15/24 and documentation and resident interview show R1 did not receive her first shower until 5/29/24 - this is 15 days after admission. On 6/13/24 at 12:15 PM, R1 indicated yesterday (Wednesday, 6/12/24) was her shower day. R1 indicated she did not receive a shower yesterday evening. R1 indicated staff probably got busy. Surveyor asked if anyone assisted R1 in brushing her teeth today. R1 indicated no one has assisted her with oral care. Surveyor looked around R1's bedroom and could not locate a toothbrush or toothpaste. Surveyor observed R1 in need of oral care. On 6/13/24 at 12:30 PM, CNA I (Certified Nursing Assistant) indicated if a resident does not get their shower on their scheduled shower day, staff will pass it on by word of mouth to the next shift that the resident still needs a shower. CNA's can also look back on the documentation from the day before to see if the shower was given. CNA I indicated she is covering down R1's hallway while the CNA assigned to hallway is on break. CNA I indicated staff are to offer residents oral care in the morning and in the evening. CNA I was unable to locate a toothbrush in R1's bedroom. CNA I provided R1 a toothbrush, toothpaste, and mouth wash. CNA I asked R1 if R1 would like to brush her teeth. R1 stated, Yes. CNA I assisted R1 with oral care. On 6/13/24 at 12:45 PM, CNA J indicated she is the CNA assigned to R1's hallway. CNA J indicated R1 is completely independent with personal hygiene cares. CNA J indicated she is unsure if it says she is independent in her care plan or Kardex. CNA J indicated she heard that R1 is independent by word of mouth from other staff. Surveyor asked CNA J if she assisted with set up or any assistance for R1 with oral care this morning. CNA J indicated, No. Surveyor asked CNA J what the process is if a shower is missed on scheduled shower day. CNA J indicated staff can try to let the next shift know and the next shift can try to get it done. CNA J indicated we follow the shower schedule. CNA J had a piece of paper that had the list of resident names she was responsible for that shift. CNA J indicated staff can write that someone needs a shower on the list. Surveyor asked if it was documented that R1 still needed a shower. CNA J indicated no, R1 still needed to be offered her shower. CNA J indicated it wasn't written down that R1 didn't get her shower the evening before. CNA J indicated she was unable to plan for R1's shower or even ask her if she wanted one today because she (CNA J) was unaware that she still needed one. CNA J indicated it (R1 needing a shower) really should be written down somewhere so I would know to ask and plan. It is important to note R1's care plan and Kardex state that R1 needs assistance x1 (times 1) for personal hygiene and oral cares. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 1:20 PM, NHA A (Nursing Home Administrator) indicated she would expect staff to follow the shower schedule. NHA A indicated if a resident declines a shower or staff couldn't get the shower done on the scheduled shower day, staff should reapproach and document, so the next shift knows the shower needs to be still given. NHA A indicated if a shower still needs to be given it is her expectation that this is documented in the 24 hour notes at the nurses stations. NHA A indicated she would expect staff to offer oral care during morning and evening cares. NHA A indicated she would expect staff would follow resident care plans and Kardex cards when determining the level of ADL assistance needed. On 6/13/24 at 2:00 PM, Surveyor reviewed shower documentation for R1. Shower documentation for 6/12/24 states, not applicable. Surveyor reviewed 24-hour nurses notes. There was no documentation that R1 still needed a shower. Surveyor reviewed R1's progress notes and there was no documentation of R1 still needing a shower. The facility failed to ensure residents receive personal care assistance per resident care plans. The facility failed to ensure residents receive showers and if a scheduled shower was not able to be given, that there is follow up with the resident to ensure a shower/bath can be given timely.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. This affected 4 of 4 residents reviewed for activities (R5, R8, R9, and R10). The facility failed to create an activity program based on the current residents' interests, preferences, and familiar routines. The facility failed to look at and collect data or activity attendance for R5, R8, R9, and R10 to decide if the program that was in place for each resident was effective or not. Surveyor observed little to no interaction and activities in the location where R5, R8, R9, and R10 reside. Evidenced by: The facility policy titled, Activity, with no date, states, in part; .It is the policy of this facility to prove an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independent and interaction within the community .2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Promote or enhance physical activity. c. Promote or enhance cognition. d. Promote or enhance emotional health. e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success, and independence. f. Reflect resident's interests and age. g. Reflect cultural and religious interests of the residents. h. Reflect choices of the residents . Example 1 R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, diabetes, dementia, heart disease, age related macular degeneration, hallucinations, insomnia, and kidney disease. R5's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/24/24, indicates R5 has a Brief Interview of Mental Status (BIMS) score of 03, indicating R5 is severely cognitively impaired. R5 has an activated power of attorney. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Comprehensive Care Plan, states, in part; .Resident has a diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit with programs designed for this population is needed as evidenced by: Moderate to severe cognitive loss .5/10/21 .Provide 1:1 and sensory stimulation daily as resident allows .Provide normalized programming based on patient assessment and interests: music, reading to resident, sensory stimulation .Focus I don't have a lot of hobbies or interests due to my impaired cognition, advancing dementia. I may be over stimulated, experience hallucinations, tire easily. I enjoy wandering about unit. 5/12/21 .Ask my family to bring in some of my things from home to do in my room: magazines about gardening and animals, family photos to look at .encourage me to try new things you think I might like .Help me obtain some of the things I like to read: devotions, gardening magazines, etc .invite me to sit in during activities programs, letting me join in at my own comfort level .invite me to join in during discussions, word games, or music such as classical, invite me to participate in activities that are related to my past and current interests, invite my family/friends to come to activity programs with me .involve me in pre-meal activities, let me do things I am more familiar doing, such as home-type tasks: folding laundry, looking at photos .I was born in (city name), and I have also lived in (town name). I completed high school and worked as a teacher and a secretary . R5's most recent activity participation review, dated 4/26/24, is completely blank. R5's resident preferences evaluation, dated 4/26/24, states, in part; .it is very important for R5 to have family/friends involved in discussion about care, very important to go outside to get fresh air. The document does not include anything personal as to what is important to R5. Surveyor requested R5's activity participation attendance for April-June 2024. The facility was unable to provide documentation for April and May 2024. The documentation for June 2024 states, Personal grooming AM, Personal grooming PM, radio/ story time, Relaxation, TV watching, 1:1 visit's June 1st-12 state resident was active. Arts and Crafts x2, Baking x1, games x2. Chat snack, current events, memory book, meal style dining, and memories state resident was active June 1st-12th. It is important to note the documentation does not state how long R5 participated in activities and if the resident enjoyed the activity. Example 2 R8 was admitted to the facility on [DATE] with a diagnoses including Alzheimer's disease, anxiety disorder, major depressive disorder, hypertension, abnormalities of gait and mobility, and muscle weakness. R8's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/19/24, indicates R8 has a Brief Interview for Mental Status (BIMS) score of 00 indicating R8 is significantly cognitively impaired. R8 has an activated power of attorney. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Comprehensive Care Plan, states, in part; .Focus: The way I prefer to participate in activities is different from others on the unit having a shorter attention span, preferring quieter areas and groups .8/5/21 As I don't like to sit still for long, please bring me to activities just before the program .Invite and encourage me to participate in programs I enjoy or that you think I might like to try, invite me to sit in the lobby or other living areas with other people for increased stimulation instead of staying in my room, invite me to sit in during activity programs, allowing me to join in at my own comfort level .Focus Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit with programs designed for this population is needed as evidenced by: moderate to severe cognitive loss 8/5/21 .I am from (town name), WI. I have 3 daughters and 2 step-children .enjoy painting pictures and wooden art .Provide normalized programming based on patient assessment and interests: reading to resident, TV, watching out windows, sensory stimulation . R8's activity participation review, dated 1/20/23, states, enjoys listening to reminiscing groups, sitting outside, being around others, other music, spiritual programs, and activities in a quiet area. It is important to note the assessment was completed over a year and a half ago. R8's resident preference evaluation, dated 2/14/24, states it is very important to take care of personal belongings or things, very important to have family or friends involved in discussion about care daughter (name), likes romance books, very important to be around animals, and very important to go outside . Surveyor requested R8's activity participation attendance for April-June 2024. The facility was unable to provide documentation for April and May 2024. The documentation for June 2024 states, Personal Grooming AM, Personal Grooming PM, Radio/story time, relaxation, TV watching, and 1:1 visits June 1st-12th resident was active .chat/snack, news, memory book, and meal/family style dining June 1st-12th resident was active. It is important to note the documentation does not state how long R8 participated in the activity and if the resident enjoyed the activity. Example 3 R9 was admitted to the facility on [DATE] with a diagnoses including Alzheimer's disease, unspecified dementia with behavioral disturbance, and constipation. R9's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/26/24, indicates R9 has a Brief Interview of Mental Status (BIMS) score of 03 indicating R9 is significantly cognitively impaired. R9 has an activated power of attorney. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's Comprehensive Care Plan, states, in part; .Focus Resident has a diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's care unit with programs designed for this population is needed as evidenced by: dementia with behavioral disturbances and poor safety awareness 1/24/18. Interventions Provide normalized programming based on patient assessment and interests: music, current events, reminiscing, family photos. Focus My level of activity participation changes due to: cognitive status. I have a diagnosis of Alzheimer's disease and dementia with behavioral disturbances. I am easily over stimulated and become agitated when out of my room, even when out of bed. I prefer quiet solitary activities. Interventions As I become less involved in group activities, please offer me 1:1 or independent activities. Be aware that I tire easily. Encourage my family members/friends to participate in activities with me as able .I had a twin sister named (name) .I enjoy the weather station .I have three sons .I need encouragement at times to participate in activities, please compliment my attempts to participate .Invite me to participate in activities related to my past and current interests such as talking about farming and sitting outside . R9's activity participation review, dated 1/24/23, states, in part; .1:1 groups, individual activities, family/friends, .favorite activities, cognitive, entertainment, spiritual, and sensory .It is important to note the assessment was completed over a year and a half ago. R9's resident preferences evaluation, dated 2/13/24, states, in part; .it is very important to have family and friends involved in discussion about care son (name), likes reading, newspapers, magazines, .it is very important to listen to music, very important to be around animals, and very important to go outside . Surveyor requested R9's activity participation attendance for April-June 2024. The facility was unable to provide documentation for April and May 2024. The documentation for June 2024 states, Personal Grooming AM, Personal Grooming PM, Relaxation, TV watching, 1:1 visits, chat/snack, news, memory book, and meal/family style dining June 1st-June 12th resident was active. It is important to note the documentation does not state how long R9 participated in an activity and if the resident enjoyed the activity. Example 4 R10 was admitted to the facility on [DATE] with a diagnoses including fracture, dementia, mood disturbance, and anxiety disorder. R10's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/15/24, indicates R10 has a Brief Interview of Mental Status (BIMS) score of 8, indicating R10 is cognitively impaired. R10 has an activated power of attorney. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R10's Comprehensive Care Plan, states, in part; Focus Resident has diagnosis of Alzheimer's or related dementia. Due to cognitive loss, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's Care unit with programs designed for this population is needed as evidenced by: Vascular dementia 12/27/22 .I have three sisters and a brother .I cannot see well, but I enjoy audio books, I am a Christian and I enjoy visitors and going for rides. I enjoy church services and cats/dogs .I will participate in activities I enjoy such as bingo, listening to all different types of music, looking at magazines that include animals and gardening, going outside when weather is good. Provide normalized programming based on patient assessment and interests . R10's activity participation review, dated 5/17/24, states, in part; .resident participates in 3-5 small to large group activities a week .entertainment games, spiritual, pet visits .trivia and good conversation .I look forward to Bingo every week. Activity adaptations .large print, card holder, easier grip objects, reduced glare/light, prefers quiet environment, needs more assistance in new/complex programs, provide shorter duration programs . R10's resident preferences evaluation dated 5/9/24, states in part: it is very important for R10 to have family and close friend involved in discussion about care .reading books, animal/pet magazines .it is very important for R10 to be around animals, do things with groups of people, do favorite activities, be outside, and participate in religious activities . Surveyor requested R10's activity participation attendance for April-June 2024. The facility was unable to provide documentation for April 2024. The facility provided May 2024 documentation that consisted of; 1:1 visits x (times) 9, reminiscing x2, bingo x3, family visit x1, hair x1, outside x2, watching tv x1. Multiple days were left blank, the length of time for activity and participation/enjoyment level was not documented for R10. The documentation for June 2024 states, in part; . Personal Grooming AM, Personal Grooming PM, relaxation, TV watching, visits with peers, 1:1 visits, chat/snack, current events, independent activity, meal/family style dining June 1st-12th. It is important to note the documentation does not state how long R10 participated in the activity and if the resident enjoyed the activity. It is important to note all four resident's June 2024 activity documentation were the same activities and did not include individualized activities nor did the documentation and activities reflect what is important to each individual resident. On 6/11/24 at 4:30 PM, LPN D (Licensed Practical Nurse) indicated there are not activities in the memory care unit. LPN D indicated that is the area of the facility, that needs structured activities the most, and it is not currently happening. On 6/12/24 at 7:30 AM, Surveyor observed R5, R8, R9, and R10. R5, R8, and R9 were in the living room with the television on with no sound. R10 was sitting in the hallway. At 7:52 AM, R5, R8, and R9 were assisted to the dining room for breakfast. At 8:55 AM, R5, R8, and R9 were done with breakfast and sitting in the living room with no stimulation. R10 was sitting in her wheelchair in the hallway with her head down sleeping. On 6/12/24 at 7:30 AM - 1:20 PM Surveyor observed R9 sitting in the living room area in front of the television with no sound on. Surveyor observed no staff interaction with R9 and no stimulation or attempts to engage R9 in any activities except when staff took R9 to the dining room for meals. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24 at 9:10 AM, CNA E (Certified Nursing Assistant) indicated there are not any activities in the memory care. CNA E indicated there aren't any activities on the weekends and CNA E tries her best to do little things when she is working, but it is hard because there are call in's and they're working short staffed. CNA E indicated the activities department is making cookies back in memory care today and this is the first time in a long time that an activity has occurred. On 6/12/24 at 9:30 AM, Surveyor observed R5 and R8 in the dining room while a staff member made cookies. R5 and R8 were both sleeping at the table through most of the activity. On 6/12/24 at 9:33 AM, Scheduler F indicated there are not many activities that occur in the memory care unit. Scheduler F indicated the activity of baking cookies right now is the first activity Scheduler F has seen in memory care in a long time. On 6/12/24 at 8:55 AM Surveyor observed R10 sleeping in her wheelchair in the hallway. Surveyor observed no meaningful activities occurring for R10 and no attempt to engage or stimulate R10. Surveyor observed R10 sleeping on and off in the hallway from 8:55 AM until lunch time at 11:20 AM. On 6/12/24 at 1:00 PM, AD G (Activity Director) indicated she previously had one staff that worked under her, but those hours have recently been cut. AD G indicated she now is responsible for memory care unit activities. AD G indicated she does not have an activity calendar for memory care and AD G indicated she is truly in the learning process for activities in memory care. AD G indicated the change has been overwhelming with not a lot of support. AD G indicated she has not done much for activities in the memory care unit. AD G indicated she will look for the activity attendance documentation. AD G indicated she would expect residents to be engaged in activities and activities to be meaningful for each resident. On 6/13/24 at 10:30 AM, AD G indicated they did not find any additional activity attendance documentation. AD G indicated she would expect activities to be documented and participation level documented as well. On 6/13/24 at 11:15 AM, AD G provided R5, R8, R9, and R10's most current quarterly activity assessments. AD G indicated these are not all up to date, but that she wasn't over in memory care until more recently. On 6/13/24 at 1:20 PM, NHA A (Nursing Home Administrator) indicated understanding on the concerns with activities and activity goal monitoring and documentation in memory care unit. The facility failed to ensure all residents have meaningful activities. The facility failed to develop a system to track, monitor, and assess activities to ensure each resident has a meaningful day.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice when experiencing a change in condition for 2 of 4 sampled residents (R3 and R12). R3 had a change in condition on 5/8/24. R3's respiratory status was not fully assessed, there is no evidence of continuous monitoring of R3's condition or respiratory status, and R3's provider was not updated timely resulting in R3 being sent to the hospital on 5/10/24 for sepsis due to pneumonia. R12 had a change of condition following a fall including increased complaints of leg pain. The facility did complete a comprehensive assessment of R12 resulting in delay of treatment. Evidenced by: The facility's 'Notification of Changes Policy,' implemented 3/1/19, states in part: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate .all pertinent information will be made available to the provider by the facility staff.Overview of Components of the Policy. 1. Requirements for notification of resident, which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident's physical, mental or psychosocial status. (i) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. 3. A need to alter treatment significantly. (i) a significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions to or discontinuation of treatments . Procedure. 1. The nurse will immediately notify the resident, resident's physician, and the resident representative(s) for the following (list is not all inclusive) .c. a need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment . 2. the nurse will notify the resident, resident's physician, and the resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. 3. document the notification and record any new orders in the resident's medical record.6. Update the resident's care plan, transcribe, and implement the provider's orders. 7. communicate the changes to the rest of the care team and inform the supervisor. 8. communicate the changes to the staff on the oncoming shift . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R3 was admitted to the facility for short term rehab and wound care. R3 had the following diagnoses: malignant neoplasm of bone and articular cartilage (cancer), acute respiratory failure with hypoxia (condition where the body's tissues don't have enough oxygen), paraplegia (chronic condition that causes the loss of muscle function and voluntary movement in the lower have of the body), pressure injury sacral (bottom of the spine that lies between the fifth segment of the lumbar spine (L5) and the coccyx (tailbone) stage 4, combined systolic (congestive) and diastolic (congestive) heart failure (condition that occurs when the heart's left ventricle can't contract normally so the heart can't pump enough blood into circulation with enough force), Peripheral Vascular Disease (PVD; circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), anxiety disorder, and Urinary Tract Infection (UTI) diagnosed on [DATE]. R3's most recent Minimum Data Set (MDS) dated [DATE] documents a score of 15 on her Brief Interview of Mental Status (BIMS), which indicates R3 was cognitively intact. R3's Care Plan indicates the following: Impaired cardiovascular status related to congestive heart failure (CHF); peripheral vascular disease (PVD) date initiated 2/23/24 . interventions: Monitor intake and output (2/23/24), observe and report headaches, flushing, nosebleeds, nausea, shortness of breath (2/23/24), observe and report signs of chest pain, edema, shortness of breath (SOB) . (2/23/24). R3's Physician Orders indicates O2 (Oxygen) per NC (Nasal Cannula) PRN (as needed) to keep O2 Stats >92% (greater than 92%) one time a day for Hypoxia, start date 4/24/24, discontinued on 5/24/24. (This order was not on any of the Medication Administration Record/Treatment Administration Records (MAR/TARs) provided to Surveyor for April or May, therefore Surveyor is unable to see documentation of how often R3 was using the PRN oxygen order.) R3's MAR for March 2024 indicated R3 used her PRN (as needed) albuterol sulfate inhaler once on 3/12, twice on 3/13, and once on 3/15. R3's MAR for April 2024 indicated R3 did not use her PRN albuterol sulfate inhaler all month. R3's TAR for March, April, and May 2024, does not indicate any oxygen orders for R3. On 5/6/24 at 1:49 PM, R3's Nurses Note states in part: Advanced Skilled evaluation . Respiratory: no signs of difficulty breathing. No shortness of breath noted. Right lung clear. Left lung clear. Humidification: No. No oxygen. HOB (head of bed) is not elevated. No cough . On 5/7/24 at 9:41 AM, R3's Nurses Note with effective date of 5/7/24 indicates: Advanced Skilled evaluation: Vitals T (temperature) 97.1 5/8/2024 10:22 .BP (blood pressure) 107/62 - 5/8/2024 10:22 . P (pulse) 88 - 5/8/2024 10:22 type regular R (respirations) 20 - 5/8/2024 10:22. O2 (oxygen) 98% - 5/8/2024 10:22 Method: oxygen via Nasal cannula Mental status: Resident is alert & oriented x3, oriented to place. Oriented to time. Oriented to person. level of cognitive impairment: Alert. Resident is coherent. Speech is clear. Language barrier: No, Resident makes self-understood. Resident understands others .Respiratory: No signs of difficulty breathing. No shortness of breath noted. Humidification: Yes: oxygen via nasal cannula. HOB (head of bed) elevated. Head elevated at 30 degrees. No cough . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/8/24 at 8:37 AM, R3's eMAR - Medication Administration Note, indicates: Note text: Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 2 puff inhale orally every 4 hours as needed for wheezing, SOB (shortness of breath) Client complaints of SOB, O2 is 97% on 2 lts (liters). RR (respiratory rate) 22, HR (heart rate) 88 Author: RN Q (Registered Nurse) On 5/8/24 at 9:20 AM, R3's eMAR - Medication Administration Note, indicates: Note text: Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 2 puff inhale orally every 4 hours as needed for wheezing, SOB (shortness of breath). PRN Administration was: Effective Author: (RN Q) On 5/8/24 at 12:40 PM, R3's Nurses note states in part: Client (R3) was having episodes of SOB (Shortness of Breath) throughout the shift while writer was in room. Client (R3) sats were holding 98-97% on 2lt (liters) no s/x (signs or symptoms) or respiratory distress, RR (respiratory rate) 18 - 20. No barrel chested or nasal flares. During these episodes (sic), writer would stay in room and do breathing exercises and do education of anxiety and ways to control. (sic) Writer visually observed client several times during shift when walking by clients (R3) room and seen client resting comfortable with no s/sx of SOB. Client (R3) took noon medication with 240ml (milliliters) of water through a straw with no difficulty or SOB. Client refused all cares due to her SOB and refused therapy. Author (RN Q) . (No lung assessment is documented for R3 or any further documentation of monitoring R3's respiratory status on 5/8/24 or 5/9/24 is noted in R3's record. No documentation indicating R3's provider was updated regarding her shortness of breath on 5/8/24, when on 5/7 and 5/6, R3 was not experiencing SOB per nurses' notes and R3 was not using oxygen on 5/6 but is using it on 5/7 and 5/8. R3 does not have an order for oxygen on her MAR or TAR.) On 5/10/24 at 11:06 AM, R3's Nurses Note indicates: Resident called c/o (complaint of) SOB this morning. Pain med given, antianxiety med given, and albuterol given thru out am. NP R (Nurse Practitioner) contacted and stated to send resident to ED (emergency department) if SOB does not resolve. At this time resident and family are deciding on the options. Will monitor. On 5/10/24 at 11:15 AM, R3's Nurses Note indicates: Advanced Skilled evaluation: Lookback: Vitals temperature 97.1, blood pressure 107/62, pulse 88, respirations 20 and oxygen 96% on room air. Pain: indicators of pain: none. Neurologic (blank) EENT (eyes, ears, nose, throat): (blank) Mental status: Resident is alert & oriented x3, oriented to time, oriented to place, oriented to person. Mood and behavior: (blank) Cardiovascular: (blank) Respiratory: (blank) (of note, no indication if R3's lungs were assessed for abnormal lung sounds) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Gastrointestinal: (blank) Nutrition: (blank) Genitourinary: Urinary catheter intact. Skin: Skin issues . Special care: (blank) Safety: (blank) Functional: (blank) Education/notification: (blank) Completed clinical suggestions: (blank) On 5/10/24 at 11:18 AM, R3's Nurses Note indicates: Advanced Skilled evaluation: Vitals temperature 97.1, blood pressure 107/62, pulse 88, respirations 20 and oxygen 96% on room air. Pain: indicators of pain: none. Neurologic (blank) EENT: (eyes, ears, nose, throat) (blank) Mental status: (blank) Mood and behavior: (blank) Cardiovascular: (blank) Respiratory: (blank) (of note, no indication if R3's lungs were assessed for abnormal lung sounds) Gastrointestinal: (blank) Nutrition: (blank) Genitourinary: Urinary catheter intact. Skin: . Special care: (blank) Safety: (blank) Functional: (blank) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Education/notification: (blank) Completed clinical suggestions: (blank) On 5/10/24 at 11:51 AM, R3's Nurses Note states in part: Resident called on light and requested to be sent to the ED (emergency department) for evaluation because SOB was getting worse. 911 called and report called to (Hospital staff name) in ED at (Hospital name). On 5/10/24 at 1:55 PM, R3's Nurses Note indicates in part: Situation: Change in condition shortness of breath (SOB), outcome of physical assessment, respiratory status evaluation shortness of breath. Nursing observations, evaluation, and recommendations are SOB and anxious, feeling like she can't catch her breath at this time. Primary care Provider feedback: send to ED (emergency department) if no relief after albuterol and medications. R3's MAR for May 2024 indicated R3 only used her PRN albuterol sulfate inhaler on 5/8/24, this medication is not signed out on 5/10/24 as being given. (There is no evidence that a nurse assessed R3's lung sounds and R3's PRN albuterol medication is not signed out on the MAR for 5/10/24.) On 5/10/24 R3's Hospital Paperwork indicates: Emergency documentation service date/time: 5/10/2024 at 2:19 PM . Time seen: 5/10/24 at 12:42 (PM). Chief complaint: SOB for the past couple days. Not eating or drinking. History of present illness: .complains of 3 days history of shortness of breath. She complains of a little wheezing but denies any fever, URI (upper respiratory infection) symptoms, cough, chest pain, abdominal pain, vomiting or diarrhea . (heart rate) 121. (Blood pressure) 93/50, (respiratory rate) 23 SPO2: 98% nasal cannula 3 L/min. constitutional: Alert, interactive, appears pale. Respiratory: bilaterally wheezing, tachypneic (breathing that is faster and shallower than normal), mild respiratory distress . Medication decision making: .patient presented to the ED with complaint of shortness of breath. Patient is always on 2l of nasal cannula. Her initial pulse ox was 90%. Her initial blood pressure was in the 70's over 40s. Her heart rate was in the 120s. patient was treated with 2 DuoNeb's (breathing treatment) and a liter of normal saline IV (intravenous). Afterwards, she appeared improved. She still has bilateral wheezing. Her heart rate is in the 1 teens. Her blood pressure is in the 90s over 50s. Chest x-ray revealed bibasilar pneumonia. Due to patient's tachycardia (rapid heart rate), hypotension (low blood pressure) and bilateral pneumonia. She will be admitted for IV antibiotics . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/10/24 R3's Hospital Paperwork indicates: History and Physical 5/10/2024 at 3:45 PM, Chief complaint SOB for the past couple days. Not eating or drinking. History of present illness: .presents to the ED today for new onset SOB. Pt is accompanied by son breathing difficulty began about 3 days prior and has been progressively worsening. She is fatigued from the breathing efforts. Has a nonproductive cough and feels like something is stuck in her chest. Notes she is nauseated. Not normally on oxygen is now requiring 5 L NC (Nasal cannula) . physical exam: .Resp (respiratory): diffuse rhonchi but L>R (left greater than right), fast shallow breathing, on nasal cannula, breath sounds bilaterally vitals & measurements .(heart rate) 119bpm (beats per minute) .(blood pressure) 94/55, SPO2% (oxygen) 85% O2 therapy: nasal cannula O2 flow rate: 5l/min .diagnostics: XR chest 1 view: XR chest 1 view (05/10/24 12:43) chest Xray portable . impression: bibasilar airspace opacities pneumonia versus atelectasis. Favor Pneumonia. Assessment/Plan: 1. Sepsis due to pneumonia continue on IV antibiotics: Cefepime. 2. Bilateral Pneumonia .admit to inpatient .bilateral pneumonia/sepsis. 3. COPD exacerbation, acute COPD exacerbation brought on by PNA (pneumonia) . On 5/15/24 at 11:22 AM, R3's Hospital Discharge/Transfer information, states in part: Discharge diagnoses: 1. Bacteremia. 2. Sepsis due to pneumonia. 3. COPD exacerbation. 4. Acute Respiratory failure with hypoxia. 4. Acute respiratory failure/hypoxia 5. Pulmonary hypertension .Hospital course/treatment rendered: presented to the ER (hospital name) with 3 days of SOB, CXR shows BL (bilateral) PNA and was septic with hypotension needing levophed after sepsis protocol fluid resuscitation. Pt was started on cefepime + vancomycin. (Sepsis is a life-threatening medical emergency that occurs when the body's immune system overreacts to an infection, which damages its own tissues and organs. Levophed is a medication used to treat low blood pressure and heart failure. Cefepime and vancomycin are antibiotics used to treat bacterial infections.) On 6/13/24 at 11:29 AM, Surveyor interviewed DON B (Director of Nursing) regarding R3. Surveyor asked DON B to read 5/8 and 5/10/24 documentation/notes. DON B indicated he would expect a lung assessment to be completed to see if there were any changes, update the provider with R3 having SOB. DON B indicated he is not able to tell how long RN Q was in R3's room with R3, and that he would expect that to be documented. DON B indicated he would expect follow up monitoring/assessments to be done on R3. DON B indicated R3 should have had monitoring on 5/8 and 5/9. DON B indicated he would expect a lung assessment to be completed on 5/10/24 as well. DON B indicated he would expect PRN breathing medications to be offered as ordered. On 6/13/24 at 1:40 PM, Surveyor interviewed NP R (Nurse Practitioner), regarding R3. Surveyor read R3's note from 5/8/24 to NP R. NP R indicated she would expect a call from the facility with any change and with a SBAR (Situation, Background, Assessment, and Recommendation). NP R indicated she would expect nursing staff to monitor R3 for a few days for further signs/symptoms. Surveyor asked NP R, if staff would have monitored R3's lung sounds and assessed her respiratory status on 5/8 and 5/9, if R3's pneumonia could have been treated sooner. NP R referred Surveyor to Medical Director and would not give an answer to the question. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/13/24 at 4:51 PM, Surveyor interviewed RN Q (Registered Nurse) regarding R3. RN Q indicated she recalled R3 having complaints of shortness of breath on a night shift and with her on another shift. (Unable to remember dates.) RN Q indicated if someone is saying they're SOB she would get vitals, check their oxygen, check for respiratory distress and if they are having respiratory distress you would need to call the provider and administer as needed medications. Surveyor asked RN Q if she would do a lung assessment. RN Q replied yes, you would do a full assessment like a head to toe. Surveyor asked RN Q if she did a full assessment on R3 on 5/8/24? RN Q indicated she is unable to say without reviewing documentation and indicated she no longer works at the facility. Surveyor read RN Q's note from 5/8/24 to her. RN Q indicated she should have done a lung assessment and charted it. RN Q indicated R3 should have been monitored for SOB if it was passed on in report. R3 experienced a change in condition on 5/8/24 per documentation and was put on 2 L of oxygen. R3's provider was not updated regarding the SOB or oxygen use. R3 was not monitored any further until 5/10/24 when R3 was sent out to the hospital and was admitted with sepsis due to pneumonia which required IV antibiotics to be provided. 30992 Example 2 R12 had a change in condition on 6/5/24 following a fall out of bed. R12 began complaining of pain and staff did not assess despite a known fall. There is no evidence of continuous monitoring of R12's condition despite obvious signs of increased pain. R12 was later found to have a hip fracture. The facility's 'Falls Management Process,' undated, states in part: In the event a resident has fallen and/or is found on the ground, a complete head-to-toe assessment must be performed prior to moving the resident . Resident is NOT to be moved until assessed for injury by a nurse unless life-threatening situation exists. Upon arrival of the nurse, a quick head-to-toe scan will be performed without unnecessary movement, palpating, and examining all areas for breaks in the skin and/or other abnormal findings. If no obvious injury or only minor injury move resident to a comfortable position. If significant injury, severe pain, or abnormal assessments observed, call 9-1-1. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility's 'Notification of Changes Policy,' implemented 3/1/19, states in part: It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate .all pertinent information will be made available to the provider by the facility staff.Overview of Components of the Policy. 1. Requirements for notification of resident, which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident's physical, mental or psychosocial status. (i) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. 3. A need to alter treatment significantly. (i) a significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions to or discontinuation of treatments . Procedure. 1. The nurse will immediately notify the resident, resident's physician, and the resident representative(s) for the following (list is not all inclusive) .c. a need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment . 2. the nurse will notify the resident, resident's physician, and the resident representative(s) for non-immediate changes of condition on the shift the change occurs unless otherwise directed by the physician. 3. document the notification and record any new orders in the resident's medical record.6. Update the resident's care plan, transcribe, and implement the provider's orders. 7. communicate the changes to the rest of the care team and inform the supervisor. 8. communicate the changes to the staff on the oncoming shift . This is evidenced by: R12 was admitted to the facility on [DATE] with diagnoses including, but not limited to, the following: displaced spiral fracture of shaft of left femur, alcohol abuse, Wernicke's encephalopathy, urinary retention, metabolic encephalopathy, hyperosmolality, and hypernatremia. R12's Admission BIMS (Brief Interview of Mental Status) demonstrates that R12 is severely cognitively impaired. R12 has an APOAHC (Activated Power of Attorney for Healthcare). R12's comprehensive care plan documents the following: Focus: Needs pain management and monitoring related to surgically repaired hip fracture, and generalized pain. (Date Initiated: 4/22/24) Goal: Patient will achieve acceptable pain level goal 4. Interventions/Tasks: Administer Pain medication as ordered; Evaluate and establish level of pain on numeric scale/evaluation tool; Evaluate characteristics and frequency/pattern of pain; Evaluate need for bowel management regimen; Evaluate need for routinely scheduled medications rather than PRN (as needed) pain med administration; Evaluate need to provide medication prior to treatment or therapy; Evaluate what makes the patient's pain worse; Repositioning for comfort as needed (All interventions with Date Initiated: 4/22/24) R12's comprehensive care plan documents, in part, the following: I have a physical functioning deficit related to: Mobility impairment, self-care, impairment r/t (related to) weakness, physical limitations, need for staff assistance, hip fx (fracture) and cognitive deficits. Goal: R12 will improve my current level of physical functioning. Interventions/Tasks: Bed mobility assistance of 1, Dressing assistance of 1, Locomotion assistance of 1 in w/c (wheelchair), Monitor and report changes in physical functioning ability, Personal hygiene assist assistance of 1, Toileting assistance of 1, Transfer assistance of 2 with full body lift (Date Initiated 4/24/24) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	At risk for falls related to cognitive deficits, weakness, physical limitations, and need for staff assistance. Actual fall on 4/30/24, 5/16/24 Goal: No serious Fall related injuries Interventions: Bolster mattress placed on bed (Date Initiated: 4/24/24), Dysom (sic) on wheelchair seat (Date Initiated: 4/20/24), Encourage participation in activities to improve strength or balance (Date Initiated: 4/19/24, Revised 4/24/24), Encourage rest periods if feeling fatigued (Date Initiated: 4/19/24, Revised 4/24/24), Encourage use of a chair with arm rests (Date Initiated: 4/19/24, Revised 4/24/24), Footwear to prevent slipping (Date Initiated: 4/21/24, Revised 4/24/24), Keep bed locked (Date Initiated: 4/21/24, Revised 4/24/24), Keep environment well-lit and free of clutter (Date Initiated: 4/21/24, Revised 4/24/24), Keep personal items within reach (Date Initiated: 4/21/24, Revised 4/24/24), Nonskid socks/slippers (Date Initiated: 4/19/2 Revised 4/24/24), Resident is not to be left in the dining room alone (5/17/24), Staff to set up an activity table for resident if appearing restless (Date Initiated: 5/11/24, Revised 5/13/24), Therapy to work with DON on positioning calf pad on wc (wheelchair) between leg rests. (Date Initiated: 5/1/24), On 6/5/24 at 5:00 PM, R12 sustained an unwitnessed fall from bed. On 6/5/24 at 5:35 PM, LPN D (Licensed Practical Nurse) documented the following progress note: R12 found on floor, no injuries, Neuro checks started. BP (Blood Pressure) 124/88, resp (Respirations): 22, Temp (Temperature): 98.1, Pulse: 52 Spo2 (oxygen concentration) 98% room air. MD (Medical Doctor) notified, ADON (now Interim Director of Nursing), IDON CC notified. Significant other notified. On 6/5/24 at 5:45 PM, LPN D documented the following Fall Risk: History of falls (past 3 months): 3 or more falls in past 3 months. Level of consciousness/mental status: Intermittent confusion. Resident is chairbound/incontinent. Systolic blood pressure: No noted drop between lying and standing. Vision status: Adequate (with or without glasses). Predisposing disease: 3 or more present. Resident did not have a change in condition in the last 14 days. Recent hospitalization history in last 30 days: No. Gait/balance: N/A (not applicable) - not able to perform function. medication: Takes 3-4 these medications (or medication classes) currently and/or within the last 7 days. Fall Risk Score: 19 (Note, R12 is at risk of falls as he was admitted to the facility with a fracture.) LPN D (Licensed Practical Nurse) documented the following Post Fall Evaluation: Fall Details Date/Time of Fall: 6/5/24 at 5:00 PM Fall was not witnessed. Fall occurred bedside. Activity at the time of fall: Attempting to self-transfer - The reason for the fall was not evident. Did an injury occur as a result of the fall: No Did fall result in ER visit/hospitalization : No Provider: Physician AA Time Notified: 6/5/24 Notified of fall with no injury. Contributing Factors: Resident change in environment: No (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Was fluid spilled on floor: No Clutter present on the floor: No Floor mat was on floor: No Poor lighting in the area: No Bed was at an improper height: No Other furniture involved: No. Wheelchair was not involved in fall. Wearing glasses at the time of the fall. No Foot wear at the time of fall: Non-skid shoes/socks. Resident was not using cane/walker as instructed. Resident was not wearing oxygen at the time of fall. Resident was using incontinent supplies at the time of the fall. Incontinent at time of fall: No Bedside call light on when Resident was found: No Bathroom call light on when Resident was found: No Personal alarm sounding when Resident found: No Other Residents were not involved in fall. Medication Changes: No Vitals at 6:01 PM: T (Temperature): 98.2 BP (Blood Pressure): 128.86, P (Pulse: 56, R (Respirations) 20, Oxygen: 98% Method: Room Air Pain: Indicators of pain: None Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor is normal. Physical Findings: Change in diagnosis status: No Recent diagnosis of stroke, TIA (Trans ischemic Accident/mini stroke) or arrhythmia: No Decrease in fluid intake: No (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Change in blood glucose levels: No Change in blood pressure: No Change in behaviors: No Change in mobility status: No Recent weight loss: No Sensory impairment: No Resident does not have orthostatic BP (blood pressure) changes. Actioned Clinical Suggestions: Blank On 6/5/24 at 5:45 PM, LPN D documented the following progress note: Type: Skin Only Evaluation - Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor is normal. On 6/5/24 at 8:09 PM, LPN D documented the following progress note: R12 c/o (complained of) pain right hip after fall, Physician AA ordered an x-ray, x-ray company called, and they are expected to come tomorrow morning. LPN D did not document R12's pain level, administer pain medication, complete range of motion, or do an assessment of R12's lower extremities. R12's MAR (Medication Administration Record) documents the following order: Tylenol Oral Tablet 325 mg (milligram) - Give 650 mg by mouth every 4 hours as needed for pain. Order Date: 6/5/24 11:12 PM The MAR indicates LPN BB (Licensed Practical Nurse) administered Tylenol to R12 at 3:05 AM with a documented pain rating of 5. LPN BB did not follow up with R12 to ensure the Tylenol was effective. The oncoming shift marked the medication with an I indicating ineffective on 6/6/24 at 8:45 AM with a pain rating of 6. On 6/6/24 at 3:05 AM, LPN BB (Licensed Practical Nurse) documented the following progress note: upon start of shift, R12 with visible pain and reporting butt and legs hurting, sitting in broda chair at time of arrival. Writer and CNA (Certified Nursing Assistant) transferred resident to bed via Hoyer. Resident yelling and hollering my leg. R12 with severe pain to right leg/hip with transferring/repositioning. Notified Physician AA of yelling and hollering, gave order for Tylenol 650 mg (milligram) Q4H (every 4 hours) PRN (as needed). It is important to note, LPN BB entered the order for Tylenol PRN in the MAR at 11:12 PM. It is important to note despite R12's known fall, yelling my leg, there was no assessment of R12's right leg or hip and no continuous monitoring of R12. On 6/6/24, there is no documentation from LPN BB or any staff after 3:05 AM until 8:41 AM to indicate if the Tylenol was effective or not. There is no follow up pain assessment or continued monitoring documented until 8:41 AM (over 5 1/2 hours). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 8:41 AM, staff document in the progress notes: Tylenol Oral Tablet 325mg - Give 650 mg by mouth every 4 hours as needed for pain. PRN (as needed) Administration was: Ineffective Follow up Pain Scale was: 6. On 6/6/24 at 10:41 AM, staff documented the following progress note: Xray of right hip post fall one time only for diagnostic for 30 days. Resident was sent to the hospital for X-ray of his right hip. Called x-ray company and talked to (name omitted) to cancel the X-ray. On 6/6/24 at 10:55 AM, IDON CC (Interim Director of Nursing) documented the following eINTERACT SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers. At the time of the evaluation resident/patient vital signs, weight and blood sugar were: Pulse P 56 6/5/24 6:01 PM RR R 20.0 6/5/24 at 6:01 PM Temp T 98.2 6/5/24 6:01 PM Weight 134.0 lb. (pounds) 6/2/24 Pulse Oximetry O2 98.0 6/5/24 at 6:01 PM Note, these vitals are not current. (The most recent vitals documented on the Neuro Checks indicates the last vitals were obtained on 6/6/24 at 7:00 AM. The vitals were as follows: Temperature: 90 (type-o), Pulse: 97, Respirations: 20, Blood Pressure: 106/64.) Outcomes of Physical Assessment: Positive findings reported on the resident/patient for evaluation for this change in condition were: Functional Status Evaluation: Fall Pain Status Evaluation: Does the resident/patient have pain: Yes. Nursing observations, evaluation, and recommendations are: R12 with unwitnessed fall out of bed last evening with no apparent injury noted. Resident developed pain overnight and increased swelling to R (right) hip joint. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: Send to ED (Emergency Department) for eval if the condition has worsened and pain has increased. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/6/24 at 4:17 PM, R12's hospital report documents, in part, as follows: Pt (patient) brought in by medic. Per report Pt fell yesterday afternoon and is c/o (complaining of) back pain and right hip pain. Pt hypotensive upon arrival to ER (emergency room). Patient with longstanding history of alcohol abuse (now with Wernicke's encephalopathy/dementia), chronic urinary retention with indwelling Foley, and a history of a multitude of fractures from multiple falls . He reportedly fell out of bed yesterday (details not available since unwitnessed) and presented to the ER today due to pain Imaging confirms a right intertrochanteric hip fracture no other acute injuries (multiple old various healed fractures noted along with the recently healed distal L (left) spiral femur fx (fracture). R12's right hip x-ray documents the following findings: Bones: Comminuted, displaced, right proximal femoral intertrochanteric fracture. Left hip arthroplasty in position. Remote right pubic rami fractures. The facility has three (3) staff statements related to R12's fall on 6/5/24. On 6/6/24, CNA Z (Certified Nursing Assistant) documented the following statement: I was in the dining room feeding a resident when I heard R12 yelling I went to see what was wrong and he was on the floor in his room I asked hi [TRUNCATED]

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on observation, interview, and record review, the facility did not ensure that a resident with a pressure injury received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new injuries from developing for 6 of 6 residents (R3, R2, R5, R8, R9, and R10) with pressure injuries or at risk for developing pressure injuries. R3 admitted to the facility with a stage IV pressure injury to her sacrum that worsened. R3 developed six other pressure injuries while in the facility, all identified as a stage III or unstageable. R3 did not have treatments done for her wounds on all dates and times as ordered. R3 had two wound care orders that were not completed. R3 did not have treatment orders transcribed for four wounds that were discovered at the facility 4/30/24 (three wounds) and 5/7/24 (one wound). The facility's failure to ensure residents with pressure injuries receive the necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing, created a finding of immediate jeopardy that began on 4/30/24 when three new wounds developed. Surveyor notified NHA A (Nursing Home Administrator) of the immediate jeopardy on 6/13/24 at 3:29 PM. The immediate jeopardy was removed on 6/15/24; however, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as evidenced by the following examples: R5, R8, R9, and R10 were observed for multiple hours not being assisted with repositioning or using the restroom. R2 did not receive treatment to his pressure ulcers 12 times between 5/1/24 and 6/10/24. This is evidenced by: The facility's Policy and Procedure entitled Wound Management dated 10/28/21, documents in part: .To promote wound healing of various types of wounds it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders .1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of treatment nurse .7. Treatments will be documented on the Treatment Administration Record . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3 was admitted to the facility for short term rehab and wound care. R3 had the following diagnoses: malignant neoplasm of bone and articular cartilage (cancer), acute respiratory failure with hypoxia (condition where the body's tissues don't have enough oxygen), paraplegia (chronic condition that causes the loss of muscle function and voluntary movement in the lower half of the body), pressure injury sacral (bottom of the spine that lies between the fifth segment of the lumbar spine (L5) and the coccyx (tailbone) stage 4, combined systolic (heart at work) and diastolic (heart at rest) heart failure (condition that occurs when the heart's left ventricle can't contract normally so the heart can't pump enough blood into circulation with enough force), Peripheral Vascular Disease (PVD; circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), anxiety disorder, and Urinary Tract Infection (UTI) diagnosed on [DATE]. R3's most recent Minimum Data Set (MDS) dated [DATE] documents, a score of 15 on her Brief Interview of Mental Status (BIMS), which indicates R3 was cognitively intact. R3's Care Plan included the following: 2/23/24 Pressure ulcer at risk due to weakness, paraplegia, and need for staff assistance for positioning. Interventions documented in part: . Float heels when in bed and as resident will allow, Nutritional and Hydration support, Provide pressure reducing wheelchair cushion, Provide pressure reduction/relieving mattress, Provide thorough skin care after incontinent episodes and apply barrier cream, Turning and repositioning about every 2 hours while awake and as resident will allow .; Intervention added 3/8/24, Resident does not want the head of the bed lowered during cares as it causes pain to her back and the wound on her coccyx. 3/7/24 Pressure ulcer actual due to admitted with stage 4 pressure injury to coccyx area. Interventions documented in part: .Provide pressure reducing wheelchair cushion, Provide pressure reduction/relieving mattress . 3/13/24 Physical functioning. Interventions documented in part: .R3 can sit up in the broda chair for half hour to 1 hour either at breakfast or for lunch. Place pillow behind legs when sitting, Floating boots on while up in broda chair . R3's Braden Scales (tool to identify residents' risks for forming pressure injuries) document the following: R3's admission Braden Scale dated 3/7/24 score was 16 which indicates she is at risk. R3's Braden Scale dated 3/14/24 score was 13 which indicates she is at moderate risk. R3's Braden Scale dated 3/26/24 score was 12 which indicates she is at high risk. R3's Braden Scale dated 4/3/24 score was 12 which indicates she is at high risk. R3's Braden Scale dated 4/17/24 score was 12 which indicates she is at high risk. It is important to note that as these Braden Scale scores worsened and R3's risk increased, the facility did not implement any further or more aggressive actions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R3's MDS dated [DATE] section M. Skin documents the following in part: R3 has two unstageable wounds present on admission. R3 should have a bed device for pressure relief, chair device for pressure relief, nutrition plan, and pressure injury care. Turning and repositioning for R3 was marked No. It is important to note that there are only measurements for one unstageable wound. R3's medical record does not contain any documentation that R3 was being turned and repositioned until 4/26/24. R3's Physician Orders document, in part: The following two orders do not include the location of the wound: 3/8/24 Wash wound with wound cleanser or NS (normal saline), dry with gauze and then pack wound with gauze moistened with Dakin's (dilute solution of sodium hypochlorite and other stabilizing ingredients) 25% and cover with dry dressing or border gauze every day shift for wound dressing through 3/12/24. 3/12/24 Wash wound with wound cleanser or NS, dry with gauze and then pack wound with gauze moistened with Dakin's 25% and cover with dry dressing or border gauze every day and evening shift for wound dressing 3/19/24. R3's Physician Orders do not include wound care orders for R3's wounds to her center midline spine (discovered 4/30/24) or additional center midline spine wounds or left inferior ischium (discovered 5/7/24) wound. It is important to note that wound care orders for center midline spine and left inferior ischium were never transcribed by the facility as a result there were no treatments done for this area. R3's Treatment Administration Record (TAR) documents, in part: R3's wound care orders for her coccyx/sacrum wound have blanks on the following dates - 3/15/24 AM, 3/19/24 AM, 3/20/24 AM, 3/22/24 AM and PM, 4/1/24 PM, 4/11/24 AM, and 4/25/24. R3's Wound Documentation documents in part: Coccyx/Sacrum wound (present on admission) - ~ Admission skin assessment dated [DATE], coccyx and buttocks stage 4 wounds with slough. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~ assessment dated [DATE] - right posterior ischium, stage 3, 62.61% granulation, 37.39% necrotic, 2.07 cm x 3.54 cm x 0.1 cm. ~ assessment dated [DATE] - right posterior ischium, stage 3, 20% granulation, 80% necrotic, 2.36 cm x 2. 47 cm x 0.1 cm. Center Midline Back - ~ assessment dated [DATE] - center midline back, stage 3, 80% granulation, 20% necrotic, 1.5 cm x 0.4 cm x 0.1 cm. ~ assessment dated [DATE] - center midline back, stage 3, 15% granulation, 85% fibrous, 4.8 cm x 1.8 cm x 0.2 cm. It is important to note that the picture of this wound dated 5/7/24 has three separate wounds that have intact skin islands between them, however there is only one set of measurements indicating two of the wounds were not assessed or received treatment. Right Lateral Leg - ~ assessment dated [DATE] - right lateral leg, unstageable, 100% necrotic, 16.17 cm x 3.67 cm x 0.1 cm. ~ assessment dated [DATE] - right lateral leg, unstageable, 100% necrotic, 16.4 cm x 4.89 cm x 0.1 cm. Left Inferior Ischium - ~ assessment dated [DATE] - left inferior ischium, stage 3, 80% granulation, 20% fibrous, 2.11 cm x 1.85 cm x 0.1 cm. R3's Progress Notes include the following: 4/30/24, there is a note by the ADON (Assistant Director of Nursing) identifying new wounds to R3's right posterior ischium and center midline spine. There is no documentation of the wound to R3's right lateral leg. There is no documentation regarding identification of the wound to R3's left inferior ischium that was discovered on 5/7/24. It is important to note that the facility has no investigation into the root cause analysis of how these wounds developed. It is important to note that on 4/30/24 three additional wounds were discovered, two at a stage III and one unstageable (full thickness pressure injury where the base of the wound is covered by dead tissue or eschar.) Of note, on 5/7/24 one more additional wound was discovered at a stage III. R3's hospitalization admit documentation of wounds, dated 5/10/24: (continued on next page)

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	525338	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Center Posterior Sacrum - stage IV pressure injury, 8.2 cm, x 8.6 cm x 2.9 cm, undermining from 7 o'clock to 5 o'clock with the deepest depth at 1 o'clock of 3.4 cm and 1 cm from 8 o'clock to 11 o'clock, 40% slough present. Right Posterior Ischium - stage III pressure injury, 2.3 cm x 3.5 cm 0.2 cm, 40% slough present. Center Midline Back - stage III pressure injury, three ulcerations with small skin island separating them located along the spinal process, 11.2 cm x 4.5 cm x 0.2 cm, 40% slough present. Right Lateral/Posterior Calf - unstageable pressure injury, 14.6 cm x 2.9 cm x > (greater than) 0.1 cm (unknown depth), 100% eschar (dead tissue that forms over healthy skin). Left Posterior Ischium - stage III pressure injury, 3 cm x 1.9 cm x 0.1 cm, 40% slough present. On 6/11/24 at 12:06 PM, Surveyor interviewed FM T (Family Member). Surveyor asked FM T what concerns she had with R3's care. FM T explained that R3 was admitted for wound care so that was the primary focus for her stay at this facility. Surveyor asked FM T what concerns she had regarding R3's wounds., FM T stated R3 is supposed to be on a special mattress; her sacral wound worsened, and she developed 6 other wounds. Neither the condition of her wounds nor the development of 6 other wounds were communicated to FM T. FM T stated the facility was giving her ProStat (high protein supplement) not Ensure, she wasn't being repositioned timely or with the correct amount of assistance, and she had boots on in the hospital but not here in the facility. Surveyor asked FM T what type of mattress R3 was on at the facility, FM T said she had a pump that hung on the footboard, but it wasn't like the mattress she was on at either hospital she was at prior to coming to this facility. Surveyor asked FM T if she had called the facility or asked the staff to give her an update on R3's wounds, FM T stated yes, and no one seemed to know, or they directed me to talk with the wound nurse who was not in the facility in evening when we typically visited. Surveyor asked FM T what her concern was with the ProStat versus Ensure. FM T explained that R3 didn't always drink the ProStat but was accepting of the Ensure Max which has more protein, FM T stated that the facility said they couldn't provide her the Ensure Max. Surveyor asked FM T if R3 was being turned and repositioned, FM T stated no, R3 would call me if they hadn't been in to turn and reposition her and then I'd have to call the nursing home. R3 didn't like to turn side to side as it caused her pain in her wound on her bottom and in her ribs but she would reposition. FM T went on to explain that when R3's family visited, no staff would come in to reposition her and on the rare occasion someone did, it would only be one staff member and R3 required two assist for repositioning. FM T stated that R3 told her that often there was only one staff so they would go behind her bed and pull her up with the sheet under her. Surveyor asked FM T if there was anything else surrounding R3's wounds that she had concerns with, FM T stated that R3 had boots on her feet in the hospital but that the facility didn't continue to use them, and she didn't understand why. On 6/13/24 at 9:12 AM, Surveyor interviewed CNA J (Certified Nursing Assistant). Surveyor asked CNA J if R3 admitted to the facility with wounds, CNA J stated yes, to her bottom. Surveyor asked CNA J if she recalled what interventions R3 had in place, CNA J said R3 had an air mattress, Broda chair, blanket between knees, and a cushion. Surveyor asked CNA J if she knew what kind of cushion it was, CNA J said no, she was unable to recall the type of cushion. Surveyor asked CNA J if R3 had boots or if her heels were floated, CNA J stated R3 didn't have any boots to start with but did end up getting boots, blue fluffy ones. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked CNA J if R3 developed other wounds while she was here, CNA J said yes. Surveyor asked CNA J what was used to move R3 while in bed, CNA J said the draw sheet. Surveyor asked CNA J what areas of R3's body would the draw sheet cover, CNA J stated buttocks, thighs, and lower back. Surveyor asked CNA J how many staff did it take to assist R3 for turning and repositioning, CNA J replied two assist. Surveyor asked CNA J if R3 was ever turned and repositioned with one assist, CNA J stated, I always got another person. On 6/13/24 at 9:13 AM, Surveyor interviewed LPN S (Licensed Practical Nurse). Surveyor asked LPN S if all wounds should have treatment orders, LPN S stated yes. Surveyor asked LPN S should wound orders include the location of wound, LPN S said yes. Surveyor asked LPN S if she recalled what interventions R3 had in place, LPN S said air mattress, pillows/wedges, and a cushion. Surveyor asked LPN S how many assist it took to reposition R3, LPN S stated normally two and if R3 wasn't repositioned when she was supposed to be, R3 would call her daughter and then her daughter would call the facility. Surveyor asked LPN S what was used to boost R3, LPN S said the draw sheet. Surveyor asked LPN S if R3 was ever turned and repositioned with one assist, LPN S replied, I don't think back then because we had more help. On 6/13/24 at 10:41 AM, Surveyor interviewed DOM Y (Director of Maintenance). Surveyor asked DOM Y if R3 had an air mattress. DOM Y stated it is our standard of practice if R3 had wounds to have an air mattress, I think when she came in she had one or if we had to order it, it would've come the next day. On 6/13/24 at 11:20 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect all wounds to have treatment orders, DON B stated yes. Surveyor asked DON B would you expect wound orders to include the location of wound, DON B replied yes. Surveyor asked DON B if R3 had wounds when she admitted , DON B said I believe she did. Surveyor asked DON B if R3 developed more wounds while here, DON B replied I believe she did develop one. Surveyor asked DON B if there was an investigation into the root cause of R3 developing other wounds, DON B explained yes there should be, R3 had a lot of stuff going on - she had cancer; Surveyor asked DON B where the investigation would be documented, DON B said it would be in the wound nurse's notes. Surveyor asked DON B what interventions were in place for R3, DON B said an air mattress, R3 spent most of the time in bed and turning and repositioning. Surveyor asked DON B if R3 had boots or heels floated, and any type of cushion, DON B stated don't recall boots, and there was a discussion about a Roho cushion. Surveyor asked DON B when the air mattress was placed on R3's bed. DON B stated it is our standard of practice that if a resident has wounds, they should have an air mattress. It is important to note that the facility was not able to confirm what date R3 had the air mattress placed on her bed. On 6/13/24 at 2:10 PM, Surveyor interviewed DON B again. Surveyor asked DON B if R3 had her offloading surfaces updated after recommendation from wound team on 3/12/24, DON B said an air mattress would've been in place that's what they write for everyone. Surveyor showed DON B a picture of R3's wound assessment documentation in R3's record dated 5/7/24 (picture clearly shows three wounds present with intact skin in-between); Surveyor then asked DON B if he would expect there to be three sets of measurements, DON B said yes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/13/24 at 4:50 PM, Surveyor interviewed CNA U. Surveyor asked CNA U if she recalled what interventions R3 had in place, CNA U stated an air mattress and we were to float bottom with pillows. Surveyor asked CNA U if R3 developed more wounds here, CNA U said I'm not sure about more, but they weren't changing the bandages every day and you could notice the smell. Surveyor asked CNA U what was used to move R3 in bed. CNA U said either a draw sheet or a bath blanket. Surveyor asked CNA U how many staff did it take to assist R3 with turning and repositioning, CNA U replied two assist. Surveyor asked CNA U if R3 was ever turned and repositioned with one assist, CNA U stated they don't have enough staff, so could have. On 6/13/24 at 5:08 PM, Surveyor interviewed RN Q (Registered Nurse.) Surveyor asked RN Q if all wounds should have treatment orders, RN Q stated they should. Surveyor asked RN Q should wound orders include the location of the wound, RN Q stated yes. Surveyor asked RN Q if R3 admitted with any wounds, RN Q said yes, stage 4 to her coccyx. Surveyor asked RN Q if R3 developed any wounds while she was here, RN Q stated she developed multiple wounds here. Surveyor asked RN Q if she recalled what interventions R3 had in place, RN Q replied, an air mattress, every 2 hours turning and repositioning, followed by the wound care team, and wound care orders. Surveyor asked RN Q if staff were able to turn/reposition R3 every two hours, RN Q explained that R3 had the head of her bed elevated for comfort and often she wasn't repositioned a lot (as in small movements) and that's how the shearing wounds to her spine happened. Surveyor asked RN Q how many staff it took to assist R3 with repositioning, RN Q said two assist for wound care, there's no way I could complete it alone. Surveyor asked RN Q what was used to reposition R3 in bed, RN Q said the draw sheet. Surveyor asked RN Q if R3 was ever turned and repositioned with one assist, RN Q stated, I don't think they could do independently without shearing her skin. On 6/13/24 at 4:48 PM, Surveyor interviewed CNA V. Surveyor asked CNA V if R3 admitted with wounds, CNA V stated yes a big wound on her lower back. CNA V shared the facility uses wound doctor's and she did notice the wound developed a really bad smell. Surveyor asked CNA V if she recalled what interventions R3 had in place, CNA V said an air mattress, pillows, floated heels used pillows, can't remember if she had boots, and Broda chair but I never used that because she never got out of bed on PM shift. Surveyor asked CNA V if R3 developed any wounds here, CNA V couldn't recall. Surveyor asked CNA V what was used to boost R3 in bed, CNA V replied draw sheet and chux pad. Surveyor asked CNA V how many staff were required to turn and reposition R3. CNA V stated turning side to side, R3 could help. On 6/13/24 at 5:55 PM, Surveyor interviewed RN X. Surveyor asked RN X if all wounds should have treatment orders, RN X stated yes. Surveyor asked RN X should wound orders include the location of the wound, RN X said yes. Surveyor asked RN X if R3 admitted with wounds, RN X replied yes on her coccyx/sacrum area. Surveyor asked RN X if R3 developed any wounds here, RN X said she did not recall. Surveyor asked RN X if she recalled what interventions R3 had in place, RN X said an air mattress, boots, turning and repositioning, and pillows. Surveyor asked RN X how many staff it took to reposition R3. RN X stated two assist. Surveyor asked RN X what was used to reposition R3 in bed. RN X said draw sheet or incontinence chux pad that was under her. Surveyor asked RN X if R3 was ever turned and repositioned with one assist, RN X stated it's possible but on NOC shift we work as a team. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/14/24 at 12:19 PM, Surveyor interviewed RN W. Surveyor asked RN W if R3 admitted with any wounds, RN W said yes to her buttocks. Surveyor asked RN W if R3 developed any wounds here, RN W replied not sure, but her wound didn't improve. Surveyor asked RN W if she recalled what interventions R3 had in place, RN W said an air mattress. Surveyor asked RN W how many assist did R3 require for repositioning, RN W stated to be done properly it would require two assist, however, cutting staff to one CNA to each hall makes everything that requires two assist a lot harder. Surveyor asked RN W what was used to reposition R3 in bed, RN W said draw sheet or chux. Surveyor asked RN W if R3 was ever turned and repositioned with one assist, RN W stated yes it happened often with one CNA. RN W went on to state not having enough staff is the basis for most of our problems, including not getting dressing changes completed and turning or repositioning. R3 admitted to the facility with a stage IV sacrum pressure injury that deteriorated. R3 developed six other pressure injuries while in the facility, all identified as stage III or unstageable. The facility failed to complete all wound treatments and failed to have wound care orders for four wounds discovered at the facility transcribed. These failures created a reasonable likelihood for serious harm, which led to a finding of immediate jeopardy beginning on 4/30/24. The facility removed the immediacy on 6/15/24 when they completed the following: Skin sweep will be completed. Audit will be completed of all residents to ensure their risk for developing pressure injuries have been identified with robust care plan interventions in place to reduce risk of developing pressure injuries or worsening of current pressure injuries. All current wounds will be reviewed to ensure treatment orders are in place. Education will be provided to all nursing leadership on next working shift regarding monitoring of the wound management program. Education will be provided to all licensed staff and CNAs on next working shift regarding turning and repositioning. Education will be provided to licensed staff on next working shift regarding completing weekly skin assessments, documentation in the TAR when completing treatments, and ensuring treatment orders are in place for all wounds. Additionally, education will be provided on reviewing risk for pressure injuries on admission to ensure robust interventions are in place to reduce risk of developing pressure injuries or worsening of current pressure injuries. Pressure injury and prevention as well as wound management policy were reviewed with no policy changes at this time. All new admissions will be reviewed for pressure injury risk to ensure robust interventions are in place to reduce risk for developing pressure injuries or worsening of current pressure injuries. Audits to be completed x4 weeks. Results to be reviewed at the QAPI meeting for further recommendations. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audits will be completed weekly with wound rounds to ensure treatment orders are in place for all wounds. Audits to be completed x4 weeks. Results to be reviewed at the QAPI meeting for further recommendations. Treatment administration record will be audited 5x (five times)/week to ensure treatments are completed as ordered and documentation is present in the medical record. Audits to be completed x4 weeks. Results to be reviewed at the QAPI meeting for further direction. 5 audits will be completed weekly to ensure residents are provided turning and repositioning as per their plan of care. Audits will be completed x4 weeks. Results to be reviewed at the QAPI meeting for further direction. 44552 Example 2: R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, diabetes, dementia, heart disease, age related macular degeneration, hallucinations, insomnia, and kidney disease. R5's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/24/24, indicates R5 has a Brief Interview Mental Status (BIMS) score of 03, indicating R5 is severely cognitively impaired. R5 has an activated Power of Attorney. R5's Comprehensive Care Plan, states, in part; .Focus Pressure ulcer risk due to: diagnosis of diabetes, functional incontinence, weakness, physical limitations and need for staff assistance 5/7/21 .air mattress, complete Braden scare per living center policy, conduct weekly skin inspections, diabetic foot monitoring, heel boots on when in bed, provide pressure reducing wheelchair cushion, provide thorough skin care after incontinent episodes and apply barrier cream .Focus Pressure ulcer actual due to stage 3 on sacrum area 5/13/24 .conduct weekly skin inspection, monitor vital signs as needed, provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress, .resident to lay down in bed following meals to off load her back side for a while as a prepositioning intervention, treatments as ordered, weekly wound assessment. Focus Impaired physical mobility 5/7/21 .1A with ADLs (Activities of Daily Living) 2A Sara lift with transfers to WC (Wheel Chair), after the noon meal resident to be placed in bed/recliner for a nap r/t (related to) falling asleep in wc, assist resident in performing movements .utilize pressure relieving devices on appropriate surfaces. Focus alteration in elimination of bowel and bladder functional incontinence .encourage exercise, encourage fluids, .evaluate frequency/timing of incontinence episodes, .use of briefs/pads for incontinence protection . R5's Kardex, states, in part: .Safety .Resident to be checked and changed during all night rounds to prevent resident restlessness .Skin Integrity .Air mattress, heel boots on when in bed .Skin integrity Provide pressure reducing wheelchair cushion, .repositioning PRN (as needed) as resident allows, resident to lay down in bed following meals to off load her back side for a while as a repositioning intervention .Resident care after the noon meal resident to be placed in bed/recliner for a nap r/t falling asleep in w/c .ADLs 1A with ADLs, 2A Sara lift with transfers to WC .Toileting use of briefs/pads for incontinence protection . (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/12/24 at 7:30 AM, Surveyor observed R5 sitting in living room area. Surveyor observed multiple residents sitting in front of a TV with no sound on. At 7:53 AM, Surveyor observed staff assist R5 to the dining room for breakfast. Surveyor observed R5 being brought from dining room to living room area around 8:55 AM. R5 was brought back to dining room area around 9:23 AM-10:40 AM to observe activities making cookies. Surveyor observed R5 from 7:30 AM-11:20 AM; at 11:15 AM, R5 was brought back down to dining room for lunch, during this time frame R5 was not assisted with repositioning, not encouraged to exercise/movement, and not assisted to use the bathroom. On 6/12/24 at 12:36 PM, Surveyor interviewed CNA H (Certified Nursing Assistant). Surveyor asked CNA H when R5 was last toileted or repositioned, CNA H replied, I don't know I was called in at 11 AM to help feed residents. On 6/12/24 at 12:38 PM, Surveyor interviewed CNA O. Surveyor asked CNA O if R5 was toileted or checked and changed before lunch, CNA O said, No. Surveyor asked CNA O when R5 was last repositioned, CNA O said she got here at 10 AM today and is unable to say. CNA O indicated that her and her partner were going to be changing folks soon. On 6/12/24 at 1:00 PM, Surveyor interviewed CNA E. CNA E indicated she has not gotten to R5 since getting her up this morning due to not enough help. CNA E indicated she worked alone this morning until Scheduler F came over to assist with getting residents up who require two staff assist. On 6/12/24 at 1:10 PM, Surveyor observed R5 sitting in her wheelchair in the lounge on the unit. Example 3: R8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, major depressive disorder, hypertension, abnormalities of gait and mobility, and muscle weakness. R8's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/19/24, indicates R8 has a Brief Interview for Mental Status (BIMS) score of 00 indicating R8 is significantly cognitively impaired. R8 has an activated Power of Attorney. R8's Comprehensive Care Plan, states, in part; .Focus: Pressure ulcer risk due to: incontinence, weakness, physical limitations, and need for staff assistance 7/19/21 .Goal: Skin will remain intact 7/19/21 .Interventions .Provide pressure reducing wheelchair cush

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36192 Based on interview and record review, the facility did not ensure residents received sufficient fluid intake or meal intake to maintain proper hydration and health for 1 of 4 sampled residents (R3). R3's fluid and meal intakes were not documented daily to ensure she met her fluid and nutrition needs. This is evidenced by: Facility policy entitled 'Hydration,' implemented 5/24/23 states in part: .The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. Definitions: Sufficient fluid means the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake) and maintain health. The amount needed is specific for each resident and fluctuates as the resident's condition fluctuates (i.e., increase fluids if resident has fever or diarrhea). Compliance guidelines: .2. Identification/assessment: a. Nursing staff shall assess hydration status upon admission and throughout the resident's stay in accordance with assessment protocols. b. The dietary manager or designee shall obtain the resident's beverage preferences upon admission . c. The dietitian will assess hydration as part of the comprehensive nutritional assessment on admission, annually, and upon significant change in condition. follow-up assessment will be completed as needed.3. Evaluation/analysis: a. the assessment shall clarify the resident's current hydration status and individual risk factors for dehydration or fluid imbalance.4. Care plan implementation: a. The resident's goals and preferences regarding hydration will be reflected in the resident's plan of care.c. Real food and beverages will be offered first before adding supplements or assisted hydration (unless clinically indicated).5. Monitoring/revision: .b. The resident will be monitored for signs and symptoms of fluid overload, electrolyte imbalance, increased fluid needs, and dehydration when applicable. d. The care plan will be updated as needed, such as when a resident's condition changes, goals are met or the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of hydration-related problems are identified. 6. Documentation: a. Documentation of fluid status will be summarized in resident record unless specific restriction orders are in place and necessary orders are written requiring increased documentation . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy entitled 'Nutrition Management,' implemented 5/24/23 states in part: .The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Definitions: Acceptable parameters of nutritional status refers to factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight food/fluid intake, and pertinent laboratory values. Nutritional Status includes both nutrition and hydration status. Compliance Guidelines: .2. Identification/assessment: a. Nursing staff shall obtain the resident's height and weight upon admission and subsequently in accordance with facility policy.c. a comprehensive nutritional assessment will be completed by a dietitian on admission, annually, and upon significant change in condition. Follow-up assessments will be completed as needed .3. Evaluation/analysis: a. The assessment shall clarify the resident's current nutritional status and individual risk factors for altered nutrition/hydration. b. The dietitian shall use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs. Current standards of practice/formulas are used in calculation these estimates. 4. Care plan implementation: a. The Resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care.c. real food will be offered first before adding supplements.d. The physician will be notified of i. significant changes in weight, intake, or nutritional status. ii. Lack of improvement toward goals. Iii. A complication associated with interventions . R3 was admitted to the facility on [DATE] for short term rehab and wound care. R3 had the following diagnoses: malignant neoplasm of bone and articular cartilage (cancer), acute respiratory failure with hypoxia (condition where the body's tissues don't have enough oxygen), paraplegia (chronic condition that causes the loss of muscle function and voluntary movement in the lower have of the body), pressure injury sacral (bottom of the spine that lies between the fifth segment of the lumbar spine (L5) and the coccyx (tailbone) stage 4, combined systolic (congestive) and diastolic (congestive) heart failure (condition that occurs when the heart's left ventricle can't contract normally so the heart can't pump enough blood into circulation with enough force), Peripheral Vascular Disease (PVD; circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), anxiety disorder, and Urinary Tract Infection (UTI) diagnosed on [DATE]. R3's most recent Minimum Data Set (MDS) dated [DATE] documents, a score of 15 on her Brief Interview of Mental Status (BIMS), which indicates R3 was cognitively intact. R3's MDS indicates she has two unstageable pressure injuries present on admission. R3's Care Plan indicates the following: Impaired cardiovascular status related to congestive heart failure (CHF); peripheral vascular disease (PVD) date initiated 2/23/24 interventions: Monitor intake and output (2/23/24) . Diet alteration related to malignant neoplasm of bone and articular cartilage, paraplegia, stage 4 pressure ulcer to sacral region, CHF, and anxiety disorder. (3/11/24) . Goal: Maintain nutritional status by consuming >/=75% at most meals and maintain CBW +/-3% (3/11/24). Interventions: Diet as ordered: regular diet with regular texture and thin consistency; monitor meal consumption daily; obtain and update food/beverage preferences; Offer 4 oz (ounces) house supplement QD (each day) (220 cals, 6 grams protein) related to decrease po intake of meals (5/6/24); Prostat 30 ml (milliliter) BID (twice daily) (200 calories, 30g protein) (3/11/24); weights per orders (3/11/24). (Of note: R3's care plan does not address what her estimated daily fluid or nutrition needs are) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alteration in elimination of bowel and bladder due to foley catheter in place related to coccyx wound, functional incontinence of bowel related to (r/t) paraplegia, weakness, physical limitations and need for staff assistance (2/23/24) Interventions: .encourage fluids (2/23/24) R3's Nutrition Data V2.1, with effective date: 3/11/24 states in part: .Type: Admission.1. Data.2. Most Recent weight. Weight: (Blank) Date: (blank) Scale: (blank). 3. Current weight. (Blank).2. Weight status. 1. Loss of 5% or more in the last month or loss of 10% or more in last 6 months. (Marked no or unknown) .3. Skin status. 1. Skin status (check all that apply) .8. Stage 4 (marked) .5. Dehydration risk factors. 1. Dehydration risk factors .4. Diuretic (not marked) .7. Daily laxative use (marked) .7. Meal intake .2. Average meal intake percentage per day: >25% (greater than 25%). 8. Pertinent lab values (past 90 days) .6. Albumin (marked none). 7. Prealbumin (marked none) . 9. Summary. 1. Additional information.she is malnourished due to moderate decrease in food intake in the last 3 months, does not know if any weight lost in the last 3 months, bed or chair bound, and resident BMI (body mass index) is not available. Recommendations: continue - regular diet with regular texture and thin consistency - Prostat 30ml (milliliters) BID (twice per day) (200 calories, 30g (grams) protein) - MVI w/minerals (multivitamin w/minerals start -220mg zinc sulfate monitor weight and intakes nutrition goal maintain nutritional status by consuming >/=75% (greater than or equal to) at most meals and maintain CBW (current body weight) +/- 3%. R3's mini nutritional assessment with effective date 3/11/24 indicates a score of 6.0 which indicates R3 is malnourished. R3's Medication Administration Record/Treatment Administration Record (MAR/TAR) for March 2024 indicates the following: Record output every shift (start date 3/14/24) is blank for Day shift on 3/15, 3/19. 3/20, 3/22. PM shift is blank on 3/21, 323 and 3/27. NOC (night) shift is blank on 3/24, and 3/29. R3's MAR/TAR April 2024 indicates the following: Encourage fluids every shift (start date 4/24/24) is marked with a check mark for AM, PM, and NOC shift 4/25-4/30/24. Record output every shift - is blank for Day shift on 4/1, 4/6, 4/11, 4/19, 4/20, and 4/26. PM shift (evening) is blank on 4/1 and 4/20. NOC shift is blank on 4/13 and 4/27. On 4/4/24 at 3:12 PM, R3's Dietary Note, states in part: .Note text: High risk (wound) .weight: no in house weight due to rt refusing. Last recorded weight from hospital: 116 lbs. BMI: 22 (underweight for age).Diet: Regular diet, regular texture, and liquids. Supplements: ProStat BID (twice a day) (100 kcals, 15 g protein/30ml) . Estimated needs based on IBW 48kg (kilograms): Calories: 30-35 kcal/kg - 1500 -1700. Protein 1.5-2g/kg (grams per kilogram) = 72 -96g. Fluid: 1ml/kcal/day. (1500 - 1700) Skin: 3/27 unstageable pressure R dorsum - 1st digit .Unstageable pressure on sacrum .at risk for malnutrition related to malignant neoplasm of bone and articular cartilage, acute RF (respiratory failure) with hypoxia, paraplegia, pressure ulcer, CHF, PVD, osteoporosis, anxiety For wound healing continues a regular diet and has a poor po (by mouth) intake 0-25% at this time. Rt (resident) family brings snacks to rt. Per 3/18 dietary note per her daughter she prefers to snack, and it is uncommon for resident to eat 3 full meals per day. Per resident her UBW (usual body weight) is 104#. Recommendations: Monitor and encourage PO intake >/=75% of meals provided. Monitor tolerance to prescribed food and fluid consistency, monitor wt./PRN. Monitor further labs as available. Monitor skin integrity. Goal is for pt to maintain adequate PO, supplement, and fluid intake to meet nutritional needs. Wt. goal: weight maintenance with no sig. wt. change .pt. will achieve and maintain hydration status and experience/maintain improved skin integrity through next review . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Documentation Survey Report for Tasks for April 2024 indicates the following: Nutrition- Fluids: AM Shift is blank on 4/1 -4/7, 4/9, 4/11-4/21, 4/25-4/30/24 and marked NA (not applicable) on 4/22-4/25. PM Shift is blank on 4/3, 4/6, 4/10, 4/11, 4/17, 4/20 and 4/24. NOC shift is blank on 4/1-4/3, 4/5-4/22, and 4/27-4/29 and Marked NA on 4/4 and 4/24. (Of note there are 62 shifts not documented on out of 90 shifts for the month of April) Amount Eaten: Breakfast is blank or not documented on 4/1-4/7, 4/9, 4/11-4/21, 4/26-4/28 and 4/30. Lunch is blank or not documented on 4/1-4/7, 4/9-4/21, 4/26-4/28 and 4/30. Supper is blank or not documented on 4/3, 4/6, 4/10, 4/17, 4/20 and 4/24. (Of note: there are 53 out of 90 meals for the month of April that were not documented on. Staff would be unable to determine if R3 is hitting her daily calorie and fluid needs of 1500-1700 a day due to lack of documentation.) On 4/30/24, R3's record has documentation of R3 having 4 wounds. A Stage 4 Pressure injury to her coccyx, Stage 3 pressure injury to her right posterior ischium, Stage 3 pressure injury to the center midline of her back and an unstageable to her right later leg. On 5/6/24 at 1:57 PM, R3's Dietary Note, states in part: IDT (interdisciplinary team) met to review residents nutrition. Nursing reports that resident has a decreased appetite and is being evaluated for comfort care. Nursing also reports that resident does not like to be weighed and refuses to be weighed often. Resident is currently offered Prostat BID for wound healing. Will start offering resident a 4 oz house supplement QD (every day) due to decreased po intakes of meals. Will continue to monitor weights, intakes and follow up as needed. (No documentation was provided regarding R3's House supplement being consumed when Surveyor requested documentation of supplement intakes) On 5/7/24, R3's record has documentation of three more pressure injuries that were discovered. R3 now has 7 total pressure injuries to her body. One stage 4 Pressure injury to her coccyx, one Stage 3 pressure injury to her right posterior ischium, one Stage 3 pressure injury to the center midline of her back along with 2 new areas to her back, one unstageable to her right lateral leg and a new pressure injury to the left ischium. R3's Documentation Survey Report for Tasks for May 2024 indicates the following: Nutrition- Fluids: AM Shift is blank on 5/2, 5/3, 5/4, 5/6, 5/7, 5/8, 5/9 and 5/10. PM shift is blank on 5/1 and 5/4 and marked NA (not applicable) on 5/3. NOC shift is blank or not documented on 5/1 and 5/6. NOC shift is marked NA (not applicable) on 5/7-5/9/24. Amount Eaten: Breakfast is blank on 5/3, 5/4, 5/6 and 5/10. Lunch is blank on 5/3, 5/4, 5/6, 5/8 and 5/9/24. Supper is blank on 5/1 and 5/4. (Of note: There were 16 out of 29 shifts for the month of May that did not have documentation to show how much fluids R3 consumed and 11 out of 27 meals were not documented on. Based on this documentation there is no way to determine if R3 met her daily needs of 1500-1700 calories/milliliters per day for her fluid or caloric needs.) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 10:14 AM, Surveyor interviewed LPN S (Licensed Practical Nurse) regarding fluids and nutrition. LPN S indicated she couldn't remember if R3 needed assistance with feeding. LPN S indicated that the CNA's (Certified Nursing Assistants) would tell the nurses how much someone ate, and the CNAs would then document the amount eaten. LPN S indicated CNA's document the amount of fluids as well unless they're on a fluid restriction then a nurse would. Surveyor asked LPN S how she would know how much fluid someone would need, LPN S indicated she would use her nursing judgement and give water every shift in their room and check a resident's output to ensure adequate amount of fluids are being consumed. LPN S indicated that R3 only had between 100 -150 ml of output a day the last few weeks she was at the facility. LPN S indicated that if R3 had no fluid or food intake she would document it, let the provider know and discuss it with speech therapy. Surveyor asked if anyone looks at the meal and fluid intakes that are documented by the CNA's, LPN S indicated the CNAs tell us if there is an issue. On 6/13/24 at 10:22 AM Surveyor interviewed CNA J regarding R3. CNA J indicated that R3 would mostly drink Ensure (family brought in) and a few bites of her meals. CNA J indicated that she worked with R3 consistently and that R3 liked chocolate milk, Ensure and juices (cranberry, apple but not orange), R3 would drink water here and there but drink random amounts. CNA J indicated that R3's normal output was between 100 and 150ml per day. CNA J indicated CNAs documented meals and fluids, but the nurses document the output amount. CNA J indicated she would encourage R3 to eat and let the nurse know if she wasn't eating or if anything changes. CNA J indicated that R3 transferred with a full body lift (Hoyer), and they could weigh R3 with the Hoyer. CNA J was unaware of R3 refusing to be weighed. CNA J indicated that R3's family would bring snacks in and that R3 really liked pickles and sweet treats. (Of note: none of R3's likes and preferences are on her care plan for other staff to know she likes these items.) On 6/13/24 at 10:42 AM, Surveyor interviewed RD P (Registered Dietitian) regarding R3. RD P indicated that R3 admitted with a pressure wound, was on Prostat twice a day, a multivitamin and recommended zinc for 14 days. RD P indicated that on 4/4/24 there was no weight in the system due to R3 refusing. RD P indicated R3's fluid needs are 1500-1700ml (milliliters) per day. Surveyor asked what the process is to ensure residents are meeting their daily needs, RD P indicated she would check food intake and consider if accepting protein supplements and would need to check with the kitchen manager to know how much protein is being served each day. RD P indicated fluids and nutrition are documented in the chart. RD P indicated she would expect fluids to be completed each shift to accurately assess fluids. Surveyor asked RD P how often fluid and nutrition intake is reviewed. RD P indicated quarterly then every 3 months, every month if they have wounds or on dialysis but can check more often if needed. Surveyor asked RD P to review R3's fluid and nutrition intake with Surveyor. RD P indicated she needs to check with the regional Dietitian to find the intake/fluid forms that Surveyor was provided and would call Surveyor back. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 12:09 PM, Surveyor received a return call from RD P. RD P indicated she was able to access R3's meal and fluid intake and noticed there is missing documentation. Surveyor asked RD P looking at April's meal and fluid documentation, would you be able to say R3 met her fluid and calorie needs? RD P indicated this wouldn't be the best source to use due to lack of documentation. RD P said she would look at R3's labs from 5/1/24 and that R3's labs would not indicate dehydration. Surveyor asked about R3's albumin and protein level, RD P indicated albumin is 1.1 (low) and protein 5.6 (low) and indicated that R3's protein goal is appropriate for wound healing. Surveyor asked RD P about R3 meeting her calorie or fluid needs in April and May, RD P indicated she was not meeting her needs, so she started her on house supplement. RD P indicated she would expect nursing staff to notify the RD if missing intake consecutively. RD P indicated it was uncommon for R3 to eat 3 full meals a day. Surveyor asked RD P about R3's weights, RD P indicated there are no weights in the system, she would expect staff to try to get a weight but R3 refused to be weighed and would expect at least an admission weight. Surveyor asked RD P how she is ensuring R3 did not experience weight loss without having weights, RD P indicated would go off hospital weight and ideal body weight for R3. RD P indicated hospital weight was 116 pounds prior to admit at the hospital on 2/28/24. RD P indicated if a Resident refuses to be weighed she would check the documentation of meals and fluids and talk to nursing. (R3's MAR/TAR for May 2024 does not have any documentation of the House supplement being consumed. There is no indication in R3's care plan that consuming 3 meals a day is uncommon for her.) On 6/13/24 at 11:29 AM, Surveyor interviewed DON B (Director of Nursing) regarding R3. Surveyor asked about fluid documentation, DON B indicated fluids are documented each shift and would include fluids with meals and any extra fluids or water consumed on each shift. Surveyor asked DON B to review R3's Fluid and Nutrition documentation for April and May 2024 with Surveyor. DON B indicated I would like to hope she drank something, and it just wasn't documented. DON B indicated he would expect fluid and nutrition to be filled out each shift. DON B indicated that if a Resident doesn't drink/eat, they should have a note if refused or reason there is no documentation. DON B indicated based on meal documentation he is not able to say if R3 ate or not or how much she consumed if she did eat. Surveyor asked DON B if he is able to say that R3 met her daily fluid or caloric needs based on the documentation, DON B replied, he was not able to say based on lack of documentation. DON B indicated as CNA's pick-up trays they should document the amount of food and fluid consumed, if a resident is going 2 or 3 days in a row without eating a meal staff should offer other options and DON B would expect a note to be written regarding refusing a meal and what alternatives were offered. DON B indicated that R3 was not eating or drinking a lot prior to going out and that staff tried cranberry juice on her tray and family brought items in. Surveyor asked DON B what encourage fluids means. DON B indicated going in the room to offer fluids and to encourage a resident to take a few sips. DON B stated this should also be documented in the medical record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 11:52 AM, Surveyor interviewed DM M (Dietary Manager) regarding R3. Surveyor asked DM M if she does nutritional assessments or care plans for R3, DM M indicated she does not, and that the dietitian does. DM M indicated that R3 did not eat much, and family would bring food in, and she wouldn't eat much of that either. Surveyor asked about the amount of protein served each day for meals, DM M indicated she is unable to say as she follows the recipe. DM M indicated they tried fortified cereals and pudding with R3. Surveyor asked where that would be documented DM M indicated on the residents' meal ticket. Surveyor asked where R3's preferences would be documented, DM M indicated on R3's meal ticket as well. DM M indicated she would try to print R3's meal ticket out for Surveyor. Surveyor asked DM M if preferences should be on the care plan, DM M indicated the RD does the care planning. At 12:05 PM, DM M came back and indicated she is unable to print the meal ticket due to R3 being gone out of the system greater than 30 days. On 6/13/24 at 1:40 PM, Surveyor interviewed NP R (Nurse Practitioner) regarding R3's nutrition. Surveyor asked NP R if there is a direct correlation between R3's nutrition, fluid consumption and development of multiple pressure injuries. NP R replied Yes, poor nutrition and poor albumin levels contributed to her pressure injury development. NP R indicated she would expect and update with missed fluids and nutrition. NP R indicated she would expect staff to monitor intake and output if intakes are poor. On 6/13/24 at 4:51 PM, Surveyor interviewed RN Q regarding R3. RN Q indicated that R3 ate very minimal meals but would eat snacks from her family. RN Q indicated she never asked R3 to be weighed, so she is unsure if she refused. RN Q indicated if a resident had poor intake she would report to dietary and R3's doctor. Surveyor asked RN Q if she ever reported R3's missing intakes to the physician or dietary, RN Q indicated she is unable to say without reviewing documentation and indicated she no longer works at the facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552 Based on observation, interview, and record review, the facility did not ensure sufficient staff were present to provide nursing and related services to assure they met resident needs in a safe manner to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, this has the potential to affect all 56 residents who reside at the facility. Facility staff voiced concerns with tasks not being completed due to not having enough staff. Residents voiced concerns regarding long call light wait times and not being assisted to the bathroom timely. Residents did not receive assistance as indicated per care plans; for assistance with meals, repositioning, and using the bathroom. Family member voiced concern that they observed orders not being followed due to not having enough staff at facility for their loved one. R7 did not receive 1:1 supervision with his meals 17 times between 5/16/24 and 6/12/24. Evidenced by: The Facility Assessment Tool, dated 8/18/17, states, in part: .The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being .Example 2 .Staff .1:22 LN ratio days and evenings (consider breaking this down by RN and LPN per shift) 1:33 LN ratio nights (consider breaking this down by RN and LPN per shift) .Direct care staff .1:14 ratio days (total licensed or certified) 1:14 ratio evenings 1:16 ratio nights . Example 1: On 6/11/24 at 10:58 AM, Surveyor talked with CNA C (Certified Nursing Assistant) who indicated CNA C was employed with the staffing agency that the facility utilizes. CNA C indicated CNA C worked a double shift at the facility on 5/12/24. CNA C indicated due to call ins CNA C was the only CNA in the entire building for the NOC shift. CNA C indicated it was unsafe and that CNA C heard from other staff that this happens often because of call ins and how the owners are staffing the facility. CNA C indicated there was a resident who had a fall and CNA C felt it was because CNA C could not answer the resident's call light fast enough because of working so short staffed. Surveyor reviewed facility schedule for 5/12/24 and time punches. Schedule and time punches verify that CNA C was the only CNA working the NOC (night) shift for entire building. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 2: R1 was admitted to the facility on [DATE] with diagnoses including diabetes, obesity, hypertension, anxiety disorder, abscess of tendon sheath/left lower leg, major depressive disorder, and attention deficit hyperactivity disorder. R1's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/22/24, indicates R1 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R1 is cognitively intact. R1 is her own person. R1's Kardex states, in part: .Personal Hygiene assistance of 1 . R1's Comprehensive Care Plan, states, in part: .Focus: I have a physical functioning deficit related to mobility impairment, self-care impairment due to weakness, leg abscess, IV (intravenous) tubing, physical limitations, and need for staff assistance 5/15/24 .Goal: I will improve my current level of physical functioning . Interventions: Personal Hygiene assistance of 1 . On 6/11/24 at 3:00 PM, R1 indicated there are not enough staff to meet resident needs. R1 indicated CNAs are so busy .there is absolutely not enough staff. R1 indicated there are times that R1 has to wait over an hour for her call light to be answered and she is incontinent because of having to wait so long. R1 stated R1 feels like a baby when this happens. Example 3: On 6/11/24 at 4:30 PM, LPN D (Licensed Practical Nurse) indicated there are times that the facility has had only one CNA for the entire building and that being short staffed is a concern. LPN D indicated there are times things do not get done because of being short staffed. LPN D indicated residents who require 1:1 assistance with meals do not always get the supervision they have ordered. LPN D indicated R7 needs 1:1 assistance and R7 doesn't get the assistance needed because of not having enough staff. LPN D indicated residents do not always get repositioned as ordered and that treatments do not always get done because of not having enough staff. Example 4: On 6/12/24 Surveyor observed R5, R8, and R9 not receive assistance repositioning and using the bathroom as indicated in their Comprehensive Care Plans due to not having enough staff. All three residents are at risk for skin break down. R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, diabetes, dementia, heart disease, age related macular degeneration, hallucinations, insomnia, and kidney disease. R5's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/24, indicates R5 has a Brief Interview of Mental Status (BIMS) score of 03, indicating R5 is severely cognitively impaired. R5 has an activated power of attorney. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R5's Comprehensive Care Plan, states, in part: .Focus Pressure ulcer risk due to: diagnosis of diabetes, functional incontinence, weakness, physical limitations and need for staff assistance 5/7/21 .air mattress, complete Braden scare per living center policy, conduct weekly skin inspections, diabetic foot monitoring, heel boots on when in bed, provide pressure reducing wheelchair cushion, provide thorough skin care after incontinent episodes and apply barrier cream .Focus Pressure ulcer actual due to stage 3 on sacrum area 5/13/24 .conduct weekly skin inspection, monitor vital signs as needed, provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress, .resident to lay down in bed following meals to off load her back side for a while as a repositioning intervention, treatments as ordered, weekly wound assessment. Focus Impaired physical mobility 5/7/21 .1A with ADLs (Activity of Daily Living), 2A (two assist) Sara lift with transfers to WC (wheelchair), after the noon meal resident to be placed in bed/recliner for a nap r/t (related to) falling asleep in wc, assist resident in performing movements .utilize pressure relieving devices on appropriate surfaces. Focus alteration in elimination of bowel and bladder functional incontinence .encourage exercise, encourage fluids, .evaluate frequency/timing of incontinence episodes, . use of briefs/pads for incontinence protection . R5's Kardex, states, in part: .Safety .Resident to be checked and changed during all night rounds to prevent resident restlessness .Skin Integrity .Air mattress, heel boots on when in bed .Skin integrity Provide pressure reducing wheelchair cushion, .repositioning PRN (as needed) as resident allows, resident to lay down in bed following meals to off load her back side for a while as a repositioning intervention .Resident care after the noon meal resident to be placed in bed/recliner for a nap r/t falling asleep in w/c .ADLs 1A with ADLs, 2A Sara lift with transfers to WC .Toileting use of briefs/pads for incontinence protection . On 6/12/24 at 1:00 PM, Surveyor interviewed CNA E (Certified Nursing Assistant.) CNA E indicated she has not gotten to R5 since getting her up this morning due to not enough help. CNA E indicated she worked alone this morning until Scheduler F came over to assist with getting residents up who require two staff assist. R8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, anxiety disorder, major depressive disorder, hypertension, abnormalities of gait and mobility, and muscle weakness. R8's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/19/24, indicates R8 has a Brief Interview for Mental Status (BIMS) score of 00 indicating R8 is significantly cognitively impaired. R8 has an activated power of attorney. R8's Comprehensive Care Plan, states, in part: .Focus: Pressure ulcer risk due to: incontinence, weakness, physical limitations, and need for staff assistance 7/19/21 .Goal: Skin will remain intact 7/19/21 .Interventions .Provide pressure reducing wheelchair cushion .Provide pressure reduction/relieving mattress .Provide thorough skin care after incontinent episodes and apply barrier cream .Focus: Impaired Communication due to: Confusion, impaired cognition 8/1/21 .Focus: I have a physical functioning deficit related to: mobility impairment, self-care impairment due to weakness, physical limitations, cognitive deficits, and need for staff assistance 10/11/23 .Goal: I will maintain my current level of physical functioning Assistive devices w/c, bed mobility assistance of 1, dressing assistance of 1, .Toileting assistance of 1, Transfer me with the Hoyer using two staff members .Focus: alteration in elimination of bowel and bladder Functional incontinence . Interventions .use of briefs/pads for incontinence protection . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R8's Kardex states, in part: .skin integrity .provide pressure reducing wheelchair cushion .provide pressure reduction/reliving mattress. Mobility: assistive devices w/c .locomotion assistance of 1 as needed. Elimination/Toileting .Toileting assistance of 1. Toileting Use of briefs/pads for incontinence protection . On 6/12/24 at 7:30 AM, Surveyor observed R8 sitting in living room area. Surveyor observed multiple residents sitting in front of a TV with no sound on. At 7:52 AM, Surveyor observed staff assist R8 to the dining room for breakfast. At 8:55 AM, Surveyor observed R8 being brought from dining room to living room area. R8 was brought back to dining room area around 9:23 AM-10:40 AM to observe activities making cookies. Surveyor observed R8 from 7:30 AM-11:20 AM; at 11:20 AM, R8 was brought back down to dining room for lunch, during this time frame R8 was not assisted with repositioning, not encouraged to exercise/movement, and not assisted to use the restroom. At 11:40 AM, Surveyor observed R8 eating lunch in the dining room and then being brought back to living room at 12:30 PM. Surveyor observed R8 sitting in living room area and R8 smelled of urine. R9 was admitted to the facility on [DATE] with a diagnoses including Alzheimer's disease, unspecified dementia with behavioral disturbance, and constipation. R9's most recent MDS with ARD of 4/26/24, indicates R9 has a BIMS score of 03 indicating R9 is significantly cognitively impaired. R9 has an activated power of attorney. R9's Comprehensive Care Plan, states, in part: .Focus I have a physical functioning deficit related to self-care impairment, cognition 1/24/18 .Interventions assistive devices WC, bilateral foot braces when in bed, .dressing assistance of 1 .have resident move/flex-extend her legs at least once per shift. Movement may be up/down, in/out or flexing/extending her legs, inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse .personal hygiene assistance of 1 .transfer assistance of 2 via Hoyer lift .Focus Pressure ulcer risk due to cognition, weakness, physical limitations, need for staff assistance, and functional incontinence 7/24/18 .Interventions .Float heels-boots to bilat feet when up, monitor vital signs as needed, provide pressure reduction/relieving mattress, provide thorough skin care after incontinent episodes and apply barrier cream, skin assessment to be completed .Focus Alteration in elimination of bowel and bladder functional incontinence .use of briefs/pads for incontinence protection . R9's Kardex, states, in part: .safety assistive device WC .transfer assistance of 2. Via Hoyer lift .Skin integrity float heels .provide pressure reduction/relieving mattress .ADLs bilateral foot braces when in bed, dressing assistance of 1, .Toileting provide thorough skin care after incontinent episodes and apply barrier cream, use of briefs/pads for incontinence protection . On 6/12/24 at 1:00 PM, Surveyor interviewed CNA E. CNA E indicated that R9 was wet and was changed just now. CNA E indicated this was the first time since getting R9 up for the day that she has been changed or repositioned. Surveyor asked CNA E the reason why R9 was not repositioned or changed since getting up, and CNA E replied due to not having enough help so she (CNA E) is not able to get to them (Residents) every two hours like she should. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/13/24 at 5:30 PM, NHA A (Nursing Home Administrator) indicated understanding on Surveyor's observations of residents not being repositioned and offered to use the bathroom. NHA A indicated she would expect residents to be offered to use the bathroom and repositioned at least every two hours and as needed. NHA A indicated she would expect residents to be assisted to the bathroom timely and ADL cares performed as per care plan and orders. NHA A indicated the facility has a weekend manager on call and the DON comes in and works shifts as needed as well. NHA A indicated the staffing agency is notified when there is a call in, and the facility is always trying to get creative when it comes to filling open shifts and call ins. NHA A indicated she would expect the facility to follow the staffing ratio on the facility assessment. The facility failed to ensure there was always sufficient staff in the facility to meet resident needs and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. 38725 Example 5: On 6/11/24 at 10:57 AM, Surveyor interviewed R2. Surveyor asked R2 when he uses his call light, do the staff come timely? R2 stated, No, I gotta go to them. Surveyor asked R2 what about when you are in bed? R2 said then I wait 30-45 minutes for my call light to be answered. Example 6: On 6/11/24 at 12:06 PM, Surveyor interviewed FM T (Family Member.) Surveyor asked FM T what concerns she had with R3's care? FM T explained that R3 was admitted for wound care so that was the primary focus for her stay at this facility. Surveyor asked FM T what concerns she had regarding R3's wounds? FM T stated R3 is supposed to be on a special mattress, her sacral wound worsened, she developed 6 other wounds, the condition of her wounds nor the development of 6 other wounds were communicated to her, that the facility was giving her ProStat (high protein supplement) not Ensure, she wasn't being repositioned timely or with the correct amount of assistance, and she had boots on in the hospital but not here in the facility. Surveyor asked FM T if R3 was being turned and repositioned? FM T stated no, R3 would call me if they hadn't been in to turn and reposition her and then I'd have to call the nursing home; R3 didn't like to turn side to side as it caused her pain in her wound on her bottom and in her ribs but she would reposition. FM T went on to explain that when R3's family visited, no staff would come in to reposition her and on the rare occasion someone did, it would only be one staff member and R3 required two assist for repositioning. FM T stated that R3 told her that often there was only one staff so they would go behind her bed and pull her up to reposition her higher in bed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/14/24 at 12:19 PM, Surveyor interviewed RN W (Registered Nurse). Surveyor asked RN W how many assist did R3 require for repositioning, RN W stated to be done properly with two assist but cutting staff to one CNA to each hall makes everything that requires two assist a lot harder; on the ACU (Alzheimer's Care Unit) census has never been low but they're still cutting staff. Surveyor asked RN W if R3 was ever turned and repositioned with one assist? RN W stated often with one CNA. RN W went on to state, not having enough staff is the basis for most of our problems; not getting dressing changes completed and turning and repositioning not getting done, behaviors on the ACU from 1:00 PM until supper are escalated-verbal and physical interactions. I think the cutting of hours comes from corporate but as the old saying goes s**t rolls down hill and the residents and CNAs are suffering the worst. 49436 Example 7: R7 was admitted to the facility on [DATE], and has diagnoses that include epileptic seizures, muscle wasting, and atrophy. R7's Comprehensive Minimum Data Set (MDS), dated [DATE], indicates R7 has a Brief Interview of Mental Status (BIMS) score of 3 indicating R7 has severe cognitive impairment. R7 has two Physician Orders for his diet. One order dated 5/16/24, indicates: Regular diet, mechanical soft texture, regular (thin) consistency. Bite size food of soft texture. Second order dated 6/5/24, indicates in part: Regular diet, mechanical soft texture, regular (thin) consistency .1:1 supervision for all meals, slow rate, small bites . R7 has a Physician Order dated 5/23/24 for, Resident to be monitored while he is eating due to choking risk. R7's therapy swallow recommendations dated 5/29/24 indicate, in part: .2. 1:1 supervision for all meals. 3. Slow rate. 4. Small bites R7's documentation for assistance with eating between the dates of 5/16/24 through 6/12/24 was recorded as the following: -6 times as independent (Resident completes the activity by themselves with no assistance from a helper). -11 times as setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity). -9 times as Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and or contact guard assistance. -1 time as partial/moderate assistance (Helper does less than half the effort). -3 times as substantial/maximal assistance (Helper does more than half the effort.) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-2 times as dependent (Helper does all the effort.) -1 time as resident refused. On 6/12/24 at 8:01 AM, Surveyor observed CNA N (Certified Nursing Assistant) delivering R7's breakfast tray. On 6/12/24 at 8:17 AM, Surveyor observed R7 sitting in his wheelchair in his room. The bedside table with the breakfast tray on it was pulled up in front of him. R7's breakfast tray was open and set up for him. Surveyor observed the breakfast tray which consisted of one waffle, one sausage patty, a bowl of dry cereal, and an open carton of milk. No staff were in the room with R7. On 6/12/24 at 8:21 AM, Surveyor stopped CNA N in the hallway outside of R7's room to ask about R7's breakfast. Surveyor asked CNA N what assistance R7 needed with eating. CNA N indicated after setting up R7's tray, another CNA from the other hall asked if CNA N could help with another resident on the other hall. CNA N indicated she just got back on the unit and was going to ask R7's nurse if R7 still required assistance. CNA N asked LPN K (Licensed Practical Nurse) if R7 still required assistance. LPN K informed CNA N that R7 needed 1:1 supervision with meals. CNA N went into R7's room to assist R7 with breakfast. On 6/12/24 at 8:24 AM, Surveyor interviewed LPN K regarding R7 getting 1:1 supervision with meals. Surveyor asked, Once a tray is set down and open, should a staff member be in there with R7? LPN K stated, In a perfect world. Yes. That would be my expectation. When we only have one CNA, you can't all the time. Surveyor asked, Do you not have enough staff to ensure residents are assisted appropriately? LPN K indicated they do not have enough staff. On 6/13/24 at 9:20 AM, Surveyor interviewed DON B (Director of Nursing) regarding 1:1 supervision while eating for R7. DON B indicated if the meal tray is open the resident should not be left alone. DON B indicated it is not appropriate for R7 to have his meal tray and no staff be present. On 6/13/24 at 9:46 AM, Surveyor interviewed DOT L (Director of Therapy) regarding R7's therapy recommendations. DOT L indicated the staff are expected to follow therapy recommendations. DOT L indicated 1:1 supervision for meals for R7 was always followed, R7 has the potential to choke.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 36192 Based on interview and record review the facility did not ensure staff postings were accurate which has the potential to affect 56 out of 56 Residents residing at the facility. Review of staffing schedules and required staff postings revealed discrepancies between the documents. This resulted in inaccuracies with the total number and the actual hours worked for licensed and non-licensed staff directly responsible for resident care each shift. This is evidenced by: Surveyor reviewed the schedules and staff postings from 5/1/24 thru 6/13/24 with the following inaccuracies: On 5/2/24, the Staff Posting indicates on AM (morning) shift that a medication technician (med. tech) was working with four CNA's (Certified Nursing Assistants), and the schedule reflects the Med. Tech for AM shift called off and 5 CNAs were working. Night shift (NOC) on the staff posting indicates 2 CNAs worked and the schedule shows 3 CNAs worked. On 5/3/24, the Staff Posting indicates 3 CNAs and 1 med. tech worked. Staffing schedule indicates 4 CNAs and 1 med. tech worked. On 5/4/24, the Staff Posting indicates on NOC shift 1 LPN (Licensed Practical Nurse) worked and the census is blank. The staffing schedule indicates 2 LPNs had worked. On 5/6/24, the Staff Posting indicates on PM shift there were 3 CNAs all shift and 1 CNA a partial shift and the census is blank. Staffing schedule indicates 5 CNAs worked. On 5/7/24, the Staff Posting indicates 4 CNAs worked the AM shift and 4 CNAs worked the PM shift. Staffing schedule indicates 5 CNAs worked the AM shift and 5 CNAs worked the PM shift. On 5/8/24, the Staff Posting indicates 4 CNAs worked AM shift and 4 CNAs worked the PM shift. NOC shift indicates 2 CNAs, 1 RN and 1 LPN worked. Staffing schedule indicates 5 CNAs worked the AM shift and 6 CNAs worked the PM shift. NOC shift 2 LPNs, 1 RN and 2 CNAs worked. On 6/1/24, the Staff Posting indicates on PM shift 3 CNAs worked a full shift, 1 Med. tech, and 2 partial shift CNAs with 1 LPN worked. Staffing schedule indicates on PM shift 3 CNAs worked a partial shift, 1 LPN and 3 CNAs worked a full shift with 1 med. tech. The staff posting indicates 38 CNA hours when the schedule reflects 44 CNA hours. On 6/3/24, the Staff Posting indicates AM shift had 3 CNAs, 2 Med. tech and 1 RN working, and PM Shift shows 5 CNAs, 1 Rn and 1 LPN worked. Staffing schedule indicates AM shift 1 RN, 2 med. techs and 5 CNA's (1 CNA was late and 1 came in for a partial shift). PM shift 1 Rn, 1 LPN and 4 CNA's and 1 Med. tech. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/7/24, the Staff Posting indicates for NOC shift 2 CNA's, 1 Med. tech and 1 LPN worked. Staffing schedule indicates 1 RN, 1 LPN, 1 Med. tech and 1 CNA worked. On 6/11/24, the Staff Posting indicates on NOC shift 2 CNAs, 1 RN, 1 LPN worked. Staffing schedule indicates 1 RN, 1 LPN, 2 CNA's and 1 Med. tech worked a partial shift (10p - 2a). The staffing total hours for all the dates indicated above are also inaccurate due to the discrepancies in the schedules and staff postings. The following days the staff posting was missing the census on the form 5/5, 5/6, 5/11, 5/12, 5/18, 5/19, 5/24, 6/1 and 6/2/24. On 6/13/24 at 5:32 PM, Surveyor interviewed NHA A (Nursing Home Administrator) regarding the staffing schedule and staff postings. NHA A indicated the Schedules are to match the posted staffing hours. NHA A indicated the scheduler fills out the staff postings daily and it should be updated each shift. NHA A indicated the schedules and postings do not match and they should match. NHA A indicate she will be doing re-education with Scheduler F regarding updating the postings daily. NHA A indicated the form should have the census on it.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on observation, interview, and record review, the facility did not ensure residents received food in the appropriate form for 1 of 4 sampled residents (R7). R7 did not receive a mechanical soft textured diet as ordered by his physician. This is evidenced by: The facility therapeutic spread report for altered texture diets is a spreadsheet that, in part, contains four columns labeled regular menu item, mech (mechanical) soft, finger foods, puree. The therapeutic spread report was printed on June 3, 2024, for week 1 Wednesday. The regular menu item column consists of, in part: . for breakfast Sausage patty 1 each . The mech soft column consists of, in part: .Sausage patty-Grnd (ground texture) 1.5 oz (ounces) . It is important to note, for the mechanical soft diet, ground sausage is to be served. R7 was admitted to the facility on [DATE], and has diagnoses that include, epileptic seizures, muscle wasting and atrophy. R7's Comprehensive Minimum Data Set (MDS), dated [DATE], indicates R7 has a Brief Interview of Mental Status (BIMS) score of 3 indicating R7 has severe cognitive impairment. R7's Physician Order, dated 5/16/24, indicates: Regular diet, mechanical soft texture, regular (thin) consistency. Bite size food of soft texture. R7's therapy swallow recommendations dated 5/29/24 indicates, in part: .1. mechanical soft/thin liquids . 4. Small bites . On 6/12/24 at 8:01 AM, Surveyor observed CNA N (Certified Nursing Assistant) delivering R7's breakfast tray. On 6/12/24 at 8:17 AM, Surveyor observed R7 sitting in his wheelchair in his room. The bedside table with the breakfast tray on it was pulled up in front of him. R7's breakfast tray was open and set up for him. Surveyor observed the breakfast tray which consisted of one waffle, one sausage patty, a bowl of dry cereal, and an open carton of milk. Of note, the sausage patty was not ground. On 6/12/24 at 8:21 AM, Surveyor interviewed CNA N regarding R7's breakfast tray and if the items on his tray were considered mechanical soft. CNA N indicated she was unsure, and she would have to ask dietary. After CNA N asked dietary, CNA N indicated R7 did not receive a mechanical soft texture tray. CNA N indicated R7 should have received a mechanical soft texture tray. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 9:27 AM, Surveyor interviewed DM M (Dietary Manager) regarding a mechanical soft diet for R7. DM M indicated ground meat is the therapeutic alternative for a mechanical soft diet. Surveyor informed DM M that R7 received a whole sausage patty and asked if R7 should have received the ground sausage instead. DM M indicated the sausage patty should have been ground to mechanical soft. On 6/13/24 at 9:20 AM, Surveyor interviewed DON B (Director of Nursing) regarding R7's breakfast tray. Surveyor informed DON B that R7 received a whole sausage patty for breakfast instead of the therapeutic mechanical soft texture (ground) sausage. DON B indicated R7 should have received the correct textured diet. On 6/13/24 at 9:46 AM, Surveyor interviewed DOT L (Director of Therapy) regarding R7's therapy recommendations. DOT L indicated the staff are expected to follow the therapy recommendations. Per physician orders and therapy recommendations, R7 did not receive the appropriate therapeutic diet.