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	03/20/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility failed to protect 2 of 6 sampled residents (R3 and R6's) right to be free from abuse, neglect, or exploitation by a CNA I (Certified Nursing Assistant). R3 stated CNA I was rude to her, yelled at her, and refused to help her put her compression stockings on during morning cares (AM), resulting in a fall, and that she is terrified of CNA I. R6 stated CNA I mocks and belittles her, and often leaves her in a wet incontinence brief for over an hour. Evidenced by: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	Facility policy entitled Abuse/Neglect/Exploitation, undated, states, in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Definitions: . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being . Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or thing their hearing distance regardless of their age, ability to comprehend, or disability . Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation . Neglect meals [sic] failure of the facility, its employees, or service providers to provide good [sic] and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents . 3. The facility will provide ongoing oversight and supervision of staff in order to assure its policies are implemented as written . III. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation . and exploitation that achieves: H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors . IV. Identification of Abuse, Neglect and Exploitation: B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse . 5. Verbal abuse of a resident overheard . 7. Psychological abuse of a resident observed. 8. Failure to provide care needs such as feeding, bathing, dressing . 10. Sudden or unexplained changes in behaviors and/or activities such as fear of a person . VI. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm . Examples include but are not limited to: C. Increased supervision of the alleged victims and residents; D. Room or staffing changes, if necessary to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation . Per the State operations Manual: Sections SS1819(c)(1)(A)(ii) and 1919(c)(1)(A)(ii) of the Social Security Act provide that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility must provide a safe resident environment and protect residents from abuse. Abuse may result in psychological, behavioral, or psychosocial outcomes including, but not limited to, the following: Fear of a person or place, of being left alone, of being in the dark, and/or disturbed sleep and nightmares; Example 1 R3 was admitted to the facility on [DATE] with diagnoses that include Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 4, Hemiplegia and Hemiparesis following Cerebral Infarction (weakness and paralysis on one side of the body). R3's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/18/25, indicates R3 has a Brief Interview of Mental Status (BIMS) of 10 out of 15, indicating R3 has moderate cognitive impairment. (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 0600 Level of Harm - Actual harm Residents Affected - Few	R3's Care Plan includes, in part: Focus: I have a physical functioning deficit related to Mobility impairment, self-care impairment due to weakness, cancer, physical limitations, and need for staff assistance. Date initiated: 2/11/25 . Interventions: Dressing assistance of 1. Date initiated: 2/11/25 Personal hygiene assistance of 1. Date initiated: 2/11/25 . Toileting assistance of 1. Date initiated: 2/11/25. Transfer assistance of 1 with gait belt and walker. Date initiated: 2/11/25 . Alteration in elimination of bowel and bladder r/t (related to) functional incontinence due to weakness, physical limitations, and need for staff assistance. Date initiated: 2/11/25 . Interventions: Provide 1 assistance to toilet. Date initiated: 2/11/25 . On 3/20/25 at 11:06 AM, Surveyor interviewed CNA F. CNA F stated that when she came in that morning, she found CNA I and R3 in the lounge. R3 was in her wheelchair in the lounge wearing an incontinence brief and t-shirt but no pants. CNA I was telling R3 that she was disrespectful, that she was on her call light all the time, and that she was going to file a grievance against R3 with the facility. CNA I told R3 that if she would have stayed in bed she wouldn't have fallen, and told R3 she should not have come out to the lounge. R3 was crying and stated she would just go hide in my room. At this point CNA F intervened, telling CNA I she could go home, and she would help R3. R3 stated she was trying to put on her compression stockings and fell out of her wheelchair because no one would help her. CNA F said that R3 was terrified of CNA I. Surveyor asked CNA F if she would consider what happened this morning as abuse. CNA F stated yes, it was an allegation of abuse and that she followed the facility abuse policy by calling NHA A (Nursing Home Administrator) at home right away. Please note: CNA F indicated throughout this exchange, CNA I was loudly berating R3, who was crying and visibly upset. On 3/20/25 at 12:47 PM, Surveyor interviewed CNA E, who said she saw the incident that happened that morning between CNA F, CNA I and R3. CNA E stated that she observed CNA I say something to R3 and then CNA F told CNA I not to talk to R3 that way and that she should just go home since her shift was over. CNA E stated she did not hear what exactly CNA I said to R3, only CNA F intervening and telling CNA I not to talk to R3 that way. CNA E indicated that she would consider the way CNA I treated R3 as abuse. CNA E stated that R3 was afraid of CNA I and says that CNA I refuses to take her to the bathroom at night. Of note: CNA E was aware of R3 being afraid of CNA I and that R3 indicated CNA I refused to take her to the bathroom at night, yet CNA E did not report this to the facility. On 3/20/25 at 1:18 PM, Surveyor interviewed NHA A, who stated that he had received no reportable incident from today. On 3/20/25 at 1:24 PM, Surveyor called and left a message with CNA I regarding the incident that happened that morning. Surveyor did not receive a call back from CNA I. On 3/20/25 at 1:40 PM, Surveyor interviewed R3 who stated that she fell out of her wheelchair this morning while trying to put on her own compression stockings. Surveyor asked R3 if the staff normally help her in applying her compression stockings. R3 stated that normally they do, but that today they didn't. R3 indicated it was CNA I who was supposed to help her, but that she was afraid to say anything for fear of retaliation from CNA I and other staff members. Surveyor asked R3 if any staff had ever been rough with her. R3 replied, No comment, but stated, It will go right back to her and I'm afraid to say anything, but no one should be yelled at, and nobody should be treated that way. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/20/25 at 4:30 PM, Surveyor interviewed R3 who stated that she was concerned that CNA I would be working again tonight. R3 stated that when she even hears CNA I's voice in the hall, she becomes anxious and is so afraid that she can't sleep all night. R3 stated that she is afraid to put her call light on to go to the bathroom, for fear that CNA I will come in and yell at her. R3 stated that she has developed a UTI (urinary tract infection) due to being afraid of CNA I taking her to the bathroom. R3 said she is afraid that CNA I is going to come in her room at night and do something to her. R3 stated, I don't want to be here tonight. Every night I get anxious. I just want to run away and die. It's terrible, I shouldn't feel that way. (Of note: R3 is indicating that CNA I's presence is affecting her routine, such as becoming anxious and not being able to sleep. A reasonable person would not want to feel afraid of someone within their own home.) On 3/20/25 at 6:44 PM, Surveyor interviewed R3 who stated that everyone tells her not to be afraid of CNA I, but that they are afraid of her too. R3 stated that CNA I is mean to her, and that she starts shaking as soon as CNA I talks to her. Surveyor observed R3 was visibly trembling while discussing CNA I. R3 again stated that if CNA I is in the building that she is so anxious that she lays awake all night, unable to sleep from fear. (Of note: per R3's interview staff were aware R3 was afraid of CNA I, and telling R3 not to be afraid.) On 3/20/25 at 7:09 PM, Surveyor interviewed RN J (Registered Nurse) who stated that she saw the entire incident between CNA I and CNA F. RN J stated that CNA F and CNA I were raising their voices and getting R3 all worked up. RN J stated she would consider what happened to R3 as psychological abuse. Surveyor asked RN J if she had told anyone about the psychological abuse she had witnessed. RN J stated no, she hadn't because everyone saw what happened. (Of note: nurses are mandatory abuse reporters, and RN J did not report abuse to the facility or intervene even though she witnessed psychological abuse.) Example 2 R6 was admitted to the facility on ,d+[DATE] with diagnoses that include Morbid Obesity, Type 2 Diabetes Mellitus, Insomnia, and Major Depressive Disorder. R6's most recent MDS, with an ARD of 1/30/25, indicates R6 has a BIMS of 15 out of 15, indicating R6 is cognitively intact. R6's Care Plan includes, in part: Focus: I have a physical functioning deficit related to Mobility impairment, self-care impairment due to morbid obesity, weakness, physical limitations. Date initiated: 1/20/25 . Interventions: Dressing assistance of 1. Date initiated: 1/20/25 Personal hygiene assistance of 1. Date initiated: 1/20/25 . Transfer assistance of 1 with gait belt and walker. Date initiated: 1/20/25 . Alteration in elimination of bowel and bladder r/t (related to) functional incontinence due to morbid obesity physical limitations and need for staff assistance. Date initiated: 1/20/25 . Interventions: Provide 1 assistance to toilet. Date initiated: 1/20/25 . (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/20/25 at 10:19 AM, Surveyor spoke with R6 who stated that CNA I makes fun of her accent and the way she talks. R6 said she feels belittled by CNA I, and there are many nights she can't sleep and just lies awake in bed and cries because of her pain, immobility, and having CNA I make fun of her on top of everything else that she is experiencing. R6 stated that many nights she will put on her call light, and CNA I will turn off her call light and tell her she will come right back, but that she doesn't come back for over an hour, resulting in her being soaked and getting a rash. R6 stated that she had talked to NHA A on more than one occasion about CNA I, her lack of care, and how she made fun of her accent, but that nothing was ever done about it. On 3/20/25 at 1:18 PM, Surveyor interviewed NHA A, who stated that he had received no reportable incident from today. On 3/20/25 at 6:12 PM, Surveyor interviewed NHA A, who stated that CNA F told him that her and CNA I had an argument over cares for a resident. NHA A stated he did not know which resident it was. NHA A said that CNA F told him that she was going to call the state, that she didn't give a reason, but it was based on how CNA I treated the residents. Surveyor asked NHA A if a staff member saw another staff being disrespectful and rude to a resident, would he expect that to be reported to him right away. NHA A replied yes. NHA A stated that both CNA I and CNA F would be educated on not arguing in the building. NHA A stated it could have been an abuse situation if a resident was around. Surveyor pointed out that R3 was around and witnessed the incident between CNA I and CNA F. Surveyor asked NHA A if he would expect staff to report allegations of abuse. NHA A replied yes, if it truly was abuse. Surveyor asked if a staff member raising their voice and refusing to help them would be considered abuse. NHA A replied yes absolutely. Surveyor asked NHA A when should staff report allegations of abuse. NHA A replied staff should report allegations of abuse to him immediately. On 3/20/25 at 7:17 PM, Surveyor interviewed NHA A who stated that no one had ever reported concerns about CNA I. Surveyor asked NHA A if R6 had ever brought concerns to him about lack of care with CNA I and that CNA I makes fun of her accent. NHA A stated that he had talked to R6's sister, and that her memory has been going a little and she will say things happened that really didn't happen. Surveyor pointed out that R6 has a BIMS of 15 and no dementia diagnosis. Surveyor asked NHA A if he should take all allegations of abuse seriously. NHA A replied yes absolutely. Surveyor pointed out that R3 and R6 do not feel safe in their own home. NHA A agreed that R3, R6, and all the residents should feel safe in their home. (Of note: NHA A was aware that R6 had concerns.) The facility failed to protect two residents from verbal abuse, including belittling, mocking, yelling and withholding of cares, resulting in ongoing fear and anxiety. R3 was afraid to speak up for fear of retaliation, and R6's concerns of humiliation were not addressed. These residents, who trust and rely on facility staff to meet their needs, have the reasonable expectation to be safe in their home and to be treated with respect and dignity. Cross Reference F609.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 2 of 2 abuse allegations involving Residents (R3 and R6). CNA F (Certified Nursing Assistant) reported an abuse allegation involving CNA I and R3 that occurred on 3/20/25 to NHA A (Nursing Home Administrator). R6 reported multiple incidents of CNA I mocking her accent to NHA A. These incidents were not treated as abuse and were not reported to the state agency. Evidenced by: Facility policy entitled Abuse/Neglect/Exploitation, undated, states, in part: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Definitions: . Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being . Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or thing their hearing distance regardless of their age, ability to comprehend, or disability . Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation . Neglect meals failure of the facility, its employees, or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents . 3. The facility will provide ongoing oversight and supervision of staff in order to assure its policies are implemented as written . VII. Reporting/Response. A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . 2. Assuring that reporters are free from retaliation or reprisal . Example 1 R3 was admitted to the facility on [DATE]. R3's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/18/25, indicates R3 has a Brief Interview of Mental Status (BIMS) of 10 out of 15, indicating R3 has moderate cognitive impairment. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 11:06 AM, during an interview with CNA F (Certified Nursing Assistant), who stated that when she came in that morning, she found CNA I and R3 in the lounge. R3 was in her wheelchair in the lounge wearing an incontinence brief and t-shirt but no pants. CNA I was telling R3 that she was disrespectful, that she was on her call light all the time, and that she was going to file a grievance against R3 with the facility. CNA I told R3 that if she would have stayed in bed she wouldn't have fallen, and told R3 she should not have come out to the lounge. R3 was crying and stated she would just go hide in my room. At this point CNA F intervened, telling CNA I she could go home, and she would help R3. R3 stated she was trying to put on her compression stockings and fell out of her wheelchair because no one would help her. CNA F said that R3 was terrified of CNA I. Surveyor asked CNA F if she would consider what happened this morning as abuse. CNA F stated yes, it was an allegation of abuse and that she followed the facility abuse policy by calling NHA A (Nursing Home Administrator) at home right away. Please note: CNA F indicated throughout this exchange, CNA I was loudly berating R3 who was crying and visibly upset. On 3/20/25 at 12:47 PM, Surveyor interviewed CNA E, who said she saw the incident that happened that morning between CNA F, CNA I, and R3. CNA E stated that she observed CNA I say something to R3 and then CNA F told CNA I not to talk to R3 that way and that she should just go home since her shift was over. CNA E stated she did not hear what exactly CNA I said to R3, only CNA F intervening and telling CNA I not to talk to R3 that way. CNA E indicated that she would consider the way CNA I treated R3 as abuse. CNA E stated that R3 was afraid of CNA I and says that CNA I refuses to take her to the bathroom at night. Surveyor asked CNA E if she had ever reported this allegation of abuse to the administration. CNA E stated no, she had not. On 3/20/25 at 7:09 PM, Surveyor interviewed RN J (Registered Nurse) who stated that she saw the entire incident between CNA I and CNA F. RN J stated that CNA F and CNA I were raising their voices and getting R3 all worked up. RN J stated she would consider what happened to R3 as psychological abuse. Surveyor asked RN J if she had told anyone about the psychological abuse she had witnessed. RN J stated no, she hadn't because everyone saw what happened. Example 2 R6 was admitted to the facility on ,d+[DATE] R6's most recent MDS, with an ARD of 1/30/25, indicates R6 has a BIMS of 15 out of 15, indicating R6 is cognitively intact. On 3/20/25 at 10:19 AM, Surveyor spoke with R6 who stated that CNA I makes fun of her accent and the way she talks. R6 said she feels belittled by CNA I, and there are many nights she can't sleep and just lies awake in bed and cries because of her pain, immobility, and having CNA I make fun of her on top of everything else that she is experiencing. R6 stated that many nights she will put on her call light, and CNA I will turn off her call light and tell her she will come right back, but that she doesn't come back for over an hour, resulting in her being soaked and getting a rash. R6 stated that she had talked to NHA A on more than one occasion about CNA I, her lack of care, and how she made fun of her accent, but that nothing was ever done about it. On 3/20/25 at 1:18 PM, Surveyor interviewed NHA A, who stated that he had received no reportable incident from today. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 7:17 PM, Surveyor interviewed NHA A who stated that no one had ever reported concerns about CNA I. Surveyor asked NHA A if R6 had ever brought concerns to him about lack of care with CNA I and that CNA I makes fun of her accent. NHA A stated that he had talked to R6's sister, and that her memory has been going a little and she will say things happened that really didn't. Surveyor pointed out that R6 has a BIMS of 15 and no dementia diagnosis. Surveyor asked NHA A if he should take all allegations of abuse seriously. NHA A replied yes absolutely. Surveyor pointed out that R3 and R6 do not feel safe in their own home. NHA A agreed that R3, R6, and all the residents should feel safe in their home. (Of note: NHA A was aware that R6 had voiced concerns.) The Facility failed to foster an environment where staff and others felt free to report all alleged violations of mistreatment, exploitation, neglect, or abuse without fear of retaliation, and failed to take all allegations of abuse seriously. The Facility failed to follow their abuse policy and did not report these accusations of abuse to the state agencies within the required timeframe. Cross Reference F600.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788 Based on observation, interview and record review the facility did not ensure that a resident who is fed by enteral means receives the appropriate treatment and services for 1 of 1 resident (R5) reviewed for gastrostomy tube (G/T, or G-Tube) care. R5 had a G-Tube placed 11/8/24 and currently does not use it. R5 does not receive the appropriate care and treatment as ordered to G-Tube to maintain the patency. Evidenced by: The facility policy entitled, Enteral Nutrition, dated January 2025, states, in part: . Policy Statement: Adequate nutritional support through enteral feeding will be provided to residents as ordered. Policy Interpretation and Implementation: . 6. If the resident has a feeding tube placed prior to admission or returning to the facility, the Physician and the interdisciplinary team will review the rationale for the placement of the feeding tube, the resident's current clinical and nutritional status, and the treatment goals and wishes of the resident . 13. Staff caring for residents with feeding tubes will be trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as: . b. Leaking and skin breakdown around insertion site . R5 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) and dysphagia (difficulty swallowing). R5's Discharge Summary, dated 12/17/24, states, in part: . admitted : 11/22/24 discharge date : 12/13/24 . Primary Discharge Diagnoses: Left middle cerebral artery stroke (occurs when blood flow to the left side of the MCA, a major artery in the brain, is interrupted) . Secondary Discharge Diagnoses: . Dysphagia (difficulty swallowing) (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Presence of externally removable percutaneous endoscopic gastrostomy (PEG) tube (a thin, flexible tube inserted through the skin and the stomach used to provide nutrition and medications to people who cannot eat or drink adequately) . Discharge Disposition: . For Skilled Nursing Facility: . -Maintain patency of G-Tube with frequent flushes . Details of Hospital Stay: . G-Tube was placed 11/15 given ongoing dysarthria/dysphagia . Dysphagia: . -Assessment & Plan SLP (Speech-Language Pathologist) eval and treat. VFSS (Videofluoroscopic swallow study) 12/8 with upgrade to general diet with thin liquids. Continue with supervision with meals. Tube Feedings discontinued, monitor PO (by mouth) intake, ongoing every 8-hour flushes for g-tube patency . (Of note, R5's discharge paperwork indicated on going every 8 hour flushes for patency, and this was never transcribed or clarified) R5's Treatment Administration Record (TAR) for months of December, January, and February do not have g-tube orders to monitor and flush. R5's TAR for March include: -Monitor G-tube site for redness or signs of infection. Clean with soap and water and apply gauze around site. Every shift for tube feeding. Order Date: 3/20/25 2:31PM R5's Order Summary Report, dated 3/20/25, include: . -Monitor G-Tube site for redness or signs of infection. Clean with soap and water and apply gauze around site. Every shift for tube feeding. Order Status: 3/20/25. Start Date: 3/20/25 . (Important to Note: this order was to be started on 3/20/25, R5 did not have an order on the Medication Administration Record (MAR)/TAR prior to Survey on 3/20/25.) R5's Care Plan, dated 3/20/25, states, in part: . (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: Tube Feeding tube in place r/t (related to) possible need r/t stroke and possible supplement if poor intake occurs. Date Initiated: 3/20/25. Goal: Maintain nutritional status and body weight. Date Initiated: 3/20/25. Target Date: 6/23/25. Interventions: *Check tube placement when flushing. Date Initiated: 3/20/25. Revision on: 3/30/25 . *G-tube site cares daily per MD (Medical Doctor) order. Date Initiated: 3/20/25 . *Observe and report skin irritation at the tube site. Date Initiated: 3/20/25 . Important to note: The feeding tube care plan was initiated on 3/20/25. Prior to 3/20/25 R5 did not have a feeding tube care plan. On 3/20/25 at 2:15 PM, Surveyor and DON B (Director of Nursing) observed R5's G-Tube site. DON B described the site as having thick, mucousy drainage around the tube site with some dried dark red drainage around that. DON B indicated it should be getting cleaned and monitored. On 3/20/25 at 11:05 AM, CNA F (Certified Nursing Assistant) indicated the nurses do not do anything to R5's G-tube, and R5 and his wife have asked for the tube to be removed. On 3/20/25 at 12:47 PM, CNA E indicated to Surveyor that the nurses do not do anything with R5's G-tube. CNA E indicated R5 does not use the G-tube. On 3/20/25 at 2:01 PM, Surveyor showed DON B the order to maintain patency of G-Tube with frequent flushes and asked what the expectations would be for the order. DON B indicated she would expect more specific instructions from MD on how frequent. DON B indicated R5 should be receiving cares to G-Tube site along with monitoring for infection and frequent flushes to keep it patent. Surveyor asked DON B if R5 should have a G-Tube care plan and orders on TAR for nurses to follow, and DON B indicated yes. On 3/20/25 at 2:39 PM, ADON C (Assistant Director of Nursing) indicated she would expect nurses to be checking R5's G-Tube placement and maintain patency. ADON C indicated she would expect physician orders to be followed. On 3/20/25 at 2:40 PM, Surveyor interviewed LPN D (Licensed Practical Nurse) and asked what interventions are in place for R5's G-Tube. LPN D indicated she does not do anything with R5's G-Tube; there is nothing on R5's TAR. LPN D indicated nurses should be flushing the G-Tube and checking for patency even if the G-Tube is not being used.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review, the facility did not ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 3 residents (R6) reviewed for pain. R6 was admitted to the facility with rhabdomyolysis (a condition where muscle tissue breaks down, causing sever muscle pain, tenderness, and muscle cramps). The facility failed to obtain R6's pain medication, and failed to offer R6 any non-pharmacological interventions to treat her pain, resulting in R6 having continued pain. Evidenced by: The facility policy titled Pain Management, dated 10/1/22, states in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents goals and preferences . Recognition: . Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to . b. Loss of function or inability to perform activities of daily living (ADLs) . e. Behaviors such as: . depressed mood or decreased participation in usually physical and/or social activities . h. Difficulty sleeping (insomnia) . i. Negative vocalizations (e.g. groaning, crying .), j. Decline in activity level . Pain Assessment: . 2. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g. nurses, practitioner, pharmacists and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident . g. Identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain. h. Impact of pain on quality of life (e.g. sleeping, functioning, appetite and mood) . j. The resident's goals for pain management and his/her satisfaction with the current level of pain control . Pain Management and Treatment: . 6. Non-pharmacological interventions will include but are not limited to . a. Environmental comfort measures . d. Physical modalities . e. Exercises to address stiffness . as well as restorative programs to maintain joint mobility . f. Cognitive/behavioral interventions . 7. Pharmacological interventions . The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain . i. Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen . R6 was admitted to the facility on [DATE] with diagnoses that include Morbid obesity, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Insomnia, Essential Hypertension, Major Depressive Disorder, and Rhabdomyolysis. R6's Brief Interview for Mental Status (BIMS) dated 1/30/25 was 15 out of 15, indicating that R6 is cognitively intact. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's Care Plan states, in part: Focus: Needs pain management and monitoring related to migraine headache and chronic pain. Date initiated: 1/20/25. Goal: Patient will achieve acceptable pain level goal of 4. Date initiated: 1/20/25. Interventions: Administer pain medication as ordered. Date initiated. 1/20/25 . Evaluate characteristics and frequency/pattern of pain. Date initiated: 1/20/25 . Evaluate need to provide medications prior to treatment or therapy. Date initiated: 1/20/25 . Evaluate what makes the patient's pain worse. Date initiated: 1/20/25 . R6's Physician Orders include the following pain medications: Acetaminophen Oral Tablet 325 mg (milligrams). Give 2 tablet by mouth every 4 hours as needed for pain. Not to exceed 4000 mg in a 24 hour period. Start Date: 1/23/25. No end date. Cyclobenzaprine HCl Oral Tablet 10 mg. Give 1 tablet by mouth every 12 hours as needed for muscle spasms. Start Date: 1/23/25. No end date. Diclofenac Oral Capsule. Give 75 mg by mouth two times a day for pain. Start Date: 3/14/25. No end date. Lidocaine External Patch 5%. Apply patches to affected area topically one time a day for pain. Bilateral shoulders and lower back and remove per schedule. Start Date 3/26/25. No end date. Morphine Sulfate Oral Tablet 15 mg. Give 7.5 mg by mouth every 6 hours as needed for pain. Start Date: 2/4/25. No end date. Pregabalin Oral Capsule 225 mg. Give 1 capsule by mouth three times a day for pain. Start Date: 1/23/25. No end date. Sumatriptan Succinate Oral Tablet 50 mg. Give 1 tablet by mouth every 2 hours as needed for migraine. Take one tablet orally PRN, may repeat 1 dose in 2 hours, not to exceed 2 tablets in 24 hours. Start Date: 1/23/25. No end date. Trolamine Sallcylate External Cream 10%. Apply to affected area topically every 24 hours as needed for moderate pain. Start Date: 1/23/25. No end date. R6's March 2025 Medication Administration Record (MAR) documents the following: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain was marked with an X and 7 beginning on 3/14/25 through 3/20/25 when surveyors were onsite. The chart code 7 indicates Other/See Nurse Progress Note. R6's Nurse Progress Notes state the following: 3/14/25 at 2:05 PM: MD (Medical Director) updated diclofenac potassium tablet 25 mg was not available on 3/13/25 as scheduled and would be available later tonight MD with no new orders except to consider hospice for pain. 3/15/25 at 1:09 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Medication to be delivered tonight. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/15/25 at 5:32 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Med on order from pharmacy. 3/16/25 at 9:36 AM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Med on order from pharmacy. 3/16/25 at 5:20 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Med on order from pharmacy. 3/17/25 at 9:03 AM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. On order. 3/17/25 at 5:26 PM: NP (Nurse Practitioner) notified of missing Diclofenac medication. No new orders. Awaiting pharmacy approval to send. 3/18/25 at 9:17 AM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Waiting for pharmacy to deliver and insurance to give authorization. MD aware. 3/18/25 at 5:01 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Med on order from pharmacy. 3/19/25 at 7:05 AM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. On order from pharmacy. 3/19/25 at 5:17 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. Waiting for pharmacy to deliver and insurance to give authorization. MD aware. 3/20/25 at 2:50 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. On order since 3/15. 3/20/25 at 5:22 PM: Diclofenac Oral Capsule give 75 mg by mouth two times a day for pain. On order from pharmacy. Daily pain monitoring every shift states the following: 3/14/25 pain scale: Day Shift: 9 out of 10 pain rating Evening Shift: 5 out of 10 pain rating Night Shift: 6 out of 10 pain rating 3/15/25 pain scale: Day Shift: 9 out of 10 pain rating Evening Shift: 5 out of 10 pain rating (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Night Shift: 6 out of 10 pain rating 3/16/25 pain scale: Day Shift: 5 out of 10 pain rating Evening Shift: 5 out of 10 pain rating Night Shift: 0 out of 10 pain rating 3/17/25 pain scale: Day Shift: 9 out of 10 pain rating Evening Shift: 0 out of 10 pain rating Night Shift: 0 out of 10 pain rating 3/18/25 pain scale: Day Shift: 8 out of 10 pain rating Evening Shift: 5 out of 10 pain rating Night Shift: 0 out of 10 pain rating 3/19/25 pain scale: Day Shift: 8 out of 10 pain rating Evening Shift: 3 out of 10 pain rating Night Shift: 0 out of 10 pain rating 3/20/25 pain scale: Day Shift: 10 out of 10 pain rating Evening Shift: 5 out of 10 pain rating It is important to note that R6 had orders for acetaminophen and morphine (as needed) for pain, and did utilize these for pain during this time period. On 3/20/25 at 11:06 AM, Surveyor interviewed CNA F (Certified Nursing Assistant) who stated that R6 was always in pain. CNA F stated that R6 told her that the pain was excruciating. CNA F stated that she tells the nurse on duty right away when R6 complains of pain, but that some of the nurses are not real timely about going to assess the residents and if a resident is getting scheduled pain medication, the nurses do not have a sense of urgency and will say I will get there when I get there. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 12:47 PM, Surveyor interviewed CNA E who stated that R6 is in a lot of pain every day, crying every day due to the amount of pain she is in. CNA E said that she tells the nurses right away about R6's pain, and that sometimes they are pretty quick about responding, and other times R6 will have to put on her call light and ask a second time for pain medication. On 3/20/25 at 1:51 PM, Surveyor interviewed R6, who stated she was in lots of pain all over and that she was receiving morphine and diclofenac for the pain. R6 explained that she has a compressed nerve in her neck and had experienced back issues most of her life. R6 stated that she had a fall in her apartment before coming to the facility in which an EMT (Emergency Medical Technician) damaged muscles in her groin when lifting her off the floor. R6 indicated that she used to be able to walk and now cannot. R6 stated, it gets depressing being in this much pain and having to just put up with it. Surveyor asked R6 what her pain rating was at that moment. R6 stated her pain was a 9 but that it never goes below an 8. Surveyor asked if R6 had spoken with management about her pain not being well managed. R6 stated she had talked to NHA A (Nursing Home Administrator) and DON B (Director of Nursing) many times. R6 indicated that she cries every day because of the pain and that the medication she receives barely takes the edge off her pain. It is important to note that R6 stated she was receiving diclofenac as part of her pain regimen and was not aware that she was not actually receiving this medication. On 3/20/25 at 2:04 PM, Surveyor notified RN K (Registered Nurse) about R6 having a pain rating of 9. RN K indicated she would see what R6 could get for pain, but she had already gotten a PRN morphine earlier. On 3/20/25 at 2:40 PM, Surveyor interviewed LPN D (Licensed Practical Nurse) who stated that although R6's pain varies, there are times that she is in a significant amount of pain and is tearful. Surveyor asked LPN D what she would do if a resident was in a significant amount of pain. LPN D indicated that she would assess the resident and then review the MAR to see what kind of PRN medications the resident had ordered. On 3/20/25 at 4:18 PM, Surveyor interviewed R6 who stated that both NHA A and DON B were aware that she was in a lot of pain. Surveyor asked if staff ever offered her any non-pharmacological interventions, such as music therapy, hot or cold packs, or massage. R6 stated that no one had ever offered her any non-pharmacological interventions for treatment of her pain. R6 stated that most nights she can't sleep due to the pain, and just lays awake and cries. On 3/20/25 at 4:21 PM, Surveyor interviewed MT G (Medication Technician). Surveyor asked MT G what the process would be if a resident was missing a medication. MT G stated that she would put in an order for the pharmacy and then call the pharmacy to make sure it is coming in the next shipment. Surveyor asked MT G what the process would be if the medication did not come when it was supposed to. MT G stated that she would call the pharmacy again and try to get the meds stat (immediately) but that the facility pharmacy is in Chicago, so it sometimes takes awhile to get the needed medications. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 5:34 PM, Surveyor interviewed DON B, who stated that R6 was not receiving the diclofenac because it was being denied due to insurance coverage. DON B indicated that the doctor was aware of it and looking into the issue. DON B stated that every time it is re-ordered, it requires an authorization. Surveyor asked DON B what non-pharmacological interventions had been tried with R6 to help manage her pain. DON B said they give R6 PRN Tylenol and have a referral to the pain management clinic. On 3/20/25 at 7:17 PM, Surveyor interviewed NHA A and asked him if he was aware that R6 had reported daily pain at a 9 or a 10 and had been missing one of her physician prescribed pain medications for almost a week. NHA A stated he was not aware that R6 was missing medications, but that he did know that R6 had requested a hospice referral because she was in so much pain. Surveyor asked NHA A if he would expect that the resident would receive all of their prescribed medications. NHA A stated he would have to talk with DON B. Facility failed to follow-up with the MD regarding a missing pain medication, the facility did not provide adequate pain management for a resident with chronic daily pain. The facility did not develop or implement non-pharmacological interventions or approaches, and did not follow the resident's plan of care, current professional standards of practice, and the resident's goals and preferences.