STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525348	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Health and Rehabilitation Center	70 Greentree Rd Clintonville, WI 54929

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49010 Based on observation, staff and resident interview, and record, review, the facility did not maintain dignity for 3 residents (R) (R20, R11, and R6) of 23 sampled residents. R20 required feeding assistance. On 4/22/25, R20 watched other residents eat in the dining room and waited 16 minutes for assistance. In addition, staff in the dining room did not address or speak to R20. R11 and R6 required feeding assistance. On 4/22/25, staff in the dining room did not speak to R11 and R6 while feeding them. Findings include: The facility's Meal, Preparing Resident for policy, dated 5/2024, indicates: It is the policy of this facility that the primary purpose of preparing the resident for a meal is to serve the meal in a pleasant environment and to make the mealtime a pleasant event. Encourage residents to eat in the dining area. This provides each resident with an opportunity to socialize and make new friends . The facility's Dietary Support Personnel, Sufficient policy, dated 1/2022, indicates: .Sufficient support personnel means having enough dietary and food nutrition staff to safely carry out all the functions of the food and nutrition services. This does not include staff, such as licensed nurses, nurse aides, or paid feeding assistants involved in assisting residents with eating . 1. On 4/22/25 at 11:30 AM, Surveyor observed the noon meal in the dining room and noted 23 residents were in the dining room during the meal. At 11:39 AM, Surveyor observed Lead [NAME] (LC)-H begin to serve residents. At 11:48 AM, Surveyor noted all residents had been served except R20. On 4/22/25 at 11:45 AM, Surveyor observed Certified Nursing Assistant (CNA)-I assist R11 and CNA-F assist R6. Surveyor noted neither CNA-I or CNA-F addressed or talked to R11 or R6 while assisting them with eating. At 11:57 AM, Surveyor observed CNA-I begin to talk and interact with R11. CNA-I continued to converse with R11 and offer choices throughout the end of the meal. CNA-F still had not spoken to R6. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 11:53 AM, Surveyor noted R20 was watching residents eat in the dining room. Staff had not yet provided R20 with a meal or drink. Surveyor also noted none of the staff in the dining room (CNA-I, CNA-F, and LC-H) had addressed R20. On 4/22/25 at 11:53 AM, Surveyor interviewed LC-H who indicated R20 requires feeding assistance and it is common for R20 to wait to eat. LC-H indicated there are three residents who require feeding assistance and usually two staff to assist with feeding. LC-H indicated one resident has to wait until the other residents eat before that resident receives assistance. On 4/22/25 at 11:55 AM, Surveyor observed CNA-F stand up and walk away from R6 who had finished eating. CNA-F did not say anything to R6 before leaving the table. Surveyor observed CNA-F walk to R20's table and sit down to assist R20. LC-H brought a plate of food to R20 and R20 was provided with a drink. CNA-F began to feed R20 but did not speak to or address R20. CNA-F did not introduce CNA-F's self to R20, did not describe the food on R20's plate, did not apologize for R20 having to wait 16 minutes to eat, and did not engage in any small talk or conversation. On 4/22/25 at 11:58 AM, Surveyor observed CNA-F stand up from feeding R20 and assist another resident who was exiting the dining room. CNA-F did not say anything to R20 and left the dining area. R20 was left sitting at the table with R20's food and drink. On 4/22/25 at 12:03 PM, Surveyor observed CNA-F walk into the dining room, turn around, and walk back out. R20 was still sitting at the table watching other residents finish their meals. R20's food and drink was still in front of R20. On 4/22/25 at 12:05 PM, Surveyor observed CNA-F walk into the dining room and sit by R20. CNA-F sat down and resumed feeding R20 but did not speak to R20. CNA-F did not ask if R20's food was cold, apologize for leaving R20 in the middle of the meal, or explain where CNA-F had gone for 7 minutes and why R20 had to wait. Surveyor observed CNA-F laugh and talk with staff in the dining room while feeding R20. On 4/22/25 at 12:08 PM, Surveyor observed CNA-I wheel R11 out of the dining room. CNA-I did not speak to R11 while CNA-I wheeled R11 out of the room. On 4/22/25 at 12:33 PM, Surveyor observed CNA-F stand up and use R20's clothing protector to wipe R20's face. CNA-F then pushed R20's wheelchair out of the dining room. CNA-F did not speak to R20 during meal service or when exiting the dining room. On 4/22/25 at 12:34 PM, Surveyor interviewed LC-H who indicated some CNAs talk to residents and some do not. LC-H indicated sometimes staff do not talk to R20 because R20 can not always respond. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 1:04 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff who assist a resident with eating should talk and interact with the resident, even if the resident is nonverbal or unable to understand what is said to them. DON-B indicated staff should offer bites of food and ensure the resident is satisfied with their food and its temperature. DON-B indicated staff should engage in small talk and ongoing communication with residents as appropriate. DON-B indicated there should be enough staff to feed residents who need assistance with eating. DON-B indicated it is not acceptable for a resident to watch other residents eat for 16 minutes before they receive food and assistance. DON-B indicated staff should not leave a resident for 7 minutes in the middle of feeding them. DON-B indicated it is not acceptable for staff to ignore residents and not speak to them while feeding them. On 4/22/25 at 1:24 PM, Surveyor interviewed CNA-F who verified CNA-F did not talk to R20 or R6 when CNA-F fed R20 and R6 lunch. CNA-F indicated CNA-F was not taught that during CNA training. CNA-F indicated it is typical for R20 or another resident to wait 20 to 30 minutes to be fed while the rest of the residents are eating or being assisted. CNA-F indicated CNA-F left the dining room while feeding R20 to assist another resident out of the dining room. After CNA-F assisted the resident to their room, CNA-F toileted the resident and helped another staff transfer a resident before CNA-F returned to the dining room to resume assisting R20. When asked if it is typical to leave the room while feeding a resident, CNA-F indicated it happens sometimes and depends on the day. When asked why CNA-F did not talk to R20 or R6 while assisting them, CNA-F indicated CNA-F does not have much to say to them. On 4/23/25 at 2:44 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff should communicate and interact with residents in the dining room while assisting them. NHA-A indicated it is not acceptable for a resident to wait up to 16 minutes to eat while other residents are being fed. NHA-A indicated it is not acceptable for a CNA to leave a resident while feeding them to provide care for another resident.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure court-ordered protective placement was obtained for 1 resident (R) (R9) of 2 sampled residents. R9 was under Guardianship. The facility did not ensure court-ordered protective placement in the least restrictive environment was obtained after R9's nursing home stay exceeded 60 days. Findings include: From 4/21/25 to 4/23/25, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, epilepsy, and major depressive disorder. R9's Minimum Data Set (MDS) assessment, dated 1/15/25, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R9 was unable to complete the interview. R9 had a Guardianship that was activated on 9/29/21. R9's medical record contained a petition for protective placement that was dated 8/22/24. On 4/23/25 at 9:12 AM, Surveyor reviewed R9's medical record with Social Worker (SW)-P who confirmed the petition for protective placement was not the final order. SW-P indicated SW-P would look for the final order. On 4/23/25 at 2:10 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A was not aware of protective placement for R9 and would inform SW-P. On 4/23/25 at 3:00 PM, Surveyor interviewed SW-P who indicated the facility usually received protective placement paperwork from the Guardian and the court usually sent paperwork to the facility upon a resident's admission. SW-P indicated the facility should have obtained protective placement for R9 in September or October of 2024 after the final protective placement hearing.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not make a prompt effort to investigate and resolve a grievance for 1 resident (R) (R5) of 1 sampled resident. R5 voiced a concern to staff and the Grievance Official that another resident repeatedly woke R5 up in the early morning hours. R5's grievance was not documented, thoroughly investigated, or resolved. Findings include: The facility's Resident and Family Grievances Policy, revised 12/2024, indicates: It is the policy of this facility to support each resident's .right to voice grievances without discrimination or fear of reprisal .Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of the complaint/grievance .1. The Social Worker has been designated as the Grievance Official. 2. The Grievance Official is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility, maintaining the confidentiality of all information associated with grievances, issuing written grievance decisions to the resident, and coordinating with state and federal agencies as necessary in light of specific allegations .4. A resident may voice grievances with respect to .the behavior of staff and other residents, and other concerns regarding their long term care stay .8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or the Grievance Official .10. 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 .to complete the form .12. The facility will make prompt efforts to resolve grievances. From 4/21/25 to 4/23/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis and anxiety disorder. R5's Minimum Data Set (MDS) assessment, dated 1/15/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 was not cognitively impaired. R5 was responsible for R5's healthcare decisions. On 4/21/25 at 10:24 AM, Surveyor interviewed R5 who indicated R5 is woken up at 5:30 AM due to another resident yelling and screaming down the hall. R5 indicated R5 has informed management, however, R5 does not think they can do anything. On 4/22/25 at 3:58 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-K and asked if CNA-K received any complaints from R5. CNA-K indicated R5 complained about another resident who wakes R5 up with noises in the early morning hours. CNA-K indicated CNA-K has not informed anyone or filed a grievance. CNA-K indicated CNA-K does not work a lot and thought other staff were aware of R5's complaint. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 9:10 AM, Surveyor interviewed Social Worker (SW)-P who confirmed SW-P is the facility's Grievance Official. SW-P indicated R5 voiced the same complaint to SW-P. R5 was offered a room change but declined. SW-P indicated SW-P's conversation with R5 and the room change offer were not documented. When Surveyor asked if a grievance should have been filed on R5's behalf, SW-P indicated it was a toss-up if a grievance should have been filed. SW-P indicated since R5 appeared to be upset and brought the issue to Surveyor's attention, SW-P should have filed a grievance. On 4/23/25 at 11:45 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated filing a grievance depended on how upset R5 still was. NHA-A indicated the facility offered R5 options which R5 declined. NHA-A indicated if a resident has a concern, they can start a grievance form. NHA-A indicated NHA-A and SW-P can start a grievance form also. NHA-A indicated the process involves talking with the person who voiced the grievance to see if they want to file a formal grievance. NHA-A does not know if R5 was offered the chance to file a formal grievance and indicated NHA-A did not recently talk to R5 regarding the issue. When Surveyor asked if NHA-A would consider R5 to be still upset if R5 brought the issue to Surveyor's attention, NHA-A indicated it is different for R5 and stated the facility can not do much because they cannot send the other resident away.

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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** 43361 Based on staff interview and record review, the facility did not ensure an injury of unknown origin was reported to the State Agency (SA) for 1 resident (R) (R32) of 4 sampled residents. On 4/2/25, staff discovered a hematoma on R32's left forearm. Facility staff and Hospice staff were unsure how the injury occurred. The facility did not report the injury of unknown origin to the SA. Findings include: The facility's Abuse Prevention policy and procedure, updated 7/2024, indicates: Identification of abuse - Identify events, such as but not limited to suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation. All alleged violations will be reported via phone or in writing within 2 hours to the State Licensing Agency. The facility shall follow up with the State Licensing Agency in writing the findings and results of the completion of the investigation within 5 days . From 4/21/25 to 4/23/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive, and palliative care. R32's Admission Minimum Data Set (MDS) assessment, dated 2/5/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 4/2/25 at 3:14 PM, indicated the writer was informed by staff that R32 had discoloration on the bilateral wrists. Upon assessment, the writer noted R32's wrists contained purplish, red/brown discoloration. R32 denied pain to the areas. The writer was informed by a Hospice Certified Nursing Assistant (CNA) that the discoloration had come and gone over the past few weeks and the Hospice nurse was aware. The Hospice nurse also verified the discoloration had come and gone over the past few weeks and and indicated the discoloration was senile purpura. R32 was interviewed and stated R32 felt safe. The note indicated staff would continue to monitor R32's arms due to R32 having increased negative behavior toward staff with cares. A progress note, dated 4/3/25 at 2:30 PM, indicated Hospice staff were in R32's room doing AM cares when the writer was called into the room and shown R32's left arm that had previous bruising. A raised hematoma that measured 9 centimeters (cm) x 10 cm was noted on the left side of R32's outer forearm. R32 had no complaints of pain or discomfort. R32 refused ice and was combative with staff. The Director of Nursing (DON) was notified. The note indicated staff would notify R32's POAHC and physician. On 4/21/25, Surveyor reviewed a facility investigation for R32's injury of unknown origin. The facility contacted R32's Power POAHC who indicated R32 was combative during a visit on 4/2/25 and hit R32's arms on the bed. The investigation determined the injury occurred when R32 hit R32's arms on the bed during the visit. The injury of unknown origin was not reported to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 2:25 PM, Surveyor interviewed DON-B who indicated the facility completed an investigation for R32's injury of unknown origin. DON-B verified the facility did not report the injury of unknown origin to the SA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure an injury of unknown origin was thoroughly investigated for 1 resident (R) (R32) of 4 sampled residents. R32 had an injury of unknown origin that was discovered on 4/2/25. The facility did not interview other residents to rule out abuse during the investigation. Findings include: The facility's Abuse Prevention policy and procedure, updated 7/2024, indicates: Identification of abuse - Identify events, such as but not limited to suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation. The investigation shall consist of: .6. Interviews with other residents to whom the accused employee provides care or services. From 4/21/25 to 4/23/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive, and palliative care. R32's Admission Minimum Data Set (MDS) assessment, dated 2/5/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). A progress note, dated 4/2/25 at 3:14 PM, indicated the writer was informed by staff that R32 had discoloration on the bilateral wrists. Upon assessment, the writer noted R32's wrists contained purplish, red/brown discoloration. R32 denied pain to the areas. The writer was informed by a Hospice Certified Nursing Assistant (CNA) that the discoloration had come and gone over the past few weeks and the Hospice nurse was aware. The Hospice nurse also verified the discoloration had come and gone over the past few weeks and indicated the discoloration was senile purpura. R32 was interviewed and stated R32 felt safe. The note indicated staff would continue to monitor R32's arms due to R32 having increased negative behavior toward staff with cares. A progress note, dated 4/3/25 at 2:30 PM, indicated Hospice staff were in R32's room doing AM cares when the writer was called into the room and shown R32's left arm which had previous bruising. A raised hematoma that measured 9 centimeters (cm) x 10 cm was noted on the left side of R32's outer forearm. R32 had no complaints of pain or discomfort. R32 refused ice and was combative with staff. The Director of Nursing (DON) was notified. On 4/3/25, the facility began an investigation for R32's injury of unknown origin. The facility interviewed R32 and all staff who worked with R32 on 4/2/25 and 4/3/25. The facility also contacted R32's POAHC who indicated R32 was combative during a visit on 4/2/25 and hit R32's arms on the bed. The facility contacted Hospice and discontinued R32's anticoagulant therapy (which can increase bruising). In addition, R32 was wearing geri-sleeves on each arm to protect R32's arms/skin. The investigation did not include interviews with other residents to rule out abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 2:25 PM, Surveyor interviewed DON-B who indicated the facility completed an internal investigation for R32's injury of unknown origin. DON-B verified the facility did not interview other residents to rule out abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not revise a care plans in accordance with current care needs for 1 resident (R) (R32) of 15 sampled residents. R32's care plan was not updated to include calling R32 by R32's preferred names. R32's care plan was also not updated when R32 incurred an injury of unknown origin and geri-sleeves were implemented to protect R32's skin. Findings include: From 4/21/25 to 4/23/25, Surveyor reviewed R32's medical record. R32 was admitted to the facility on [DATE] and had diagnoses including dementia, adult failure to thrive, and palliative care. R32's Admission Minimum Data Set (MDS) assessment, dated 2/5/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R32 had severely impaired cognition. R32 had an activated Power of Attorney for Healthcare (POAHC). On 4/21/25 at 1:15 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who indicated when R32 was first admitted , staff called R32 by a shortened version of R32's name. CNA-C indicated R32 also told staff to call R32 grandma which staff sometimes did. CNA-C indicated R32 could be behavioral during cares and sometimes calling R32 grandma helped calm R32. CNA-C indicated one of R32's family members heard CNA-C call R32 grandma when they visited. CNA-C indicated R32's family member stated staff should not call R32 grandma because R32 was not their grandma and R32 did not like that. CNA-C told Assistant Director of Nursing (ADON)-D and the Social Worker (SW) who were going to talk to R32's POAHC. CNA-C was not sure of the outcome of the conversation and indicated CNA-C no longer calls R32 grandma. On 4/21/25 at 2:23 PM, Surveyor interviewed ADON-D who indicated ADON-D was working on the evening that CNA-C called R32 grandma and R32's family member got upset. ADON-D indicated the facility contacted R32's POAHC to explain what happened and that it sometimes helps if staff call R32 grandma when R32 is having difficulty with cares. R32's POAHC gave approval for staff to call R32 grandma if it helped. R32's medial record indicated R32 had an injury of unknown origin that was discovered on 4/3/25. The facility completed an investigation for R32's injury. R32 was known to be combative at times. The investigation indicated R32 was combative, swung R32's arms, and hit R32's arms on the bed during a visit with R32's POAHC. The facility, in conjunction with Hospice staff, initiated geri-sleeves (sleeves worn to protect skin) to protect and prevent injury to R32's skin. On 4/21/25, Surveyor reviewed R32's plan of care and noted there were no care plan updates related to the preferred names staff should call R32 or that R32 should wear geri-sleeves on the bilateral upper extremities. On 4/21/25 at 2:23 PM, ADON-D indicated the facility had not yet care planned the information. (continued on next page)

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Greentree Health and Rehabilitation Center	70 Greentree Rd Clintonville, WI 54929

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/21/25 at 2:25 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed R32's care plan was not updated to include the preferred names staff should call R32 or that R32 should wear geri-sleeves on both arms to protect R32's skin. DON-B confirmed R32's care plan should have been updated.

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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** 45943 Based on observation, staff interview, and record review, the facility did not ensure 3 residents (R) (R7, R12, and R186) of 17 sampled residents received assistance as needed to complete activities of daily living (ADLs). R7 did not receive assistance with positioning, toileting, and breakfast. R12 did not receive weekly showers. In addition, the facility did not address R12's request for more showers. R186 did not receive a shower while at the facility. Findings include: The facility's Activities of Daily Living (ADLs) policy, dated 12/2024, indicates: Care and services will be provided for the following ADLs: 1. Bathing, dressing, grooming, and oral care; 2. Transfer and ambulation; 3. Toileting; 4. Eating to include meals and snacks .3. A resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .5. The facility will maintain individual objectives of the care plan. The facility's Resident Showers policy, dated 12/2024, indicates: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation, and help prevent skin issues as per current standards of practice .1. Residents will be provided showers per request or the facility's schedule protocol and based upon resident safety . 1. From 4/21/25 to 4/23/25, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, diabetes, moderate protein calorie malnutrition, and dysphagia. R7 received Hospice services. R7's Minimum Data Set (MDS) assessment, dated 3/5/25, indicated R7 required staff assistance with eating set up, substantial/maximal assistance with rolling left and right, and substantial/maximal assistance with toileting. The MDS assessment also indicated R7 had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R7 had severe cognitive impairment. R7 had a Guardian for healthcare decisions. A care plan (initiated 5/5/22) indicated R7 had an ADL self care performance deficit related to immobility, overall decline, and decreased motivation. The care plan contained the following interventions: Bed mobility: Requires substantial/maximal assistance with lying to sitting on end of bed, sitting to lying, and rolling left and right; Eating: May have meals/snacks/drinks independently in room with frequent visual checks at mealtime to ensure safety; and Toilet use: Requires two-person assistance .and is dependent for toileting hygiene. A care plan (initiated 8/9/24) indicated R7 had the potential for pressure ulcer development related to incontinence and spending a lot of time in bed. The care plan contained an intervention for R7 to be repositioned every two hours while in bed as tolerated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan (initiated 5/5/22) indicated R7 was at high nutritional risk secondary to protein calorie malnutrition, Hospice care, Alzheimer's disease, kidney disease, and diabetes. The care plan contained an intervention to monitor/document/report to MD as needed for signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, and if appears concerned during meals. On 4/21/25 at 10:27 AM, Surveyor observed R7 in bed. Surveyor noted R7 was leaning to the right side and had slid to the bottom of the bed. R7 indicated R7 was not comfortable. On 4/23/25 at 8:30 AM, Surveyor observed R7 in bed with the head of the bed elevated 45 degrees. R7 was leaning to the right side. Surveyor noted R7's breakfast tray was not set up and was in front of R7 untouched. The tray contained a plate of food that was uncovered, however, R7's milk, orange juice, and cereal were still covered. On 4/23/25 at 9:31 AM, Surveyor observed R7 in bed with the head of the bed elevated 45 degrees. R7 was leaning to the right side with R7's head touching the right bed rail. R7's breakfast tray was still untouched and not set up for breakfast. On 4/23/25 at 9:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who stated breakfast trays are usually delivered around 8:00 AM. CNA-C indicated dietary staff were supposed to bring in the tray and remove covers from the plate, liquids, and cereal. CNA-C indicated R7 liked to sleep in and usually did not touch R7's breakfast tray until between 9:30 and 10:00 AM. CNA-C also indicated R7 was repositioned every two hours by CNAs or Hospice staff. CNA-C was assigned to R7 that shift and indicated the AM shift started at 6:00 AM. CNA-C stated CNA-C had not yet turned, repositioned, or checked and changed R7 or checked to see if R7 was eating. On 4/23/25 at 9:43 AM, Surveyor interviewed Assistant Director of Nursing (ADON)-D who indicated ADON-D observed dietary staff pass by with trays approximately 30 minutes ago. ADON-D indicated dietary staff typically set up R7's tray. ADON-D indicated R7 had a history of non-compliance with eating in an upright position and a history of aspiration and recent pneumonia. ADON-D indicated R7 should be repositioned by facility CNAs or the Hospice aide. ADON-D had not observed Hospice with R7 yet that day. ADON-D reviewed orders (dated 9/26/24) that indicated R7 could eat meals and snacks in R7's room unsupervised (discussed with Guardian) and staff should frequently check on R7 during meals and snacks. ADON-D stated CNAs should have offered and/or done repositioning by that time. On 4/23/25 at 10:15 AM, Surveyor interviewed CNA-C who stated R7 was just repositioned and changed for the first time that shift. CNA-C indicated R7 was having difficult eating cereal so another staff was assisting R7 with eating. On 4/23/25 at 3:14 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should check, change, and reposition R7 every 2-3 hours. DON-B indicated most residents are checked, changed, and repositioned before and after meals and before shift change on the AM and PM shifts unless care planned for every 2 hours like R7. DON-B verified the AM shift starts at 6:00 AM and confirmed staff should have checked, changed, and repositioned R7 before 9:36 AM and set up R7's tray before 10:15 AM. DON-B indicated meal set up includes removing covers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 3:24 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-E who indicated LPN-E heard R7 call out at approximately 9:36 AM and checked on R7. With the assistance of Clinical Market Leader (CML)-G, LPN-E checked, changed, and repositioned R7 who was incontinent of a medium amount of urine and a smear of stool. LPN-E indicated R7's condom catheter was not in place. LPN-E reheated R7's plate of food and removed covers from R7's oatmeal and liquids. CML-G assisted R7 with eating oatmeal. LPN-E indicated R7 required assistance with eating at times due to confusion and a history of swallowing issues. R7's Guardian had signed a diet non-compliance form to liberalize R7's diet for comfort when R7 started Hospice services. LPN-E agreed with DON-B that R7 should have been checked, changed, repositioned, and set up, assisted, or frequently checked on during eating. 49010 2. From 4/21/25 to 4/23/25, Surveyor reviewed R12's medical record. R12 was readmitted to the facility on [DATE] and readmitted again on 4/2/25 after a three-day discharge. R12 had diagnoses including traumatic brain injury, urinary incontinence, urinary catheter, morbid obesity with alveolar hypoventilation, and urinary tract infection (UTI). R12's MDS assessment, dated 4/4/25, had a BIMS score of 15 out of 15 which indicated R12 was not cognitively impaired. The MDS assessment also indicated R12 required substantial/maximal assistance with showering/bathing, upper and lower body dressing, and putting on/taking off footwear. On 4/21/25 at 12:15 PM, Surveyor interviewed R12 who indicated R12 did not receive weekly showers and R12's scalp and hair were greasy. R12 indicated R12 would like to shower more than once weekly. R12 indicated R12 told staff that R12 needed to shower more than once per week but still did not receive regular showers. R12 indicated R12 was told staff have a lot of other residents to shower and were not able to give R12 a shower. On 4/22/25, Surveyor observed a grievance from R12, dated 1/6/25. The grievance indicated R12 wanted to shower two times per week. The grievance also indicated R12 wanted staff to wake R12 up and get R12 ready for breakfast daily. The action taken was listed as discussed with resident and staff. The summary of pertinent findings stated resident would like to be up for breakfast daily. The summary of the grievance did not mention R12's shower request. The corrective action taken was listed as Care plan and Kardex (an abbreviated care plan used by nursing staff) updated. Staff aware/updated. R12's plan of care (initiated 10/31/22) indicated R12 had an ADL self care performance deficit related to muscle weakness and fracture to right distal femur that was surgically repaired. The goal indicated R12 will maintain current level of function or improve in: bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene. The plan of care contained the following intervention: Bathing: R12 requires substantial/maximal assistance with shower transfer and requires substantial/maximal assistance with showering and bathing (initiated 1/10/23). Surveyor noted there was not an update to R12's care plan following the grievance request to shower twice per week. R12's Kardex also did not indicate R12 would like to shower twice weekly. On 4/23/25, Surveyor reviewed the facility's shower schedule which indicated R12 was scheduled for a shower on the Monday AM shift. The shower schedule was not updated for twice weekly showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 10:17 AM, Surveyor interviewed LPN-J who indicated LPN-J fills out a shower sheet for every resident shower. LPN-J indicated shower sheets need to be completed even if the resident refuses the shower and a nurse must still complete a skin check for the resident (which is documented on the shower sheet). LPN-J indicated shower sheets are given to DON-B. On 4/23/25 at 11:15 AM, Surveyor reviewed R12's shower sheets for 1/1/25 through 4/23/25. Surveyor noted 6 shower sheets dated 1/6/25, 1/13/25, 1/20/25, 3/10/25, 4/7/25, and 4/21/25. On 4/23/25 at 11:15 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed the 6 shower sheets received for R12 were the only shower sheets the facility had for R12 in 2025. On 4/23/25 at 1:14 PM, Surveyor interviewed DON-B who indicated residents should be offered showers at least once weekly. DON-B indicated staff need to fill out a shower sheet or a refusal sheet and a nurse needs to complete a skin check even if the resident did not receive a shower. DON-B indicated if a resident files a grievance indicating they would like two showers per week, the resident should be offered two showers per week. DON-B also indicated the shower schedule, care plan, and Kardex should be updated with the twice weekly schedule. Surveyor and DON-B discussed R12's shower request, grievance, and the 6 shower sheets for R12. When asked why there were only 6 showers for R12 and why R12's care plan and Kardex and shower schedule were not updated after R12 filed a grievance, DON-B indicated there was a break in the system. On 4/23/25 at 2:44 PM, Surveyor interviewed NHA-A who indicated residents should be offered weekly showers. NHA-A indicated R12's shower grievance should have been completed and R12 should have been offered twice weekly showers. NHA-A indicated R12's care plan, Kardex, and shower schedule should have been updated to twice weekly showers. NHA-A also indicated there should have been audits to ensure the grievance was addressed and R12's expectations were met. 3. From 4/21/25 to 4/23/25, Surveyor reviewed R186's medical record. R186 was readmitted to the facility on [DATE] and had diagnoses including methicillin-resistant Staphylococcus aureus (MRSA) infection, epilepsy, morbid obesity, above knee right leg amputation, urinary retention, and urinary tract infection. R186's MDS assessment, dated 4/10/25, indicated R186 required substantial/maximal assistance with showering/bathing, upper and lower body dressing, and putting on/taking off footwear. The MDS assessment had a BIMS score of 10 out of 15 which indicated R186 had moderately impaired cognition. On 4/21/25 at 12:53 PM, Surveyor interviewed R186 who indicated R186 would like a shower. R186 indicated R186 had not been offered a shower since R186 was admitted to the facility two weeks prior. R186's plan of care indicated R186 had an ADL self care performance deficit related to weakness, physical deconditioning, pain, and right above the knee amputation (initiated 4/8/25). The plan of care contained a goal that R186 will safely perform ADLs through the review date. The plan of care contained the following intervention: Bathing (Shower/Bath Self): The resident ranges from being independent to requiring partial/moderate assistance with personal hygiene (initiated 4/8/25). Surveyor noted R186's MDS assessment and plan of care contained conflicting information on the level of assistance R186 needed for showers/bathing. On 4/23/25, Surveyor reviewed the facility's shower schedule which indicated R186 was scheduled for a shower on the Monday PM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 10:17 AM, Surveyor interviewed LPN-J who indicated LPN-J fills out a shower sheet for every resident shower. LPN-J indicated shower sheets need to be completed even if the resident refuses the shower and a nurse must still complete a skin check for the resident (which is documented on the shower sheet). LPN-J indicated shower sheets are given to DON-B. On 4/23/25, Surveyor requested shower sheets for R186 since R186's admission on 4/8/25. On 4/23/25 at 11:15 AM, NHA-A indicated there were no shower sheets, refusals, or skin check sheets for R186. On 4/23/25 at 1:14 PM, Surveyor interviewed DON-B who indicated residents should be offered showers at least once weekly. DON-B indicated staff need to fill out a shower sheet or a refusal sheet and a nurse needs to complete a skin check even if the resident did not receive a shower. DON-B indicated a resident should be assigned a shower day upon admission. DON-B reviewed R186's medical record and confirmed there were no skin checks completed. DON-B indicated it was not acceptable that R186 had not received a shower since admission. On 4/23/25 at 2:44 PM, Surveyor interviewed NHA-A who indicated residents should be offered weekly showers.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff and resident interview and record review, the facility did not ensure 1 resident (R) (R86) of 1 sampled resident was transferred appropriately and in accordance with the facility's policy. On 4/5/25, Certified Nursing Assistant (CNA)-K transferred R86 without a gait belt. R86 fell during the transfer and sustained a head injury that required 3 staples. Findings include: The facility's Safe Resident Handling/Transfers Policy, revised 12/2024, indicates: It is the policy of this facility to ensure residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping employees safe in accordance with current standards and guidelines .All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them . Compliance Guidelines: 1. The Interdisciplinary Team (IDT) or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well as weight and cognitive status . 5. Handling aids may include gait belts .and other devices .11. Staff will be educated on the use of safe handling/transfer practices .upon hire, annually, and as the need arises or changes in equipment occur .13. Staff are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care . The facility's Fall Prevention Program policy, revised 12/2024, indicates: .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. On 4/21/25, Surveyor reviewed R86's medical record. R86 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke) affecting the right dominant side and long-term use of anticoagulant (blood thinning) medication. R86's Minimum Data Set (MDS) assessment, dated 4/4/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R86 was not cognitively impaired. The MDS assessment indicated R86 transferred with substantial/maximal assistance from staff. An admission activities of daily living (ADL) self-care performance deficit care plan (initiated 1/3/25) indicated R86 required substantial/maximal assistance with transfers with a hemi-walker for wheelchair to bed, bed to wheelchair, wheelchair to recliner, recliner to wheelchair with hemi-walker, minimal assistance and 1 person. The care plan indicated staff should use a 2-wheeled walker for safety with clothing and hygiene for toileting. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A therapy communication sheet on transferring for Certified Nursing Assistants (CNAs), dated 3/13/25, indicated: Please resume transferring (R86) (to/from) wheelchair and bed, (to/from) wheelchair and recliner, and (to/from) wheelchair and toilet with hemi-walker and (minimal) (assistance) of one; For toileting, use 2 (wheeled-walker) for safety with clothing and hygiene. On 4/21/25 at 10:07 AM, Surveyor interviewed R86 who indicated R86 fell when getting into bed. R86 indicated R86 hit R86's head and received staples at the hospital. Surveyor observed several scabs on the right side of R86's head. R86's medical record indicated R86's provider was notified of the fall on 4/5/25 and gave an order to send R86 to the Emergency Department (ED) due to a laceration on the right side of the head. An ED discharge summary, dated 4/5/25, indicated R86 stated R86 was trying to stand without a gait belt and fell which caused a laceration on the right side of R86's head. R86 was on anticoagulant medication and sustained a 1.5 centimeter (cm) right temporal laceration with active bleeding. A computed tomography (CT) scan of the head and neck indicated R86 incurred a right frontal scalp hematoma (abnormal pooling of blood in the body under the skin)/laceration. An office visit note, dated 4/7/25, indicated R86 was seen in the ED for a head laceration on 4/5/25. R86 received staples that were to be removed in 10 to 14 days. On 4/22/25, Surveyor reviewed a summary of R86's fall, dated 4/7/25, and noted verbal education on using a gait belt during transfers was provided to CNA-K via phone. On 4/22/25, Surveyor reviewed CNA-K's witness statement, dated 4/5/25, that indicated CNA-K assisted R86 by pivot/walking with a walker next to R86's bed. R86 fell forward and hit R86's head on the bed frame. CNA-K was behind R86 and thought if R86 fell , R86 would fall backward. CNA-K tried to catch R86. A therapy communication sheet on transferring for CNAs, dated 4/8/25, indicated: Please complete transfers only to/from wheelchair and bed, to/from wheelchair and recliner, to/from wheelchair and toilet with use of hemi-walker, minimal assistance (of) 1 and gait belt - no walking, transfers only. On 4/22/25 at 11:48 AM, Surveyor interviewed Director of Nursing (DON)-B regarding R86's care plan which did not indicate a gait belt should be used during transfers. DON-B indicated the general guideline is to use a gait belt for pivot transfers. DON-B reviewed R86's care plan and confirmed the care plan was not updated after R86's fall. On 4/22/25 at 3:50 PM, Surveyor interviewed CNA-K who indicated the fall occurred during CNA-K's first time pivot transferring R86. CNA-K indicated the gait belt was next to the hemi-walker. CNA-K verified CNA-K knew that using a gait belt was the standard of practice when transferring residents. CNA-K indicated CNA-K was nervous to transfer R86 and forgot to use the gait belt. CNA-K knew CNA-K should have used the gait belt as soon as R86 fell . CNA-K held onto R86's clothing and hip during the transfer. CNA-K indicated CNA-K understood the transfer verbiage in R86's care plan prior to therapy staff changing the verbiage following the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/22/25 at 4:08 PM, Surveyor interviewed DON-B and Nursing Home Administrator (NHA)-A. DON-B indicated the root cause of R86's fall was an unsafe transfer without a gait belt. DON-B indicated R86's knees buckled and R86 fell forward when R86 was transferred from wheelchair to bed without a gait belt. DON-B indicated DON-B verbally educated CNA-K regarding the use of a gait belt. DON-B indicated the therapy verbiage stated to transfer R86 from wheelchair to bed, toilet, and chair but did not state how to transfer R86. Therapy was asked to clarify the transfer verbiage. DON-B indicated R86's laceration required 3 staples which DON-B did not feel was not a serious bodily injury. DON-B indicated the nurse applied pressure right away but the bleeding would not stop and R86 was sent to the ED. On 4/23/25 at 8:19 AM, Surveyor interviewed Occupational Therapist (OT)-O who confirmed R86 was a 1 assist pivot transfer with a hemi-walker. OT-O indicated a gait belt should always be used which therapy clarified in R86's transfer verbiage following the fall. OT-O indicated nursing staff should only complete transfers and not ambulation and indicated therapy staff wanted to make sure nursing staff used a gait belt and walker for transfers. On 4/23/25 at 8:44 AM, Surveyor received an education sign-in sheet, dated 4/10/25, that referenced using a gait belt during pivot transfers. Surveyor noted 14 nursing staff signed the education and 13 staff were verbally educated via phone. On 4/23/25 at 9:53 AM, Surveyor interviewed CNA-I regarding gait belt with pivot transfer education. CNA-I indicated CNA-I received education on 4/22/25. On 4/23/25 at 9:55 AM, Surveyor interviewed DON-B in NHA-A's office. When Surveyor indicated the education form was dated 4/10/25, however, CNA-I indicated CNA-I was educated on 4/22/25, DON-B indicated some staff on the education form were educated on 4/22/25. DON-B highlighted their names. On 4/23/25 at 11:07 AM, Surveyor interviewed DON-B who indicated education forms are located at the nurses' station for staff to read and sign. When Surveyor asked if staff who were educated verbally signed the education form, DON-B indicated DON-B was unable to find the education form for a period of time but found the form last evening (4/22/25). DON-B indicated staff who received verbal education were not in the building to sign. On 4/23/25 at 11:26 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-M via phone. LPN-M's name was highlighted on the education form which indicated LPN-M was verbally educated via phone on 4/22/25. LPN-M verified DON-B educated LPN-M on gait belt use with pivot transfers via phone on 4/22/25. On 4/23/25 at 11:29 AM, Surveyor interviewed LPN-L via phone. LPN-L's name was not highlighted on the education sheet which indicated LPN-L was verbally educated via phone on 4/10/25. LPN-L indicated LPN-L received education on gait belt use with pivot transfers yesterday evening (4/22/25) via phone. On 4/23/25 at 11:42 AM, Surveyor interviewed CNA-N whose name was not highlighted on the education sheet which indicated CNA-N was verbally educated via phone on 4/10/25. CNA-N indicated CNA-N worked at the facility for 4 years and the facility emphasized the use of gait belts during pivot transfers at meetings. CNA-N indicated CNA-N received education on gait belt use with pivot transfers via phone on 4/22/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/23/25 at 4:58 PM, Surveyor interviewed NHA-A and asked if nursing staff should have been educated on the need to use a gait belt with a pivot transfer prior to 4/22/25. NHA-A indicated nursing staff should have been educated prior to 4/22/25.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, staff interview, and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 2 residents (R) (R23 and R189) of 3 sampled residents. On 4/22/25, staff administered R23's AM and noon medications more than an hour after the scheduled times. On 4/22/25, staff left R189's medications at the bedside for R189 to self-administer. R189 did not have a physician order to self-administer medication or a self-administration of medication assessment that indicated R189 could safely and accurately self-administer medication. Findings include: The facility's undated Medication Administration-General Guidelines policy indicates: Medications are administered as prescribed in accordance with good nursing principles and practices .Administration: .k. Medications are administered in accordance with written orders of the attending physician .o. Medications are only administered after the 5 rights have been reviewed .4) right time; .r. Medications are administered within 60 minutes of scheduled time .Residents are allowed to self-administer medication when specifically authorized by the attending physician and in accordance with procedures for self-administration of medication . The facility's Self-Administration of Medication policy, dated 4/2025, indicates: Purpose: To determine the ability of alert residents to participate in self-administration of medication. To maintain the safety and accuracy of medication administration .2. If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on changes in the resident's status .4. If the resident is a candidate for self-administration of medication, this will be indicated in the medical record .9. Resident's care plan will be updated to reflect self-administration when applicable. 1. On 4/22/25, Surveyor reviewed R23's medical record. R23 was admitted to the facility on [DATE] and had diagnoses including quadriplegia, major depressive disorder, and history of urinary tract infections (UTIs). R23's Minimum Data Set (MDS) assessment, dated 3/21/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R23 was not cognitively impaired. R23 had a Guardian. On 4/22/25 at 2:01 PM, Surveyor observed Assisted Director of Nursing (ADON)-D prepare R23's noon medications. Per ADON-D, R23's noon medications should be administered during lunch time which was 11:00 AM to 1:00 PM. ADON-D verified R23's noon medications were late. ADON-D indicated R23's AM medications were administered at 10:30 AM and 11:00 AM which is why R23's noon medications were being administered at that time. R23's noon medications were administered at 2:14 PM. R23's Medication Administration Record (MAR) contained the following orders: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ Buspirone 10 milligram (mg) tablet Give 10 mg three times daily at AM 06 (6:00 AM), Lunch, PM 15 (3:00 PM) ~ Baclofen 20 mg tablet Give 20 mg three times daily at AM 06 (6:00 AM), Lunch, PM 15 (3:00 PM) On 4/22/25 at 2:15 PM, Surveyor interviewed Director of Nursing (DON)-B who verified medication times are an hour before to an hour after the medication is scheduled. DON-B indicated a resident's MAR turns red if the resident's medications are more than an hour past the scheduled time. Surveyor informed DON-B of what Surveyor observed for R23. DON-B verified R23's medications were considered late. 2. On 4/22/25, Surveyor reviewed R189's medical record. R189 was admitted to the facility on [DATE] and had diagnoses including peripheral vascular disease (PVD) and cellulitis. R189's MDS assessment, dated 4/4/25, had a BIMS score of 15 out of 15 which indicated R189 was not cognitively impaired. R189 made R189's own medical decisions. On 4/22/25 at 7:34 AM, Surveyor observed ADON-D prepare R189's AM medication. R189's MAR contained the following orders: ~ Acetaminophen 500 mg Give 1000 mg three times daily ~ Acyclovir 400 mg tab Give 1 tablet twice daily ~ Multivitamin 1 tab Give 1 tablet once daily ~ Vitamin C 1000 mg Give 1000 mg by mouth once daily ~ Vitamin D 1000 international units (IU) Give 1000 units by mouth once daily ~ Prednisolone AC 1%, 1 drop to left eye once daily every other day On 4/22/25 at 7:40 AM, Surveyor observed ADON-D leave a cup with R189's AM medication on R189's bedside table. ADON-D then left R189's room, shut the door, and retrieved Arginaid (wound healing medication) from the medication storage room. R189's medical record did not contain a physician order to self-administer medication or a self-administration of medication assessment that indicated R189 could self-administer medication. On 4/22/25 at 7:47 AM and 8:15 AM, Surveyor interviewed ADON-D who verified ADON-D left R189's AM medication on the bedside table. ADON-D verified R189 did not have a physician order to self-administer medication. ADON-D indicated R189 was going to wait to take the medication. ADON-D indicated ADON-D usually stored prepared medication in a locked medication cart and usually did not leave medication with residents to self-administer without supervision.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not monitor for adverse reactions of a high-risk medication for 1 resident (R) (R86) of 5 sampled residents. R86 was prescribed gabapentin (an anticonvulsant medication). The facility did not monitor for adverse reactions or side effects of the high-risk medication. Findings include: Per medlineplus.gov, potential side effects of gabapentin include: Loss of balance or coordination, double vision, blurred vision, uncontrollable movements of the eyes, difficulty thinking or concentrating, difficulty speaking, headache, drowsiness, dizziness, diarrhea, constipation, loss of appetite, weight loss, nausea, vomiting, and uncontrollable shaking of a part of the body. Some side effects can be serious such as swelling of the face, throat, tongue, lips, and eyes, difficulty swallowing or breathing, hoarseness and seizures . On 4/21/25, Surveyor reviewed R86's medical record. R86 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right dominant side and long-term use of anticoagulants (blood thinning medication). R86's Minimum Data Set (MDS) assessment, dated 4/4/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R86 was not cognitively impaired. R86's medical record contained the following order: ~ Gabapentin capsule 400 milligrams (mg). Give 1 capsule by mouth once daily for neuropathic pain. Give 1 capsule by mouth in the afternoon for neuropathic pain. Give 1 capsule by mouth at bedtime for restless leg syndrome. R86's medical record did not indicate R86 was monitored for adverse reactions/side effects of gabapentin. On 4/23/25 at 3:05 PM, Surveyor interviewed Director of Nursing (DON)-B who reviewed R86's medical record and confirmed R86's medical record did not contain monitoring interventions for adverse reactions/side effects of gabapentin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff and resident interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 39 residents residing in the facility. Enhanced Barrier precautions (EBP) were not implemented for R187 who had an indwelling urinary catheter. Staff did not complete appropriate hand hygiene after providing care for R6. Residents were not offered hand hygiene prior to the lunch meal on 4/22/25. Finding includes: The facility's ICPC Standard and Transmission-Based Precautions (TBP) policy, dated 2/2025, indicates: . Enhanced Barrier Precautions (EBP): Expand the use of personal protective equipment (PPE) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of multidrug-resistant organisms (MDROs) to staffs' hands and clothing then indirectly transferred to residents or from resident to resident (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs.) A. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with: i. Wounds and/or indwelling medical devices regardless of MDRO colonization; ii. MDRO infection or colonization .C. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include: i. dressing; ii. bathing/showering; iii. transferring; iv. providing hygiene; v. changing linens; vi. changing briefs or assisting with toileting; vii. device care or use: central vascular line (including hemodialysis catheters) indwelling urinary catheter, feeding tube, tracheostomy/ventilator .vii. wound care: any skin opening requiring a dressing . The facility's Infection Control Policy/Procedure for Laundry Services, dated 3/2025, indicates: It is the policy of this facility to ensure a clean supply of linens and to protect employees who handle and process the laundry. 1. Routine handling of soiled linens: A. Soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling the linen. B. All soiled linen should be bagged or put into carts at the location where used . The facility's Hand Washing policy, dated 3/2025, indicates: It is the policy of this facility to cleanse hands and prevent transmission of possible infectious material and provide a clean, healthy environment for residents and staff .For specific hand washing and waterless hand hygiene procedures, the facility refers to the Centers for Disease Control and Prevention (CDC) and the World Health Organization current guidelines. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Disease Control and Prevention (CDC) About Handwashing information from CDC.gov, dated 2/16/24, indicates: Many diseases and conditions are spread by not washing hands with soap and clean, running water. Hand washing with soap is one of the best ways to stay healthy. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surface to person when you: Touch your eyes, nose, and mouth with unwashed hands; Prepare or eat food and drinks with unwashed hands; Touch surfaces or objects that have germs on them; Blow your nose, cough, or sneeze into your hands and then touch other peoples' hands or common objects. You can keep yourself and your loved ones healthy by washing your hands often, especially during key times when you are likely to get and spread germs: Before, during, after preparing food; Before and after eating food . The facility's Meal, Preparing Resident for policy, dated 5/2024, indicates: .9. Encourage and assist residents to wash his/her hands and face before receiving the meal or to use wipes available in the dining areas . 1. From 4/21/25 to 4/23/25, Surveyor reviewed R187's medical record. R187 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, vascular dementia, urinary retention, and urinary device. R187 had an indwelling urinary catheter. R187's Minimum Data Set (MDS) assessment, dated 4/4/25, had a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated R187 was not cognitively impaired. On 4/21/25 at 1:01 PM, Surveyor interviewed R187 and noted there was not an EBP sign or a PPE cart near the entrance to R187's room. R187 indicated staff complete catheter care for R187 approximately 4 to 5 times per day. Surveyor also noted there was not a PPE cart inside the room. On 4/23/25 at 10:08 AM, Surveyor interviewed R187 and observed an EBP sign on the wall near the entrance to R187's room and a PPE cart near the foot of R187's bed. R187 was unsure why the cart was place there and indicated staff recently put it there. When asked if staff wear gowns and gloves during catheter care, R187 stated staff wear gloves but do not wear gowns. R187's medical record contained a physician order, dated 3/27/25, for a 16 French Foley catheter and Foley catheter care per facility policy. R187's plan of care contained an intervention for catheter care beginning 4/2/25. R187's plan of care also indicated R187 should be on EBP (initiated 4/2/25). On 4/23/25 at 10:52 AM, Surveyor interviewed Director of Nursing (DON)-B who was also the facility's Infection Preventionist (IP). DON-B indicated DON-B put an EBP sign near R187's door on the evening of 4/21/25. DON-B verified R187 should have been on EBP prior to 4/21/25 since R187 returned from the hospital with a catheter. When asked why R187 was not on EBP from 3/27/25 to 4/21/25, DON-B indicated it was missed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 4/21/25 at 12:20 PM, Surveyor observed Certified Nursing Assistant (CNA)-F exit R6's room with a clear plastic bag of unknown items in one hand and a Hoyer sling in the other hand. Surveyor noted CNA-F was not wearing gloves. CNA-F walked down the hall to two covered receptacles. CNA-F unsnapped the lid of one receptacle, placed the plastic bag inside, and snapped the lid in place. CNA-F then unsnapped the lid of the second receptacle, put the Hoyer sling and another item in the receptacle, and snapped the lid in place. Without completing hand hygiene, CNA-F then walked down the hall and into the dining room to assist residents. On 4/21/25 at 12:22 PM, Surveyor attempted to interview CNA-F who indicated CNA-F was in the middle of getting residents out of the dining room and did not have time to talk to Surveyor. On 4/21/25 at 1:25 PM, Surveyor interviewed CNA-F who became agitated when Surveyor asked what was in the clear plastic bag that Surveyor observed CNA-F carrying at 12:20 PM. CNA-F indicated the bag contained a poopy diaper. CNA-F indicated CNA-F also carried a soiled Hoyer sling and a resident's pants and put them in the laundry receptacle. CNA-F verified CNA-F should have completed hand hygiene after placing the items in the receptacles but indicated CNA-F only lifted the garbage lids and did not put CNA-F's whole hand inside. CNA-F then unsnapped the lid of a nearby garbage receptacle with bare hands, lifted the lid, waved a hand over the garbage, and snapped the lid back in place. CNA-F did not complete hand hygiene after touching the garbage can lid. Surveyor then observed CNA-F use a touch screen on the wall with a bare hand directly after opening the garbage can. When Surveyor asked if CNA-F should have completed hand hygiene after touching the garbage can, CNA-F forcefully put CNA-F's hand under a hand sanitizer dispenser causing hand sanitizer to get on the touch screen and Surveyor. CNA-F completed hand hygiene and yelled, There are you happy now? CNA-F then left the area. On 4/23/25 at 1:14 PM, Surveyor interviewed DON-B who indicated the proper procedure to remove soiled linens and clothing from a resident's room is to bag the items for transport and complete hand hygiene immediately after placing the items in the soiled linen receptacle. DON-B indicated staff should complete hand hygiene after depositing garbage in the garbage receptacle before doing anything else. 3. On 4/22/25 at 11:30 AM, Surveyor observed the noon meal and noted there were 20 residents in the dining room. Surveyor noted there were no sanitizing hand wipes on the tables. At 11:39 AM, the lunch meal was served to the residents. At 11:45 AM, Surveyor observed R5 arrive in the dining room. R5 was served drinks and a meal but was not offered hand hygiene prior to eating. At 12:04 PM, R26 entered the dining room. At 12:06 PM, R26 was served drinks and a meal but was not offered hand hygiene prior to eating. On 4/22/25 at 11:59 AM, Surveyor interviewed R188 who indicated R188 was not offered hand hygiene prior to the meal. On 4/22/25 at 12:28 PM, Surveyor interviewed R26 who indicated R26 was not offered hand hygiene before the meal and was not usually offered hand hygiene before meals. On 4/22/25 at 12:34 PM, Surveyor interviewed Lead [NAME] (LC)-H who indicated CNAs should offer residents hand hygiene before meals. LC-H indicated there are hand wipes available for residents and showed Surveyor the hand wipes in the dining room. LC-H indicated the CNAs in the dining room for lunch were CNA-F and CNA-I. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 1:04 PM, Surveyor interviewed DON-B who indicated residents should be offered hand hygiene prior to meals. DON-B indicated residents should be offered hand sanitizing wipes or a pump of hand sanitizer gel to sanitize hands before eating. On 4/22/25 at 1:24 PM, Surveyor interviewed CNA-F who indicated CNA-F did not offer residents hand hygiene during the lunch meal. When Surveyor asked why hand hygiene was not offered, CNA-F replied, I don't know. I couldn't tell you. On 4/23/25 at 2:44 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated staff have been trained and should follow the facility's infection control and hand hygiene policies.