STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Health Services	5778 Chapin St Florence, WI 54121

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on staff interview and record review, the facility did not ensure 1 resident (R) (R15) of 2 residents reviewed for hospitalization received the proper notice of transfer, reason for transfer, location of transfer, appeal rights, and contact information for the State Long-Term Care Ombudsman. In addition, the facility did not notify the Ombudsman of one of R15's transfers. R15 was transferred to the hospital on 8/6/24 and 9/4/24. Neither R15 or R15's Power of Attorney (POA) were provided with a written transfer notice for either transfer. In addition, the Ombudsman was not notified of R15's 8/6/24 transfer. Findings include: The facility's Transfers and Discharges document, revised 7/12/22, indicates: .Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility .Transfer and discharge include movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not .7. Emergency Transfers/Discharges-initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident .j) Provide transfer notice as soon as practicable to resident and representative, k) Social Services Director, or designee shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via a monthly list. From 11/11/24 to 11/13/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including stroke, hemiplegia (paralysis) and hemiparesis (weakness) affecting the left side, dysphagia (difficult swallowing) following stroke, aphasia (inability to speak) following stroke, gastrostomy (creation of an artificial opening in the stomach for feeding tube placement) status, and osteoarthritis. R15's Minimum Data Set (MDS) assessment, dated 8/23/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R15 had moderately impaired cognition. R15 had an activated Power of Attorney (POA). R15's medical record indicated R15 was sent to the Emergency Department (ED) with a head injury after a fall from a Hoyer lift on 8/6/24 and was hospitalized on [DATE] due to aspiration pneumonia. R15's medical record did not contain a written transfer notice that was provided to R15, R15's POA, or the Ombudsman. (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: 525358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1:01 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who indicated LPN-F was not familiar with the facility's transfer process. On 11/12/24 at 2:06 PM, Surveyor received R15's written transfer notices from Director of Nursing (DON)-B and noted DON-B signed the signature line designated for R15/R15's POA. The transfer notices indicated R15/R15's POA were notified via phone for both transfers. DON-B indicated the forms were not signed by R15's POA. DON-B indicated the 9/4/24 transfer notice was mailed, but R15's POA did not fill out the form or return the form to the facility. DON-B confirmed there was no documentation that the transfer notices were mailed to R15's POA. In the bottom corner of the transfer notice, dated 9/4/24, was a hand-written note that indicated mailed, 9/4/24 to POA. A sticky note that stated Not signed but mailed out, never returned was also attached to the form. Surveyor noted the date of the transfer was written as 8/7/24, however, R15's medical record indicated R15 was transferred to the ED on 8/6/24 and returned to the facility on [DATE]. On 11/13/24 at 4:58 PM, Surveyor interviewed Business office Manager (BOM)-E who indicated residents who are sent to the ED but not admitted to the hospital do not need to be provided with a written transfer notice. On 11/13/24 at 5:02 PM, Surveyor interviewed Social Worker (SW)-D who confirmed the Ombudsman was not notified of R15's transfer on 8/6/24. SW-D indicated SW-D did not know SW-D needed to inform the Ombudsman when residents were transferred to the ED and returned to the facility.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **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) (R15) of 2 residents reviewed for hospitalization received written information of the duration of the bed hold policy, the reserve bed payment policy, and the right to return to the facility. R15 was transferred to the hospital on 8/6/24 and 9/4/24. Neither R15 or R15's Power of Attorney (POA) were provided with a written notice of the bed hold policy. In addition, the bed hold policy form was not filled out by the facility. Findings include: The facility's Transfer and Discharge policy, revised 7/15/22, indicates: .7. Emergency Transfers/Discharges initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident .i) Provide a notice of the bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours after the transfer. From 11/11/24 to 11/13/24, Surveyor reviewed R15's medical record. R15 was admitted to the facility on [DATE] and had diagnoses including stroke, hemiplegia (paralysis) and hemiparesis (weakness) affecting the left side, dysphagia (difficult swallowing) following stroke, aphasia (inability to speak) following stroke, gastrostomy (creation of an artificial opening in the stomach for feeding tube placement) status, and osteoarthritis. R15's Minimum Data Set (MDS) assessment, dated 8/23/24, had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which indicated R15 had moderately impaired cognition. R15's medical record indicated R15 was sent to the Emergency Department (ED) with a head injury after a fall from a Hoyer lift on 8/6/24 and was hospitalized on [DATE] due to aspiration pneumonia. R15's medical record did not indicated a written bed hold notice was provided to R15 or R15's POA. On 11/12/24 at 1:01 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who indicated LPN-F was not familiar with the facility's bed hold policy or bed hold notice form. On 11/12/24 at 2:06 PM, Surveyor received R15's written bed hold notices from Director of Nursing (DON)-B who indicated the forms were not signed by R15's POA. DON-B indicated the 9/4/24 form was mailed, but R15's POA did not fill out or return the form to the facility. DON-B confirmed there was no documentation that the bed hold notices were mailed to R15's POA. Surveyor noted the bed hold form was dated 8/7/24, however, R15's medical record indicated R15 was transferred to the ED on 8/6/24 and returned to the facility on [DATE]. Surveyor also noted the bed hold forms did not contain the effective dates or daily rates. On 11/13/24 at 4:58 PM, Surveyor interviewed Business Office Manager (BOM)-E who stated the bed hold policy is filled out and BOM-E later sends the forms which are not provided at the time of transfer. BOM-E indicated residents who were sent to the ED but not admitted to the hospital did not need a bed hold notice.

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NAME OF PROVIDER OR SUPPLIER Florence Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 5778 Chapin St Florence, WI 54121	

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49010 Based on observation, staff and resident interview, and record review, the facility did not ensure nutritional needs were met for 1 resident (R) (R31) of 17 sampled residents. The facility did not honor R31's meal preferences during the lunch meal on 11/12/24. Findings include: The facility's Meal Distribution document, revised February 2023, indicates: 1. All meals will be assembled in accordance with the individualized diet order, plan of care and preferences .4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients . The facility's Dining and Food Preferences document, revised October 2022, indicates: .7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies, intolerances, and preferences. 8. Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value. 9. The alternate meal and/or beverage will be provided in a timely manner. On 11/12/24 at 11:27 AM, Surveyor observed lunch service. Surveyor observed Dietary Manager (DM)-G serve meatloaf, potatoes, and green beans from the steam table while Registered Dietician (RD)-H made four hamburgers on the stove top. DM-G asked RD-H to make two pieces of French toast for two residents. DM-G then asked RD-H to make a third piece of French toast for R31. During the meal service, Surveyor observed [NAME] (CK)-I ask RD-H four separate times to make a piece of French toast for R31. The French toast was not made. At 12:16 PM, Surveyor observed RD-H ask DM-G who the leftover hamburger was for. DM-G indicated it must be an extra. RD-H indicated RD-H would offer the hamburger to R31 instead of the French toast. On 11/12/24 at 12:19 PM, Surveyor interviewed RD-H who indicated RD-H offered R31 a hamburger, but R31 didn't want it. RD-H indicated R31 wasn't feeling well, left the dining area without eating, and returned to R31's room. On 11/12/24 at 12:21 PM, Surveyor interviewed CK-I who indicated CK-I was upset that R31 did not get the French toast R31 asked for. CK-I indicated RD-H did not know what RD-H was doing and usually didn't cook. On 11/12/24 at 12:29 PM, Surveyor interviewed DM-G who indicated RD-H didn't cook at the facility and did not know R31 preferred French toast for every meal. DM-G indicated DM-G and CK-I usually ensure R31 gets French toast at every meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:48 PM, Surveyor and Administrator in Training (AIT)-C interviewed R31 who was awake in bed. R31 indicated R31 felt okay. When Surveyor asked if R31 received lunch, R31 indicated R31 did not receive lunch that day. R31 stated R31 asked for and waited for French toast, but staff did not give R31 any food. R31 stated R31 talked to kitchen staff in the past so R31 could have French toast at every meal because that is what R31 could eat without feeling ill. R31 stated R31 did not know why R31 didn't receive a meal that day. R31 indicated R31 left the dining room without eating because lunch was over and no one had brought R31's meal. When Surveyor asked if R31 was hungry, R31 indicated R31 was hungry and would eat French toast. At 12:54 PM, AIT-C stated AIT-C would go to the kitchen and have staff make R31 French toast. On 11/12/24 at 2:52 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and AIT-C. NHA-A stated NHA-A expects resident's preferences to be honored and indicated staff usually give residents what they want. NHA-A stated residents are encouraged to share their likes and preferences and it is common at every meal to accommodate them. NHA-A also indicated NHA-A expects that residents who want to eat are fed. AIT-C indicated R31 eventually received French toast and ate it all. On 11/13/24 at 11:02 AM, Surveyor interviewed DM-G who indicated DM-G was aware that R31 ate French toast for every meal and had done so for a month or two. DM-G indicated DM-G should have fixed R31's meal ticket to reflect R31's preferences rather than changing it at each meal. DM-G indicated DM-G and CK-I usually anticipated R31's request and made French toast for R31 at each meal along with two other residents who typically ate French toast at each meal. DM-G confirmed it was not okay that R31 left the dining room receiving lunch. On 11/13/24 at 11:06 AM, Surveyor interviewed RD-H who stated there was no more egg mixture and RD-H did not make French toast for R31 because RD-H did not know how to make the egg batter recipe. RD-H indicated RD-H discussed preferences, nutrition, and health risks/benefits with R31 earlier that day. RD-H indicated R31 stated R31 still wanted to have French toast for every meal. RD-H indicated RD-H discussed adding protein to each meal as well as French toast and R31 was agreeable. RD-H indicated RD-H updated R31's meal preferences, meal ticket, and care plan accordingly.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff interview, and record review, the facility did not ensure meals were prepared by a method that conserved nutritive value for 2 residents (R) (R10 and R38) of 2 residents who received pureed diets. Kitchen staff did not follow a recipe when preparing pureed food items to ensure and conserve the nutritive value of the food. Kitchen staff did not provide R38 all of the items listed on R38's meal ticket. Findings include: The facility's contracted food service's document, dated February 2018, indicates: The federal requirements for the provision of therapeutic diets stipulates that food must be in a form to meet individual needs and that a mechanically-altered diet is part of the physician prescribed diet order .As outlined in the position description for the Cook, the ability to properly prepare texture-modified foods is a part of the required skillset for the position. The facility's contracted food service's Menus Policy Statement, dated October 2022, indicates: Menus will be planned in advance to meet nutritional needs of the residents/patients in accordance with established national guidelines 3. Menus will include standardized recipes. According to the publication All About Recipes, Part II from the College of Agriculture, Biotechnology and Natural Resources [NAME], A., and [NAME], S. 2021, It is important to follow a recipe to ensure accurate nutrition content, which is important for schools, hospitals, and nursing homes. Modifying a recipe by adding water lowers the nutritional quality of the food. The menu for the facility indicated the lunch meal on 11/12/24 included meatloaf, parmesan green beans, mashed potatoes, a cranberry muffin, and German chocolate cake. On 11/12/24, Surveyor reviewed R10's medical record. R10 was admitted to the facility on [DATE] and had diagnoses including dysphagia (difficulty swallowing) oropharyngeal phase. R10's prescribed diet was a consistent carbohydrate diet, dysphasia level 1 puree, with nectar consistency liquids. On 11/12/24, Surveyor reviewed R38's medical record. R38 was admitted to the facility on [DATE] and had diagnoses including dysphagia oropharyngeal phase, pneumonitis due to inhalation of food and vomit, and unspecified severe protein calorie malnutrition. R38's prescribed diet was a regular diet, pureed texture, with nectar consistency liquids. On 11/12/24 at 11:27 AM, Surveyor observed lunch service. At 12:04 PM, Surveyor observed Dietary Manager (DM)-G take several broken pieces of meatloaf from the pan of meatloaf being served. DM-G placed the meatloaf pieces in a food processor, filled a container with water from the faucet, and poured an unmeasured amount of water in the food processor on top of the meatloaf. As DM-G pureed the meatloaf, DM-G stated to Surveyor DM-G knew DM-G should use gravy or broth and add it in one tablespoon at a time. When the meatloaf was pureed, DM-G scooped the meatloaf onto two plates. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:09 PM, Surveyor observed DM-G take two four-ounce scoops of green beans from the steam table and place them in a food processor. DM-G filled a container with water from the faucet and poured an unmeasured amount of water in the food processor on top of the green beans. When the beans were pureed, DM-G poured the green beans onto the plates with the pureed meatloaf. The two pureed plates of food were microwaved and a serving of mashed potatoes was added to each. The plates were then served to R10 and R38. R38's individual meal ticket for the 11/12/24 lunch meal listed 1 pureed cranberry muffin which was not provided to R38. On 11/12/24 at 2:52 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A expects staff to follow kitchen policies and procedures for meal preparation. On 11/13/24 at 11:02 AM, Surveyor interviewed DM-G who verified DM-G should not have used water to puree the meatloaf and green beans for the 11/12/24 lunch meal. DM-G confirmed DM-G should have used broth or gravy instead. DM-G indicated pureed food recipes were available and should be followed. DM-G also confirmed R38 should have received a pureed cranberry muffin on 11/12/24 but did not. DM-G stated the muffin was already pureed and on the dessert tray but DM-G was nervous and forgot to send the muffin with R38's meal. On 11/13/24 at 11:06 AM, Surveyor interviewed Registered Dietitian (RD)-H who indicated DM-G should have used broth or gravy to puree the meatloaf and green beans. RD-H also indicated DM-G should have used the recipes available when pureeing food to maintain the nutritional value.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49010 Based on observation, staff interview, and record review, the facility did not ensure food was stored and prepared in a sanitary manner. This practice had the potential to affect 50 of 53 residents residing in the facility. Three residents received nutrition via tube feeding. Staff did not store food in a manner to ensure food safety and did not date food appropriately. Staff did not follow safe microwave safe heating procedures. Staff did not adhere to temperature requirements for testing sanitizing solution. Findings include: On 11/11/24 at 9:20 AM, Dietary Manager (DM)-G indicated the facility followed the Food and Drug Administration (FDA) Food Code as their standard of practice. Food Labeling/Storage: The 2022 FDA Food Code documents at 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food (TCS), Date Marking: (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the Food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (Celsius) (41 F) (Fahrenheit) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The 2022 FDA Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A food specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or package that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). The facility's contracted food service's Labeling and Dating document, dated 2017, indicates: Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a first in, first out (FIFO) manner .All foods should be dated upon receipt before being stored. Food labels must include: The food item name; The date of preparation/receipt/removal from freezer; The use-by date as outlined in the attached guidelines . Items that are removed from a labeled case in the freezer and placed in the refrigerator for thawing should be labeled with the date of removal from the freezer and the use by date .Leftovers must be labeled and dated with the date they are prepared and the use-by date .The manufacturer's date, when available, is the use-by for unopened items .Day of preparation or opening is considered Day 1 when establishing the use-by date .Guidelines apply, regardless of storage location (e.g., kitchen, pantries, etc.) .All Time/Temperature Control for Safety (TCS) foods that are to be help for more than 24 hours at a temperature of 40 degrees or less will be labeled and dated with a prepared date (Day 1) and a use-by date (Day 7). (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During an initial kitchen tour that began at 9:20 AM on 11/11/24, Surveyor and DM-G observed the following items in the walk-in cooler and dry storage area:

Cooler:

- Two open and partially used half gallons of tomato juice. One was dated 11/11 and the other was dated 11/7. Per DM-G, the dates on the containers were the received dates. There were no open dates or use-by dates.

- Five English muffins in a package with a received date of 11/11. There was no open or use-by date.

- Two open and partially used bags of cinnamon raisin bagels. One bag had a received date of 11/6. The other bag had a received date of 11/1. There were no open or use-by dates.

Dry Storage:

- Two open and partially used 25-pound bags of salt. Both bags were dated 9/5/24. Per DM-G, the dates were received dates There were no open or use-by dates.

- One open and partially used 25-pound bag of powdered sugar dated 12/13/23. Per DM-G, the date was the received date. There was no open or use-by date.

- One open and partially used 50-pound bag of flour dated 10/21/24. Per DM-G, the date was the received date. There was no open or use by date.

- One open and partially used 50-pound bag of sugar dated 5/9/24. Per DM-G, the date was the received date. There was no open or use-by date.

- One plastic container of Rice Krispies with an open date of 11/4/24 and a use-by date of 2/4/24.

- One plastic container of Corn Flakes with an open date of 10/2/24 and a use-by date of 1/2/24.

- One plastic container of Toasted Oats with an open date of 11/5/24 and a use-by date of 1/5/24.

- One plastic container of Raisin Bran with an open date of 10/21/24 and a use-by date of 11/21/24.

Surveyor interviewed DM-G who stated the single dates on the opened food items were received dates. DM-G stated all items should have a received on date that indicates the date the food was received, an opened on date that indicates when then item was opened, and a use-by date that indicates when the item should be used by or discarded. DM-G could not indicate the use by date on many of the open and undated items. DM-G eventually located a policy posted in the kitchen, however, the policy didn't mention some of the items (including sugar and salt) and there were no opened on dates on the items. Surveyor noted the cereals were incorrectly dated and/or inconsistent with the facility's dating policy. DM-G indicated the incorrect date was DM-G's fault when DM-G dated in a hurry.

Microwave Procedure:

(continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Food Code documents at 3-401.12 Microwave Cooking: The rapid increase in food temperature resulting from microwave heating does not provide the same cumulative time and temperature relationship necessary for the destruction of microorganisms as do conventional cooking methods. In order to achieve comparable lethality, the food must attain a temperature of 74 degrees C (165 degrees F) in all parts of the food. Since cold spots may exist in food cooking in a microwave oven, it is critical to measure the food temperature at multiple sites when the food is removed from the oven and then allow the food to stand covered for two minutes post microwave heating to allow thermal equalization and exposure. Although some microwave ovens are designed and engineered to deliver energy more evenly to the food than others, the important factor is to measure and ensure that the final temperature reaches 74 degrees C (165 degrees F) throughout the food. The 2022 FDA Food Code documents at 3-403.11 Reheating for Hot Holding (B): Time/Temperature control for safety food reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. The facility's undated Microwave Temp Log document indicates: How to safely reheat foods in a microwave: 1. Place food in a microwave safe bowl and cover with lid. 2. Reheat food, then let it sit for two minutes. 3. Remove the lid and stir well with a clean utensil. 4. Wipe clean the probe of the food thermometer using single use food grade wipe, then insert probe into food so stem is covered. 5. Food is ready for consumption at 165 degrees F. 6. Clean probe with new wipe and discard wipe. On 11/12/24 at 12:07 PM, Surveyor observed Registered Dietician (RD)-H open a can of baked beans and pour the contents into a bowl. RD-H microwaved the beans uncovered and immediately took the temperature. RD-H again microwaved the beans and temped the beans without waiting two minutes. RD-H then put the beans on a resident's tray. On 11/12/24 at 12:09 PM, Surveyor observed DM-G put pureed meatloaf and pureed green beans on two plates. DM-G put one plate on top of the other and put both plates in the microwave uncovered. DM-G removed the plates and immediately temped the meatloaf. DM-G stacked the plates of food and put them back in the microwave uncovered. DM-G again removed the plates and temped the meatloaf with no time delay. The meatloaf was not stirred. DM-G again stacked the two plates of food and put them back in the microwave uncovered. DM-G removed the plates a third time and temped the meatloaf right away. DM-G again stacked the plates of food and put them back in the microwave uncovered. DM-G repeated the same process a total of five times. After the fifth time, DM-G stated the meatloaf was 180 degrees and sent the meatloaf for service. DM-G did not temp the pureed green beans during the process. On 11/13/24 at 11:02 AM, Surveyor interviewed DM-G who indicated the meatloaf was hard to temp because it was a small amount so DM-G kept putting the meatloaf back in the microwave. DM-G indicated DM-G should have pureed the food ahead of time and had the food at serving temp on the steam table. On 11/13/24 at 11:06 Surveyor interviewed RD-H who agreed with DM-G that the food should have been prepped ahead of time. RD-H did not respond to Surveyor's question why the two minute wait time was not observed for temping microwaved food. Sanitizing Solution Testing: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Food Code documents at 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. During an initial kitchen tour that began at 9:20 AM on 11/11/24, Surveyor observed red and green buckets with sanitizing solution in the kitchen. One set of each color bucket was near an empty three-compartment sink and an empty single sink near the microwave. Surveyor interviewed DM-G who indicated the sanitizer buckets were checked once per shift with Hydrion test strips. DM-G stated DM-G did not test the temperature of the sanitizing solution but used the strips to record the parts per million (PPM) of sanitizing solution. Surveyor noted the facility used Ecolab Oasis 146 Multi Quat Sanitizer. A poster on the wall contained Quat Sanitizer manufacturer directions that indicated the appropriate sanitization was 150-400 PPM for sanitizing buckets and sanitization of cookware, dishes, and utensils during manual dishwashing. The Hydrion Quaternary test strip package insert directions indicated the test solution should be between 65 and 75 degrees F at the time of testing. On 11/12/24 at 12:30 PM, Surveyor observed red and green buckets of sanitizing solution in the kitchen. One set of each color bucket was near an empty three-compartment sink and by a sink near the microwave. Surveyor reviewed the facility's Three Compartment Sink and Sanitizer Bucket Log that contained documentation of sanitizing solution testing that was completed three times daily (once at each meal). The columns for each daily meal included time, water temp (Water *F), PPM, and initials. The PPMs documented on the daily logs were within the PPMs indicated on the Quat sanitizer directions and Hydrion Quaternary test strip indications for appropriate sanitization. There were no missing PPMs. Surveyor noted the Water *F column was crossed out for every day and every meal. There were no water temperatures recorded on any of the sanitizer testing logs in October 2024 and through 11/12/24. On 11/12/24 at 12:37 PM, Surveyor asked DM-G to test the sanitizing solution in the buckets. DM-G dipped a Hydrion test strip in a green bucket. Approximately 5 seconds later, DM-G removed the test trip and compared it to the back of the package. The color registered 400 PPM. DM-G again indicated DM-G does not test the water temperature, just the PPMs. On 11/12/24 at 1:56 PM, RD-H indicated the sanitizing solutions buckets should be tested according to what it says on the Hydrion test strip package. On 11/12/24 at 2:52 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A expects staff to follow the facility's kitchen policies and procedures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infection. This practice had the potential to affect all 53 residents residing in the facility. The facility did not maintain thorough surveillance/tracking documentation for a COVID-19 outbreak in September 2024 and did not report the outbreak to the local health department in a timely manner. In addition, the facility did not maintain thorough surveillance/tracking for a Respiratory Syncytial Virus (RSV) outbreak between 3/19/24 and 3/21/24 and did not report the outbreak to the local health department in a timely manner. The facility did not ensure consistent symptom tracking and documentation was completed for 5 residents (R) (R2, R18, R28, R31, and R163) of 6 residents who tested positive for COVID-19 in September 2024. Infection Preventionist (IP)-F also worked as a floor nurse. IP-F was unable to maintain the facility's infection prevention and control program which resulted in incomplete and/or inaccurate infection control surveillance. R6 had a wound but did not have an order or a care plan for enhanced barrier precautions (EBP). R8 had a multidrug-resistant organism (MDRO) and was not on EBP. Findings include: The facility's COVID-19 Prevention, Response and Reporting policy, dated 5/18/23, indicates: It is the policy of the facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 and promptly respond to any suspected or confirmed COVID-19 infections. COVID-19 information will be reported through the proper channels as per federal, state and/or local health authority guidance .26. Responding to a newly identified SARS-CoV-2 infected HCP or resident: a. The facility should defer to the recommendations of the jurisdiction's public health authority when performing an outbreak response. b. A single new case of SARS-CoV-2 infection in a healthcare provider (HCP) or resident should be evaluated to determine if others in the facility could have been exposed. c. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based approach (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contact cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission .27. The Infection Preventionist, or designee, will monitor and track COVID-19 related information including, but no limited to: a. The number of residents and staff who exhibit signs and symptoms of COVID-19. b. The number of residents and staff who have suspected or confirmed COVID-19 and date of confirmation. c. Staff and resident vaccination status .e. Employee compliance with standard and transmission-based precautions . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Wisconsin State Legislature, Chapter DHS 145, Appendix A, Communicable Diseases and Other Notifiable Conditions: The following diseases are of urgent public health importance and shall be reported by telephone to the patient's local health officer or to the local health officer's designee upon identification of a case or suspected case .In addition to the immediate report, complete and fax, mail, or electronically report an Acute and Communicable Disease Case Report (DHS F-44151) to the address on the form, or enter the data into the Wisconsin Electronic Disease Surveillance System, within 24 hours . Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) . The facility's Infection Outbreak Response and Investigation Policy, with a review date of 2/26/23, indicates: . d. An outbreak will be reported to the local and/or state health department in accordance with the state's reportable diseases website. The facility's Infection Surveillance policy, revised on 3/8/23, indicates: .10. Employee, volunteer, and contract employee infections will be tracked, as appropriate, such as influenza or gastrointestinal infection outbreaks. The Wisconsin Department of Health Services' Nursing Homes Provider Resources webpage indicates under Outbreak Reporting Requirements: In Wisconsin, confirmed or suspected outbreaks of any disease in health care facilities, including long-term care facilities, are a Category I Disease, meaning they shall be reported immediately by telephone to the patient's local health officer, or to the local health officer's designee, upon identification. The Wisconsin Department of Health Services publication Prevention and Control Recommendation for Acute Gastroenteritis Outbreaks in Wisconsin Long-Term Care Facilities, dated December 2017, indicates: Staff should exclude themselves from resident care and food service duties at the onset of the symptoms, including nausea, vomiting, abdominal pain, and/or diarrhea .Such exclusions shall remain in effect until the employee is asymptomatic and free of diarrhea and vomiting for 48 hours .A log should be maintained to record ill staff symptoms, date when they became ill, date they became well, and date they returned to work. The facility's Infection Preventionist policy, dated 9/22/22, indicates: .7. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the infection prevention and control program for the facility .The policy also indicates the IP must: .b. Establish facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff and visitors. The facility's Enhanced Barrier Precautions (EBP) policy, with a revised date of 8/8/24, indicates: It is the policy of this facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDROs) .1c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities .2b. An order for EBP will be initiated for residents with any of the following: .i. Wounds (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) .ii. Infection or colonization with a CDC-targeted or novel MDRO when contact precautions do not otherwise apply .4. High-contact resident care activities include: Dressing; Bathing; Transferring; Providing hygiene; Changing linens; Changing briefs or assisting with toileting . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. From 11/11/24 through 11/13/24, Surveyor reviewed the facility's infection prevention and control program surveillance documents and noted the facility experienced a COVID-19 outbreak in September 2024. Documentation pertaining to the COVID-19 outbreak consisted of a Monthly Infection Control Log, dated September 2024. The log included 6 residents who were COVID-19 positive. The log documented where the residents resided, the date of onset, and the date resolved. No additional surveillance or tracking was noted. Surveyor reviewed the rest of the facility's infection prevention documents for the month of September 2024 and noted the following: ~ A staff and resident line list, dated September 2024, included sections for tracking symptoms, date and time of last symptom, well date, return to work date (staff), and date removed from precautions (resident). The line list included 18 entries. Surveyor noted the line list was incomplete and did not contain the date and time of the last symptom, well dates, return to works dates, and removed from precautions dates. Surveyor also noted the line list did not include the 6 residents identified as COVID-19 positive on the Monthly Infection Control Log. ~ A blank Surveillance Floor Map. ~ An Infection Summary, dated September 2024, was incomplete and only contained information the for infection type and unit. The Infection Summary did not include a section for tracking COVID-19 and did not include the 6 positive residents. The facility's September 2024 COVID-19 outbreak surveillance also did not include documentation for symptomology, testing, the facility's response to the outbreak, preventative actions, or dates of outbreak reporting. On 11/13/24 at 3:15 PM, Surveyor interviewed IP-F who confirmed IP-F was responsible for the facility's infection prevention and control program. IP-F confirmed the facility had a COVID-19 outbreak in September 2024. Surveyor reviewed with IP-F documentation from the outbreak. IP-F confirmed surveillance documents, including an infection summary, surveillance map, and infection control line list were incomplete and did not contain the necessary information to ensure adequate surveillance and tracking. 2. On 11/13/24, Surveyor reviewed the medical records of the 6 residents who were diagnosed as COVID-19 positive in September 2024 and noted 5 (R2, R18, R28, R31 and R163) of the 6 residents had contradicting documentation regarding their COVID-19 symptoms. R2 was admitted to the facility on [DATE]. R2 tested positive for COVID-19 on 9/9/24 and was placed on droplet/contact precautions. R2's nursing notes contained the following entries: ~On 9/9/24 at 10:51 AM, Licensed Practical Nurse (LPN)-K documented R2 had shortness of breath (SOB) with exertion or while lying flat and an occasional cough. ~On 9/9/24 at 6:24 PM, nursing staff documented R2 was asymptomatic. ~On 9/10/24 at 9:10 AM, Director of Nursing (DON)-B documented R2 stated R2's SOB with exertion was improving. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~On 9/11/24 at 9:50 PM, nursing staff documented R2 was asymptomatic. ~On 9/12/24 at 12:30 PM, nursing staff documented R2 was asymptomatic. ~On 9/16/24 at 1:44 PM, Administrator in Training (AIT)-C documented R2 had SOB when lying flat. ~On 9/16/24 at 2:30 PM, nursing staff documented R2 had SOB. R2's medical record did not indicate whether R2's SOB resolved or when R2 was removed from droplet/contact precautions. R18 was admitted to the facility on [DATE]. R18 tested positive for COVID-19 on 9/7/24 and was placed on droplet/contact precautions. R18's nursing notes contained the following entries: ~On 9/7/24 at 3:22 PM, LPN-K documented R18 had SOB with exertion and while laying flat and a dry cough. ~On 9/7/24 at 9:33 PM, nursing staff documented R18 had no SOB and was asymptomatic. ~On 9/9/24 at 8:20 AM, nursing staff documented R18 was asymptomatic. ~On 9/12/24 at 12:31 PM, nursing staff documented R18 was asymptomatic. R18's medical record did not indicate when R18's symptoms resolved or when R18 was removed from droplet/contact precautions. R28 was admitted to the facility on [DATE]. R28 tested positive for COVID-19 on 9/13/24 and was placed on droplet/contact precautions. R28's nursing notes contained the following entries: ~On 9/13/24 at 11:08 AM, LPN-K documented R28's lungs were diminished and R28 had an occasional cough and SOB while lying flat and with exertion. ~On 9/13/24 at 11:47 AM, IP-F documented R28 had no symptoms and noted R28's respirations were regular and unlabored. ~On 9/13/24 at 12:43 PM, IP-F documented R28 was asymptomatic. R28's medical record did not indicate when R28's symptoms resolved or when R28 was removed from droplet/contact precautions. R31 was admitted to the facility on [DATE]. R31 tested positive for COVID-19 on 9/9/24 and was placed on droplet/contact precautions. R31's nursing notes contained the following entries: ~On 9/9/24 at 10:54 AM, LPN-K documented R31 had SOB with exertion or while lying flat and an occasional dry cough. ~On 9/9/24 at 6:17 PM, nursing staff documented R31 was asymptomatic. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	~On 9/10/24 at 8:40 AM, DON-B documented R31's SOB with exertion was improving. ~On 9/11/24 at 9:48 PM, nursing staff documented R31 was asymptomatic. ~On 9/12/24 at 12:29 PM, nursing staff documented R31 was asymptomatic. ~On 9/16/24 at 1:50 PM, AIT-C documented R31 had SOB when laying flat and with exertion. R31's medical record did not indicate when R31's symptoms resolved or when R31 was removed from droplet/contact precautions. R163 was admitted to the facility on [DATE]. R163 tested positive for COVID-19 on 9/5/24 and was placed on droplet/contact precautions. R163's nursing notes contained the following entries: ~On 9/5/24 at 7:33 PM, LPN-K documented R163 had a cough, chills, and congestion. R163 also had SOB at rest, while lying flat, and with exertion. ~On 9/6/24 at 9:14 AM, DON-B documented R163 had a cough and congestion. ~On 9/7/24 at 9:30 PM, nursing staff documented R163 was asymptomatic. R163's medical record did not indicate when R163's symptoms resolved or when R163 was removed from droplet/contact precautions. On 11/13/24 at 3:15 PM, Surveyor interviewed IP-F who indicated IP-F was not sure why the charting was inconsistent for 5 of the 6 residents who tested positive for COVID-19. IP-F stated none of the residents who tested positive were symptomatic. IP-F confirmed resident's symptoms were not documented as part of the IP surveillance. IP-F indicated symptoms were only monitored through charting and nurse-to-nurse communication. IP-F stated LPN-K assisted IP-F with the infection prevention and control program until October 2024 and was responsible for the line list and resident testing. On 11/13/24 at 3:50 PM, Surveyor interviewed LPN-K who stated resident symptoms were tracked on one line list. LPN-K indicated if residents were diagnosed and prescribed an antibiotic, they were placed on the Monthly Infection Control Log. LPN-K stated some of the residents who tested positive for COVID-19 were symptomatic. LPN-K stated LPN-K did not know why there were discrepancies in the charting on whether a resident had symptoms or not. LPN-K stated LPN-K charted based on LPN-K's assessment of the resident. 3. From 11/11/24 through 11/13/24, Surveyor reviewed the facility's September 2024 COVID-19 outbreak surveillance documents which indicated the first staff member tested positive on 9/4/24 and the first resident tested positive on 9/5/24. The documents did not indicate the facility reported the outbreak to the local health department. On 11/13/24 at 3:40 PM, Surveyor interviewed AIT-C who indicated AIT-C reported the outbreak to the local health department. AIT-C provided an e-mail, dated 9/12/24, that contained communication with the health department, but not the date the outbreak was reported. AIT-C stated AIT-C initially reported the outbreak via phone to the health department. AIT-C was not certain of the date and did not have documentation of the date the outbreak was reported. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/14/24 at 10:38 AM, Surveyor interviewed Public Health Nurse (PHN)-J who stated the facility reported the COVID-19 outbreak via phone on 9/11/24 which was 7 days after the first individual tested positive. 51043 4. On 11/12/24 at 4:07 PM, Surveyor interviewed IP-F who provided an incomplete staff line list titled Employee Infection Line List/Log. The log did not have a date in the space provided at the top left side of the form but listed 8 dates next to the 8 staff listed on the form. The dates listed were 5/7, 6/5, 6/4, 6/5, 6/11, 7/7, 7/15, and 7/27. The form listed the unit where each staff worked and their symptoms. The form contained columns that were not filled out for any of the staff including Seen by Physician Y/N, Confirmed Infection (MD or Lab), Number of Hours with No Symptoms, and Return to Work Date. The Date/Time of Onset of Symptoms column contained two dates listed for two of the staff. When Surveyor asked IP-F about return to work dates for staff with complaints of nausea, emesis (vomiting), and diarrhea to ensure staff did not infect residents or other staff upon their return to work, IP-F indicated return to work dates depended on symptoms and were usually 24 hours after symptoms subsided. IP-F stated the facility calls and asks staff if they are able to return for their next shift. For COVID-19, IP-F indicated IP-F would have staff test and return to work 24 hours after their symptoms resolved and 1 negative test unless the policy stated otherwise. For nausea and diarrhea, IP-F indicated staff can return to work 24 hours after their symptoms subside. IP-F indicated IP-F had no further information regarding the dates and times of staffs' last illness symptoms and when staff returned to work. Per the Wisconsin Department of Health Services, staff should not return to work until at least 48 hours after their last episode of diarrhea or vomiting. On 11/13/24 at 10:33 AM, Surveyor interviewed IP-F and requested a completed Surveillance Map since the only Surveillance Map located in the facility's Infection Control binder to track resident infections was blank. IP-F verified IP-F had not been completing Surveillance Maps. On 11/13/24 at 2:42 PM, Surveyor reviewed the March 2024 Monthly Resident Infection Control Log which indicated 6 residents were Respiratory Syncytial Virus (RSV) positive between 3/19/24 and 3/21/24 which constituted an outbreak per the Wisconsin Department of Health Services and should have been reported within 24 hours. On 11/14/24 at 10:38 AM, Surveyor interviewed PHN-J who indicated the RSV outbreak was reported via phone and e-mail on 3/26/24. 5. On 11/13/24 at 3:33 PM, Surveyor interviewed IP-F who indicated IP-F did not have enough time to maintain the facility's infection prevention and control program and indicated it should be a designated 40-hour per week position. When Surveyor asked IP-F how many hours IP-F currently devoted to the position, IP-F stated maybe 2 hours a week and indicated IP-F also worked as a floor nurse. 49010 6. On 11/11/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including type two diabetes mellitus with diabetic neuropathy, congestive heart failure (CHF), and dementia. R6's Minimum Data Set (MDS) assessment, dated 10/09/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R6 had moderately impaired cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R6's medical record indicated R6 had a diabetic ulcer on the ball of the right foot. R6's plan of care did not indicate R6 was on EBP. On 11/11/24 at 12:37 PM, Surveyor observed R6's room entrance and noted there was no EBP sign on or near the door. On 11/11/24 at 12:51 PM, Surveyor interviewed DON-B who stated there should be an EBP sign outside R6's room since R6 was on EBP due to an active foot wound. DON-B posted an EBP sign near R6's room entrance. On 11/12/24, Surveyor reviewed R6's physician orders. R6 had a wound care order, dated 10/4/24, for the diabetic ulcer on R6's right foot. R6 did not have an order for EBP. Surveyor reviewed R6's diagnoses list which did not contain R6's right diabetic foot ulcer. On 11/13/24 at 8:49 AM, Surveyor interviewed R6 who indicated R6 had an open foot wound that nursing staff cleaned and dressed regularly. Surveyor observed a bandage on R6's right foot that was dated 11/11/24. On 11/13/24 at 8:50 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-L who indicated CNA-L used EBP for R6 due to R6's foot wound. On 11/13/24 at 8:56 AM, Surveyor interviewed CNA-M who indicated CNA-M used EBP for R6 due to R6's foot wound. On 11/13/24 at 1:50 PM, Surveyor interviewed IP-F who stated R6 was on EBP for a foot wound and should have an order in R6's medical record. IP-F indicated R6 used to have an EBP order, however, the EBP order wasn't reinitiated after R6 went to the hospital in September 2024. IP-F indicated IP-F and others involved with admissions should have ensured an order for EBP was in R6's medical record upon readmission. On 11/13/24 at 2:54 PM, Surveyor interviewed DON-B who confirmed R6's EBP order should have already been in place since staff were implementing EBP. DON-B indicated R6 should also have a care plan for EBP and indicated R6's foot wound should be listed on R6's diagnoses list. 7. On 11/11/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), bipolar disorder, excoriation (skin picking) disorder, and anxiety. R8's MDS assessment, dated 9/17/24, had a BIMS score of 13 out of 15 which indicated R8 was not cognitively impaired. R8's medical record indicated R8 had an order for EBP due to an MDRO. A care plan, dated 10/28/24, indicated R8 was on EBP due to an MDRO and for wounds due to skin picking. R8 had a physician order for EBP, dated 10/30/24, due to MDROs. R8's diagnoses list did not contain an MDROs. On 11/11/24 at 12:37 PM, Surveyor observed R8's room entrance and noted there was no EBP sign on or near R8's door. (R6 and R8 were roommates) On 11/11/24 at 12:51 PM, Surveyor interviewed DON-B who stated R8 was not on EBP. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Florence Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 5778 Chapin St Florence, WI 54121	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24 at 8:50 AM, Surveyor interviewed CNA-L who indicated R8 was not on EBP and CNA-L did not know of any reason why R8 would be on EBP. CNA-L indicated EBP was for R8's roommate (R6). On 11/13/24 at 8:56 AM, Surveyor interviewed CNA-M who indicated CNA-M did not use EBP for R8. CNA-M indicated EBP was for R8's roommate (R6) only. On 11/13/24 at 9:53 AM, Surveyor interviewed DON-B. When Surveyor asked why R8 had an order and a care plan for EBP but staff did not use EBP for R8, DON-B stated DON-B was wrong and staff should use EBP for R8 if R8 had an EBP order. When Surveyor asked why R8 had a care plan for MDROs and an EBP order for MDROs but did not have an MDRO diagnosis in R8's diagnoses list, DON-B stated DON-B would look into it. On 11/13/24 at 10:14 AM, Surveyor interviewed DON-B who indicated DON-B spoke with AIT-C and confirmed R8 had a history of an MDRO. DON-B indicated R8's diagnoses list would be updated and DON-B would ensure staff used EBP for R8. On 11/13/24 at 1:50 PM, Surveyor interviewed IP-F who stated IP-F was not aware R8 had an EBP order or why EBP would be used for R8 just for an MDRO. When Surveyor asked if an MDRO should be listed in a resident's diagnoses list, IP-F indicated IP-F was unsure. On 11/13/24 at 2:54 PM, Surveyor interviewed DON-B who confirmed R8 had a history of an MDRO and indicated extended-spectrum beta lactamase (ESBL) resistance was added to R8's active diagnoses list. DON-B confirmed the orders should have already been in place and EBP should have been ongoing. DON-B indicated R8 was now on the EBP list and staff would use EBP with R8 going forward.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 51043 Based on staff interview and record review, the facility did not implement their antibiotic stewardship program by ensuring the accurate use of an antibiotic for 1 resident (R) (R261) of 5 sampled residents. R261 was transferred to the hospital on 1/5/24 and prescribed an antibiotic for a urinary tract infection (UTI) that did not meet the facility's criteria for infection. Fourteen doses of the unnecessary antibiotic were administered. Findings include: The facility's Antibiotic Stewardship Program Policy, reviewed 11/18/22, indicates: The purpose of the program is to optimize the treatment of infections while reducing adverse events associated with antibiotic use .i. Monitor response to antibiotics and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out). ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. iii. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. On 11/12/24, Surveyor reviewed the facility's January 2024 resident line list. R261 was on the line list for a UTI that was identified on 1/5/24 at the hospital while R261 was being evaluated for another condition. The provider completed a urinalysis and ordered Bactrim DS (an antibiotic) (trimethoprim/sulfamethoxazole 160 milligrams (mg)/800 mg) every 12 hours for seven days. Per the line list, R261 did not meet the McGeer's criteria (a set of guidelines for identifying infections in long-term care facilities) for infection. R261's culture result from the 1/5/24 urinalysis, dated 1/7/24, indicated there was >100,000 colony-forming units per milliliter (cfu/ml) of Pseudomonas aeruginosa bacteria R261's urine. According to a graph at the bottom of the culture result, Pseudomonas aeruginosa bacteria was resistant to Bactrim DS. R261's medical record did not indicate R261's physician was updated with the culture result. As a result, R261 completed the seven-day course (fourteen doses) of Bactrim DS without identification that the antibiotic was resistant to the bacteria. On 11/12/24 at 4:07 PM, Surveyor interviewed Infection Preventionist (IP)-F who indicated when a resident starts an antibiotic, IP-F ensures the charting is complete. If a resident meets McGeer's criteria, IP-F puts a progress note on a McGeer's criteria form and monitors the effectiveness of the antibiotic. IP-F indicated an antibiotic time-out is needed if a resident is on an antibiotic for a long time. IP-F indicated the the antibiotic is stopped, a culture is obtained, and if indicated, another antibiotic order is obtained. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 10:33 AM, Surveyor interviewed IP-F about R261's antibiotic use after the 1/5/24 UTI diagnosis and Bactrim order. IP-F reviewed R261's urine culture and verified the physician should have been notified. IP-F indicated the facility's policy indicates nurses should pass along lab updates in report. IP-F verified the process for coordinating antibiotic stewardship activities was to check IP-F's folder in the Director of Nursing's (DON's) office one to two times per week or check the facility's medical record system for antibiotics ordered.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48794 Based on staff interview and record review, the facility did not ensure the Infection Preventionist (IP) dedicated a minimum number of part-time hours to adequately manage the facility's infection prevention and control program. This had the ability to affect all 53 residents residing in the facility. Licensed Practical Nurse (LPN)-F was designated as the facility's IP. LPN-F also worked as a full-time floor nurse which resulted in LPN-F's inability to adequately maintain the facility's infection prevention and control program. Findings include: The facility's Infection Preventionist policy, dated 9/22/22, indicates: The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program .1. The facility will designate a qualified individual as Infection Preventionist (IP) whose role is to coordinate and be actively accountable for the facility's infection prevention and control program including the antibiotic stewardship program .6. The IP must be employed at least part-time. Designated IP hours per week may vary based on the facility and its resident population .7. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the infection prevention and control program for the facility, address training requirements, and participate in required committees .11. The responsibilities of the IP include but are not limited to: a. Develop and implement an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections b. Establish facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors. c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control. d. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program. e. Oversight of resident care activities (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, medication administration, etc.). g. Review/revise and approve infection prevention and control training topics and content and ensure staff are trained on the facility's infection prevention and control program. On 11/13/24, Surveyor reviewed the Facility Assessment, dated 8/7/24, which listed a position for Infection Preventionist and indicated the IP work at least part-time at the facility. There were no designated hours or number of hours noted. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/13/24 at 3:15 PM, Surveyor interviewed LPN-F who confirmed LPN-F was the facility's IP and had been for four years. LPN-F stated another nurse assisted with the line lists until September 2024, however, LPN-F was responsible for the infection prevention and control program. LPN-F stated LPN-F designated maybe 2 hours a week to infection prevention and control because LPN-F also worked as a floor nurse. LPN-F stated LPN-F did not feel that was enough time for the infection prevention and control program and indicated it should be a designated 40 hour per week position. Director of Nursing (DON)-B and Administrator in Training (AIT)-C were present during the interview with LPN-F. Neither DON-B or AIT-C disputed LPN-F's statement that LPN-F was only able to designate 2 hours per week as the IP or LPN-F's statement that it was not sufficient time to complete IP responsibilities. From 11/11/24 to 11/13/24, the survey team noted the facility did not have a thorough infection prevention and control program as evidenced by incomplete line lists, lack of symptom tracking, lack of follow through on vaccinations, and an incomplete antibiotic stewardship program. (See F880, F881, F883, and F887 for additional information.)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51043 Based on staff interview and record review, the facility did not ensure vaccinations were reviewed, offered, or administered for 2 residents (R) (R29 and R48) of 5 sampled residents. Staff did not offer R29 or R48 the PCV20 (Prevnar 20(R)) vaccine. Findings include: Abbreviations (www.cdc.gov): PCV13: 13-valent pneumococcal conjugate vaccine (Prevnar13(R)) PCV15: 15-valent pneumococcal conjugate vaccine (Vaxneuvance(R)) PCV20: 20-valent pneumococcal conjugate vaccine (Prevnar 20(R)) PPSV23: 23-valent pneumococcal polysaccharide vaccine (Pneumovax23(R)) The most recent Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccinations indicate: For adults [AGE] years or older who have only received PPSV23, the CDC recommends: Give 1 dose of PCV15 or PCV20. The PCV15 or PCV20 dose should be administered at least 1 year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For those who have received PCV13 and 1 dose of PPSV23, the CDC recommends you give 1 dose of PCV20 at least 5 years after the last pneumococcal vaccine. For adults [AGE] years or older who have received PCV13, give 1 dose of PCV20 or PPSV23 at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete. The CDC recommendation for adults [AGE] years or older who have no pneumococcal vaccinations is to give 1 dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccinations. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising conditions, cochlear implants, or cerebrospinal fluid leaks. The facility's Infection Prevention and Control Program policy, with a review date of 7/23/24, indicates: .7. Influenza and Pneumococcal Immunization: .b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere . The facility's Pneumococcal Vaccine (Series) policy, with a review date of 9/18/24, indicates: .The type of pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC guidelines and recommendations . (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at approximately 10:00 AM, Surveyor reviewed vaccines for 5 residents and noted R29 and R48's pneumococcal vaccines were not up to date. Surveyor noted R29 and R48's medical records did not contain declination forms for pneumococcal vaccines in 2024 or progress notes that indicated the risks and benefits of the vaccines were discussed. According to the CDC, R29 should be given one dose of PCV15, PCV20, or PCV21. If PCV20 or PCV21 were administered, R29's pneumococcal vaccination was complete. According to the CDC, R48 should be given one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23 which (according to R48's Wisconsin Immunization Record) was administered on 11/7/2000. On 11/13/24 at 10:33 AM, Surveyor interviewed Infection Preventionist (IP)-F who provided R29's pneumococcal, influenza, and COVID-19 declination forms from 8/22/23 (R29 was admitted to facility on 8/10/23). IP-F did not have a pneumococcal declination form for R48 (R48 was admitted to the facility on [DATE]). IP-F indicated the facility's Social Worker gets vaccine declination forms signed on admission. IP-F indicated IP-F did not have a system in place for pneumococcal vaccines and focused more on COVID-19 and influenza vaccines. IP-F indicated if IP-F is aware that a resident needs a pneumococcal vaccine, IP-F contacts the pharmacist to verify which pneumococcal vaccine the resident should receive and then asks the resident if they want the vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794 Based on staff interview and record review, the facility did not ensure 3 residents (R) (R8, R11, and R29) of 5 sampled residents were offered or received a COVID-19 vaccine. R8, R11, and R29's medical records did not indicate R8, R11, and R29 received, were offered, or declined the most recent COVID-19 vaccine. Findings include: The facility's COVID-19 Vaccination policy, dated 9/13/24, indicates: It is the policy of the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering residents and staff the COVID-19 vaccine .Up-to-date is defined as receiving a 2024-2025 updated COVID-19 vaccine (as per CDC) .11. The facility will educate and offer the COVID-19 vaccine to residents and staff and maintain documentation of such .14. Consent will be signed prior to administration of the COVID-19 vaccine. This information will be retained in the resident's medical record .16. Residents or resident representatives retain the right to accept, decline, or change their decision about COVID-19 immunization .17. The resident's medical record will include documentation of the following: a. Education to the resident or their representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine; b. Each dose of the vaccine administered to the resident, or; c. If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal. On 11/13/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE]. R8's medical record contained a declination form dated 4/7/20. R8's medical record did not indicate R8 received or declined the 2024-2025 COVID-19 vaccination. On 11/13/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE]. R11's medical record contained a declination form dated 4/23/21. R11's medical record did not indicate R11 received or declined the 2024-2025 COVID-19 vaccination. On 11/13/24, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE]. R29's medical record conained a declination form from August 2023. R29's medical record did not indicate R29 received or declined the 2024-2025 COVID-19 vaccination. On 11/13/24 at 10:33 AM, Surveyor interviewed Infection Preventionist (IP)-F who verified R8, R11 and R29's medical records did not contain documentation that indicated if R8, R11 or R29 were offered or refused the 2024-2025 COVID-19 vaccine.