STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525397	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Superior	1800 New York Ave Superior, WI 54880

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on interview and record review, the facility did not provide reasonable accommodation of resident needs and preferences for 1 of 16 sampled residents (R7). -R7 was not provided a wheelchair to allow her to get out of bed while residing in the facility. Findings include: The facility's policy titled, Resident Rights, reads in part .To ensure that all residents have a right to a dignified existence, self-determination and communication with and access to persons and services and outside of the facility. 3. The facility will provide care to the resident in a manner and environment that promotes the maintenance or enhancement of his/her quality of life. 5. Equal access to quality care will be provided to each resident regardless of diagnosis, severity of condition, or payment source. R7 was admitted to the facility on [DATE]. Diagnoses include left sided paralysis, stage 1 pressure ulcer to back, buttock and hip, bi-polar disorder, and anxiety. Minimum Data Set (MDS) assessment completed on 01/25/25 included the following: -R7 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. -R7 uses no mobility devices (cane, walker, wheelchair). -R7 is dependent on staff for assistance with ADLs. -MDS reported R7's transfers as: chair to bed transfer, not applicable (N/A), toilet transfer N/A, tub/shower transfer, dependent. R7's most recent PHQ-9 scores were: -06/13/24=0 (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/10/24=1 -01/10/25=2 R7's care plan included: -Potential/actual impairment to skin integrity r/t morbid obesity, frequent sweating, and yeast. At risk for injury due to fragile skin. Interventions: Encourage frequent repositioning, cushion to wheelchair. -ADL Self Care Performance Deficit. Performance deficit is related to impaired mobility. Interventions: 01/19/24, therapy to evaluate wheelchair positioning. On 03/11/25 at 9:30 AM, Surveyor interviewed R7. R7 reported she does not have a wheelchair. R7 states she got a new wheelchair after Christmas, but only used it one day as it did not fit. R7 reported she had to borrow another resident's wheelchair to attend her appointment on 03/10/24. R7 stated she lays in bed 24 hours a day. R7 reported she does not attend activities because she has no way to get there. R7 stated she used to play bingo and attend movie nights. R7 reported she is upset as St. Patrick's Day is coming up and she will not be able to attend the St. Patrick's Day activities, as she does not have a wheelchair. R7 stated she would attend activities if she had a wheelchair. R7 reported her mood is more depressed, since she just lays in her bed 24 hours/day. R7 reported no one has followed up with her about another wheelchair. On 03/11/25 at 9:36 AM, Surveyor interviewed Certified Nursing Assistant (CNA) I. CNA I reported she is aware R7 does not have a wheelchair and was not sure why. CNA I confirmed R7 [NAME] another resident's wheelchair when R7 has appointments, but otherwise R7 does not get out of bed. CNA I stated she feels R7 should have her own wheelchair, and that R7 would attend activities if she had a wheelchair. On 03/11/25 at 2:47 PM, Surveyor interviewed Rehabilitation Director (RD) J. RD J reported she is not sure why R7 does not have a wheelchair and reported R7 has had a few different wheelchairs. RD J reported the facility does have a chair that fits R7, and R7 shares this wheelchair with another resident. RD J stated, Since neither of them get up very often we felt it was a good trade off. RD J reported she was not aware R7 wanted her own wheelchair.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on interview and record review, the facility did not promote and facilitate resident self-determination through support of resident choice for 1 of 16 sampled residents (R10). R10 reported her dissatisfaction with male caregivers providing personal care assistance after the facility identified R10's preference for female caregivers only. Findings: The facility policy titled, Resident Rights, reads in part .To ensure that all residents have a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside of the facility. 1. The facility will protect and promote the right of each resident . 3. The facility will provide care to the resident in a manner and environment that promotes the maintenance or enhancement of his/her quality of life . 10. The facility will assist residents in exercising rights in regards to autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care . R10 was admitted to the facility on [DATE]. Diagnoses included depression, dementia, mood disturbance, and anxiety. R10's Minimum Data Set (MDS) assessment completed on 02/21/25 confirmed R10 scored 13/15 during Brief Interview for Mental Status (BIMS) indicating intact cognition. R10 is dependent on staff for transfers to the toilet and dressing lower body. R10 requires substantial assistance with bathing, showering, and personal hygiene. R10's care plan indicated the following: -I have challenging behaviors related to diagnoses of dementia. I prefer female caregivers. Date initiated 02/01/24, revision on 02/18/25. -Interventions: Cares in pairs and only female caregivers related to personal preferences and history of traumatic experiences with males. On 03/10/25 at 1:11 PM, Surveyor interviewed R10. R10 stated she is not to have a male caregiver. R10 has a history of rape. R10 stated the facility is aware of request to have no male caregivers and it is in her care plan. R10 reported last week a male caregiver gave her a shower and this morning a male caregiver provided assistance with morning cares. R10 stated she does not want this. Surveyor reviewed R10's care plan and noted on 05/08/24, the facility identified R10 requested female caregivers only. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed staff schedule for 03/10/25 and noted Certified Nursing Assistant (CNA) O, a male caregiver, provided R10 with cares on the morning of 03/10/25. Surveyor reviewed R10's shower schedule for previous four weeks but was unable to identify a male caregiver providing R10 with a shower. On 03/11/25 at 1:24 PM, Surveyor interviewed CNA Y. CNA Y reported she is aware R10 has requested to have female caregivers only. CNA Y stated this is printed on R10's Kardex and the CNAs are required to sign off they have read the Kardex each shift they work. On 03/11/25 at 1:30 PM, Surveyor interviewed CNA H. CNA H reported she was aware R10 prefers female caregivers only and stated R10, generally does not have male caregivers. CNA H reported she did not assist R10 with morning cares on 03/10/25. CNA H reported she assisted R10 with a shower on this date 03/11/25, but she was not aware who provided R10 with showers in the previous weeks. On 03/12/25 at 11:48 AM, Surveyor interviewed CNA O. CNA O reported there are two residents on the first floor who prefer female caregivers, (note R10 resides on the first floor). CNA O did not identify R10 as one of the residents who refers a female caregiver. CNA O identified two residents on the first floor who require cares in pairs. CNA O did not identify R10 as one of the residents who requires cares in pairs. CNA O verified he assisted R10 with personal cares on 03/10/25. CNA O stated he completed cares without any other caregivers present due to scheduling conflicts. CNA O denied providing R10 with a shower, stating it has been approximately one year since he assisted R10 with any showers. On 03/12/25, Director of Nursing (DON) B was present during interview with CNA O. Surveyor interviewed DON B. DON B reported R10 changes her mind and picks and chooses when she wants female/male caregivers or who she will accept assistance from. DON B did acknowledge R10's care plan indicated she does not want male caregivers doing personal cares.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, interview and record review, the facility did not develop and implement a comprehensive person-centered care plan addressing medical and nursing needs. This occurred for 1 of 16 residents reviewed (R25). -R25 did not have a care plan identifying interventions for controlling and preventing the spread of infection related to Extended Spectrum Beta Lactamase (ESBL) resistance. Findings: The facility's policy titled Comprehensive Care Plan, read in part . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. 6. The comprehensive care plan will include measurable objectives and timeframes to [NAME] the resident's needs and identified in the resident's comprehensive assessment. According to the Centers for Disease Control (CDC), multidrug-resistant organisms (MDROs) are bacteria that have developed resistance to one or more classes of antibiotics, making treatment more difficult. Extended-spectrum beta-lactamses (ESBL) resistance is a type of MDRO. R25 was admitted to the facility on [DATE]. Diagnoses include ESBL Resistance; ESBL is an enzyme found in some bacteria which is resistant to many antibiotics (a type of MDRO). R25's Minimum Data set (MDS) assessment completed 02/21/25, confirmed R25 scored 09/15 during Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. R25 had a foley catheter in place. R25's MDS assessment indicated R25 had septicemia and UTI (in the last 30 days). MDS assessment indicated R25 did not have an MDRO. MDRO was indicated on all previous assessments. R25's care plan included: -The resident has impaired immunity related to indwelling foley catheter. Date initiated 11/13/24, date revised 11/13/24. Interventions: Discontinue precautions when foley catheter is removed. Enhanced Barrier Precautions, use personal protective equipment during high contact with foley catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident has indwelling foley catheter related to urinary retention, history of urinary tract infections, and prostate enlargement. Date initiated 12/21/24, date revised 12/31/24. Interventions: Catheter care, monitor and document intake and output, monitor and document pain/discomfort, urology appointments as scheduled. R25's physician orders included: Sulfamethoxazole-Trimethoprim oral tablet 800-160, give one tablet two times daily for ESBL in urine and previous left percutaneous drain site for 28 days. Order date: 03/05/25, start date: 03/06/25, end date: 04/03/25. R25 was hospitalized from 02/12/25-02/17/25 for septicemia related to urinary tract infection (UTI). 02/13/25, urinalysis with culture and sensitivity was completed and indicated an abnormal result of ESBL. On 03/10/25 at 11:13 AM, Surveyor observed R25 had an indwelling foley catheter and was not placed on transmission-based precautions. On 03/11/25 at 9:50 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G. LPN G reported knowledge of R25's recent hospitalization and indwelling foley catheter. LPN G verified R25 had been on enhanced barrier precautions before his hospitalization . LPN G did not provide additional information related to R25's ESBL resistance. On 03/12/25 at 9:21 AM, Surveyor reviewed R25's record and noted primary provider documentation on 02/27/25, noted R25 was on Bactrim (an antibiotic) which was the only oral medication available for R25 to take for ESBL infection, per infectious disease. On 03/12/25 at 10:00 AM, Surveyor interviewed Director of Nursing (DON) B. DON B confirmed a care plan for an infectious disease such as ESBL resistance, would require a care plan with interventions to reduce the spread of infection. DON B reported she would, 'look into' R25's care plan. Surveyor did not receive additional information related to R25's care plan.

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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** 40181 Based on record review, observation and interview, the facility did not ensure a resident who required substantial assistance for repositioning and toileting received timely assistance for 1 of 4 residents (R) reviewed for Activities of Daily Living (ADLs) (R9). R9 who is frequently incontinent of urine did not receive assistance with repositioning or toileting for 4 1/2 hours. Findings include: R9 was admitted to the facility on [DATE] with the following diagnoses in part, chronic kidney disease, vascular dementia, unspecified urinary incontinence, leg pain, and osteoarthritis. R9's Minimum Data Set (MDS) assessment, dated 01/06/25, identified R9 was unable to complete a Brief Interview for Mental Status assessment due to severe cognitive impairment. The MDS assessment further identified R9 had no behaviors of rejection of cares and required substantial or maximal assistance for all mobility and toileting. The MDS assessment also indicated R9 was frequently incontinent of urine and always incontinent of bowel. The MDS assessment identified R9 was at risk for development of pressure injuries. R9's care plan had the following focus area: Alteration in elimination d/t [due to] bladder incontinent at times. Fluctuations/declines could be expected r/t [related to] end stage disease process. Date Initiated: 12/09/2021 Revision on: 10/17/2024 Goals: Resident's skin will be clean, dry and intact through the review date. Date Initiated: 12/09/2021 Revision on: 10/17/2024 Interventions: Assist of 1 with toileting q [every] 2-3 hrs and PRN [as needed]. Date Initiated: 04/11/2023 Revision on: 09/06/2023 Provide assistance with peri-cares AM, HS and PRN. Date Initiated: 12/09/2021 Revision on: 09/06/2023 Provide incontinent products and assist to change PRN. Date Initiated: 12/09/2021 Revision on: 09/06/2023 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 7:06 AM, Surveyor observed R9 sitting in a wheelchair at the table in the dining area on 3rd floor. At 9:24 AM, Surveyor observed R9 still sitting in the wheelchair at the table with eyes closed and an untouched food tray on the table. Licensed Practical Nurse (LPN) G came over and and attempted to get R9 to eat, but did not offer to reposition or assist R9 with toileting. At 9:47 AM, Surveyor observed Certified Nursing Assistant (CNA) D approach R9 at the table and asked how R9 was doing. R9 stated she was bored. CNA D brought the newspaper and a package of snacks for R9. CNA D took the breakfast tray away and got R9 some juice. CNA D did not assist R9 to reposition or offer to take R9 to the bathroom. At 10:06 AM, Surveyor observed R9 lean over and rest her head on the arm rest of the wheelchair and close her eyes. At 10:51 AM, Surveyor observed R9 still seated in the same position in the wheelchair at the dining room table. R9 had her head resting on her hand with eyes closed. At 11:35 AM, Surveyor observed CNA O take R9 to her room to check and change and assist to the toilet. This was a 4 1/2 hour continuous observation of R9 seated in one position without being assisted to go to the bathroom, or checked for incontinence. On 03/12/25 at 11:36 AM, Surveyor interviewed CNA D and asked how often they reposition, toilet or check and change R9. CNA stated usually they did that about every 2 hours, but R9 had been more incontinent lately, so they should do it more often than that if they could get to it. Surveyor asked if R9 had been repositioned or toileted since R9 was brought out to the dining room this morning. CNA D stated no she had not, but CNA O was going to do that now. Surveyor asked CNA D if it had been greater than 2 hours since R9 had been assisted to reposition, or checked for incontinence, or assisted to the bathroom. CNA D stated yes, it probably had been greater than 2 hours. On 03/12/25 at 12:12 PM, Surveyor interviewed Director of Nursing (DON) B and described the continuous observation of R9 sitting in wheelchair from 7:06 AM to 11:35 AM without being repositioned or assisted with toileting. Surveyor asked DON B if that was an acceptable practice. DON B stated they would be talking to staff. Surveyor asked DON B what their expectation for frequency of repositioning and toileting would be for R9. DON B stated they expect residents who cannot do that themselves should be repositioned and assisted with toileting or incontinent cares every 2-3 hours.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 16 residents (R) reviewed for quality of care (R58). R58 had a witnessed fall and was transferred from floor to bed by Certified Nursing Assistant (CNA) before a Registered Nurse assessed the resident for injuries. Findings include: R58 was admitted to the facility on [DATE] with the following diagnoses in part, unspecified dementia with psychotic disturbance, Alzheimer's disease, age-related physical debility, osteoporosis, unspecified visual disturbance, weakness, and abnormalities of gait and mobility. R58 had a fall risk assessment score of 20 on 02/20/25 which indicated R58 was high risk for falls. R58 had two recent falls resulting in a left humerus fracture and and a left femoral neck fracture. On 03/13/25 at 6:41 AM, Surveyor observed the ambulance team arrive on 3rd floor with a stretcher and Nursing Home Administrator (NHA) A directed them to R58's room. Surveyor asked NHA A what happened and NHA A said R58 fell again and hit her head and she was being transferred to the hospital for evaluation On 03/13/25 at 7:52 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K who was working at the time of R58's most recent fall. LPN K stated she was sitting at the nurses' station completing end of shift documentation when she heard a thump and then a female voice swearing down the hall. LPN K entered R58's room and CNA L was just coming to the door of the room and stated R58 fell . LPN K stated R58 was lying in bed and rubbing the back of her head when LPN K entered the room. R58 had the gait belt around her waist and gripper socks on. Surveyor asked LPN K if CNA L put R58 back in bed before a nurse completed an assessment on R58. LPN K stated R58 was lying in bed when LPN K entered the room, so CNA L must have put R58 in bed. On 03/13/25 at 8:46 AM, Surveyor interviewed DON B about R58's fall earlier that morning and asked if they interviewed CNA L about R58's fall. DON B stated they interviewed CNA L prior to sending her home. Surveyor asked DON B if CNA L transferred R58 back into bed before a Registered Nurse assessed R58 for injuries. DON B stated CNA L did transfer R58 to bed before calling for help. Surveyor asked if that was an acceptable practice, DON B stated no, the nurse should have assessed R58 before moving her. DON B stated they pulled CNA L from the floor and provided immediate education on the fall policy and procedure and the need to have a nurse assess residents before moving them after a fall.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41945 Based on observation, interview and record review, the facility failed to provide care consistent with standards of practice, to prevent pressure injuries (PI) for 1 of 5 residents (R) reviewed for pressure injuries (R36). -R36 was at risk for development of pressure injuries and was not repositioned to reduce pressure for greater than 4 hours. Findings include: According to the National Pressure Injury Advisory Panel (NPIAP) 2019, page 115, . Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. The underlying cause and formation of pressure injuries is multifaceted; however, by definition, pressure injuries cannot form without loading, or pressure, on tissue. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues and, ultimately, in tissue damage . According to Wound Care Education Institute (WCEI) 2018, for immobile or bed bound individuals, a full change in position should be conducted a minimum of every two hours. Some individuals require more frequent repositioning due to their high-risk status. R36 was admitted to the facility on [DATE] with the following diagnoses including vascular dementia severe without behaviors, Alzheimer's disease unspecified, essential hypertension, hemiplegia and hemiparesis, and major depressive disorder. R36's Minimum Data Assessment (MDS, dated [DATE] stated R36 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated facility could not determine BIMS for R36 due to R36 rarely/never understood. MDS indicated that R36 is totally dependent on staff for all cares. R36 at risk for skin breakdown with potential pressure injury. R36 MDS indicated that R36 had pressure relieving device in chair. Surveyor reviewed R36's care plan, which indicated: R36 has potential for pressure ulcer development r/t immobility and incontinence- -The resident will remain intact and free of irritation through review date. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. -Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated. Surveyor reviewed R36's nurse admission assessment dated on 12/20/23 that indicated no skin issues on admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R36's Braden skin assessments: -On 12/20/23 Braden scale score was 11.0 indicating R36 had a high risk for skin breakdown. -On 09/17/24 Braden scale score was 12.0 indicating R36 had a high risk for skin breakdown. -On 12/17/24 Braden scale score was 12.0 indicating R36 had a high risk for skin breakdown. Surveyor reviewed R36's skin observation tool assessments: -On 03/07/25 skin intact. On 03/12/25 at 6:41 AM, Surveyor observed R36 in dining room lying backwards at 30-degree angle in Broda chair sleeping. Surveyor did not observe a pressure relieving device in Broda chair, nor any further repositioning. On 03/12/25 at 8:27 AM, Surveyor observed Certified Nurse Assistant (CNA) S push R36's Broda chair up to 90 degrees to assist R36 with breakfast tray. Surveyor did not observe a pressure relieving device in Broda chair, nor any further repositioning. On 03/12/25 at 8:52 AM, Surveyor observed CNA S finish assisting with breakfast for R36. CNA S placed R36 back down in Broda chair to a 30-degree angle. Surveyor did not observe a pressure relieving device in Broda chair, nor any further repositioning. On 03/12/25 at 11:19 AM, Surveyor interviewed CNA S and asked what CNA S's knowledge on repositioning residents is. CNA S indicated that all residents should be repositioned every 2 hours or so. Surveyor indicated to CNA S that Surveyor only saw CNA S transfer R36 to bed, checked for incontinence, and then placed R36 back in Broda chair but no other repositioning or care was observed. CNA S indicated that CNA S thought the transfer to bed and back for checking incontinence was enough repositioning. Surveyor indicated to CNA S that R36 was still lying on R36's back and bottom the entire time. Surveyor observed R36 on back from 6:41 AM continuous to 11:19 AM, and R36 is at risk for skin breakdown. CNA S indicated that CNA S is sorry, and that CNA S should have repositioned R36 a couple times by now. On 03/12/25 at 11:31 AM, Surveyor interviewed Trained Medication Aide (TMA) V and asked what the expectation is for repositioning residents who need assistance with cares and are at risk for skin breakdown. TMA V indicated that all staff should reposition residents who are dependent on staff for cares every 2-3 hours. (continued on next page)

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Dove Healthcare - Superior	1800 New York Ave Superior, WI 54880

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 12:15 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is for repositioning residents who need assistance with cares and are at risk for skin breakdown. DON B indicated that all staff should reposition residents every 2-3 hours. Surveyor indicated to DON B that Surveyor observed R36 not repositioned for a continuous observation from 6:41 AM-11:19 AM. DON B indicated that CNA S should have repositioned R36 within 2-3 hours of being placed in Broda chair. Surveyor indicated to DON B that R36 is at a high risk for skin breakdown, and Surveyor did not see a pressure relieving cushion in R36's Broda chair even though R36's MDS indicates that R36 had a pressure relieving cushion implemented in Broda chair on admission and current MDS documentation. DON B indicated that DON B would investigate why R36 did not have a pressure relieving cushion in Broda chair and that CNA S should have placed one in R36's Broda chair.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51804 Based on observations, interviews and record review, the facility did not ensure residents with limited mobility received services to maintain or prevent further reduction in mobility for 1 of 1 resident (R) R23. R23's walking program was not developed to maintain or prevent reduction in mobility. Facility staff were not providing assist of 1 with front wheel walker and gait belt walking program. This is evidenced by: The facility policy, titled Restorative Nursing Program- Superior, dated April 2007 states: Maintenance Restorative Program Definition: This program is designed for those residents who through assessment require interventions with the goal to maintain present functioning. Due to the resident's physical or cognitive condition the assessment is that the resident will not progress and may be expected to decline. Example: The resident ambulates well but cognitively is unable to safely ambulate alone. If the Certified Nursing Assistant (CNA) or other nursing staff will be carrying out the interventions, the information will be included on the CNA assignment sheet . The CNA staff will document that the intervention was completed and any other details that will assist in evaluating the appropriateness of the intervention. Monthly progress notes will be completed . The facility policy, titled Restorative Charting Guidelines, dated April 2007 states: 2. Daily charting of interventions will be completed by the individual aide or nurses that performs the task with the resident. 3. Residents who are on [restorative] program will have progress charted by a licensed nurse at least monthly . R23 was admitted to the facility on [DATE] with the diagnoses that effect mobility and range of motion, in part, osteoporosis with current pathological (due to pre-existing condition) fracture, weakness, spondylosis lumbar spine (osteoarthritis lower back), cervicalgia (pain in upper neck), fracture of humerus (bone between elbow and shoulder), pain in right hip, and history of falls. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R23's Minimum Data Set (MDS) assessment, dated 12/2/24, scored R23's ability to transfer from chairs, bed, toilet as partial to moderate assist and R23's ability to roll side to side, go from lying to sitting, from sitting to standing scored as supervision touching assistance to partial assistance. A score of 4 or 3 with the reference ranges being 6 as independent and 1 being dependent. R23 has a wheelchair that R23 self-propels usually. R23's therapy discharge summary, dated 1/28/25, states: Functional Maintenance Program established? Ambulation Yes R23's care plan, updated 2/11/2025, states: Self Care deficit r/t weakness, impaired mobility, pain . Interventions include Ambulation: follow therapy recommendation Walking Program: Walk to/from all meals with assist of 1, using FWW (front wheeled walker) and gait belt. (Program was added with revision on 1/30/2025) On 3/10/2025 at 11:35 AM, Surveyor observed R23 self-propel wheelchair to dining room for lunch. On 3/11/2025 at 11:30 AM, Surveyor observed R23 self-propel to dining room to await lunch. On 3/12/2025 at 7:24 AM, Surveyor interviewed R23 who stated that she does not get a chance to walk very often. R23 does not know of any care planned intervention to walk to meals. Surveyor observed R23 self-propel to dining room for breakfast after interview. On 3/12/2025 at 1:48 PM, Surveyor interviewed CNA U. CNA U stated CNA U knows what to do with residents off their paper. CNA U clarified that it (the paper) was the Kardex (CNA care plan). CNA U stated another CNA who works up here walks with R23 when she is here. CNA U reviewed the Kardex with Surveyor. CNA U stated that to/from each meal means 3 times a day, but R23 calls the shots and walks when she wants. CNA U stated we chart our activities in the computer. CNA U stated there is no paper charting. CNA U stated that if the intervention doesn't happen or the resident refuses, they should document that too. On 3/12/2025 at 3:15PM, Surveyor reviewed records and did not find any progress notes, CNA charting, or documentation that walking program was implemented other than entry in care plan. On 3/13/25 at 7:48 AM, Surveyor observed R23 self-propel to dining room for breakfast. On 03/13/25 at 8:04 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated her expectations are that staff follow physical therapy orders. DON B stated staff would document walks or refusals in the chart. DON B was shown R23's Walking Program and asked for expectation. DON B stated R23 should walk three times a day. DON B stated there is no spot for charting (the walking program intervention) and did not find any monthly progress notes. DON B provided copies of the CNA Documentation Survey report for CNA charting that confirmed no charting. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 8:20 AM, Surveyor interviewed Rehabilitation Director (RD) J. RD J stated the expectation is that staff walk residents per plan and if they (residents) decline or refuse then it should be documented. RD J stated she expects that if there are a lot of refusals they (staff) should come to me (RD J) and say this is not working.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48793 Based on observation, interview and record review, the facility did not ensure the resident's environment remains as free of accident hazards as possible. The facility did not ensure staff followed transfer precautions and supervision when needed to prevent accidents which had the potential to affect 21 out 62 residents. -Surveyor observed Certified Nurse Assistant (CNA) U bathe R57 in bath house without a call system in place for emergencies during bath/shower cares. -R41 was at risk for falls. Facility did not implement new interventions put into place post falls. -Staff ambulated R41 without gait belt in place during ambulation transfer process. -R58 had a history of frequent falls with major injury and the facility failed to ensure adequate supervision and implementation of interventions to prevent further falls. Findings include: Example 1 Facility policy titled, Fall Prevention Program, dated reviewed on [DATE], states in part: .#6. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify the provider and resident representative. e. Review the resident's care plan and update as indicated. f. Document all assessments/observations and actions. g. Obtain witness statements in the case of injury. -Neruo checks will be completed of any unwitnessed fall or witnessed fall where a resident hits their head. -Initially, then EVERY (Q)15minutes x3, then, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Q4 hours x 2, then, -Q8 hours x 8, staff to alert provider of any abnormal findings from the neuro checks. #7. Review each fall/fall investigation during the next morning meeting/clinical meeting with the Interdisciplinary team (IDT). Actions may include: a. Review investigation and determination of potential root cause of fall. b. Review of fall risk care plan and updates. c. Additional revisions to the care plan. d. Education of staff to as any care plan revisions as needed. e. Scheduling care conferences. f. Verification of timely notification of provider and responsible party . Facility policy titled, Safe Resident Handling/Transfers, dated revised on [DATE], states in part, .#5. Handling aides may include gait belts, transfer boards, and other devices . R41 was admitted to the facility on [DATE], readmitted on [DATE], with following diagnoses, in part, Alzheimer's disease, atherosclerotic heart disease, essential primary hypertension, and depression. R41's minimum data set (MDS) assessment, completed on [DATE] confirmed R3 scored ,d+[DATE] during a brief interview for mental status (BIMS), indicating intact cognition. R3 was at risk for falls. R3 requires substantial maximal assistance from staff for toileting, sit to stand, transferring, dressing lower body, and putting on/taking off footwear. R41's Activities of Daily Living (ADL)s care plan states: -Transfer: Assist of 1 with gait belt, assure proper footwear is on before standing initiated on [DATE]. R41's fall care plan states: *Falls on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. -Resident will be safe and free from falls through the review date, initiated on [DATE]. -Keep room clean and free of clutter, initiated on [DATE]. -Keep call-light within reach, initiated on [DATE]. -Grabber or reacher provided to resident, initiated on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident to wear gripper socks at night, initiated on [DATE]. -Gripper strips to floor next to toilet, bed and couch, initiated on [DATE]. -Dycem to recliner, initiated on [DATE]. -Pharmacy medication review, initiated on [DATE]. -Pharmacist alerted for request for medication review. Care conference has been scheduled initiated on [DATE]. Surveyor reviewed nurse progress notes for R41's falls: -On [DATE], unwitnessed fall sent to ER. Facility did not implement any new fall interventions until [DATE]. -On [DATE], R41 had an unwitnessed fall. R41 to have neuros for fall follow up. Fall intervention: Dycem to recliner added to R41's care plan. Surveyor reviewed R41's Electronic Health Record (EHR) and did not find documentation of neuros completed for R41 after unwitnessed fall on [DATE] per the facility falls policy. -On [DATE], R41 had another fall. Care plan intervention added to add a chair in hallway at nurses' station to sit and rest while ambulating. Surveyor reviewed R41's EHR and did not find documentation of neuros completed for R41 after fall on [DATE]. -On [DATE], R41 had unwitnessed fall. Surveyor reviewed R41's EHR and did not find documentation of neuros completed for R41 after [DATE] fall per the facility fall policy. Surveyor did not find any significant interventions implemented for unwitnessed fall. -On [DATE], R41 had fall next to the nurse's station. New intervention was to place a chair at the nurse's station for R41 to help give R41 a rest if needed while ambulating. Surveyor did not observe a chair placed at nurses' station for R41 during 4 day observation of R41 ambulating on the unit. -On [DATE], R41 had a fall. Surveyor reviewed R41's EHR and did not find documentation of medication review as care planned after R41 suffered a fall on [DATE]. Surveyor did not find any other significant interventions implemented for R41's fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On [DATE], R41 had an unwitnessed fall, found on floor. Surveyor reviewed R41's EHR and did not find documentation of neuros completed for R41 after [DATE] fall per the facility policy. Surveyor did not find any significant interventions implemented for unwitnessed fall. -On [DATE], R41 had an unwitnessed fall, found on floor. -On [DATE], R41 had witnessed fall by wife. R41 fell out of recliner. On [DATE] 10:14 AM, Surveyor observed R41 sitting against wall in dining room. On [DATE] at 1:33 PM, Surveyor observed Trained Medication Aide (TMA) V and CNA R transfer R41 from dining room chair and ambulate with R41 down hallway to room. Surveyor observed R41 very unsteady on R41's feet and staff highly encouraged R41 to stand straight and take steps forward. Surveyor did not see TMA V and CNA R utilize a gait belt when ambulating R41. Surveyor observed staff holding onto R41's hands, and R41 kept trying to let go of staff's hands while walking down the hallway towards R41's room. Surveyor did not observe a chair at the nurse's station to provide R41 a rest with R41's unsteadiness. On [DATE] at 1:45 PM, Surveyor interviewed TMA V and asked if R41 should have gait belt on when ambulating to room from dining room. TMA V indicated that R41 should have gait belt on because R41 is sometimes unsteady with gait. On [DATE] at 8:33 AM, Surveyor observed CNA U, CNA T, and CNA R enter R41's room. Surveyor observed CNAs provide peri cares and get R41 up for the day. Surveyor observed CNA U and CNA R swing R41's legs over to the edge of bed and sit R41 up. CNA U and CNA R stood R41 up by grabbing hands and under arm pits to a standing position. CNA U and CNA R had R41 take a step forward and tried to get R41 to lift feet to place shoes on. R41 was confused and did not cooperate well. CNA U and CNA R had to sit R41 back down in the bed and then CNA U suggested to CNA R to apply gait belt. CNA R applied gait belt. Upon placing shoes onto R41, CNAs let go of R41 while R41 was leaning in bed, and R41 fell backwards and hit R41's head into the wall. CNAs quickly grabbed under arms and gait belt and lifted R41 forward to sitting position. CNA R rubbed back of R41's head and finished getting R41 up out of bed. CNA R and CNA U ambulated R41 out of room and down the hall. Surveyor did not observe a chair at the nurse's station to provide R41 a rest with R41's unsteadiness. On [DATE] at 9:42 AM, Surveyor interviewed CNA U and asked if R41 is supposed to have gait belt on when ambulating or transferring. CNA U indicated that CNA U should have told CNA R to apply gait belt before CNA U and CNA R stood R41 up the first time. On [DATE] at 1:20 PM, Surveyor interviewed CNA U and asked if CNA U had reported R41's fall and hitting head to appropriate staff on duty. CNA U indicated that CNA U reported the event to MDS Coordinator P who was on floor at the time. CNA U indicated that once MDS Coordinator P reported off the floor to RN Q, then CNA U reported to Registered Nurse (RN) Q that R41 had fallen and hit head on wall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:31 PM, Surveyor interviewed RN Q what time RN Q came on shift. RN Q indicated that RN Q arrived around 10:00 AM. Surveyor asked RN Q if RN Q was told in report any issues or concerns with R41. RN Q indicated that only issue that was reported was the staff member who had almost passed out. Surveyor asked RN Q if RN Q was aware that R41 fell backwards in bed and hit R41's head on the wall. RN Q indicated that RN Q did not know about the fall and needs to do something immediately. Surveyor asked RN Q what the facility policy is for resident falls. RN Q indicated that staff should report the fall to nursing. Nursing should have assessed R41, completed vitals, neuros, and notified provider right away. RN Q indicated that next steps would be to open a risk management incident and follow facility protocol. Surveyor asked RN Q if the proper measures have been completed for R41. RN Q indicated no none of this has been done as this is the first time RN Q was notified of the event. RN Q asked Surveyor to follow Surveyor upstairs to MDS Coordinator P's office on 3rd floor to ask MDS Coordinator P about the incident. On [DATE] at 1:45 PM, Surveyor interviewed MDS Coordinator P and asked if MDS Coordinator P was told in report any issues or concerns with R41. Surveyor asked MDS Coordinator P if MDS Coordinator P was aware that R41 fell backwards in bed and hit R41's head on the wall. MDS Coordinator P indicated that MDS Coordinator P did not know about the fall. Surveyor asked MDS Coordinator P what the facility policy is for resident falls. MDS Coordinator P indicated that staff should report the fall to nursing. MDS Coordinator P indicated staff should have assessed R41, completed vitals, neuros, and notified provider right away per the facility falls policy. On [DATE] at 2:33 PM, Surveyor interviewed Director of Nursing (DON) B and asked if DON B was notified of R41 falling this morning. DON B indicated that MDS Coordinator just left DON B's office and made DON B aware of the issue. DON B indicated the correct process that staff should have completed for R41 this morning would be immediately start a risk management incident and complete the work up that includes assessment of R41, vitals, neuros, contact provider and POA, and continue to follow up with frequent assessments through the day. Surveyor indicated to DON B that Surveyor could not find that any of the actions for R41 falling were completed. DON B indicated that staff would get on top of the incident right away and that it was not completed for R41. Surveyor indicated to DON B that Surveyor observed TMA V and CNA R transfer R41 from dining room to bedroom without gait belt. Surveyor observed CNA U and CNA R transfer R41 from bed to standing position and R41 took a step forward and was wobbling in place. Surveyor indicated to DON B that R41 was unsteady on R41's feet and CNA U asked R41 to lift each foot to place shoes on but R41 could not without swaying backwards and to the side. CNA U and CNA R then sat R41 down on the bed and applied gait belt. DON B indicated that staff should always use gait belt with R41 when R41 is standing and ambulating. On [DATE] at 9:23 AM, Surveyor observed CNA U and CNA R set R41 in R41's recliner. Surveyor did not observe R41 to have a Dycem pad in R41's recliner. Surveyor interviewed CNA U and CNA R and asked if R41 has a dycem pad in R41's recliner. CNA U and CNA R indicated there is no Dycem pad in R41's recliner and never has been. Surveyor had CNA U and CNA R check R41's closet. CNA U indicated there is no Dycem pad in R41's closet and has never seen one. Surveyor observed no grip strips in front of recliner in R41's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:23 AM, Surveyor observed CNA U and CNA R set R41 in R41's recliner. Surveyor did not observe R41 to have a Dycem pad in R41's recliner. Surveyor interviewed CNA U and CNA R and asked if R41 has a Dycem pad in R41's recliner. CNA U and CNA R indicated there is no Dycem pad in R41's recliner and never has been. Surveyor had CNA U and CNA R check R41's closet. CNA [NAME] indicated there is no Dycem pad in R41's closet and has never seen one. Surveyor observed no grip strips in front of recliner in R41's room. On [DATE] at 11:21 AM, Surveyor interviewed DON B and asked if any neuros were completed for R41's previous fall on [DATE]. DON B indicated that DON B does not see any neuros completed for R41 post fall for [DATE], [DATE], [DATE], nor for [DATE]. DON B indicated there were no new interventions put into place post falls for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. DON B indicated that DON B was unaware of the lack of interventions put into place post falls and would be educating staff on correct expectation. Surveyor indicated to DON B that after R41's fall on [DATE], staff care planned for R41 to have a chair in hallway at nurses' station for R41 to sit and rest while ambulating. Surveyor did not observe a chair at the nurses' station readily available for R41. DON B indicated that staff should have had a chair out at the nurses' station as R41's care plan states to have chair at nurses' station readily available for unsteadiness or exhaustion. Surveyor asked DON B what occurred with the intervention of a medication review post fall for R41 on [DATE]. DON B indicated that there was not a med review until [DATE] and should have been completed for R41 back in September when R41 fell . Example 2 Facility policy titled, Call light, dated, [DATE],states in part, .Policy Explanation and Compliance Guidelines: #7. The call system must be accessible to the resident at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. #8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied . (Examples include: replace Call light, provide a bell or whistle, increase frequency of rounding, etc) . Record review identified R57 was admitted to the facility on [DATE] with following diagnoses, in part, vascular dementia moderate with delusional behaviors, dysphagia, cerebral infarction due to embolism, and essential hypertension. On [DATE] at 7:22 AM, Surveyor observed CNA U look out of bath house and ask TMA V for assistance as R57 was falling forward out of the bath chair. TMA V indicated to CNA U that TMA V will send someone in as soon as TMA V sees someone walking by. Surveyor observed CNA U go back in bath house. On [DATE] at 7:26 AM, Surveyor entered bath house to observe CNA U with R57. Surveyor observed R57 sitting back in bath chair. CNA U indicated that CNA U assisted R57 back into bath chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 7:28 AM, CNA U asked Surveyor if Surveyor could wait in bath house while CNA U goes to get a brief CNA U forgot for R57 in R57's room. Surveyor indicated to CNA U that Surveyor cannot be left alone to supervise R57. Surveyor asked CNA U if this happens often where CNA U will leave R57 in bath house in bath chair. CNA U stated, Not usually, just thought since another person was here, I could grab it since i forgot it. Surveyor asked CNA U what CNA U would normally do. CNA U indicated that CNA U would normally call for assistance. Surveyor looked around for call light and could not find one. Surveyor asked CNA U where the call light was in the bath house. CNA U pointed to the wall near shower and stated, We use to have one in here, but maintenance took it out and placed this panel over the hole. Surveyor asked CNA U what if there is an emergency or like the situation that just occurred when CNA U needed assistance because R57 was falling forward out of the bath chair. CNA U stated, I would peek my head out the door or scream really loud for help. Surveyor asked CNA U if CNA U has any walkie talkies to ask for assistance. CNA U indicated that CNA U does not have walkies. Surveyor then observed CNA U pop head back out from the bath house and ask for assistance. Lack of a call light in the bath house has the potential to affect 21 residents on the second floor. On [DATE] at 7:35 AM, Surveyor observed CNA T enter bath house to assist CNA U with transfer of R57. CNA U and CNA T began pushing stand lift to R57 and instructed R57 to help stand. CNA U and CNA T grabbed underneath R57's arm pits and began lifting. Surveyor did not observe CNAs utilize a gait belt when lifting R57 from bath chair. Surveyor observed CNA U take a dry towel and wipe R57's groin and buttock area without wearing gloves. CNA U then dropped the dry towel as R57 was dropping to sit down. Surveyor observed CNA U don gloves and CNA U and CNA T began standing R57 again. CNA U then used dry towel again to dry off groin area and buttock area. Surveyor observed R57 drop again to sitting on bath chair. CNA U then instructed R57 to stand again while CNA U pulled brief and pants up for R57 with soiled gloves. Surveyor observed R57 was weak and difficult to stand. Surveyor observed R57 kept dropping down to sit instead of standing. CNA U and CNA T had to re-lift R57 under R57's arm pits 5 times before CNA U could pull R57's brief and pants up. On [DATE] at 7:51 AM, Surveyor interviewed CNA U and CNA T. Surveyor asked if CNA U and CNA T should use a gait belt with transfers from bath chair to stand lift as R57 kept dropping to sit down due to weakness. CNA U indicated that usually R57 is easy to stand but today R57 must be feeling weak. CNA U indicated to Surveyor that CNA U probably should have used gait belt instead of lifting under R57's arm pits. On [DATE] at 10:01 AM, Surveyor interviewed Maintenance Director W and asked if Maintenance Director W knew there was no call light in the bath house on second floor. Maintenance Director W indicated that Maintenance Director W was not aware and unsure time frame that the call light became inactive. Surveyor asked Maintenance Director W to visualize no call light in the bath house on second floor. Surveyor and Maintenance Director W entered bath house on second floor. Maintenance Director W observed no call light near the shower where all call lights are supposed to be located. Maintenance Director W observed further in the back of bath house where the bathtub was, and Maintenance Director W indicated there was no call light for that either. Maintenance Director W indicated it is necessary to have a call light in the bath house. Maintenance Director W indicated there must have been a work slip put in a while back and something went wrong that one of the Maintenance Technicians must have taken light out, capped the hole to prevent water from getting in there and then never came back to re-install a call light in bath house. Surveyor asked Maintenance Director W if Maintenance Director W could find when the work slip was placed and how long the call light system has been inoperable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:59 AM, Surveyor interviewed DON B and asked DON B if DON B had knowledge there was not a call light in the bath house on second floor down North wing. DON B indicated that DON B was unaware of a call light issue in the bath house on second floor, which could affect 21 residents on that floor. DON B indicated that all CNAs have walkie talkies that staff utilize if they do need assistance. Surveyor indicated to DON B that Surveyor interviewed CNAs, and CNAs noted they do not have walkie talkies on them. Surveyor asked DON B what DON B would consider to be appropriate for using to call for assistance when CNAs don't have the walkie talkie on them. DON B stated, I guess the CNAs will need to yell out for help. On [DATE] at 8:45 AM, Maintenance Director W approached Surveyor and indicated that Maintenance Director W could not find the work slip that bath house on 2nd floor call light had issues and wasn't working. Maintenance Director W indicated to Surveyor that sometimes staff let maintenance crew know verbally about issues and Maintenance Director W knows that call light has been in failure for at least the last month. 40181 Example 3 R58 was admitted to the facility on [DATE] with the following diagnoses in part, unspecified dementia with psychotic disturbance, Alzheimer's disease, age-related physical debility, osteoporosis, unspecified visual disturbance, weakness, and abnormalities of gait and mobility. R58's Minimum Data Set (MDS) assessment, dated [DATE], identified R58 had a Brief Interview for Mental Status score of 03 out of 15, which indicated R58 had severe cognitive impairment. The MDS identified R58 had disorganized thinking behaviors that fluctuated and varied in severity. R58 also had hallucinations and delusions present during the MDS assessment period. R58 had a fall risk assessment score of 20 on [DATE] which indicated R58 was high risk for falls. R58 had two recent falls resulting in a left humerus fracture and a left femoral neck fracture. R58 had the following care plan focus in place: At risk for falls r/t [related to] history of repeated falls r/t Confusion, Deconditioning, Gait/balance problems, Unaware of safety needs. She is non compliant with wearing her knee brace and her sling. Has order brace and for knee brace and arm sling. She does not use assistive device as recommended for ambulation. She lowers herself to her knees to go in her drawers or look for something and gets herself up and also to clean up spills or just wipe up on the floor. She attempts to rearrange furniture. [DATE]- Fall [DATE]- Fall [DATE]- [R58] was witness to lose her balance and regain her balance when she stumbled. She did not fall but she did report this as a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE]- Fall [DATE]- Fall [DATE]- Fall [DATE]-Fall Date imitated [DATE] Goal: [R58] will be free of falls through the review date and not sustain serious injury through the review date. Date Initiated: [DATE] Revision on: [DATE] Interventions: [DATE]- Being sent out to ER. Date Initiated: [DATE] [DATE]- [NAME] has been removed from my room for safety. Date Initiated: [DATE] [DATE]- encourage wearing tennis shoes when up in my wheelchair. Date Initiated: [DATE] [DATE]- Soft touch call light in place. Date Initiated: [DATE] [DATE]- Resident was moved to a different room once returned back from ER. Date Initiated: [DATE] [DATE]- Resident placed on direct 1:1. Update-[DATE]- Direct 1:1 supervision-Staff to stay with her at all times. Stay at arm's length of her. Arrange for 1:1 replacement to be with [R58] at all times before leaving her. Date Initiated: [DATE] Revision on: [DATE] [DATE]. Encourage [R58] to be in the social areas at all times when not in bed. Date Initiated: [DATE] [DATE]- Grippy socks to be worn when out of bed. Date Initiated: [DATE] Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated: [DATE] Revision on: [DATE] Encourage to transfer/change positions slowly. Date Initiated: [DATE] Revision on: [DATE] Ensure that the resident is wearing appropriate non-skid footwear when ambulating or mobilizing in w/c. Date Initiated: [DATE] Revision on: [DATE] Pt evaluate and treat as ordered or PRN. Date Initiated: [DATE] Recreation Dept. provided [R58] with a laundry/cleaning cart to fold linens and dust to help keep her busy. Supervise her with this activity. Date Initiated: [DATE] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Remind, Educate, assist [R58] to wear her knee brace and sling as ordered. Date Initiated: [DATE] Revision on: [DATE] S/P Fall [DATE] Intervention Toilet [R58] every ,d+[DATE] hours and as needed. Date Initiated: [DATE] Revision on: [DATE] R58's Activities of Daily Living self-care performance deficit care plan had the following intervention in place, . TRANSFER: Stand pivot transfer with assist of 1, using gait belt. Date initiated: [DATE] Revision on: [DATE] . R58 had the following treatment orders in place, dated [DATE], Direct 1:1 supervision-Staff to stay with her at all times. Stay at arm's length of her. Assigned 1:1 staff member needs to Arrange for 1:1 replacement to be with [R58] at all times before leaving her. On [DATE] at 6:41 AM, Surveyor observed the ambulance team arrive on 3rd floor with a stretcher and Nursing Home Administrator (NHA) A directed them to R58's room. Surveyor asked NHA A what happened and NHA A said R58 fell again and hit her head and she was being transferred to the hospital for evaluation. On [DATE] at 7:52 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K, who was working at the time of R58's most recent fall. LPN K stated she was sitting at the nurses' station completing end of shift documentation when she heard a thump and then a female voice swearing down the hall. LPN K had just sent the Certified Nursing Assistant (CNA) downstairs to take out trash, so she was the only one on the floor other than the 1:1 CNA in R58's room. LPN K got up and checked all the rooms on the hall where the sound came from, but didn't go into R58's room first because CNA L was in that room providing 1:1 care. When LPN K did not find any problems in the other rooms, she entered R58's room and CNA L was just coming to the door of the room and stated R58 fell . LPN K stated R58 was lying in bed and rubbing the back of her head when LPN K entered the room. R58 had the gait belt around her waist and gripper socks on. LPN K immediately assessed and felt a lump at the back of R58's head, but no bleeding or break in skin observed. LPN K did neuro checks and vital signs and assessed for any other injuries, but did not find any other injuries. They applied an ice pack to the back of R58's head, called Director of Nursing (DON) B, notified the provider and got orders to transport R58 to the hospital for evaluation. LPN K asked CNA L what happened and CNA L stated she was assisting R58 with a transfer while holding the wheelchair and instructing R58 to turn and sit in the chair. R58 turned and sat on the very edge of the bed instead and slid off and landed on the floor, hitting her head on the side rail. Surveyor asked if CNA L was holding the gait belt to assist with the transfer. LPN K was not sure, but said it sounded like CNA L was not holding the gait belt, but behind the wheelchair. Surveyor asked if R58 was safe to transfer with just one staff person. LPN K stated R58 was assessed as a one-person transfer with a gait belt. Surveyor asked what that meant. LPN K stated staff should hold onto the gait belt during the transfer. Surveyor asked if CNA L put R58 back in bed before a nurse completed an assessment on R58. LPN K stated R58 was lying in bed when LPN K entered the room, so CNA L must have put R58 in bed. On [DATE] at 8:32 AM, Surveyor interviewed Physical Therapy Assistant (PTA) M who stated she worked with R58 and was familiar with R58's safety issues and therapy-approved transfer status. PTA M stated R58 was safe with a one-person transfer using a gait belt. Surveyor asked what that meant. PTA M stated staff should have the gait belt securely around the resident's torso and should be holding the gait belt and supporting and guiding the resident to pivot when doing a transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:46 AM, Surveyor interviewed DON B about R58's fall earlier that morning and asked if they interviewed CNA L about R58's fall. DON B stated they interviewed CNA L prior to sending her home. CNA L reported R58 was seated in the wheelchair folding laundry while CNA L carried bags of soiled laundry and trash to the doorway of the room for end of shift. CNA L turned and observed R58 stand from the wheelchair and before CNA L could get to R58, R58 turned and sat at the very edge of the bed. R58 then slid off to the floor and hit her head on the bed. CNA L got LPN K who assessed R58. Surveyor asked DON B if CNA L followed the care plan to stay within arms length of R58. DON B stated CNA L stated she had carried bags to the door when R58 stood and fell . Surveyor asked if CNA L transferred R58 back into bed before a Registered Nurse assessed R58 for injuries. DON B stated CNA L did transfer R58 to bed before calling for help. Surveyor asked if that was an acceptable practice, DON B stated no, the nurse should have assessed R58 before moving her. DON B stated they pulled CNA L from the floor and provided immediate education on the fall policy and procedure and the need to have nurse assess residents before moving them after a fall.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52382 Based on observation, interview and record review, the facility did not ensure residents with indwelling foley catheters received care and treatment consistent with professional standards of practice to prevent complications or urinary tract infections (UTI) from the catheter for 1 of 1 resident (R) R25 reviewed for catheter. -Urology recommended foley be removed when R25's strength increased; facility removed foley the following day. -No monitoring after removal of foley catheter. Findings include: The facility policy titled, Indwelling Catheter Use & Removal, reads in part .It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice .Monitoring for excessive post void residual, after removing a catheter that was inserted for obstruction or overflow incontinence .Verify practitioner's order . Assess for first voiding post-catheter removal .Document procedure . R25 was admitted on [DATE]. Diagnoses include: Bacteria in urine, abscess in urinary tract, urinary tract infection, bladder infection with blood present in urine, obstruction and backflow of urine, acute kidney failure, sepsis, and severe sepsis with septic shock Minimum Data Set (MDS), completed on 02/21/2025, confirmed R25 scored 9/15 during Brief interview for Mental Status (BIMS), indicating moderately impaired cognition. R25's care plan included the following: Focus: The resident has impaired immunity related to (r/t): Indwelling foley catheter. Goal: The resident will not display any complications related to potential for immune deficiency r/t presence of foley catheter. Interventions: Discontinue precautions when foley catheter is removed Enhanced barrier precautions: Use Personal Protective Equipment (PPE) during high contact resident's foley catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintain PPE equipment per center Staff may dispose of my trash in regular containers or as visibly soiled Record review shows resident was recently hospitalized with a urinary tract infection (UTI) and Sepsis on 02/12/2025 and returned to facility on 02/17/2025 with active infection treatment. Urology order from 02/26/2025 read in part: Plan: Can remove foley when he gets his strength back. Upon record review, primary provider for R25 notes on 02/27/25 reported misinterpretation of orders the previous day. Foley catheter was removed, and no monitoring was completed. Primary provider attempted use of bladder scanner to check post-void residual volume (PVR) and scanner was not working. Catheterization for residual performed resulting in 850ml of urine return. Foley catheter was replaced. Upon record review, primary provider notes on 03/03/25 included: Creatinine increased from 0.7mg/dL to > 1.75mg/dL after misinterpretation of urology order and catheter removal, which could indicate increased kidney damage. Normal range for creatinine is 0.7mg/dL-1.27mg/dL. Follow up complete metabolic panel (CMP)s collected on 02/28/2025 with a result on 1.63mg/dL and 03/06/2025 with a result of 1.23mg/dL which indicate improvement since catheter was replaced. On 03/11/25 at 9:50 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G. LPN G reported R25 received orders on 02/26 for Foley removal and trial void. LPN G also reported facility had a bladder scanner available at that time and that they usually perform Post-Void Residuals (PVR)s x3. On 03/11/25 at 10:50 AM, Surveyor reviewed order in R25's chart. The ordered showed Director of Nursing (DON) B entered orders to remove foley on 2/26. Surveyor interviewed DON B. DON B stated the original orders were not clear, and the orders had stated the catheter could be removed when R25 gets up. Surveyor could not locate the foley catheter removal order in R25's chart. DON supplied order which stated the catheter could be removed once resident gets his strength back. From 03/11/2025 through 03/13/2025 Surveyor requested to observe emptying of R25's catheter three times and staff completed without Surveyor present. The facility did not review and clarify orders to remove R25's Foley catheter, and did not complete appropriate monitoring after catheter removal.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observations, record review and staff interviews, the facility did not ensure 1 of 1 resident (R) reviewed who required oxygen and respiratory care was provided such services consistent with professional standards of practice, the resident's comprehensive person-centered care plan, and physician orders (R2). -On 03/11/25, Certified Nurse Assistant (CNA) S did not connect portable oxygen tank to R2 when CNA S placed R2 in dining room for breakfast. -Facility did not attempt a weaning schedule R2 off of oxygen as able. Findings include: Facility policy titled, Oxygen Administration Policy, dated reviewed on December 2024 states in part: .Policy Explanation and Compliance Guidelines: #1. Oxygen is administered under orders of a physician, except in the case of an emergency. #3. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. #4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: b. When to administer, such as continuous or intermittent and/or when to discontinue. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered . R2's original admission to the facility was on 01/26/24, with the following diagnoses including quadriplegia unspecified, unspecified intracranial injury, emphysema. R2 was hospitalized and readmitted on [DATE] with influenza and acute respiratory failure with needed oxygen therapy. R2's minimum data set (MDS) assessment, completed on 02/27/25 confirmed R3 scored 8/15 during a brief interview for mental status (BIMS), indicating moderately impaired cognition. R2 requires substantial maximal assistance from staff for toileting, eating, sit to stand, transferring, dressing lower body, and putting on/taking off footwear. R2, once readmitted on [DATE], needed oxygen use. Surveyor reviewed R2's care plan. Surveyor did not find a respiratory care plan to address R2's oxygen uses in place. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R2's discharge orders from 03/05/25, which indicated: R2 discharged from hospital for acute respiratory failure with hypoxia and orders are- Oxygen (O2) 2 Liters (L), keep O2 sats greater than 90% and check sats every day. Continue to wean oxygen as able and goal is for O2 sat to be greater than 90%. Surveyor reviewed R2's physician orders: -On 03/05/25, Oxygen tube suctioning oral, and frequency as needed -On 03/05/25, O2 at 2 LPM per NC via concentrator or tank to keep O2 sats greater than 90%. Contact MD (Medical Doctor) if oxygen is initiated due to low O2. -On 03/05/25, Oxygen at 2LPM (Liters Per Minute) via nasal cannula via O2 concentrator and/or tank every shift for oxygen Keep Sats greater than 90%. -On 03/06/25, Check oxygen Sats daily one time a day. -On 03/07/25, Check o2 Saturation on Room Air weekly in the evening every Friday. -On 03/07/25, Complete skilled assessment documentation including respiratory assessment, O2 use, nebulizer treatment every shift. Surveyor reviewed R2's nurse progress notes: On 03/08/25, respiratory assessment completed. Surveyor did not find a respiratory assessment completed when R2 was admitted with oxygen. Surveyor did not find a respiratory assessment completed on 03/06/25 and 03/07/25 as physician orders specify. Surveyor did not find documentation in R2's Electronic Health Record (EHR) regarding respiratory assessment of oxygen weaning as physician discharge orders specified from hospital visit. On 03/12/25 at 7:25 AM, Surveyor observed CNA S wheeling R2 up to nurses' station and to the oxygen room. Surveyor observed CNA S in oxygen room fiddling around with tanks and then wheeled R2 to the dining room and parked R2. Surveyor did not observe CNA S apply oxygen tubing to R2's nose. Surveyor observed oxygen tubing disconnected on back of R2's wheelchair. On 03/12/25 at 7:32 AM, Surveyor approached CNA S and asked CNA S if R2 is supposed to be on continuous oxygen or is it as needed. CNA S stated, Oh she is supposed to be on continuous oxygen but she takes the tubing off. Surveyor indicated to CNA S that Surveyor observed CNA S exit the oxygen room when getting a new tank for R2. Surveyor did not see R2's oxygen tubing on R2's face. CNA S indicated that CNA S must have forgot to place the tubing on R2. Surveyor observed CNA S walking away from dining room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 7:34 AM, Surveyor asked Trained Medication Assistant (TMA) V to please check R2's oxygen stats. TMA V grabbed pulse oximeter and placed it on R2's finger. TMA V indicated that oxygen was at 96% on 2 Liters (L). TMA V indicated no further action needed at this time. On 03/12/25 at 9:30 AM, Surveyor observed TMA V assess R2's oxygen saturation with oximeter. TMA V indicated the result was 96% on 2 Liters. Surveyor observed CNA S say, Can you double check the tank and make sure oxygen is coming out? TMA V checked back of R2's wheelchair, unzipped oxygen tank bag and stated, Oh no the tank is empty; it's all the way in the red. We need to get that fixed now. Luckily, she was at 96% still. Surveyor observed TMA V wheel R2 over to the oxygen room and grab a full oxygen tank. TMA V placed oxygen tank on wheelchair in the oxygen bag and zipped it back up. On 03/12/25 at 9:42 AM, Surveyor interviewed TMA V and asked who is responsible for checking portable oxygen tanks. TMA V indicated that everyone is responsible for checking portable oxygen tanks. TMA V indicated that TMA V would have never known to check portable oxygen tank since TMA V was just grabbing a pulse oximeter reading until CNA S asked TMA V to check the oxygen tank for R2. TMA V indicated that TMA V is unsure of the reasoning. On 03/12/25 at 9:47 AM, Surveyor interviewed CNA S and asked who is responsible for checking portable oxygen tanks. CNA S indicated that everyone is responsible for checking portable oxygen tanks. Surveyor asked CNA S why CNA S thought to ask TMA V to check R2's portable oxygen tank. CNA S indicated that CNA S checks oxygen tanks every 2-3 hours just to check them. Surveyor asked CNA S if CNA S knew R2's oxygen tank was empty and scroll was in the red, and that TMA V had to change the whole tank. CNA S stated, That is weird because I changed it this morning in the oxygen room. Surveyor indicated to CNA S that Surveyor observed CNA S go into oxygen room with door open but did not see a complete oxygen tank change. CNA S indicated that CNA S did change the oxygen tank. Surveyor asked CNA S if facility keeps a sign out sheet or form for when a portable oxygen tank is filled. CNA S indicated there is a sign out sheet, but CNA S did not sign it out. CNA S showed Surveyor the empty space where portable tank should have been signed out and CNA S stated, I will sign it now and sign the one [TMA V] filled. Surveyor reviewed Oxygen Cylinder Log form, which stated in part, Last filled signature was March 10th, 2025. Surveyor then observed CNA S sign out the filled oxygen tank. On 03/12/25 at 10:02 AM, TMA V approached Surveyor and indicated that R2's provider is in facility and TMA V made provider aware of the oxygen tank being empty. TMA V indicated that provider questioned TMA V on why R2 was even on oxygen as hospital discharge orders indicated that R2 did not qualify for needed oxygen. Provider indicated to TMA V that provider would be discontinuing oxygen orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 12:21 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is for staff checking portable oxygen tanks. DON B indicated expectation is for CNAs to check portable oxygen tanks and refill as needed every two hours. Surveyor indicated to DON B that Surveyor observed CNA S in oxygen room fiddling around with tanks and then wheeled R2 to the dining room and parked R2. Surveyor did not observe CNA S apply oxygen tubing to R2. Surveyor interviewed CNA S who indicated that CNA S must have forgotten to hook R2 up to the oxygen tubing. DON B indicated that CNA S should have hooked R2 to oxygen immediately after filling the tank. Surveyor indicated to DON B that Surveyor observed R2's oxygen tank empty around 9:30 AM, and TMA V had to refill oxygen tank. Surveyor asked DON B how DON B keeps track of when portable tanks are re-filled and how long a portable tank lasts when R2 is on 2L of oxygen. DON B indicated that DON B is unsure how long a portable tank lasts when R2 is on 2L of oxygen. DON B indicated that DON B would try to find the information for Surveyor. Surveyor reviewed R2's physician orders and indicated to DON B that R2 is supposed to be weaned off oxygen and asked DON B how does staff know when to wean R2 off oxygen as discharge from hospital orders specify. DON B indicated that facility does not have a set procedure for weaning residents off oxygen and that DON B would investigate weaning of oxygen.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40181 Based on observation, interview and record review, the facility did not ensure that sufficient nursing staff was provided for the third floor to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (R). This has the potential to affect all 14 residents residing on the third floor. Residents on the third floor have had multiple falls with injuries. A resident (R19) had an unwitnessed fall and no staff responded to calls for help until Surveyor intervened. R9 who is frequently incontinent of urine did not receive assistance with repositioning or toileting for 4 1/2 hours. Findings include: Facility Assessment, dated 02/03/25, stated in part: .Information About Our Staffing Patterns section stated Average Nurse Aide/Resident Ratio (Direct Care Staff) Average about 1 Nurse Aide to 10 Residents . Surveyor reviewed the daily staffing postings and nursing schedules for the past month. The schedule showed one nurse and one Certified Nursing Assistant (CNA) scheduled for 3rd floor, with one additional CNA who was scheduled for 1:1 care of one resident. That CNA was not available to answer call lights and provide direct care to any other residents on the unit. The daily census on third floor during the survey was 14 residents. During the day and evening shifts on 03/10/25, and on the morning of 03/11/25, Surveyor observed one nurse and one CNA providing direct care on the third floor for 14 residents. On the morning of 03/11/25, Surveyor observed one Licensed Practical Nurse (LPN) and one CNA working on the third floor. At 9:44 AM, Surveyor heard a loud noise from one of the rooms toward the end of the hall farthest from the nursing station. A couple of minutes later, Surveyor heard a resident calling for help from room [ROOM NUMBER]. CNA D was in another resident room and did not hear or respond to the call for help. LPN C was passing medications to a resident on a different hall and did not hear or respond to the call for help. After two minutes, Surveyor walked down to room [ROOM NUMBER] and observed R19 lying on the floor by the bathroom. Surveyor alerted LPN C that R19 had fallen and was calling for help. LPN C finished giving medications to a resident and then went to the room and found R19 on the floor by the bathroom. LPN C yelled for help from the doorway, but CNA D did not hear or respond to the call for help. After a few minutes, Surveyor observed Registered Nurse (RN) X walking down a different hall and headed for the elevator. Surveyor informed RN X a resident had fallen and LPN C needed assistance. RN X responded to the room to assist. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/11/25 at 10:22 AM, Surveyor interviewed LPN C who stated R19 was supposed to be up with assistance, but R19 frequently forgot to call for help. LPN C stated with just one CNA and one nurse working on the unit, it was hard to hear R19 when she got up independently. LPN C stated R19 did get a small skin tear on one arm from the fall this AM. Surveyor interviewed LPN C about staffing patterns on the third floor. LPN C stated when she works the third floor they consistently have one nurse and one CNA working on the unit for both day and PM shifts. LPN C stated there are typically about 14 to 15 residents on the unit. LPN C stated they have a staff person scheduled to provide 1:1 care for R58, but that person cannot leave R58's room to help answer call lights or help with cares for residents. LPN C stated they just called in another CNA to help assist with resident cares on the floor after R19 fell , but it probably only happened because the Surveyors were in the building. LPN C stated in her experience they never call extra help up to the third floor. LPN C stated there have been a lot of resident falls on the third floor and they need two CNAs on the unit all the time to try to prevent the falls. On 03/11/25 at 10:53 AM, Surveyor interviewed CNA D who stated they usually worked on the third floor. CNA D stated they usually scheduled just one nurse and one CNA working on the unit for about 15 residents. CNA D stated they had a really busy morning, and it was good that they called in extra help. CNA D stated they try to call in help extra help sometimes, but it was rare that someone agreed to come in. CNA D said it would be better for the residents if they had two CNAs scheduled for the third floor. On 03/11/25 at 10:56 AM, R3 requested to speak to Surveyor in her room. R3 stated she was the resident council president and she had brought up staffing concerns at their meetings in the past, but nothing was ever done about it. They usually have one nurse and one CNA working on the floor for 14-15 residents. R3 stated she is fairly independent, and does not need a lot of physical assistance from the staff, but R3 believes the residents who are more dependent don't get the care they deserve because there is not enough help. R3 stated she had observed multiple residents, who are dependent and can't speak for themselves, left in their chairs at the dining room for many hours, sometimes from before breakfast until after lunch. R3 stated that many of the falls that have occurred are due to not enough staff to assist the residents to the bathroom or with transfers. On 03/12/25 at 8:21 AM, Surveyor observed R19, who had fallen the day before, get up and begin walking with a 4-wheeled walker toward the bathroom. R19 did not press the call light or call for help. R19 appeared unsteady on her feet and there was no staff around to observe or assist R19. Surveyor alerted CNA E who at at the other end of the hall providing 1:1 care for R58. CNA E was able to locate CNA D, who came down the hall to assist R19 to the bathroom. On 03/12/25 from 7:06 AM to 11:35, AM, Surveyor had a continuous observation of R9 seated in one position without being assisted to go to the bathroom, or checked for incontinence. Record review identified R9 had severe cognitive impairment, required substantial or maximal assistance for all mobility and toileting, and was frequently incontinent of urine and always incontinent of bowel. R9 was also assessed at risk for development of pressure injuries. R9 had care plan interventions instructing staff to assist with toileting every 2-3 hours and as needed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/25 at 7:14 AM, Surveyor interviewed LPN G who was an agency staff member working at the facility since November. LPN G stated she frequently worked on the third floor. LPN G said there is usually one CNA and one nurse scheduled for the third floor when LPN G worked on there. LPN G stated there were usually around 15 residents on the unit and a lot of them have a history of frequent falls. LPN G stated they could use more help on the third floor to try to prevent some of the falls. On 03/12/25 at 7:29 AM, Surveyor interviewed CNA E who was working on the third floor. CNA E stated she usually works on first floor, but was called in extra today and asked to float to the 3rd floor. CNA E she had been assigned to work on the third floor for the first time on 02/14/25 when R58 had a fall. CNA E stated she was the only CNA working the floor and there was another CNA doing 1:1 care with R58. CNA E stated when the other CNA left the unit for a break, the nurse told CNA E to cover the 1:1 care for R58. CNA E was not told she could not leave the room when doing 1:1 care for R58 and the nurse was not answering lights and covering the floor while CNA E was in R58's room. CNA E left to answer call lights on the unit and that is when R58 fell . CNA E stated one nurse and one CNA scheduled for third floor was not enough to safely meet the residents' needs and that is why there were so many falls on that unit. On 03/12/25 at 12:12 PM, Surveyor interviewed Director of Nursing (DON) B about R19's fall on 03/11/25 and explained continuous observation of R9 not repositioned or assisted to the bathroom for 4 1/2 hours. Surveyor also informed DON B of interviews from staff and residents reporting inadequate staffing on the third floor resulting in delayed cares and falls. Surveyor asked DON B if they had considered if some of the resident falls were related to inadequate staffing levels on the third floor. DON B stated they would review staffing levels.

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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** 51804 Based on observation, interview and record review, the facility did not provide pharmaceutical services, including procedures that ensured the accurate acquiring, dispensing, administering, storage, and disposal of all drugs and biologicals. The facility did not ensure controlled medications were disposed of timely and per appropriate standard of practice or agency policy for 1 out of 1 resident (R) 60. Findings include: The Statute DHS 132.65 Pharmaceutical Services refers to the handling of medication in Wisconsin facilities, including hospitals and nursing homes. It states in part, .(c) Destruction of medications. 1. 'Time limit.' Unless otherwise ordered by a physician, a resident's medication not returned to the pharmacy for credit shall be destroyed within 72 hours of a physician's order discontinuing its use, the resident's discharge, the resident's death or passage of its expiration date. The facility policy titled Medication Destruction, dated [DATE], states in part, All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations: 2. Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed. 5. Our facility utilizes a waste disposal service or reverse distributor to destroy dangerous drugs and controlled substances. 6. An inventory of dangerous drugs and controlled substances destroyed will be verified by consultant pharmacist. This information shall be recorded on our Destruction of Controlled Substances Record. 7. The sealed container must be maintained in a secure area in the pharmacy or in a locked cabinet in the medication room until transferred to the waste disposal service or the reverse distributor by the consultant pharmacist, an agent of the state board of pharmacy, the facility administrator or the director of nursing services. On [DATE] at 9:19 AM, Surveyor observed Director of Nursing (DON) B and a second Registered Nurse reconcile narcotics. During observation Surveyor observed a Ziploc bag with an RX label on the outside and numerous unlabeled fluid filled syringes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Narcotic: ABH gel 1mg/25mg/2ml #30 syringes for R60 received and discontinued on [DATE]. Stored in Medication cart starting on [DATE] and still there [DATE]. (ABH gel is the name given to a compounded medication made from the medications trade named: lorazepam (Ativan), haloperidol (Haldol), and diphenhydramine (Benadryl). It is not commercially available and is compounded by specialty pharmacies and is typically dispensed in a large multi-use syringe or several single-use syringes.) On [DATE] at 9:22 AM, Surveyor interviewed DON B. DON B stated that the medication was ABH gel which was never administered because it was a chemical restraint and discontinued before ever administered. DON B took Surveyor downstairs to the administration offices area lobby where a table was staged to be used for medication destruction. DON B stated that that their destruction process is to have two RN or 1 RN/1TMA do the destruction. If there is 1 TMA then the RN needs to be # 1. Medication log sheet from book is read off by # 1 and entered into the Red book by the other staff member. Then medication is counted again and quantity is confirmed. The medication is then added to a bottle called Drug Disposal, cap closed and bottle shaken to mix. The bottles are then eventually thrown out when full. DON did not state a timeframe as to when medication should have been destroyed. Medication of ABH gel was not removed from storage area and destroyed within 72 hours as per regulation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on interview and record review, the facility did not ensure medication reviews were completed for 5 out of 5 residents (R) reviewed (R65, R17, R53, R41, and R61) for unnecessary medications. Medication reviews were not completed at least monthly by a licensed pharmacist and documentation of review was not maintained in the resident's medical records. Findings include: The facility policy titled, Consultant Pharmacist Reports IIIA1: Medication Regimen Review revised December 2019, states in part, .B. The consultant pharmacist the medication regimen of each resident at least monthly . H. At least monthly, the consultant pharmacist reports any irregularities to the attending physician, medical director and the director of nursing, at a minimum . The policy titled, Consultant Pharmacist Reports IIIA2: Documentation and Communication of the consultant Pharmacist Recommendations revised December 2019, states in part, .A. A record of the consult pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, prescribers, and the care planning team. This should include: 1) Documentation of the date each medication regimen review is completed and notation of the findings in the medical record or other designated manner . Example 1 R65 was admitted to the facility on [DATE] with diagnoses including, orthopedic after care following surgical amputation, type 2 diabetes mellitus, obsessive compulsive disorder, adult failure to thrive, major depressive disorder with suicidal ideations, and history of pulmonary embolism. Surveyor reviewed R65's medication orders and noted the following: Aripiprazole oral tablet 5 MG (Aripiprazole) Give 1 tablet by mouth one time a day for major depressive disorder. Active 2/5/2025. Fluoxetine HCl Oral Capsule 40 MG (Fluoxetine HCl) Give 2 capsule by mouth one time a day for major depressive disorder. Active 2/4/2025. Insulin aspart subcutaneous solution pen-injector 100 unit/ml (Insulin Aspart): Inject as per sliding scale: if 191 - 220 = 1 unit; 221 - 250 = 1 unit; 251 - 280 = 2 units; 281 - 310 = 2 units; 311 - 340 = 3 units; 341 - 370 = 3 units; 371 - 400 = 4 units; 401 - 430 = 4 units; 431 - 460 = 5 units; 461 - 490 = 5 units; 491 - 520 = 6 units; 521 - 550 = 6 units; 551 - 580 = 7 units; 581 - 610 = 7 units; 611 - 999 = 8 units, subcutaneously at bedtime for Diabetes. Active 2/4/2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin aspart subcutaneous solution pen-injector 100 unit/ml (Insulin Aspart) Inject as per sliding scale: if 161 - 190 = 1 unit; 191 - 220 = 2 units; 221 - 250 = 3 units; 251 - 280 = 4 units; 281 - 310 = 5 units; 311 - 340 = 6 units; 341 - 370 = 7 units; 371 - 400 = 8 units; 401 - 430 = 9 units; 431 - 460 = 10 units; 461 - 490 = 11 units; 491 - 520 = 12 units; 521 - 550 = 13 units; 551 - 580 = 14 units; 581 - 610 = 15 units; 611 - 999 = 16 units, subcutaneously with meals for diabetes. Active 2/4/202. Eliquis oral tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for major depressive disorder take with breakfast and supper. Active 2/4/2025. Cyanocobalamin oral tablet 1000 MCG (Cyanocobalamin) Give 1 tablet by mouth one time a day for . Active 2/4/2025. Clonazepam oral tablet 1 MG (Clonazepam) Give 1 tablet by mouth two times a day. Active 2/4/2025. Buprenorphine HCl-Naloxone HCl sublingual film 12-3 mg (Buprenorphine HCl-Naloxone HCl Dihydrate) Give 1 film sublingually three times a day for withdrawals ***Follow the order in the computer*** and give 1 film sublingually one time only for withdrawals until 02/07/2025 23:59. Active 2/7/2025 13:30. Buspirone HCl oral tablet 10 MG (Buspirone HCl) Give 2 tablet by mouth three times a day for anxiety and give 2 tablets by mouth one time only for anxiety until 02/07/2025 23:59. R65 did not have documentation that a pharmacist reviewed R65's medications in the month of February 2025 or that any recommendations made were acknowledged by a physician. R65's medication orders do not indicate reasons for prescribing cyanocobalamin or clonazepam. On 3/13/25 at 7:48 AM, Surveyor interviewed Director of Nursing (DON) B about R65's medication orders missing indications of use. DON B acknowledged missing information in R65's medication orders and a plan to have orders corrected. Example 2 R17 was admitted to the facility on [DATE] with pertinent diagnosis including, schizophrenia, unspecified on admission, 3/27/2017, residual schizophrenia, 11/27/2024, and anxiety. Surveyor reviewed R17's medication orders and noted the following: Seroquel oral tablet 25 MG (Quetiapine Fumarate) Give 1 tablet by mouth as needed for . related to generalized anxiety disorder and residual schizophrenia for 14 Days 25mg one time daily as needed. Active 2/27/2025 Seroquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 3 tablet by mouth at bedtime for anxiety related to schizophrenia. Active 9/20/2024 Zoloft tablet (Sertraline HCl) Give 100 mg by mouth one time a day for anxiety. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided no documentation of a pharmacy review. Documentation of staff monitoring R17's and R65's behaviors was provided. On 3/13/25 at 7:51 AM, Surveyor interviewed DON B. Surveyor requested monthly pharmacy reviews and any documented physician follow up for sampled residents. DON B acknowledged the facility does not have a system in place to monitor monthly pharmacy reviews. DON B is unable to verify there has been any pharmacy review of medications. DON B reported a secure email had been sent from the current contracted pharmacy in January and February, but these emails can no longer be opened as they were sent with a timed security code. DON B provided a printout of the pharmacy email indicating a locked attachment from pharmacy for January and February 2025. DON B stated, That's all I have. On 3/13/2025 at 9:30 AM, Surveyor met with Nursing Home Administrator (NHA) A. NHA A acknowledged there are no pharmacy review documents or evidence of follow up on recommendations. 48793 Example 3 Record review identified R53 was admitted to the facility on [DATE] with the following diagnoses, in part, Alzheimer's disease with late onset dementia with moderate behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R53's medical record identified pharmacy was not reviewing R53's medications on a consistent monthly basis. Pharmacy reviews are missing and/or pharmacy signatures for 01/24, 02/24, 03/24, 09/24, 11/24, 12/24, 01/25, and 02/25. Example 4 R41 was admitted to the facility on [DATE], readmitted on [DATE], with the following diagnoses, in part, Alzheimer's disease, atherosclerotic heart disease, essential primary hypertension, and depression. R41's medical record identified pharmacy was not reviewing R41's medications on a consistent monthly basis. Pharmacy reviews are missing and/or pharmacy signatures for 01/24, 03/24, 04/24, 06/24, 07/24, 08/24, 09/24, 10/24, 11/24, 12/24, 01/25, and 02/25. 44863 Example 5 R61 was admitted to the facility on [DATE]. Diagnoses included atrial fibrillation, history of stroke, dementia, anxiety, cognitive impairment, delusional disorders, abnormal weight loss, and malnutrition. R61's MDS assessment, completed on 01/28/25, confirmed R61 scored 07/15 during BIMS, indicating severe cognitive impairment. R61 experiences hallucinations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R61's care plan included: -Impaired cognitive function/dementia or impaired thought process related to dementia, impaired decision making, psychotropic drug use. Diagnoses include anxiety, mild cognitive impairment, and delusional disorder. Interventions included: Review medications and record possible causes of cognitive deficit. Date initiated 11/05/24, revised 11/05/24. -I use psychotropic medications related to behavior management. I take an antidepressant and antipsychotic medication. Interventions: Consult with pharmacy, MD to consider dosage reduction when clinically appropriate, at least quarterly. Date initiated 11/05/24. R61's physician orders included: -Citalopram for anxiety, 09/11/24. -Eliquis for atrial fibrillation, 09/11/24 -Risperidone for delusional disorders, 09/11/24. On 03/13/25, Surveyor reviewed R61's record and noted pharmacy reviews were not conducted on a consistent monthly basis. Review of record confirmed pharmacy reviews were missing from record, not conducted, or documentation of follow-up of pharmacist recommendations was not evident in the record. Pharmacy reviews are not completed or documentation is not evident for 08/24, 09/24, 10/24, 12/24, 01/25, and 02/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51804 Based on observations, interview and record review, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional practice. This had the potential to affect 6 out of 6 residents (R) (R2, R34, R36, R40, R62, R69) for proper storage. 7 new unopened insulin pens, 1 unopened injectable solution, 1 unopened vaccine, and 1 unopened oral suspension that are temperature sensitive were found in an out of temperature range refrigerator on second floor. On second floor refrigerator, temperature logs are incomplete for 4 out of the 5 last months. Findings include: The facility policy, titled Medication Storage, dated 8/7/2015 states: a. All medication requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. b. Temperature are maintained within 36-46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee. The Wisconsin Pharmacy Chapter 6 titled, Pharmacy Licenses and Equipment states: (e) Refrigerator means a place in which the temperature is maintained between 36 and 46 degrees Fahrenheit. The Wisconsin Childhood Immunization Guidelines states: 1. Vaccines must be stored within these ranges: o Refrigerator: Store between 2.0 C to 8.0 C or 36.0 F to 46.0 F 2. Temperature review and documentation Daily temperature review of each storage unit is required. On 3/11/25 at 1:45 PM, Surveyor observed the second floor medication room refrigerator thermometer with Registered Nurse (RN) Q. Thermometer read between 48-50 F. RN Q stated the thermometer read 50 F. RN Q could not confirm what the process for checking temperatures was, stating I believe it is a night shift duty. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 1:48 PM, Surveyor observed the Temperature Log for March on second floor medication refrigerator did not have a temperature recorded for 3/2/25. Surveyor requested temperature logs for last 6 months. On 3/11/25 at 4:06 PM, Surveyor and RN Q rechecked the thermometer. RN Q looked at thermometer and stated it was 48 F. Twelve residents had medication in the refrigerator, not all were temperature sensitive. Temperature sensitive medication in the refrigerator included: Konvomep Suspension - 84 ml for R36 Lantus - 3 insulin pens for R40 Lantus - 1 insulin pen for R62 Lispro- 1 insulin pen for R62 Humulin N- 2 insulin pens for R69 Tocliizumab injection- for R34 Shingrix Vaccine- for R2 On 3/12/25 at 3:30PM, Surveyor reviewed temperature logs for all 3 floors. Nursing Home Administrator (NHA) A stated these are all the logs we have for the last 6 months. In the last 6 months on 2nd floor, the medication refrigerator was not checked and documented on 17 days. In the records for 1st and 3rd floor refrigerators, there were individual dates and full month temperature logs missing. On 3/13/2025 at 8:01 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated her expectation is for night shift nurses to care for the refrigerators and freezers, cleaning and tracking temperatures daily and completing the temperature logs on each floor. DON B stated if the refrigerator is out of range, the night shift nurses should report to day shift nurses and maintenance can use the laser thermometer to make sure the thermometer is accurate and things are pulled away. DON B stated going forward the sheets will have temperature range and action steps and if out of range what to do. DON B stated she will be doing staff education with demonstrations back.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40181 Based on observation, interview and record review, the facility did not ensure that snack/nourishment refrigerators on the first floor and third floor were maintained with the proper temperatures and food items are dated and labeled to prevent the potential for food-borne illness. This has the potential to effect all residents on the first floor and third floor. Findings include: According to the US Food and Drug Administration (FDA) Food Code 2022: Annex 3-123 .Date marking is the mechanism by which the Food Code requires active managerial control of the temperature and time combinations for cold holding. Industry must implement a system of identifying the date or day by which the food must be consumed, sold, or discarded. Date marking requirements apply to containers of processed food that have been opened and to food prepared by a food establishment, in both cases if held for more than 24 hours, and while the food is under the control of the food establishment . According to the US FDA Food Code 2022: Annex 3-164 to 165: .A permanent temperature measuring device is required in any unit storing time/temperature control for safety food because of the potential growth of pathogenic microorganisms should the temperature of the unit exceed Code requirements. In order to facilitate routine monitoring of the unit, the device must be clearly visible .The required incremental gradations are more precise for food measuring devices than for those used to measure ambient temperature because of the significance at a given point in time, i.e., the potential for pathogenic growth, versus the unit's temperature. The food temperature will not necessarily match the ambient temperature of the storage unit; it will depend on many variables including the temperature of the food when it is placed in the unit, the temperature at which the unit is maintained, and the length of time the food is stored in the unit . On 03/11/25 at 8:36 AM, Surveyor observed the snack/nourishment refrigerator located at the third floor nurses' station. The temperature log on the front of the refrigerator had each date completed with temperatures within appropriate limits for the refrigerator and freezer. Surveyor observed the internal thermometer in the refrigerator read 38 degrees F. Surveyor observed there was no internal or external thermometer in the freezer. Surveyor asked Licensed Practical Nurse (LPN) C who checked the refrigerator and freezer temperatures. LPN C stated dietary staff checked the unit refrigerators. On 03/11/25 at 8:44 AM, Surveyor checked the snack/nourishment refrigerator at the first floor nurses' station. Surveyor observed LPN G remove a bottle of salad dressing and an uncovered cup of liquid to dispose of them. The salad dressing bottle was opened and half empty and the cup of liquid was uncovered. Neither item was marked with a date opened or a use-by date. LPN G stated dietary staff was supposed to make sure food and beverage items were labeled and stored correctly in the unit refrigerators. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor observed the temperature tracking log on the front of the refrigerator had each date completed and all temperatures recorded for the refrigerator and freezer were within acceptable limits. Surveyor observed the internal freezer thermometer read 4 degrees. Surveyor observed there was no internal thermometer in the refrigerator. On 03/11/25 at 9:59 AM, Surveyor observed [NAME] N using a hand-held device to check the ambient temperatures in the unit refrigerator and freezer on the third floor. Surveyor interviewed [NAME] N, who stated they always used the hand-held device to check the internal temperatures of the refrigerators and freezers because the internal thermometers often go missing. [NAME] N said dietary staff is also supposed to make sure that all opened foods and beverages are labeled with the date opened, are covered, and stored correctly in the unit refrigerators and freezers. On 03/12/25 at 2:09 PM, Surveyor interviewed Dietary Manager (DM) F and reviewed the above observations and interviews related to the unit refrigerators on the first floor and third floors. DM F stated the dietary staff should have caught and removed the uncovered and undated food items and disposed of them when they did their morning checks. Surveyor asked if it was acceptable according to the US FDA Food Code to use the hand-held ambient temperature device to measure the internal temperatures of the unit refrigerators and freezers if the internal thermometers were missing. DM F thought it was an acceptable way to measure the unit temperatures. Surveyor provided the correct information from the US FDA Food Code and informed DM F the hand-held devices to measure temperatures was not following the Food Code guidance.

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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** 44863 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This had the potential to affect all 62 residents in the facility. -The facility did not have a water management program to reduce the risk of growth and spread of Legionella and other opportunistic waterborne pathogens. -Facility surveillance does not provide adequate evidence of tracking and monitoring infections. -Residents with known infections were not placed on precautions or placed on incorrect precautions. -Bins for discarding personal protective equipment (PPE) were placed in the hallways. Soiled PPE was hanging outside of the bins and exposed. -Clean linens were not covered during transport. Clean linens were stored in shower rooms inside shower stall and on shower bench. -Staff did not sanitize mechanical lifts between use. -Staff provided a resident with a wheelchair to attend an appointment. The wheelchair was borrowed from a resident on precautions for Clostridium difficile (C Diff, a bacterium in the large intestine that is highly contagious). -Shared shower room contained used bars of soap and used disposable razors. -No hand hygiene and glove change by Certified Nursing Assistant (CNA) when performing cares on a resident. Findings: Example 1 WATER MANAGEMENT The facility's policy titled Water Management, read in part, .This procedures purpose it to reduce the risk of growth and spread of Legionella and other waterborne pathogens. 1. Our facility has a Water management Team to specifically address safe water management . The facility's policy titled Legionella Surveillance, read in part, .It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. 1. Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/11/25 at 11:04 AM, Surveyor interviewed Environmental Services Director (ESD) Z. ESD Z stated he was not familiar with the facility having a water management program. Surveyor requested evidence of a description of the facility's water system, identification of areas in the water system that could be potentially hazardous, control measures for potentially hazardous areas, and monitoring of control measures. ESD Z stated he did not have the information Surveyor was requesting. On 03/12/25 at 10:09 AM, Surveyor interviewed Director of Nursing (DON) B. DON B reported the facility had a water management program and this would be provided to Surveyor. On 03/12/25 at 2:47 PM, Nursing Home Administrator (NHA) A provided update to Surveyor. NHA A reported the facility does not have a water management program. NHA A provided a blank document titled Water Management-Weekly Flushes. NHA A stated the facility was implementing the monitoring of areas identified as potentially hazardous. Example 2 SURVEILLANCE The facility's policy titled Infection Surveillance, read in part, .2. Outcome surveillance is accomplished in the following manner and is completed for both residents and staff. a. Infections or potential infections related to residents are identified and reported through the nurse charting system, verbal communication, and review of antibiotic use. e. The facility tracks existing cases of infections both old and new. g. Documentation will be completed on a line listing form tracking symptoms that may be representative of potential infective processes. This information is evaluated by the Director of Nurses or designee on an ongoing basis . On 03/11/25, the facility provided a Performance Improvement Plan (PIP) titled, Infection Control Line Listing of Staff. This document read in part, .Was noted that staff line listing was not being completed routinely with DON change over. ICP module in Point Click Care was purchased to easily track/trend resident and staff. The ICP module provides data for potential outbreaks and tracking and trending. -Action taken for affected staff: immediately start line listing, implementation of PCC IP Module. For Jan paper line listing. Regional VP of Clinical Ops set up binder for DON and [name] to complete while working through ICP module in PCC. Status (ongoing or completed with date of completion), 01/01/25. -Identification of other potentially affected residents and action: All staff. Status (ongoing or completed with date of completion), 02/01/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Systemic measures to prevent recurrence: 1) Staff are to notify nurse on call of s/s infection. 2)Nurse manager will ensure DON or designee enters the data into PCC for line listing module. Status (ongoing or completed with date of completion), 02/01/25. -Performance effectiveness and monitoring (must include review by QA Committee): 1) Scheduler and DON will meet in morning review and staff call offs. 2) Line listing will be kept on PCC for documentation of staff call offs r/t infection. 3) ICP Module will be reviewed at QAPI each month to determine and track trends. 4) QAPI will determine if further audits are needed and substantial compliance. Status (ongoing or completed with date of completion), Ongoing . On 03/11/25, the facility provided a printed line list of resident infections, beginning 01/02/25 through current date. Surveyor reviewed document and noted the following: -Laboratory testing and diagnostic testing was not completed. Notably for residents diagnosed with pneumonia, influenza A, and Clostridium difficile. -Criteria for infection was not included on the line list. -Residents with known multidrug-resistant organism (MDRO) were not included on the line list, (R25). -Isolation precautions were blank for residents with open wounds and drainage. Isolation start and end dates was completed with N/A. -Residents prescribed antibiotics were not included on the line list, (R41). On 03/11/25, the facility provided a staff line list for dates 02/26/25-current. Surveyor reviewed document and noted all entries, except for one, indicated staff had influenza A infection. Documentation did not identify signs and symptoms, and date staff returned to work. On 03/12/25 at 10:09 AM, Surveyor interviewed DON B. DON B indicated surveillance is documented and monitored via an electronic system. DON B indicated the information missing on the printed line list was being monitored via electronic surveillance. Surveyor requested access for the facility's electronic surveillance monitoring. Surveyor was not provided access to the facility's electronic surveillance monitoring. Example 3 TRANSMISSION BASED PRECAUTIONS The Centers for Disease Control (CDC) recommends contact precautions be implemented for individuals with Extended Spectrum Beta Lactamase (ESBL), a type of MDRO. On 03/10/25 at 11:13 AM, Surveyor observed R25 had an indwelling catheter. Surveyor observed R25 was not placed on enhanced barrier precautions (EBP). On 03/10/25 at 12:18 PM, Surveyor observed staff placing EBP signs on R25's room door and PPE bins outside of room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor reviewed R25's record and noted R25 was diagnosed with an MDRO. Surveyor reviewed urinalysis completed on 02/13/25, indicating R25 was actively infected with ESBL, a type of MDRO. On 03/11/25 at 8:23 AM, Surveyor interviewed Certified Nursing Assistant (CNA) H. CNA H reported licensed nursing staff places signage, PPE, and bins for transmission-based precautions, to correspond with type of precautions the resident should be on. On 03/12/25 at 10:09 AM, Surveyor interviewed DON B. DON B indicated R25 not being placed on precautions initially, and then being placed on EBP, must have been a mistake. Example 4 PPE On 03/10/25 at 10:09 AM, Surveyor observed R43 was on contact precautions related to C. Diff infection. Surveyor observed PPE bin outside of R43's room which contained soiled PPE, which was not contained within the bin, and soiled PPE was sticking out and hanging from the bin. On 03/11/25 at 8:06 AM, Surveyor observed PPE bin outside of R43's room which contained soiled PPE, which was not contained within the bin, and soiled PPE was sticking out and hanging from the bin. On 03/12/25 at 10:09 AM, Surveyor interviewed DON B. DON B stated the facility's policy and expectation is that PPE bins are kept inside the resident's room, and staff are to discard PPE in the room and before exiting the room. DON B did not provide further statement or clarification related to PPE bins located outside of resident rooms. Example 5 LINENS On 03/12/25 at 7:42 AM, Surveyor observed a clean linen cart with linens, cart was uncovered. On 03/12/25 at 7:49 AM, Surveyor interviewed Laundry Aide (LA) AA. LA AA reported she brings clean linens in laundry cart from basement where laundry room is located. LA AA reported she fills the cart as full as she can to prevent multiple trips to the basement. LA AA did not make any statements related to clean linens required to be covered. On 03/12/25 at 8:27 AM, Surveyor observed clean linens in shower room. Clean linens were placed in shower stall, over handrailing in shower stall, and on shower bench. On 03/12/25 at approximately 9:35 AM, Surveyor toured laundry facility with LA AA. Surveyor observed resident clean clothing was covered. Surveyor observed clean linen cart. LA AA confirmed she does not cover clean linen cart when transporting linens. On 03/12/25 at 10:09 AM, Surveyor interviewed DON B. DON B confirmed clean linens should be covered during transport. Example 6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MECHANICAL LIFTS On 03/11/25 at 7:39 AM, Surveyor observed two CNAs assist a resident using a mechanical hoyer lift for transfer. Surveyor observed after completing the transfer, CNA H removed the lift from the resident's room and placed it in the hallway. Surveyor noted the lift did not contain wipes or equipment to disinfect lift. CNA H spoke with another CNA briefly and then began walking towards a different hallway. Surveyor interviewed CNA H. CNA H reported lifts are to be disinfected after use with each resident and/or between resident use. CNA H reported this lift is generally only used on this hallway. CNA H confirmed there are usually disinfecting wipes in the bag attached to the lift. CNA H stated she would ask maintenance to bring some wipes for cleaning the lift. Surveyor observed CNA H come back with purple top wipes, clean the lift, and place the wipes in the attached bag. Surveyor noted R43 resides on this hallway and has an active C. diff infection. R43's PPE bin is located outside of his room in the hallway and soiled PPE is exposed, hanging out of the bin. On 03/12/25 at 10:09 AM, Surveyor interviewed DON B. DON B confirmed staff should be disinfecting mechanical lifts after use with each resident. Example 7 SHARED DURABLE MEDICAL EQUIPMENT On 03/11/25 at 2:11 PM, Surveyor interviewed R7. R7 was unavailable for interview on 03/10/25 as she had an appointment for an endoscopy procedure. R7 reported she was frustrated as the facility has not provided her with a wheelchair (w/c) for approximately eight or more weeks, (see citation F588 for reasonable accommodation of needs). Surveyor asked R7 how she was able to attend her appointment on 03/10/25 if she did not have a wheelchair. R7 stated staff borrowed R43's w/c, as it is a bariatric w/c. Surveyor noted R43 was currently on contact precautions related to a C. diff infection. Surveyor immediately interviewed CNA I. CNA I stated, Ok, I had nothing to do with this. I helped [R7] get ready for her appointment yesterday morning. I don't know why she doesn't have a w/c. I asked Nursing Home Administrator (NHA) and DON what I should do, and they told me to use [R43's] w/c, as [R7] needed a bariatric w/c. I knew [R43] had C. Diff. They told me to clean the w/c before I used it. I was not going to be responsible for someone getting C. diff because I didn't clean the chair properly. I mean, I don't have time to be cleaning w/c's with bleach. I told them to clean it. NHA and [Nurse Manager (NM) BB] cleaned the w/c and brought it to [R7's] hallway for me. When I got the w/c, I know they did not clean it with bleach because I could not smell bleach. I could smell the purple top wipes. I know what those smell like. Example 8 SHOWER ROOM On 03/11/25 at 8:16 AM, Surveyor observed clean linens in shower room on railings, inside shower stall, and on shower bench. Personal care items including a bar of soap and disposable razor were present inside shower in an open metal rack. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/11/25 at 8:27 AM, Surveyor observed clean linens lying on a shower cot and on top of a cabinet, as well as a personal sweatshirt. On 03/11/25 at 9:09 AM, Surveyor interviewed CNA Y. CNA Y reported staff get the items they need prior to giving a shower. Resident personal items are taken in the shower room for use and taken back to their rooms after. The facility items are kept on shelves in the shower room. On 03/11/25 at 9:17 AM, Surveyor interviewed CNA H. CNA H stated personal items and linens are taken in at the time of the shower. Dirty linens and personal care items are also removed when done. CNA H stated at times, clean linens that are extra get left in the shower room, but if they remove them, then they would have to be considered dirty and put into laundry. CNA H also reported any disposable razors get placed in sharps containers after use. When asked about facility soaps, CNA H only stated they retrieve them from the supply room. On 03/12/25 at 10:09 AM, Surveyor interviewed DON B. DON B made a note of Surveyor's observations of the shower room. DON B did not offer additional information. 48793 Example 9 On 03/11/25 at 7:35 AM, Surveyor observed CNA T enter bath house to assist CNA U with transfer of R57. CNA U and CNA T began pushing stand lift to R57 and instructed R57 to help stand. Surveyor observed CNA U take a dry towel and wipe R57's groin and buttock area without wearing gloves. CNA U then dropped the dry towel as R57 was in the process of sitting down. Surveyor observed CNA U don gloves, and CNA U and CNA T began standing R57 again. CNA U then used dry towel again to dry off groin area and buttock area. Surveyor observed R57 in the process of sitting on bath chair. CNA U then readjusted R57's hair out of R57's face with the soiled gloves on. CNA U then instructed R57 to stand again while CNA U pulled brief and pants up for R57 with soiled gloves. Surveyor observed CNA U grab wheelchair and place under R57. R57 sat down in wheelchair. Surveyor observed CNA U exit bath house with soiled gloves on and wheeled R57 to the dining room. Surveyor observed CNA U rearrange two dining room chairs to make room for R57 with same soiled gloves on. Surveyor observed CNA U lock wheelchair brakes on R57's wheelchair with soiled gloves and then placed a clothing protector/towel on R57. Surveyor observed CNA U then take soiled gloves off in dining room and throw in the trash. Surveyor observed CNA U walk back to the bath house and started cleaning the bath house. Surveyor did not observe CNA U sanitize hands. On 03/11/25 at 8:05 AM, Surveyor interviewed CNA U and asked CNA U what is the correct process for hand hygiene after peri cares are completed on resident. CNA U indicated that CNA U should have applied gloves the first time before cleaning R57's peri area, then sanitized hands after and before placing gloves on. CNA U indicated that before leaving the shower room CNA U should have sanitized hands again before taking R57 to the dining room for breakfast. On 03/11/25 at 9:13 AM, Surveyor interviewed DON B and asked DON B what expectation does DON B have with staff and hand hygiene when staff are completing peri cares on a resident. DON B indicated hands should be sanitized before and after glove use, and when exiting resident care areas.

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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** 44863 Based on interview and record review, the facility did not have documentation included in the resident's medical record that the resident either received or did not receive the pneumococcal and/or the influenza vaccination for 2 of 5 residents (R) reviewed for immunizations (R41 and R53). -R41's record does not include evidence resident was offered pneumococcal vaccination. -R53's record does not include evidence resident was offered influenza or pneumococcal vaccination. Findings include: The facility's policy titled Pneumococcal Vaccine Series, read in part .2. Each resident will be offered a pneumococcal immunization unless it is contraindicated, or the resident has already been immunized. 4. The resident/representative retains the right to refuse the immunization. The facility will document in the clinical record the reason for the refusal or the medical contraindication of the immunization. The facility policy titled Influenza Exposure Control, read in part .2. The current season's influenza vaccine will be offered to residents and staff in accordance with facility's policy for influenza vaccination. R41 R41 was admitted on [DATE]. Diagnoses included dementia, Alzheimer's disease, traumatic brain injury, depression, and psychotic disorder. Minimum Data Set (MDS) assessment completed on 01/27/25, confirmed a Brief Interview for Mental Status (BIMS) could not be conducted, and staff assessment of R41's mental status indicated severe impairment. R41's MDS assessment indicated R41 was offered and declined the pneumococcal vaccination. On 03/11/25, Surveyor reviewed R41's record and was unable to find evidence R41 was offered and either received or declined the pneumococcal vaccination. There was no evidence in the record to support a contraindication to the pneumococcal vaccination. On 03/12/25 at 10:09 AM, Surveyor interviewed Director of Nursing (DON) B. DON B reported the expectation is that residents will be offered immunizations annually. If a resident declines a vaccination, the facility will continue to offer the vaccination annually. Surveyor requested documentation to support R41 was offered and either received, declined, or evidence of a contraindication to the vaccine. Surveyor did not receive any additional documentation. R53 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525397	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - Superior	1800 New York Ave Superior, WI 54880

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53 was admitted to the facility on [DATE]. Diagnoses included dementia, Alzheimer's disease, anxiety, and depression. MDS assessment completed 02/19/25 confirmed R53 scored 01/15 during BIMS, indicating severe cognitive impairment. R53's MDS assessment indicated R53 was offered the influenza and pneumococcal vaccinations and declined. On 03/11/25, Surveyor reviewed R53's record and was unable to find evidence R53 was offered and either received or declined the influenza and pneumococcal vaccinations. There was no evidence to support a contraindication to either vaccine. Surveyor requested documentation to support R53 was offered and either received, declined, or evidence of a contraindication to the vaccines. Surveyor did not receive additional documentation.