STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525413	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcrest Health Services	3821 S Chicago Ave South Milwaukee, WI 53172

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47094 Based on interview and record review the facility did not ensure the State Long Term Care Ombudsman was notified when 2 (R10, R51) of 2 residents were reviewed for hospitalization s. 1.) R10 was admitted to the hospital on 10/23/2023, 11/21/2023, 12/28/2023, and 1/23/2023. The facility did not notify the Ombudsman of R10's hospitalization s. 2.) R51 was admitted to the hospital on 10/17/2023, 12/15/2023, and 3/16/2024. The facility did not notify the Ombudsman of R51's hospitalization s. Findings include: 1.) On 3/26/2024 Surveyor reviewed R10's medical record which indicated R10 was admitted to the hospital on 10/23/2023 for Hyperkalemia (high potassium), 11/21/2023 for cellulitis, 12/27/2023 for altered mental status, and 1/23/2023 for acute cystitis (bladder infection). 2.) On 3/24/2024 Surveyor reviewed R51's medical record which indicated R51 was admitted to the hospital on 10/17/2023 for a GI (gastrointestinal) bleed, 12/15/2023 for critical lab results, and 3/16/2024 for an unresponsive episode while at dialysis for treatment. On 3/26/2024 at 2:15 PM Surveyor interviewed Social Services Coordinator (SSC)-K who stated administration of the facility are the ones who notify the Ombudsman of hospital admissions. On 3/26/2024 at 3:42 PM Surveyor asked Nursing Home Administrator (NHA)-A who notifies the Ombudsman on resident admissions to the hospital. NHA-A replied that Social Services is in charge of notifications to the Ombudsman. Surveyor stated the SSC-K stated administration were to notify the Ombudsman. NHA-A stated NHA-A would get back to Surveyor. (continued on next page)

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

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 3/27/2024 at 7:52 AM NHA-A stated that the prior NHA of the facility notified the Ombudsman of hospitalization s on a monthly basis, when the prior NHA left the facility the prior Director of Nursing (DON) took over the obligation of notifying the Ombudsman monthly of hospital admissions. NHA-A showed Surveyor past email notifications to the Ombudsman. The last email sent to the Ombudsman for hospitalization was for July 2023. NHA-A stated that the current DON started at the facility in August 2023 and NHA-A started at the facility September 2023. Surveyor confirmed that the Ombudsman has not been getting notifications for the facility for resident hospitalization s since July 2023. NHA-A stated that is correct, the Ombudsman has not been getting notifications from the facility regarding hospitalization s.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not ensure 1 (R127) of 1 Residents who did not have fully signed DNR (do not resuscitate) documents was provided with CPR (Cardiopulmonary Resuscitation). R127 returned from the hospital on [DATE]. Upon return there is a verbal consent obtained on [DATE] from the POA (power of attorney)/daughter on the (CPR) Cardiopulmonary resuscitation consent form & Emergency Care Do Not Resuscitate Order (DNR). Facility staff did not follow up on having R127's POA/daughter sign these forms and the physician did not sign the Emergency Care Do Not Resuscitate Order (DNR). The Facility therefore did not have a valid DNR order. On [DATE] R127 experienced a choking episode, became unresponsive was not breathing & pulseless. Facility staff did not administer CPR as they thought R127 was a DNR. Failure to have a fully signed document for DNR and provide CPR in the absence of a signed DNR created a finding of Immediate Jeopardy (IJ), which began on [DATE]. NHA (Nursing Home Administrator)-A , DON (Director of Nursing)-B and [NAME] President of Success-C were notified of the immediate jeopardy on [DATE] at 12:40 p.m. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan. Findings include: The Cardiopulmonary Resuscitation (CPR) policy last reviewed/revised [DATE] under policy documents It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement guidelines regarding cardiopulmonary resuscitation (CPR). Under policy explanation and compliance guidelines documents 1. The facility will follow current American Heart Association (AHA) guidelines regarding CPR. 2. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and; a. In accordance with the resident's advance directives, or b. In the absence of advance directives or a Do Not Resuscitate order; and c. If the resident does not show obvious signs of clinical death (e.g. rigor mortis, dependent lividity, decapitation transection, or decomposition). R127's diagnoses includes diabetes mellitus, congestive heart failure, Atrial Fibrillation, kidney disease, peripheral vascular disease, right below knee amputation, dysphagia and dementia. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R127 was originally admitted to the facility on [DATE], was discharged to the hospital on [DATE] and readmitted on [DATE]. R127's POA (power of attorney) for healthcare was activated on [DATE]. The physician order dated [DATE] documents full code. The (CPR) Cardiopulmonary resuscitation consent form is checked for resuscitation and is signed by R127's POA on [DATE]. The Resident has an advanced directive in place care plan initiated [DATE] documents an intervention also dated [DATE] of Follow advanced directive per MD (medical doctor) orders. The admission MDS (minimum data set) with an assessment reference date of [DATE] has a BIMS (brief interview mental status) score of 10 which indicates moderate cognitive impairment. The eInteract SBAR (situation, background, assessment, and recommendation) dated [DATE] at 18:08 (6:08 p.m.) under Nursing observations, evaluation, and recommendations are: Lab results came and creatinine was high; resident had difficulty breathing (used accessory muscles to breath). Under Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: Updated MD (Medical Doctor) [Name] from [Name of Medical Group] about the resident changed of condition and suggested to sent resident in the E.R. (emergency room) and MD [Name] approved it. This SBAR note was written by LPN (Licensed Practical Nurse)-S. R127 was hospitalized from [DATE] to [DATE]. The hospital discharge summary dated [DATE] documents Advanced Directives/Goals of Care: Patient is decisional: No. Power of Attorney designee/healthcare agent - Activated: Code Status: Selective treatment/DNR - no CPR/no intubation/no cardioversion. The (CPR) Cardiopulmonary resuscitation consent form is checked for No resuscitation (no cardiopulmonary resuscitation or external defibrillation). Refer to State approved DNR form if required. There is a handwritten notation at the bottom on this consent form which documents Verbal obtained [DATE] [Name] POA/daughter. There is no staff signature on this form and the Resident's authorization representative signature & date are blank. The Emergency Care Do Not Resuscitate Order (DNR) is checked for male, with R127's name and date of birth. There is a handwritten notation on the bottom of this consent form which documents verbal DNR obtained [DATE] [Name] POA/daughter. The signature for Patient or legal guardian or health care agent of an incapacitated patient & date are blank along with the signature & date of attending health care professional. The above signatures and dates are required for this order to be valid and its intent carried out. The nurses note dated [DATE] at 16:57 (4:57 p.m.) documents spoke with [Name], daughter/POA, regarding return to facility, reviewed wounds, wishes to continue DNR, discussed hospice care, is interested will have SW (social worker) follow up. Aware of Amitriptyline, Olanzapine, & Hydroxyzine need for consent, obtained verbal, will be in on Sat (Saturday) [DATE] to sign. This nurses note was written by RN (Registered Nurse) Manager-M. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 19:13 (7:13 p.m.) documents Resident is 82 Y.O. (year old) male with mild cognitive impairment. DNR (do not resuscitate) and POA [Name] daughter. Alert but confused, able to make needs known. VSS (vital signs stable), afebrile; SOB (shortness of breath) occurs when lying flat and exertion. Eats in room tonight; feeds self, and appetite good. Swallows good and take pills whole. Used urinal and emptied 200 mL; per report from hospital([hospital initials) had BM (bowel movement) this morning. Currently in bed in high fowler's watching TV. Bed is in low position, and call light and urinal within reach. Resident c/o (complained of) pain of ,d+[DATE]; Tylenol is given as ordered, and was effective per resident upon reassessment. This nurses note was written by LPN-S. The telephone order dated [DATE] documents DNR. Surveyor noted this is not a valid DNR order as R127's POA & physician did not sign the required DNR forms. APNP (Advance Practice Nurse Prescriber)-Y initial visit note dated [DATE] for code status documents Full Code/Allow Resuscitation. APNP (Advanced Practice Nurse Prescriber)-Y note dated [DATE] under code status documents Full Code/Allow Resuscitation. Under subjective documents Patient is seen lying in bed this afternoon. He has had an increase in behaviors and confusion since yesterday. He has been tearful, irritable, restless, positive fall. He now has a black left eye. Staff has had a difficult time redirecting. SW (Social Worker) did reach out to family regarding hospice/palliative care options. Currently awaiting callback from family. ROS (review of systems) questions or not quite as appropriately responsive as the prior day, however he states he is currently comfortable while lying in bed. We will continue close monitoring, plan of care would be ideal to transition to hospice. Warfarin will be discontinued due to multiple repeated falls since admission. The nurses note dated [DATE] at 20:31 (8:31 p.m.) documents Around 2030ish, (8:30 p.m.) Resident requested some snacks and was given Peanut Butter and Jelly, and Oatmeal Creme Pie. Then set him up on the table by the lounge by nurses' station with a cup water while watching TV. Approximately 2044 (8:44 p. m.); Nurse one, witnessed in wheelchair ambulating away from TV; resident was looking at something on the wall, nurse witnessed this and asked what are you up to [R127's first name]?. Then resident's head tilted to the right. Nurse attempted to wake resident. Resident didn't respond. Nurse called out for second nurse. Second nurse attempted to arouse resident. Resident stopped breathing and Heimlich maneuver started. Oral sweep attempted but teeth clamped down initially. More abdominal thrusts performed. Approximately 2046 (8:46 p.m.), 911 called. Oral sweep performed, suctioning started, followed by Oxygen therapy. Around 2050ish (8:50 p.m.) EMT (emergency medical technicians) arrived CPR (cardiopulmonary resuscitation) initiated. Approximately 2130 (9:30 a.m.), Resident declared departed by EMT. This nurses note was written by LPN-S. The nurses note dated [DATE] at 20:58 (8:58 p.m.) POA (Power of Attorney) updated changing conditions and CPR was initiated by EMT's, POA then request that resident be sent to hospital. At 2132 (9:32 p.m.), [Name] - POA updated that resident departed. Approx 2150 (9:50 p.m.), POA arrived at facility; updated that resident will be sent to [Name of County] Medical Examiner. This note was written by LPN-S. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 22:00 (10:00 p.m.) documents At 2045 (8:45 p.m.) writer heard commotion coming for around the corner on the North unit and went to investigate. Observed resident slumped in w/c (wheel chair). LPN was attempting to arouse resident and then performed Heimlich. Informed by LPN that resident was eating immediately prior to event. Resident assessed for respirations, none were apparent Resident was pale/ ashen gray. Writer performed 6 to 7 thrusts from behind the w/c, on one knee reaching around to front of resident and gaining good leverage. These were unsuccessful. Staff instructed to call 911. LPN attempted oral suction. EMTs arrived within minutes and took over care of resident. This note was written by RN (Registered Nurse)-II. The nurses note dated [DATE] at 23:04 (11:04 p.m.) documents Medical examiner will send unit to pick up the deceased . This nurses note was written by RN-II. The nurses note dated [DATE] at 23:41 (11:41 p.m.) documents Resident transported by [Name of County] Medical Examiner team to Medical Exam Office. [telephone number]. This nurses note was written by LPN-R. The Fire Department patient care report documents unit dispatched on [DATE] at 20:49:17 (8:49:17 p.m.) on scene on [DATE] at 20:50:49 (8:50:49 p.m.) and at patient on [DATE] at 20:50:50 (8:50:50 p.m.) Primary impression documents Respiratory-Foreign Body Airway. Secondary Impression: CV - Cardiac Arrest. Assessment summary on [DATE] at 20:50:50 for mental status documents Unresponsive, for chest/lungs documents Breath sounds absent right, breath sounds absent left. Under section chief complaint for complaint type documents Chief (Primary), for Complaint documents pulseless not breathing, for Duration of Complaint documents 10, and for Time Units of Duration of Complaint documents Minutes. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Under Narrative documents [Fire Department initials] was dispatched to an assisted living facility for someone choking. Upon arrival a nurse came up to ems (emergency medical services) staff and stated they tried a Heimlich maneuver once they found the patient choking but soon after the pt did not have a pulse. The nurse stated they were going to assist the patient to the ground since he was in a wheel chair but they assumed the patient was a DNR (do not resuscitate). [Fire Department initials] stated they need a properly signed document with a doctor's signature and many of the workers went to the computers to try to get one. [Fire Department initials] found the [AGE] year old male patient in his wheel chair. There was a half eaten sandwich in the room near the patient. The workers stated they thought the pt choked on his peanut butter sandwich. The pt was found by ems crew to not have a pulse and was quickly assisted to the ground with CPR (cardiopulmonary resuscitation) being initiated with a lucas device. The pt's rhythm started in asystole. [Fire Department initials] obtained IO (intraosseous) access in the left leg. [Fire Department initials] cleared the pt's airway by suctioning big chunks of what appeared to be a sandwich. [Fire Department initials] was able to place a green LMA (laryngeal mask airway) in the pt's airway with positive equal breath sounds bilaterally with proper chest rise and fall. [Fire Department initials] administered a total of five epinephrine's during CPR. About the half way marker of the code [Fire Department initials] called for a doctor for further instructions. Doctor 0179 came on and told [Fire Department initials] to continue with ACLS (advanced cardiovascular life support). Doctor 0179 advised [Fire Department initials] to administer 3 grams of calcium and to hold off on epi's after the 5th administration. The pt switched into a wide complex PEA (pulseless electrical activity) rhythm but later switched back to asystole rhythm. ETCO2 (end tital carbon dioxide) remain ,d+[DATE] throughout the incident. [Fire Department] initials administered one liter of normal saline via IO throughout the code. No proper paperwork was given to [Fire Department initials] during the code even though the staff continually stated that pt has a DNR. At 2130 (9:30 p.m.) hours doctor 0179 stated to do a thirty second pause check. [Fire Department initials] had no signs of life with an asystole rhythm. Doctor 0179 then called for a 1099 at 2130 hours. Medical examiner was called by [Fire Department initials] with the body being released back to the nursing facility care. On [DATE] at 3:13 p.m. Surveyor asked RN (Registered Nurse)-II what staff should do when a resident is choking. RN-II informed Surveyor ask if the resident can cough, speak or breath if not begin Heimlich maneuver. Surveyor asked RN-II if he remembers R127 and if he could tell Surveyor what happened on [DATE] when R127 had a choking incident. RN-II informed Surveyor he was passing pills at the end of the hall and heard noise, just the commotion, hurried voices like in distress. RN-II explained R127's unit was around the corner from his unit. Surveyor asked RN-II what he saw. RN-II informed Surveyor the patient was in a wheelchair in front of the nurses station, had been in the lounge area. RN-II informed Surveyor the lounge is across from the nurses station and the nurses station is kind of between the two units. RN-II indicated there were two staff trying to arouse R127. RN-II informed Surveyor he didn't know if they had performed thrusts already but he got behind the chair and gave several thrusts. LPN-R said we have to do CPR, we put him on the floor, I think we began CPR and he had already told staff to call 911. Surveyor asked RN-II did you see staff performing CPR. RN-II replied I can't remember if they had just started or EMT. Surveyor asked RN-II if there is a choking episode is there normally a page. RN-II replied yes but didn't know if there was one but there were 3 of the 4 nurses there. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:04 a.m. Surveyor spoke with CNA (Certified Nursing Assistant)-T. Surveyor asked CNA-T if R127 could feed himself. CNA- informed Surveyor he could eat himself but he was suppose to be supervised at the time. CNA-T informed Surveyor at the time of the incident, she grabbed the crash cart, stated I wasn't part of the next steps. Surveyor inquired if 911 was called CNA-T informed Surveyor they called 911. Surveyor asked CNA-T if she remembers who called 911. CNA-T informed [name of] LPN-S but she wasn't 100% sure. Surveyor asked CNA-T if she knew who lowered R127 to the floor. CNA-T informed Surveyor she doesn't remember and wasn't sure if it was the ambulance. Surveyor asked CNA-T if she was in the area when the fire department arrived. CNA-T replied yes. Surveyor asked if she remembered when they did. CNA-T informed Surveyor they started chest compressions with the machines, doesn't know for how long but felt like it went on for 40 minutes. On [DATE] at 9:28 a.m. Surveyor asked DON (Director of Nursing)-B to show Surveyor where the AED (automated external defibrillator) is located. Surveyor observed there is an AED located in the small alcove opposite room [ROOM NUMBER]. Surveyor observed there is a sign on the defibrillator box stating extra AED pads located in the north nurses station medication room. The AED battery expires ,d+[DATE]. Surveyor noted this AED is located in the center hallway of R127's unit. On [DATE] at 9:52 a.m. Surveyor spoke with RN Manager-M. Surveyor asked RN Manager-M if codes are called at the Facility. RN Manager-M replied yes. Surveyor inquired what type of codes are there. RN Manager-M informed Surveyor they basically have code blue or stat for what ever the situation is. RN Manager-M the situation is through the phone system, the crash cart comes, and someone grabs the AED as there is one on each unit. Surveyor inquired when a code blue would be called. RN Manager-M informed Surveyor if someone is unresponsive, choking, sometimes if there is a fall with bleeding may call for extra help. Surveyor inquired if the page is overhead. RN Manager-M replied no it goes through all the phones. Surveyor asked if staff was not at the nurses station would they hear the page. RN Manager-M informed Surveyor if staff were in a resident's room they would not hear it and if the nurse was passing meds (medications) and was at the end of the hall they wouldn't hear it. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] a 10:09 a.m. Surveyor spoke with LPN-R on the telephone and asked LPN-R if he could explain to Surveyor what happened the night R127 died . LPN-R informed Surveyor he was coming from the center hall, went by the nurses station, looked to the left and saw R127 rolling towards the nurses station but facing the wall with the light switch. LPN-R informed Surveyor he knows R127 was a fall risk and asked R127 along the lines of what are you up to. LPN-R informed Surveyor R127 kind of looked like he heard him but R127 looked up at the wall, was looking at the wall and then his head tilted to the right then straight down. R127 became unresponsive, he did a sternal rub, saw LPN-S walking towards him and told her to come here. LPN-R informed Surveyor he checked for a pulse, had a faint pulse, and LPN-S pointed out she had just set up R127 with a sandwich. LPN-R informed Surveyor he did an oral sweep, initiated Heimlich maneuver which was not effective, got the suction machine tried to suction him, continued with the Heimlich, at some point R127 no longer had a pulse and no longer was breathing, and informed Surveyor he's not sure from there. LPN-R then informed Surveyor someone called to check the code status and 911 was called but wasn't sure who called 911. LPN-R informed Surveyor they (referring to the fire department) were pretty darn quick, thinks they started CPR compressions. Surveyor asked LPN-R if anyone at the Facility started CPR. LPN-R replied it was the EMT, he was DNR as far as I know. Surveyor asked if anyone brought the AED or crash cart. LPN-R replied crash cart yet, AED no in relation to him being a DNR. Surveyor asked LPN-R if a Resident was choking and became pulseless, not breathing would you start CPR on them. LPN-R replied no, he was not grabbing for his throat, can't say if breathing. Surveyor asked LPN-R how he knew R127 was a DNR. LPN-R replied I called out not sure who I spoke to remember saying pull chart want to see code status even if had a pulse want to know what the code status is. Surveyor asked LPN-R if R127 was his patient. LPN-R informed Surveyor no and he hadn't taken care of R127. On [DATE] at 11:12 a.m. Surveyor called [Name of County] medical examiners office and spoke with [Name]. Surveyor asked what R127's cause of death was. [Name] informed Surveyor accidental. The immediate cause is asphyxia due to choking. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:08 p.m. Surveyor asked RN Manager-M what the process is for obtaining CPR/DNR for a resident. RN Manager-M informed Surveyor on admission the admitting nurse will go over with the patient if they are their own person or if activated then get a determination one way or another. Surveyor asked what happens if a resident is readmitted . RN Manager-M informed Surveyor it gets readdressed each admission. Surveyor asked what happens if a verbal consent is received for CPR/DNR. RN Manager-M informed Surveyor if the POA says they will be in the next week she will leave it on the chart so it can be signed and if they are not local will ask if they want it sent to them. Surveyor inquired who follows up to ensure the POA has signed. RN Manager-M informed Surveyor she knows social service does audits or she would when she is doing a chart review. Surveyor asked how often chart reviews are done. RN Manager-M informed Surveyor on admission and then quarterly. Surveyor asked RN Manager-M if Surveyor was a resident at the Facility and had an activated POA and my POA said they would be in to sign the DNR form when would this be followed up on to make sure my POA came in. RN Manager-M replied depends on charting I would think within a week. Surveyor asked when does the doctor sign. RN Manager-M informed Surveyor they only sign for DNR not full code. Surveyor asked RN Manager-M if a DNR is valid without the POA & doctors signature. RN Manager-M replied that's a good question, I think it would be if a family member told me, would write verbal consent. RN Manager-M informed Surveyor once the family signs then they would have the doctor sign. Surveyor asked RN Manager-M what happens if there is a verbal consent, the signatures haven't been obtained and the resident stops breathing & is pulseless. RN Manager-M informed Surveyor she would call the family & asked what the wishes are. RN Manager-M informed Surveyor she doesn't know if she would start CPR and doesn't know if she's come across that situation. Surveyor asked RN Manager-M what the protocol is if a Resident is choking. RN Manager-M informed Surveyor if the resident is choking & breathing would try to get them to cough and do the Heimlich maneuver. If they are having trouble breathing call 911, we would still treat them. Surveyor asked if a resident was choking & stopped breathing would they start CPR. RN Manager-M informed Surveyor guess to error on the sign of caution would start CPR. If can't get a hold of family and CPR/DNR is not signed I don't know, would have to be clarified. (continued on next page)

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	525413	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcrest Health Services	3821 S Chicago Ave South Milwaukee, WI 53172

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:48 p.m. Surveyor asked LPN-S how she knows if a Resident is DNR or CPR. LPN-S informed Surveyor it's in PCC (pointclickcare) and in their chart. LPN-S explained in PPC when you click profile you can see code status and in paper chart it's after profile. Surveyor asked LPN-S if she could explain to Surveyor what happened the night R127 choked. LPN-S informed Surveyor she was at the desk. R127 wheeled himself next to her and asked for a snack, he wanted a sandwich. LPN-S informed Surveyor she asked if he wanted a peanut butter and jelly sandwich. LPN-S informed Surveyor she placed a bed side table side ways in the lounge area as R127 wanted to watch TV with the sandwich and water. LPN-S indicated she placed the bed side table so they could see R127. LPN-S informed Surveyor when R127 was eating she was doing charting or she had her check list of what she had done at the nurses station. LPN-S informed Surveyor there was a light on in a Resident's room, a CNA came and told her the resident wanted a boost. LPN-S informed Surveyor she yelled she was going to help the aide and went to the room. LPN-S informed Surveyor there was a CNA at the desk and LPN-R was on the other side. LPN-S informed Surveyor when she came out LPN-R called her name, R127 was facing the wall, his neck tilted to the right. LPN-R was rubbing R127's chest, R127 was not visibly breathing, LPN-S indicated she told LPN-R R127 was just eating and LPN-R jumped to the conclusion R127 was choking and started the Heimlich maneuver. LPN-S said she check R127's wrist and carotid for pulse. Surveyor asked if R127 had a pulse. LPN-S replied no and not visibly breathing. LPN-R attempted a oral sweep but the teeth were clamped down so did more Heimlich maneuver. LPN-R ask what kind of status he has. LPN-S told him DNR. LPN-R said we need to do suction, the other CNA got the crash cart and LPN-R tried to use suction. Surveyor inquired if LPN-R was able to remove any food. LPN-S replied no nothing, seems like a little bit of powder. We assumed bread. We used oxygen therapy and called 911. Surveyor asked LPN-S who called 911. LPN-S informed Surveyor she did. Surveyor asked LPN-S how long was it between when she went over to LPN-R until 911 was called. LPN-S stated think it was about 10 minutes then stated maybe 5. Surveyor asked LPN-S if she or LPN-R did CPR. LPN-S replied no we didn't do CPR we grabbed crash cart to use suction and oxygen therapy. LPN-S informed Surveyor when the EMT came they asked us about code status. I told them R127 was DNR. LPN-S informed Surveyor an EMT told her to call R127's POA. Surveyor asked LPN-S what she said to R127's POA. LPN-S informed Surveyor she asked the daughter if she was coming, your dad is not feel good right now, not breathing was eating a peanut butter and jelly sandwich. The daughter asked did you do CPR, did you save my dad, told her we couldn't do that because your dad is DNR. The daughter/POA told LPN-S she wants to change it wants us to save her dad. Surveyor asked LPN-S if the EMT's asked for any code status paperwork. LPN-S informed Surveyor there was paperwork for DNR but it was just verbal. Surveyor asked LPN-S if anyone paged a code. LPN-S replied no. Surveyor asked if she knew why a code wasn't called. LPN-S informed Surveyor it didn't cross her mind. Surveyor asked LPN-S why didn't she call 911 right away. LPN-S informed Surveyor they were checking R127's pulse, LPN-R was conversing with her, R127 was eating a sandwich after that need to do suction, it was going on so fast, we tried to provide basic needs best we can, tried to provide everything we can use then call 911. On [DATE] at 2:28 p.m. Surveyor asked DON-B for facility's choking policy and any investigation regarding R127 on [DATE] & any education provided. DON-B informed Surveyor the Facility does not have a choking policy. Surveyor was provided with an incident report dated [DATE], a handwritten statement from RN-II, staff statements obtained by Prior DON-NN from RN-II, LPN-S, & LPN-R, preliminary autopsy findings, and education provided to Social Service. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted RN-II's handwritten statement dated [DATE] documents Heard nurses on north unit talking to one another. Hear CNA say who is supervisor? Should I get [RN-II's first name]. I walked over to unit and saw [LPN-R's first name] and [LPN-S's first name] with patient in w/c (wheelchair). [LPN-R's first name] attempted Heimlich on patient. [LPN-S first name] tried from front as [LPN-R's first name] applied O2 (oxygen)/attempted suctioning. I got down and wrapped arms around chair and patient attempting Heimlich. I wanted patient on the floor for CPR and 911 called since this started as choking. Nurses both said he was no code. 911 was called. [LPN-S first name] phone with daughter. Daughter wanted CPR continued. Fireman had started when thy got here until shown no code order. Patient was pronounced. Staff hoyered patient to bed. The facility's failure to ensure R127 had a fully signed DNR document and CPR not being performed led to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility implemented the following action plan: * The DON initiated re-education of following resident choice for code status and ensuring medical record has a code status noted upon admission. This re-education will be completed with licensed nurses prior to next scheduled shift. * The DON initiated re-education with current floor staff on the facility's code response procedure. * The SW (Social Worker) or designee initiated an audit of in house resident to determine CPR wishes are on file and accurate. * Code drills were started once per shift for 48 hours and 3 per week, involving each shift for 4 weeks. * The Director of Nursing and Social Services completed an audit of current in house residents to assure code status form and order was in electronic medical record. Interdisciplinary team reviewed cardiopulmonary policy with Medical Director including an ad hoc QAPI meeting. * The Director of Nursing/designee to initiate interviews of 5 nurses per week x 4 weeks on various shifts using case studies and what if scenarios to validate understanding and expectations required during a choking or code situation. * DON/designee will audit new admissions and readmissions to ensure code status and orders are present x 8 weeks. Results of the above audits will be brought to the QAPI committee for further recommendations, if warranted. * An ad hoc QAPI completed with Executive Director, Medical Director, Social Worker, Director of Nursing, IDT (interdisciplinary team), and VPS.

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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. 21855 Based on observation, record review and interview, the facility did not ensure pressure injury interventions were accurately implemented. This was observed in 1 (R57) of 5 residents reviewed for pressure injuries. *R57 was observed in bed with the air mattress at an incorrect setting. Findings include: On 03/24/24 at 10:11 AM Surveyor observed R57 laying in bed. The low air loss mattress was set at 300# (pounds). R57 appeared thin with defined bone structure. On 03/25/24 at 9:29 AM Surveyor observed R57 laying in bed. The alternating air mattress setting was at 300#. R57's medical record was reviewed by Surveyor. R57's current MD (Medical Doctor) orders indicate: Alternating pressure relief air mattress to bed, check settings/function Q (each) shift. Settings 100# (pounds) every shift. This had a start date of 2/22/24, and 3/21/24, for alternating pressure relief mattress. R57's 5-day MDS (minimum data set) assessment completed 2/28/24 indicates a weight of 84 pounds. R57 had a wound consult assessment for the sacrum completed on 3/18/24: Etiology (quality) Pressure MDS 3.0 Stage 4 Duration > (greater than) 43 days Objective Healing/Maintain Healing Wound Size (Length x Width x Depth): 3 x 2.5 x 1 cm (centimeter) This visit's measurements are noted by the clinician to be exactly the same as the previous visit. Surface Area: 7.50 cm^2 Cluster Wound open ulceration area of 6.00 cm^2 Undermining: 0.5 cm. at 6 o'clock Exudate: Moderate Serous Slough: 20% (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Granulation tissue: 60% Skin: 20% R57's wound consult assessment for the sacrum completed on 3/25/24: Etiology (quality) Pressure MDS 3.0 Stage 4 Duration > 50 days Objective Healing/Maintain Healing Wound Size (L x W x D): 3.5 x 2.5 x 0.8 cm Surface Area: 8.75 cm^2 Cluster Wound open ulceration area of 7.88 cm^2 Undermining: 1 cm. at 2 o'clock Exudate: Moderate Serous Thick adherent devitalized necrotic tissue: 10% Slough: 40% Granulation tissue: 40% Skin: 10% Wound progress: Exacerbated due to generalized decline of patient. R57's plan of care for At risk for alteration in skin integrity related to: history of pressure ulcer, impaired mobility, nutritional deficit, Date initiated 1/29/24 indicates the following interventions: -Alternating pressure air mattress on bed. Monitor inflation and settings. Settings 100#, 10 min date initiated 1/29/24 On 3/25/24 at 1:35 PM Surveyor observed R57's wound treatment by (Registered Nurse) RN-L and Wound MD-N. The alternating air mattress was set at 300#. Surveyor queried about the mattress setting. RN-L indicated it's supposed to be at 100# and adjusted it to 100#. Wound MD-N indicated the weight setting effects the air positioning and there would be no harm in a higher setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 3:42 PM at the facility Exit Meeting. Surveyor shared the concerns with R57's air mattress setting.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not ensure each Resident received adequate supervision and assistance devices to prevent accidents for 3 (R127, R63, & R45) of 8 Residents. R127 was readmitted to the facility on [DATE]. The hospital discharge summary for a discharge date of [DATE], under discharge recommendations documents 5. Diet: Diabetic (carb controlled) diet, low sodium; add protein supplements with meals (sugar free gelatin and low carb Glucerna). Per Speech Therapy: 1) Cont (continue) general solids, thin liquids; constant supervision/assist for all intake. 2) Meds (medication) whole in puree or with sips of liquid (minimum of 3 oz (ounce) liquid wash following same). 3) Small bites/sips, alternate solids/liquids consistently, slow pacing, stop intake if coughing increased, reflux precautions. The speech evaluation dated [DATE] documents R127 required supervision 91 to 100% of the time and food feeling of stuck. Swallowing strategies included alternation of liquids/solids, bolus size modifications, rate modification and general swallow techniques/precautions, along with the following maneuvers: upright posture during meals and upright posture for > (greater) 30 mins (minutes) after meals. Reflux precautions. R127's care plan was not revised to include supervision and swallowing strategies. On [DATE] R127 requested a snack and was provided with a peanut butter and jelly sandwich. R127 was given this sandwich with a glass of water on a bed side table in the lounge area with the TV located across the hallway from the nurses station. R127 was eating the sandwich approximately 20 feet from where staff were located behind the nurses station. LPN-S who provided R127 with the sandwich indicated she yelled to staff she was going to help a CNA boost another Resident and there was a CNA doing charting at the nurses station & LPN-R was on the other hall. LPN-R informed Surveyor he came from the center hall, turned left and looked to the left where he saw R127 who was a fall risk and asked R127 along the lines of what are you up to. LPN-R informed Surveyor R127 kind of looked like he heard him but R127 looked up at the wall, was looking at the wall and then his head tilted to the right then straight down. R127 became unresponsive and he did a sternal rub. LPN-R saw LPN-S walking towards him and told her to come here. LPN-R informed Surveyor he checked for a pulse, had a faint pulse, and LPN-S pointed out she had just set up R127 with a sandwich. LPN-R informed Surveyor he did an oral sweep, initiated Heimlich maneuver which was not effective, got the suction machine tried to suction him, continued with the Heimlich, at some point R127 no longer had a pulse and no longer was breathing. 911 was called. Upon arrival at 8:50 p.m. the Fire Department was informed by staff they tried a Heimlich maneuver once they found the patient choking but soon after the pt did not have a pulse. The fire department provided CPR to R127 and cleared the pt's airway by suctioning big chunks of what appeared to be a sandwich. Cardiopulmonary resuscitation care was provided to R127 until 9:30 p.m. when had no signs of life with an asystole rhythm and R127 was declared. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Failure to provide adequate supervision when R127 was eating a peanut butter & jelly sandwich which led to a choking incident and subsequent death created a finding of Immediate Jeopardy (IJ), which began on [DATE]. NHA (Nursing Home Administrator)-A , DON (Director of Nursing)-B and [NAME] President of Success-C were notified of the immediate jeopardy on [DATE] at 12:40 p.m. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a severity/scope level of D (potential for more than minimal harm/isolated) as the facility continues to implement its removal plan & as evidenced by the following examples: * R63's falls on [DATE] & [DATE] were not thoroughly investigated and the root cause was not determined to help prevent further falls. * R45's fall on [DATE] was not thoroughly investigated and the root cause was not determined to help prevent further falls. Findings include: The NSG (nursing) Accident and Supervision policy revised [DATE] under policy documents: The resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary. Under Policy Explanation and Compliance Guidelines documents: 2. Evaluation and Analysis: the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location etc. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, location, etc. 4. Monitoring and Modification - Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Ensuring that interventions are implemented correctly and consistently. b. Evaluating the effectiveness of interventions. c. Modifying or replacing interventions as needed. d. Evaluating the effectiveness of new interventions. 5. Supervision - Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a Defined by type and frequency. b. Based on the individual resident's assessed needs and identified hazards in the resident environment. R127's diagnoses includes diabetes mellitus, congestive heart failure, Atrial Fibrillation, kidney disease, peripheral vascular disease, right below knee amputation, dysphagia and dementia. R127 was originally admitted to the facility on [DATE], was discharged to the hospital on [DATE] and readmitted on [DATE]. R127's POA (power of attorney) for healthcare was activated on [DATE]. The increased nutrient needs care plan initiated [DATE] documents the following interventions: * Eating - (SPECIFY: independent, assist of 1, setup, supervision). Initiated [DATE]. * Provide diet as ordered - Consistent carbohydrate, low sodium diet; regular texture Initiated [DATE]. * Administer medications as ordered. Initiated [DATE]. * Administer vitamin/mineral supplements as ordered. Initiated [DATE]. * Fluid restriction as ordered. Initiated [DATE]. * Honor advanced directives r/t (related to) nutritional/hydration support. Initiated [DATE]. * Honor food preferences. Initiated [DATE]. * Obtain labs as ordered and notify MD of results. Initiated [DATE]. * Provide supplements as ordered. Initiated [DATE]. * Record weight per facility protocol/MD orders. Initiated [DATE]. * Review weights and notify RD (Registered Dietitian), MD and responsible party of significant weight change. Initiated [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Document % (percentage) of meals consumed. Initiated [DATE]. * Monitor status of skin integrity per nursing report/WAR (weekly at risk); f/u (follow up) with rec (recommendations) prn (as needed) and per pt (patient) preference. Initiated [DATE]. * Nutrition edu (education) prn/as welcomed by pt. Initiated [DATE]. The admission MDS (minimum data set) with an assessment reference date of [DATE] has a BIMS (brief interview mental status) score of 10 which indicates moderate cognitive impairment. R127 is assessed as not having any behavior, is independent with set up help for eating, and does not have any signs or symptoms of possible swallowing disorder or dental concerns. The physician orders dated [DATE] documents Consistent Carbohydrate diet Regular texture, Regular/Thin consistency, 2000 cc (cubic centimeters) fluid restriction. This order was discontinued when R127 was discharged to the hospital. The nutrition assessment note dated [DATE] by Dietitian-W documents Diet order: Consistent Carb (carbohydrate) diet. 2000 mL (milliliter) FR (fluid restriction) Average meal intake: ,d+[DATE]% with snacks. Eating ability: Independent. Current weight: W 186.2 lb pounds - [DATE] 12:59 Scale: Wheelchair scale. BMI (body mass index): 33. Weight stable. Skin condition: Pressure injury Other. No edema present. Summary: Current diet order remains appropriate for management of resident Resident appears to be tolerating diet texture/consistency. Resident is consuming adequate calories to maintain weight. Current diet order/oral nutritional supplement(s) order provides adequate calories/protein to meet estimate nutritional needs. Resident is receiving diet of choice. Weight remains stable without significant variances. Resident has potential for weight fluctuation r/t (related to) fluid shifts. No new recommendations needed at this time. Will continue to monitor. PCC (pointclickcare) BMI adjusted to account for right BKA (below knee amputation). Continue current nutrition plan of care. The eInteract SBAR (situation, background, assessment, and recommendation) dated [DATE] at 18:08 (6:08 p.m.) under Nursing observations, evaluation, and recommendations are: Lab results came and creatinine was high; resident had difficulty breathing (used accessory muscles to breath). Under Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: Updated MD (Medical Doctor) [Name] from [Name of Medical Group] about the resident changed of condition and suggested to sent resident in the E.R. (emergency room) and MD [Name] approved it. This SBAR note was written by LPN (Licensed Practical Nurse)-S. R127 was hospitalized from [DATE] to [DATE]. The hospital discharge summary for discharge date of [DATE] under discharge recommendations documents 5. Diet: Diabetic (carb controlled) diet, low sodium; add protein supplements with meals (sugar free gelatin and low carb Glucerna). Per Speech Therapy: 1) Cont (continue) general solids, thin liquids; constant supervision/assist for all intake. 2) Meds (medication) whole in puree or with sips of liquid (minimum of 3 oz (ounce) liquid wash following same). 3) Small bites/sips, alternate solids/liquids consistently, slow pacing, stop intake if coughing increased, reflux precautions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R127's nutrition care plan was not revised to include hospital speech therapy recommendations from the discharge summary dated [DATE] of Small bites/sips, alternate solids/liquids consistently, slow pacing, stop intake if coughing increased, reflux precautions. The physician orders dated [DATE] documents May follow dietitian's recommendations and document fluid intake from meals. On 2000 cc fluid restriction. The nurses note dated [DATE] documents Resident is 82 Y.O. (year old) male with mild cognitive impairment. DNR (do not resuscitate) and POA [Name] daughter. Alert but confused, able to make needs known. VSS (vital signs stable), afebrile; SOB (shortness of breath) occurs when lying flat and exertion. Eats in room tonight; feeds self, and appetite good. Swallows good and take pills whole. Used urinal and emptied 200 mL; per report from hospital([hospital initials) had BM (bowel movement) this morning. Currently in bed in high fowler's watching TV. Bed is in low position, and call light and urinal within reach. Resident c/o (complained of) pain of ,d+[DATE]; Tylenol is given as ordered, and was effective per resident upon reassessment. This nurses note was written by LPN-S. The speech evaluation and plan of treatment dated [DATE] under the section Clinical Bedside Assessment of Swallowing for Solids Assessed documents Solids Assessed = Unable to assess at this time (Attempted to grab snack for assessment - unable to find a snack in multiple locations at facility). For Thin Liquids documents Thin Liquids = Mild, Clinical S/S (signs/symptoms) Dysphagia: Slight wet vocal quality noted after the swallow on single and sequential sips. For Oral Containment documents How often does patient exhibit difficulty with oral containment/secretion management? = ,d+[DATE]% of the time. For Supervision documents How often does patient require supervision/assistance at mealtime d/t (due to) swallow safety? = ,d+[DATE]% of the time. For Esophageal Phase documents Esophageal: Patient/medical record indicates: Foods feeling stuck. Pt reports infrequent heartburn. Under the section Recommendations for Recommended documents Liquids = Thin liquids. Solids = Regular textures. For Swallow Strategies documents Compensatory Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies during oral intake: alternation of liquids/solids, bolus size modifications, rate modification and general swallow techniques/precautions, along with the following maneuvers: upright posture during meals and upright posture for > (greater) 30 mins (minutes) after meals. Reflux precautions. The Medicare 5 day MDS with an assessment reference date of [DATE] did not assess R127's cognition. R127 is assessed as having physical, verbal, other, and refusal of care for one to three days. Is independent with eating, and does not have swallowing disorder. No is checked for mechanically altered diet and yes for therapeutic diet. R127 does not have any dental concerns. APNP (Advanced Practice Nurse Prescriber)-Y note dated [DATE] under subjective documents Patient is seen lying in bed this afternoon. He has had an increase in behaviors and confusion since yesterday. He has been tearful, irritable, restless, positive fall. He now has a black left eye. Staff has had a difficult time redirecting. SW (Social Worker) did reach out to family regarding hospice/palliative care options. Currently awaiting callback from family. ROS (review of systems) questions or not quite as appropriately responsive as the prior day, however he states he is currently comfortable while lying in bed. We will continue close monitoring, plan of care would be ideal to transition to hospice. Warfarin will be discontinued due to multiple repeated falls since admission. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcrest Health Services	3821 S Chicago Ave South Milwaukee, WI 53172

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated [DATE] at 20:31 (8:31 p.m.) documents Around 2030ish, (8:30 p.m.) Resident requested some snacks and was given Peanut Butter and Jelly, and Oatmeal Creme Pie. Then set him up on the table by the lounge by nurses' station with a cup water while watching TV. Approximately 2044 (8:44 p. m.); Nurse one, witnessed in wheelchair ambulating away from TV; resident was looking at something on the wall, nurse witnessed this and asked what are you up to [R127's first name]?. Then resident's head tilted to the right. Nurse attempted to wake resident. Resident didn't respond. Nurse called out for second nurse. Second nurse attempted to arouse resident. Resident stopped breathing and Heimlich maneuver started. Oral sweep attempted but teeth clamped down initially. More abdominal thrusts performed. Approximately 2046 (8:46 p.m.), 911 called. Oral sweep performed, suctioning started, followed by Oxygen therapy. Around 2050ish (8:50 p.m.) EMT (emergency medical technicians) arrived CPR (cardiopulmonary resuscitation) initiated. Approximately 2130 (9:30 a.m.), Resident declared departed by EMT. This nurses note was written by LPN-S. The nurses note dated [DATE] at 20:58 (8:58 p.m.) POA (Power of Attorney) updated changing conditions and CPR was initiated by EMT's, POA then request that resident be sent to hospital. At 2132 (9:32 p.m.), [Name] - POA updated that resident departed. Approx 2150 (9:50 p.m.), POA arrived at facility; updated that resident will be sent to [Name of County] Medical Examiner. This note was written by LPN-S. The nurses note dated [DATE] at 22:00 (10:00 p.m.) documents At 2045 (8:45 p.m.) writer heard commotion coming for around the corner on the North unit and went to investigate. Observed resident slumped in w/c (wheel chair). LPN was attempting to arouse resident and then performed Heimlich. Informed by LPN that resident was eating immediately prior to event. Resident assessed for respirations, none were apparent Resident was pale/ ashen gray. Writer performed 6 to 7 thrusts from behind the w/c, on one knee reaching around to front of resident and gaining good leverage. These were unsuccessful. Staff instructed to call 911. LPN attempted oral suction. EMTs arrived within minutes and took over care of resident. This note was written by RN (Registered Nurse)-II. The nurses note dated [DATE] at 23:04 (11:04 p.m.) documents Medical examiner will send unit to pick up the deceased . This nurses note was written by RN-II. The nurses note dated [DATE] at 23:41 (11:41 p.m.) documents Resident transported by [Name of County] Medical Examiner team to Medical Exam Office. [telephone number]. This nurses note was written by LPN-R. The Fire Department patient care report documents unit dispatched on [DATE] at 20:49:17 (8:49:17 p.m.) on scene on [DATE] at 20:50:49 (8:50:49 p.m.) and at patient on [DATE] at 20:50:50 (8:50:50 p.m.) Primary impression documents Respiratory-Foreign Body Airway. Secondary Impression: CV - Cardiac Arrest. Assessment summary on [DATE] at 20:50:50 for mental status documents Unresponsive, for chest/lungs documents Breath sounds absent right, breath sounds absent left. Under section chief complaint for complaint type documents Chief (Primary), for Complaint documents pulseless not breathing, for Duration of Complaint documents 10, and for Time Units of Duration of Complaint documents Minutes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Under Narrative documents [Fire Department initials] was dispatched to an assisted living facility for someone choking. Upon arrival a nurse came up to ems (emergency medical services) staff and stated they tried a Heimlich maneuver once they found the patient choking but soon after the pt did not have a pulse. The nurse stated they were going to assist the patient to the ground since he was in a wheel chair but they assumed the patient was a DNR (do not resuscitate). [Fire Department initials] stated they need a properly signed document with a doctor's signature and many of the workers went to the computers to try to get one. (Cross-reference F678). [Fire Department initials] found the [AGE] year old male patient in his wheel chair. There was a half eaten sandwich in the room near the patient. The workers stated they thought the pt choked on his peanut butter sandwich. The pt was found by ems crew to not have a pulse and was quickly assisted to the ground with CPR (cardiopulmonary resuscitation) being initiated with a lucas device. The pt's rhythm started in asystole. [Fire Department initials] obtained IO (intraosseous) access in the left leg. [Fire Department initials] cleared the pt's airway by suctioning big chunks of what appeared to be a sandwich. [Fire Department initials] was able to place a green LMA (laryngeal mask airway) in the pt's airway with positive equal breath sounds bilaterally with proper chest rise and fall. [Fire Department initials] administered a total of five epinephrine's during CPR. About the half way marker of the code [Fire Department initials] called for a doctor for further instructions. Doctor 0179 came on and told [Fire Department initials] to continue with ACLS (advanced cardiovascular life support). Doctor 0179 advised [Fire Department initials] to administer 3 grams of calcium and to hold off on epi's after the 5th administration. The pt switched into a wide complex PEA (pulseless electrical activity) rhythm but later switched back to asystole rhythm. ETCO2 (end tital carbon dioxide) remain ,d+[DATE] throughout the incident. [Fire Department] initials administered one liter of normal saline via IO throughout the code. No proper paperwork was given to [Fire Department initials] during the code even though the staff continually stated that pt has a DNR. At 2130 (9:30 p.m.) hours doctor 0179 stated to do a thirty second pause check. [Fire Department initials] had no signs of life with an asystole rhythm. Doctor 0179 then called for a 1099 at 2130 hours. Medical examiner was called by [Fire Department initials] with the body being released back to the nursing facility care. On [DATE] at 8:14 a.m. Surveyor spoke with ST (Speech Therapist)-LL regarding R127. ST-LL informed Surveyor she was not the speech therapist when R127 was at the Facility. ST-LL looked at the Facility's speech therapy records and informed Surveyor R127 had a speech evaluation with one treatment. The Facility speech therapist at this time recommended solids with thin liquids and constant supervision. On [DATE] at 8:32 a.m. Surveyor asked Rehab Director-MM how nursing staff are aware of speech therapy's recommendations. Rehab Director-MM explained they have communication sheets which are given to dietary and nursing so they can be care planned and put on the Resident's diet slip. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:04 a.m. Surveyor spoke with CNA (Certified Nursing Assistant)-T. Surveyor asked CNA-T if R127 could feed himself. CNA- informed Surveyor he could eat himself but he was suppose to be supervised at the time. Surveyor asked CNA-T if she could explain to Surveyor what happened to R127 on [DATE] when R127 died . CNA-T informed Surveyor she was charting at the desk, basically in here to supervise him eating as R127 was given a little snack after dinner. Surveyor asked CNA-T what she means by supervising. CNA-T replied have to be in the vicinity of where he is, small bites and things like that. CNA-T informed Surveyor she and a nurse were at the nurses station and R127 was at a table, showing Surveyor the lounge R127 was in. Surveyor asked CNA-T if she was behind the desk when R127 was in the lounge. CNA-T replied yes charting. CNA-T informed Surveyor when R127 was finished he wheeled himself right by the garbage can, was messing with the light switch and [Name of] LPN-R, the other nurse saying hi to him, what are you doing buddy, R127 kind of had a blank stare, looking through LPN-R. R127 kind of nodded off unresponsive. CNA-T informed Surveyor what happened next is the fuzzy part. CNA-T informed Surveyor she grabbed the crash cart, stated I wasn't part of the next steps. On [DATE] at 9:52 a.m. Surveyor asked RN (Registered Nurse) Manager-M if a Resident requires constant supervision where should staff be in relationship to the Resident. RN Manager-M informed Surveyor the Resident would eat in the dining room or if the Resident eats in their room then staff should be in the room during the meal. Surveyor asked what if a Resident requests a snack would staff be in a room with the Resident. RN Manager-M informed Surveyor if they are in their room staff should be in the room or if in a common area in line of sight. Surveyor asked can staff be doing their charting while the Resident has their snack. RN Manager-M informed Surveyor if they are at the same table they could be. Surveyor asked if staff could be charting behind the nurses station when a Resident is having a snack in the lounge or in the hall. RN Manager-M informed Surveyor she would have the expectation they would be near to the resident. On [DATE] a 10:09 a.m. Surveyor spoke with LPN-R on the telephone and asked LPN-R if he could explain to Surveyor what happened the night R127 died . LPN-R informed Surveyor he was coming from the center hall, went by the nurses station, looked to the left and saw R127 rolling towards the nurses station but facing the wall with the light switch. LPN-R informed Surveyor he knows R127 was a fall risk and asked R127 along the lines of what are you up to. LPN-R informed Surveyor R127 kind of looked like he heard him but R127 looked up at the wall, was looking at the wall and then his head tilted to the right then straight down. R127 became unresponsive, he did a sternal rub, saw LPN-S walking towards him and told her to come here. LPN-R informed Surveyor he checked for a pulse, had a faint pulse, and LPN-S pointed out she had just set up R127 with a sandwich. LPN-R informed Surveyor he did an oral sweep, initiated Heimlich maneuver which was not effective, got the suction machine tried to suction him, continued with the Heimlich, at some point R127 no longer had a pulse and no longer was breathing, and informed Surveyor he's not sure from there. LPN-R then stated someone checked the code status and not sure who called 911. Surveyor asked LPN-R if R127 was his patient. LPN-R informed Surveyor no and he hadn't taken care of R127. Surveyor asked LPN-R if a Resident requires supervision while eating where would staff have to be. LPN-R replied within viewing distance, I suppose don't have to be on top of them. On [DATE] at 11:12 a.m. Surveyor called [Name of County] medical examiners office and spoke with [Name]. Surveyor asked what R127's cause of death was. [Name] informed Surveyor accidental. The immediate cause is asphyxia due to choking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:27 p.m. a Surveyor asked DM (Dietary Manager)-JJ if peanut butter and jelly sandwiches are made in the kitchen or on the unit. DM-JJ informed Surveyor they make the sandwiches in the kitchen and the sandwiches are given to the nurses. Surveyor inquired what type of snacks are given to Residents. DM-JJ informed Surveyor they have peanut butter & jelly sandwiches, string cheese, crackers, fruit, oatmeal cream pie, chocolate pies, diabetic cookie. DM-JJ indicated they use wheat bread for their sandwiches. On [DATE] at 1:48 p.m. Surveyor spoke to LPN-S regarding R127. Surveyor asked LPN-S if R127 could feed himself. LPN-S informed Surveyor R127 could feed himself but part of their care plan was to supervise or watch him. Surveyor asked LPN-S why R127 had to be supervised. LPN-S informed Surveyor had a situation when came back from hospital R127 had swallowing problems. LPN-S informed Surveyor when R127 came back from the hospital they have to do supervision when he eats. Surveyor asked what supervision means. LPN-S informed when eating can see him. Surveyor asked when R127 was eating did he have to alternate liquids and solids. LPN-S informed Surveyor he could just eat normal foods. Surveyor then asked LPN-S if R127 took a bite of chicken would R127 then have to take a drink of a liquid after. LPN-S replied no. Surveyor asked LPN-S if she could explain to Surveyor what happened the night R127 choked. LPN-S informed Surveyor she was at the desk. R127 wheeled himself next to her and asked for a snack, he wanted a sandwich. LPN-S informed Surveyor she asked if he wanted a peanut butter and jelly sandwich. LPN-S informed Surveyor she placed a bed side table side ways in the lounge area as R127 wanted to watch TV with the sandwich and water. LPN-S indicated she placed the bed side table so they could see R127. LPN-S informed Surveyor when R127 was eating she was doing charting or she had her check list of what she had done at the nurses station. LPN-S informed Surveyor there was a light on in a Resident's room, a CNA came and told her the resident wanted a boost. LPN-S informed Surveyor she yelled she was going to help the aide and went to the room. LPN-S informed Surveyor there was a CNA at the desk and LPN-R was on the other side. LPN-S informed Surveyor when she came out LPN-R called her name, R127 was facing the wall, his neck tilted to the right. LPN-R was rubbing R127's chest, R127 was not visibly breathing, LPN-S indicated she told LPN-R R127 was just eating and LPN-R jumped to the conclusion R127 was choking and started the Heimlich maneuver. LPN-S said she checked R127's wrist and carotid for pulse. Surveyor asked if R127 had a pulse. LPN-S replied no and not visibly breathing. LPN-R attempted a oral sweep but the teeth were clamped down so did more Heimlich maneuver. LPN-R ask what kind of status he has. LPN-S told him DNR. LPN-R said we need to do suction, the other CNA got the crash cart and LPN-R tried to use suction. Surveyor inquired if LPN-R was able to remove any food. LPN-S replied no, nothing, seems like a little bit of powder. We assumed bread. We used oxygen therapy and called 911. On [DATE] at 2:18 p.m. Surveyor asked LPN-S to show Surveyor where in the lounge she placed R127 to eat the peanut butter and jelly sandwich. LPN-S showed Surveyor where she had placed R127. Surveyor noted R127 was approximately 20 feet away from the nurses station. On [DATE] at 4:07 p.m. Surveyor asked LPN-S if R127 usually asked for a peanut butter and jelly sandwich as his snack. LPN-S informed Surveyor R127 asked for a sandwich and the only thing we have is peanut butter and jelly. LPN-S informed Surveyor R127 was usually in bed, but that night he was waiting for his daughter. LPN-S informed Surveyor usually the CNAs (Certified Nursing Assistants) would give him his snack. Surveyor asked LPN-S if there are any CNA's working today that worked with R127. LPN-S replied no, we change a lot of CNAs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:13 a.m. Surveyor asked RN Manager-M when a Resident is admitted or readmitted who reviews the discharge summary from the hospital. RN Manager-M replied the admitting nurse and she would. If the resident is admitted on the weekend, she would review the discharge summary on Monday. Surveyor asked RN Manager-M if she remembers reviewing R127's hospital discharge summary dated [DATE]. RN Manager-M informed Surveyor she doesn't recall. Surveyor informed RN Manager-M the discharge summary included speech therapy recommendations of alternating liquids & solids, small bites which Surveyor did not note on the care plan. On [DATE] at 9:50 a.m. Surveyor asked Dietitian-W if there are any Resident who should not receive a peanut butter & jelly sandwich. Dietitian-W informed Surveyor Residents who are on a puree diet and some on level 3, one level down from regular. Surveyor inquired if R127 should have had a peanut butter & jelly sandwich. Dietitian-W informed Surveyor she heard about the choking incident but was never asked. Surveyor inquired what R127's diet was when R127 returned from the hospital on [DATE] as Surveyor noted an order to follow dietitian's recommendations. Dietitian-W explained that's a standing order and R127 had a consistent carbohydrate low sodium diet, had fluid restrictions, regular texture and fluids. Surveyor asked Dietitian-W if she assessed R127 after he returned from the hospital. Dietitian-W informed Surveyor she didn't as he was only back for a short time. Dietician-W informed Surveyor she's at the Facility on Monday, Wednesday, & Friday. Surveyor noted R127 returned on a Thursday. Surveyor asked Dietitian-W if she was aware R127 had swallowing precautions. Dietitian-W replied I was not. Dietitian-W informed Surveyor she was never aware there were concerns with swallowing. Surveyor Dietitian-W informed Surveyor if R127 had been at the Facility a couple more days she would have definitely looked into this and asked for clarification. The facility's failure to provide adequate supervision when R127 was eating a peanut butter & jelly sandwich which led to a choking incident and subsequent death led to a finding of immediate jeopardy. The immediate jeopardy was removed on [DATE] when the facility implemented the following action plan: * The DON initiated re-education with nursing staff on following physician orders or Speech Therapy recommendations to include but not limited to level of required supervision, and ensuring that those residents requiring supervision while eating snacks or meals have nursing staff at dining table or at bedsi [TRUNCATED]

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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** 47094 Based on observation, interview, and record review the Facility did not ensure 1 (R10) of 2 residents reviewed received appropriate services related to catheter care. R10 did not have a follow up appointment made as requested to see Urology after a hospitalization on [DATE] per discharge recommendation. Findings include: R10 was readmitted to the facility on [DATE] after a hospital admission on 1/23/2023 for acute cystitis with hematuria. R10 was admitted back to the facility with a foley catheter in place. Surveyor reviewed R10's discharge summary from the hospital from 1/26/2024. R10 experienced episodes of urinary retention requiring a straight catheter a few times while in the hospital requiring R10 to have a foley catheter placed and discharged back to the facility. Per discharge summary R10 was to have a follow-up appointment scheduled with urology in 3 weeks to be seen for a possible trial void and cystoscopy. Surveyor reviewed R10's medical record and noted R10 did not follow up with urology 3 weeks after R10's discharge on 1/26/2024. On 3/26/2024 at 10:02 AM Surveyor interviewed Registered Nurse manager (RNM)-M who stated R10 was admitted back to the facility with the foley catheter in place during R10's 1/23/2024 hospitalization . RNM-M stated RNM-M received a letter stating that R10 had an appointment on 4/10/2024 with Urology and was to get a cystoscopy at that time. Surveyor asked RNM-M if R10 has seen Urology prior to receiving the letter. RNM-M stated that R10 has not seen Urology and was not sure how RNM-M received the letter for R10 to go to the Urology visit. On 3/26/2024 at 10:47 AM Surveyor interviewed Admissions Director (AD)-OO who stated that AD-OO and RNM-M noticed that the follow- up appointment R10 was to have with Urology 3 weeks after R10's discharge from the hospital on 1/26/2024 was missed and never made. AD-OO stated AD-OO called the Urology office to make the follow up appointment for R10 and had the order for the cystoscopy faxed over for 4/10/2024. The faxed order for the cystoscopy was then given to RNM-M. Surveyor asked AD-OO when it was noticed that the follow up appointment was missed. AD-OO stated she was notified on 3/22/2024 by RNM-M and called that same day to make the appointment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on observation, record review and interview, the facility did not provide adequate nutritional support to 2 (R21, R66) of 4 residents reviewed for Nutrition. *R21 sustained a weight loss in January 2024. The facility did not follow recommendations from the facility's dietician to implement weekly weights for R21. *R66 sustained a significant weight loss in January 2024. The facility did not follow recommendations from the facility's dietician to implement weekly weights for R66. Findings include: 1.) R21 was admitted to the facility on [DATE] with diagnoses of hypothyroidism and osteoporosis. Surveyor reviewed the facility's policy titled Weight Monitoring with a revision date of 12/21/22. The facility's policy reads: . 6.) Any weight change of 5 pounds or more since the last weight assessment will be retaken for confirmation 8.) The threshold for significant weight change will be based on the following criteria: 1 month-5% weight change is significant; greater than 5 % is severe. 3 month-7.5% weight change is significant, greater than 7.5% is severe. 6 months-10% weight change is significant; greater than 10% is severe. 10.) The nursing staff will notify the individual or responsible party, physician or RD (Registered Dietician) or designee of any individual with an unintended significant weight change. Surveyor reviewed R21's medical record including physicians orders, weights and comprehensive care plan. Surveyor noted R21's documented weight upon admission to the facility on [DATE] was 141.0 pounds. Surveyor reviewed facility's weight documentation for R21. Surveyor noted R21's documented weight of 137. 2 on 12/2/23. Surveyor noted R21's documented weight of 136.0 on 12/4/23. Surveyor noted R21's documented weight of 136.6 on 12/7/23. Surveyor noted R21's documented weight of 139.8 on 12/14/23. Surveyor noted R21's documented weight of 134.8 on 12/21/23. Surveyor noted R21's documented weight of 124.4 on 1/3/24. No additional weights were documented after R21's documented weight loss until 1/22/24 where R21's weight was documented as 127.8. Surveyor reviewed Dietician-W's progress notes from December 2023 to March 2024. Surveyor noted an order for boost supplement shakes twice daily was initiated on 2/9/24. On 3/11/24, Dietician-W made a recommendation to conduct weekly weights for R21. Surveyor noted R21's last documented weight of 126.0 on 3/6/24. Surveyor noted from December 2023-March 2024, R21 sustained an overall weight loss of 10.6 %, indicating severe weight loss for R21. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/24 at 12:10 PM, Surveyor conducted interview with Unit Manager-V. Surveyor asked Unit Manager-V how they would know how often residents should be getting weighed. Unit Manager-V responded that the orders should be in the electronic medical record and should be put on the resident's Treatment Administration Record. Surveyor asked Unit Manager-V if they were aware that Dietician-W had recommended weekly weights for R21. Unit Manager-V told Surveyor that they would need to review R21's medical record. Unit Manager-V informed Surveyor that they are not sure why R21's order for weekly weights did not reflect in their physician orders. Unit Manager-V told Surveyor that they would obtain a weight from R21 after they finished eating their lunch. Surveyor was not provided any additional information at this time regarding R21's current weight. On 3/27/24 at 9:45 AM, Surveyor conducted interview with Dietician-W. Surveyor asked Dietician-W what the facility's protocol for obtaining and assessing weights on admission. Dietician-W responded that nursing staff should weigh the resident three days in a row then weekly for 3 weeks and then on a monthly schedule unless a physician or the Dietician has a different recommendation for a resident. Surveyor asked Dietician-W why boost supplement shakes were not initiated until 2/9/24 when R21 was noted with weight loss on 1/22/24. Dietician-W responded that the facility was conducting lab work for R21 at that time so they didn't think including an order for a supplement was necessary at that time. Surveyor asked Dietician-W if R21 should be weighed on a weekly basis. Dietician-W responded that they had made recommendations for R21 to be weighed weekly on 3/11/24. On 3/27/24 at 1:10 PM, Surveyor conducted an interview with NHA (Nursing Home Administrator)-A. Surveyor shared concerns related to R21's nutritional problems including a 10.6% overall weight loss from 12/1/23 to 3/6/24. Surveyor shared concerns that Dietician-W had made recommendations on 3/11/24 for R21 to receive weekly weight monitoring, which has not been implemented by the facility. NHA-A did not provide any additional information at this time. 16584 2.) R66 was admitted to the facility on [DATE] with diagnoses that includes Hemiparesis, major depressive disorder, Dementia and anxiety disorder. On 8/16/23 the facility conducted an admission Nutrition Assessment. R66 receives a general diet and the average meal intake: >/= (greater than or equal to) 75% thus far. Eating ability: Independent. Current weight: W 127.8 lb - 8/15/2023 12:15 Scale: Wheelchair scale. BMI: 22.6. Weight stable. Skin condition: No skin issues noted. No edema present. Summary: Current diet order remains appropriate for management of resident appears to be tolerating diet texture/consistency. Resident is consuming adequate calories to maintain weight. Resident is receiving diet of choice. Weight remains stable without significant variances. Pt admitted for rehab s/p (status post) hospital stay dt (due to) R (right) thalamic stroke with IVH (intraventricular hemorrhage) and later developed AKI (acute kidney disease) on CKD (chronic kidney disease). Per hospital dc (discharge) summary will continue with a Regular diet at this time to encourage po intakes. Pt (patient) is tolerating Regular diet/textures without issue. Independent with feeding self-meals; setup prn (as needed). No skin impairments reported by nursing. No s/s (signs/symptoms) of GI (gastrointestinal) distress. Preferences up to date. Weight stable. No new recommendations at this time. Will continue to monitor. Continue current nutrition plan of care. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor conducted a review of R66's individual plan of care. The plan states that R66 is at risk for nutritional status change r/t (related to) recent thalamic stroke; h/o (history of) HLD (hyperlipidemia), HTN (hypertension), CKD3A, significant weight loss. 2/2024 - Unintentional weight loss r/t sporadic appetite changes AEB (as evidenced by)ongoing weight loss with significant 15.6# (pound) (13%) weight loss x90 days and 26# (20%) weight loss x180 days/admission, sporadic changes to appetite and variable meal intakes. 11/2023 - experienced a 9.8# (7.6%) weight loss x90 days (since admit 8/14) while maintaining adequate meal/nutritional and fluid intakes. Stable Oct-Nov Interventions included: Will maintain weight as evidenced by no significant wt changes (>/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days). Will exhibit no chewing or swallowing problems with current diet texture as evidenced by no s/s of aspiration, choking, or complaints of difficulty eating. Will maintain highest level of independence with po intakes. Document % of meals consumed. Honor food preferences Monitor po/fluid intakes. Nutrition supplements as ordered; document % consumed as ordered. Obtain labs as ordered and notify MD of results Provide diet as ordered - Regular diet/textures/fluids. Assist with intakes prn. Ice cream with lunch & dinner Report S&S of diet and/or texture intolerance Review weights and notify RD, MD, and responsible party of significant weight change Therapy eval and treat as ordered Weekly weights (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/2024 at 12:09 a.m. Nutrition/Dietary Note Text: Writer discussed resident's (R66) ongoing weight loss with NP (Nurse Practitioner). She has experienced an 11.8# (10%) weight loss over the last 30 days. Current weight 102.4#, BMI 18.1. Monitoring with weekly weights. Nursing reporting resident's meal intakes have increased a bit as of late r/t encouragement to consume meals provided. She continues to enjoy most meals in DR (dining room). Accepts fluids well. Increased acceptance of nutrition supplement with avg intake 50-100% BID. Does consume snacks b/t (between) meals on occasion. No reported or c/o (complaints of) s/s of increased c/s (chewing/swallowing) difficulty. No n/v/d/c (nausea, vomiting, diarrhea, & constipation). Will f/u to update preferences to assist goal of increased po intakes. No updated labs to review. Will continue to monitor po (by mouth) /fluid intakes, weight. A review of the current MD Orders: Med Plus 2.0 120 ml two times a day for supplemental nutrition; weight loss Supplement Active 1/19/2024 Weekly Weight one time a day every Fri for weight monitoring Other Active 1/26/2024 Boost Breeze one time a day for supplemental nutrition for weight loss give 8oz well chilled Supplement Active 3/10/2024. Surveyor conducted a review of R66's weights that are in the electronic medical record. (15.7 % weight loss from 10/1/23 to 2/1/24) 3/8/2024 10:26 105.6 Lbs Wheelchair scale 3/1/2024 09:16 103.8 Lbs Wheelchair scale 2/23/2024 13:55 103.8 Lbs Wheelchair scale (Manual) 2/9/2024 14:08 104.0 Lbs Wheelchair scale 2/1/2024 11:43 102.0 Lbs Wheelchair scale 1/27/2024 07:47 102.2 Lbs Wheelchair scale 1/23/2024 10:15 102.4 Lbs Wheelchair scale 1/22/2024 09:50 103.4 Lbs Wheelchair scale (Manual) 1/19/2024 11:14 103.6 Lbs Wheelchair scale 12/15/2023 14:58 114.2 Lbs Standing (Manual) 12/1/2023 14:10 115.0 Lbs Wheelchair scale 11/1/2023 08:44 119.6 Lbs Wheelchair scale (Manual) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/1/2023 13:55 121.0 Lbs Wheelchair scale (Manual) 10/1/2023 12:37 191.0 Lbs Wheelchair scale (Manual) On 2/19/2024 at 12:19 p.m., Nutrition Assessment Note Text: Diet order: Regular diet. Average meal intake: 51-100% with 8 intakes 26-50% x 30 days Enjoys snacking on popcorn. Received nutritional supplements and/or fortified foods. Nutrition juice with breakfast - 100% intake. Provides 200kcal, 6g protein as ordered. 4oz MedPass BID - 100% intake AM; 25-100% intake PM Provides 480 kcal, 20g protein as ordered. Eating ability: Independent. Current weight:W 104.0 lb - 2/9/2024 14:08 Scale: Wheelchair scale. BMI: 18.4. Significant weight change present. Has experienced a significant 15.6# (13%) weight loss x90 days and total 25.4# (20%) x180 days/admission. Weight has remained stable 1/19 to 2/9. Continues with weekly weights. Updated nursing of updated weekly weight needed. Last weight documented 2/9. Skin condition: Other. Skin tear to right elbow 2/16 - healing and scabbed No edema present. Summary: Current diet order remains appropriate for management of resident Resident appears to be tolerating diet texture/consistency. Resident is consuming adequate calories to maintain weight. Current diet order/oral nutritional supplement(s) order provides adequate calories/protein to meet estimate nutritional needs. Resident is receiving diet of choice. Resident reviewed for quarterly. Continues to tolerate Regular diet/textures without issues reported. Remains independent with feeding self-meals with setup prn. Enjoys meal in DR. Staff provides encouragement at meal. Generally good intakes of ONS (oral nutritional supplements). Accepts fluids well. Continues to work with therapy. Reports no concerns to writer during review, however, continues with sporadic changes in appetite. Will discuss with IDT at upcoming WAR (weekly at risk) if appetite stimulant is appropriate for pt. Will continue to monitor. Continue current nutrition plan of care. Surveyor conducted a review of the quarterly MDS (Minimum Data Set), dated 2/20/24. R66 has a BIMs (brief interview of mental status) score of 8 (moderately impaired cognition). The assessment states that R66 weighs 104 pounds and there is no weight loss or gain. On 3/13/24 the MD monthly compliance note: * R63.4 - Abnormal weight loss *: Continued weight loss noted. Dietitian has initiated med Pass twice daily, and boost has been discontinued. Monitor nutritional intake and weight for improvement. Surveyor conducted a review of the Meal Percentage and Fluid Intake records for R66 for the months of January, February and March, 2024. It was noted that there were several entries left blank where no meal intake was documented for various breakfast, lunch and dinner meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/28 at 9:30 a.m., Surveyor interviewed Registered Dietician (RD)-W regarding R66. RD-W stated that upon admission, Residents are to be weighed daily times 3 days then weekly for 3 weeks and then monthly after that unless specified in the orders to conduct weights more frequently. RD-W stated that IDT team talks about weights in WAR meetings held each Friday. RD-W stated she usually looks for triggers in the weight and vitals tab of the electronic medical record. The Unit Managers put out weight list for the CNA's to get weights on particular residents. I will request weights prior to WAR or at WAR. RD-W stated she will look at meal intakes as well. DON-B will run nutrition report. % meal intake, you can gather 4 weeks at time. Surveyor then asked about R66 and the weight loss she has experienced. Surveyor asked RD if she is aware that the weekly weights were not being taken per the physician order. RD-W stated I am aware that weight has not been taken since 3/8/24. RD-W stated she will verbally ask Unit Manager regarding weight. I can't remember last time I verbally asked about a weight for R66. I do lay eyes on her weekly. I watch her eat as well. Watching supplement intake. No concerns with observations. I know she has anxiety and that can impact her appetite. I have not been able to get weight back on her. When I noticed, back in December 2023. She has always had weight fluctuations due to anxiety. She was agreeable to boost. End of December, I was on holiday. I came back and asked for weight and weekly weights. I checked in with nurse and R66 was not really liking boost. She liked med pass instead. R66 was doing good with nutrition juice at breakfast. Preferences updated. Trying to get extra things on her tray that she liked- ice cream 2 times daily. I had them order boost breeze instead of juice due to availability of juice. R66 is not doing well with med pass in the evening the past few weeks. I will try and obtain weight today. I'm also going to try and address the med pass with her (R66) today because she has not been accepting it in the evenings. 03/27/24 10:48 AM RD-W relayed to Surveyor that a weight was just obtained for R66 and the weight is 107. 8 pounds. Surveyor shared concerns at the daily exit on 3/27/24 regarding the facility not completing weekly weights for R66 to help determine in a timely manner if R66 continues to lose weight. In addition the concern was brought forth that the facility staff was not consistently documenting on R66's meal intakes, per the plan of care. As of the time of exit, no additional information was provided concerning R66.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 20483 Based on observation, interview, and record review the Facility did not ensure a resident with a gastrostomy tube received the appropriate care and services for 1 (R63) of 2 residents with gastrostomy tubes. R63's water flush bag was not labeled for two days. Findings include: R63's diagnoses includes cerebrovascular accident (CVA) & dysphagia. The feeding tube care plan initiated 2/27/23 includes an intervention also dated 2/27/23 of Administer tube feeding formula, hydration, and flushes per order. The annual MDS (minimum data set) with an assessment reference date of 1/12/24 has a BIMS (brief interview mental status) score of 8 which indicates moderate cognitive impairment. R63 is assessed as being dependent for eating and is checked yes for tube feeding while a resident. The physician orders dated 12/6/23 documents at bedtime for supplemental nutrition run Osmolite 1.5 at 60 ml (milliliters) per hour for 8 hours via pump per PEG tube. Run water flush at 60ml/hr (milliliter per hour) via pump. Start infusion at 2100 (9:00 p.m.) and continue until 0500 (5:00 a.m.). The physician orders dated 12/6/23 documents Three times a day for additional hydration flush feeding tube with 200 ml water. On 3/25/24 at 9:50 a.m. Surveyor observed R63 sitting in a Broda chair in the room. Surveyor observed R63's tube feeding is not running. The feeding bag labeled with the formula name and dated. Surveyor observed the water flush bag which contains water is not labeled and does not have a date. On 3/25/24 at 11:10 a.m. Surveyor observed R63 sitting in a Broda chair in the room watching Gunsmoke. The Broda chair has been reclined with R63's legs extended. Surveyor observed the water flush bag is still not labeled or dated. On 3/25/24 at 12:31 p.m. Surveyor observed R63 sitting in a Broda chair in the room. The back of the Broda chair is reclined slightly. Surveyor observed the water flush bag is still not labeled or dated. On 3/26/24 at 7:32 a.m. Surveyor observed R63 in bed on the right side with the head of the bed elevated. Surveyor observed R63's tube feeding is not running. The feeding bag labeled with the formula name and dated. Surveyor observed the water flush bag which contains water is not labeled and does not have a date. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 8:35 a.m. Surveyor observed LPN (Licensed Practical Nurse)-F place on a gown & gloves and inform Surveyor R63 has an order to flush with 200 ml water and R63 can get the water flush between 7 and 9:00 a.m. LPN-F informed R63 she was going to flush her tube and LPN-F checked the placement of R63's gastrostomy tube. LPN-F informed Surveyor the settings are pre set, cleansed the tip of the feeding tube and connected the tube telling R63 she is going to give her a flush. At 8:42 a.m. Surveyor asked LPN-F if she had to put any water in the flush bag. LPN-F informed Surveyor when she came in she added a little water for the 200 ml flush bag. Surveyor asked LPN-F if the water flush bag should be dated. LPN-F replied it should be labeled with the resident's name and date. LPN-F then stated they have the formula bag dated. At 8:49 a.m. when R63's water flushes were completed, LPN-F disconnected the tube, removed her gloves & gown, and cleansed her hands. On 3/26/24 at 4:11 p.m. Surveyor observed R63 in bed on her right side. Surveyor checked R63's water flush bag and noted the water flush bag is now labeled and dated. On 3/26/24 at 3:52 p.m. during the end of the day meeting with NHA (Nursing Home Administrator)-A, DON (Director of Nursing)-B and [NAME] President of Success-C, Surveyor asked if the water flush bags should be dated. DON-B informed Surveyor they should have a separate sticker on them. Surveyor informed DON-B of the observations of R63's water flush bag not being labeled for two days. On 3/27/24 at 7:27 a.m. Surveyor observed R63 in bed on the right side. Surveyor observed there are no bags hung from the tube feeding pole at this time.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 21855 Based on observation, record review and interview, the facility did not ensure intravenous fluids were administered appropriately. This was observed with 1 (R57) of 1 residents observed with IVF (intravenous fluids). - R57 had a 1 liter bag of 0.9 sodium chloride being infused intravenously with no identifying factors to include name, date, rate, purpose of IVF. Findings include: Surveyor reviewed the facility policy and procedure Intravenous Fluid and Drug Administration General Policies dated 8/21. The policy includes: 9. The nurse will verify the the container's label coincides with the prescriber's order. Verify content, dose, prescribed rate, and expiration date of the solution. On 3/24/24 at 10:13 AM Surveyor observed R57 in bed with IVF running. The IVF bag did not have a label, date, name, rate or any other identifiable prescribed information. The IVF bag was 0.9% sodium chloride 1000 ml (milliliters). R57 had a the IV inserted in their right hand. There was no date to identify the date of insertion. The IVF tubing had a circular device with the dial set at 50/hr running. The IVF was a full bag. On 3/25/24 at 9:27 AM Surveyor observed the IVF bag was empty. The IV remains inserted in R57's right hand, there is a clear covering over the site with no date. R57 medical record was reviewed by Surveyor. The Progress Note on 3/23/2024 at 10:21 AM includes: order for .9 ns (normal saline) at 50 ml hour x 1 liter, may increase oxygen up to 4 liters. (Name of) ambulance started perph (IV) site, bag up at 830 AM The Progress Note on 3/24/2024 at 2:18 PM includes: orders received for oxygen at 3 liters per nc(nasal cannula), to have labs 3/25, 1 liter ns at 50 cc (cubic centimeter)/hr (hour). R57's Physician Summary, dated 3/21/24, does not include any IV prescribed orders for administration and care of an IV administration. R57's Treatment Administration Record for March 2024 indicates the following: - Start date 3/24/24 at 2:30 PM with a discontinued date of 3/25/24 at 5:28 PM Sodium Chloride intravenous use 1 liter intravenously every shift for hydration until 3/25/24 8:59 PM at 50 ml/hr-started at 7:30 AM on 3/24/24. This is documented as administered on 3/24/24 for the evening and night shift, and on 3/25/24. There is no documentation on the Treatment Administration Record related to the IV insertion site in R57's right hand. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 9:16 AM Surveyor spoke with (Registered Nurse/ Unit Manager) RN UM-M. They thought that R57 received a liter of fluids on Saturday, then there was another order on Sunday to administer another liter of fluid. RN UM-M indicated there should be an administration label on the IVF. Surveyor shared there was no dates or identifiable information. R57's IV administration orders did not align with observations. On 3/26/24 at 3:42 PM at the facility Exit Meeting. Surveyor shared the concerns with R57's IVF management.

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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. 21855 Based on observation, record review and interview, the facility did not ensure oxygen humidification was implemented. This was observed with 1 (R57) of 1 resident's observed with oxygen administration. -R57 had orders for oxygen humidification and this was not implemented. Findings include: On 3/24/24 at 10:13 AM Surveyor observed R57 in bed with oxygen administration at 3.5 lpm (liter per minute) via nasal cannula. There is no humidifier with the oxygen administration. On 3/25/24 at 9:30 AM Surveyor observed R57 in bed with oxygen administration at 2.5 lpm per nasal cannula. There is no humidifier with the oxygen administration. R57's medical record was reviewed by Surveyor. R57 has a physician order from 3/21/24 to change oxygen tubing and humidifier bottles weekly. R57's March 2024 Treatment Administration Record indicates the following: Change oxygen tubing and humidifier bottles weekly. On 3/26/24 at 9:20 AM Surveyor spoke with (Registered Nurse/ Unit Manager) RN UM-M. They did not know about the humidifier and thought maybe it was a batch type order. They will look into it. On 3/26/24 at 3:42 PM at the facility Exit Meeting. Surveyor shared the concerns with R57's oxygen humidifier. On 3/27/24 at 1:54 PM Surveyor observed R57 with humidification with oxygen administration.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 38829 Based on interview and record review, the facility did not complete a performance review for 5 of 5 CNAs (Certified Nursing Assistants) reviewed. This had the potential to affect a pattern of all 78 Residents who reside in the facility as the 5 CNA's work throughout the building as needed. Findings include: Administrator (NHA-A) informed Surveyor on 3/29/24 at 3:37 PM that there is no policy and procedure for performance reviews of CNAs. NHA-A provided Surveyor with an email dated 3/29/24, at 3:23 PM from VP (vice president) of Human Resources (VPHR)-BB that states the facility does not have a formal evaluation process but according to the employee handbook the following is written: .Your supervisor will evaluate your performance in writing at least annually. The written evaluation form will be discussed with you. The emphasis will be to constructively review your strengths and weaknesses and to set new job performance goals. Surveyor notes the facility assessment, last updated 3/28/24, documents the following in regards to performance reviews for CNAs. .Required in-service training for nurse aides. In-service training must: -Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of Residents as determined by facility staff. On 3/29/24 at 12:10 PM, the Surveyor asked for the performance reviews for: CNA-CC who was hired by the facility on 10/01/17, CNA-DD who was hired by the facility on 03/08/22, CNA-EE who was hired by the facility on 6/22/20, CNA-FF who was hired by the facility on 09/24/19, and CNA-T who was hired by the facility on 06/22/21. On 3/29/23 at 2:09 PM performance evaluations were reviewed by Surveyor and indicated: CNA-CC's last performance evaluation was 7/31/21, CNA-DD's last performance evaluation was 3/30/22, CNA-EE's last performance evaluation was 6/9/21, (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA-FF's last performance evaluation was 5/18/21 and CNA-T's last performance evaluation was 8/23/21. On 3/29/24 at 3:47 PM, Surveyor was informed by NHA-A that NHA-A does not know if a competency performance review is done yearly, but agrees the expectation is that a competency performance review should be done for all CNAs. Surveyor shared the concern that the facility did not complete a performance review at least once every 12 months for CNA-CC, CNA-DD, CNA-EE, CNA-FF, and CNA-T. No further information was provided by the facility at this time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on interview, and record review, the Facility did not ensure 2 (R72, R66) of 5 residents were free from unnecessary medications. *R72 was prescribed antipsychotic medication without a timely Abnormal Involuntary Movement Scale (AIMS) assessment. *R66 was prescribed antipsychotic medication without a timely Abnormal Involuntary Movement Scale (AIMS) assessment. Findings include: Facility policy entitled, Psychotropic Medications, revised on 10/24/22, documents: Residents should not received psychotropic drugs unless the medication is necessary to treat specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrator by monitoring and documentation of the resident's response to the medication .The indications for use of any psychotropic drug will be documented in the medical record .Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation .Residents who receive an antipsychotic medication will have an AIMs test performed on admission, at least every 6 months, when the antipsychotic medication is changed and PRN (as needed.) . R72 was admitted to the facility on [DATE] with diagnoses of major depressive disorder and anxiety disorder. On 2/16/24, R72 was seen by psychiatric services at the facility and prescribed the antipsychotic medication Seroquel. Surveyor reviewed R72's medical record. Surveyor could not identify any AIMS assessments completed by the facility when antipsychotic medication was prescribed to R72. On 3/27/24 at 12:15 PM, Surveyor conducted interview with Unit Manager-V. Surveyor asked Unit Manager-V who would be responsible for conducting AIMS assessment for residents receiving antipsychotic medications. Unit Manager-V told Surveyor that they don't usually complete AIMS assessments for residents. Unit Manager-V added that they think the facility's DON (Director of Nursing)-B completes AIMS assessments for residents. On 3/27/24 at 1:10 PM, Surveyor conducted an interview with NHA (Nursing Home Administrator)-A. Surveyor shared concerns related to not being able to locate a completed AIMS Assessment for R72 upon initiation of their prescribed antipsychotic medication on 2/16/24. The facility did not provide any additional information at this time. 16584 2.) R66 was admitted to the facility on [DATE] with diagnoses that includes Hemiparesis, major depressive disorder, Dementia, and anxiety disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility conducted an AIMS- Abnormal Involuntary Movement admission assessment on 8/14/23. R66 scored a zero and was at low risk of movement disorder. Surveyor conducted a review of R66's plan of care and noted that R66 is at risk for adverse effects r/t (related to) use of anti-depressant, anti-anxiety, mood stabilizer [Psychotropic's] Interventions included: Increase resident's ability to fall asleep or maintain sleep AIMS testing per facility guidelines (upon admission, initiation of, change of, every 6 months, and PRN) Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs Non-Pharm Interventions for behaviors 1. Address in a calm manner 2. Attempt to orientate to place and time 3. Allow resident to express feelings or frustrations and provide reassurance as needed. <p> 4. Provide assistance as needed 5. Family visits 6. Offer activities of choice 7. Provide emotional support to resident as needed 8. Offer to close door and curtains to facilitate sleep Psychiatrist consult and follow up as needed The following medication changes were noted in the plan of care for R66: Seroquel PRN (as needed) discontinued 9/22/23 start scheduled Seroquel 9/27/23 discontinue Lexapro 9/27/23 start Zoloft dose x10 days then increase dose 9/27/23 start Lorazepam (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/23/23 GDR (gradual dose reduction) Seroquel x14 days then discontinue 11/9/23 GDR Trazodone 11/9/23 increase Zoloft 12/14/23 start Depakote ER (extended release) 1/18/24 increase Depakote On 3/26/24 at 3:30 p.m., Surveyor requested to review the most current AIMS assessment for R66. On 3/27/24 at 7:30 a.m. the facility provided Surveyor with the admission AIMS, dated 8/14/23. Surveyor conducted a review of the facility's policy and noted the AIMS assessment was to be conducted upon admission, every 6 months and with medication changes. Surveyor noted that the facility didn't conduct the AIMS assessment for R66 when psychotropic medications were increased and decreased over the period since admission 8/14/23. No addition information was provided as of the time of exit from the facility.

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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. 46517 Based on observation, interview, and record review the facility did not ensure that drugs and biological's used in the facility were labeled in accordance with currently accepted professional principles including the expiration date when applicable for 1 of 2 medication carts reviewed and 1 of 1 medication rooms reviewed. *The North team two medication cart also contained containers of eye drops that were either not labeled with an opened date, had an illegible opened date, or were expired. *The East medication room contained 13 bottles of Optum Daily Rescue supplement that were expired 8/2023. Findings include: The facility policy entitled, Medication Administration general guidelines, dated 01/23, stated: .b. The nurse shall place a date opened sticker on the medication .and enter the date opened c. Certain products or packaging types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating, once opened, to ensure medication purity and potency. When date open expiration dating is not available from the manufacturer, the following may be considered in determining facility policy: Position statements from American Society of Ophthalmic Registered Nurses and American Society of Cataract & Refractory Surgery state that multi-use eye drops and ointments should be disposed of 28 days after initial use . On 03/26/24 at 10:00 AM, Surveyor reviewed the East medication room. Surveyor inspected the stock medication cabinet and noted 13 bottles of Optum Daily Rescue Supplement that were expired. Surveyor showed one of the bottles to Licensed Practical Nurse (LPN)-Q. LPN-Q stated she would dispose of the expired medication. Per LPN-Q the Health Unit Coordinator/Scheduler is responsible for checking the stock medications and disposing of expired medications. On 03/26/24 10:21 AM, Surveyor reviewed the North team 2 medication cart. Surveyor noted the medication cart contained the following: R11 had one opened bottle of lubricant eye drops that were dated, but the date was illegible; an opened bottle of Brimonidine eye drops that was not dated, and an opened bottle of artificial tears that was dated but the date was illegible. A container of artificial tears with a resident's last name (no longer at the facility) that was dated November 2023. R9 had an opened bottled of Brimonidine Timolol Maleate 0.2% eye drops that was not dated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51 had an opened bottle of refresh tears eye drops that was not dated and an opened bottle of Ketotifen Fumerate eye drops that was dated 2/8/24 On 03/26/24 at 11:32 AM, Surveyor interviewed Director of Nursing (DON)-B, Nursing Home Administrator-A and [NAME] President of Success-C. Surveyor shared the above concerns. No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46517 Based on observation and interview the facility did not follow professional standards for food service safety to ensure dishes and utensils were properly handled properly after sanitization from the dishwasher. This had the potential to affect all 78 residents if they receive food from the kitchen. *Dietary staff were observed going from the dirty side of the dishwashing machine to the clean side without performing hand hygiene. Findings include: On 03/25/24 at 10:00 AM, Surveyor observed Dietary Aide (DA)-E at the dishwashing station. DA-E was rinsing dishes on the right side of the dishwasher and placing them in a tray. DA-E then opened the dishwasher and removed a tray of clean dishes and slid the tray down the counter. Surveyor noted DA-E was wearing gloves, however, DA-E did not change his gloves. Surveyor continued to observe DA-E and noted DA-E wore the same gloves while continuing to rinse dishes, place them on a tray and put in the dishwasher and then remove trays with clean dishes from the dishwasher. DA-E then began sorting through the clean silverware tray to the left of the dishwasher. Surveyor observed DA-E put clean dishes away as well as remove dishes that needed to be rewashed. During this time DA-E did not change his gloves. Surveyor asked DA-E to explain the dish washing process. DA-E stated he rinses and scrubs the dishes on the right side of the dishwasher and puts the trays through the machine. DA-E informed Surveyor the dishes and trays to the left side of the machine are clean. Per DA-E sometimes he goes from the dirty side to the clean side, but he always rinses his gloves really well when touching the clean dishes after touching/rinsing the dirty dishes. Surveyor asked DA-E if he ever changes his gloves when going from the dirty side to the clean. Per DA-E yes he does sometimes. Surveyor asked DA-E if he changed his gloves just prior when going from the dirty side to the clean side. DA-E said no. On 03/25/24 at 10:20 AM, Surveyor relayed the above concern to Dietary Manager (DM)-D. Per DM-D gloves should be changed and hand hygiene performed when moving from dirty to clean. DM-D stated she was going to educate the staff right now. On 03/26/24 at 3:30 PM, during the end of the day meeting with Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A, and [NAME] President of Success-C, Surveyor relayed the observation of DA-E not performing hand hygiene or changing his gloves when moving from rinsing dirty dishes to handling clean dishes. No additional information was provided.

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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. 21855 Based on observation, record review and interview, the facility did not implement an effective Water Management Committee, along with infection prevention with medication administration. This was observed with 1 (R38) of 4 residents observed with medication administration. The facility did not include a closed unit in their water plan, which has the potential to effect all 74 residents in the facility. - The facility has a closed unit with no water assessment to prevent Legionella. - R38's medications were administered in a unsanitary manner. Findings include: Surveyor reviewed the facility's policy and procedure Legionella Surveillance Policy dated 10/24/22. The policy indicates the facility will establish primary and secondary strategies for the prevention and control of Legionella infections. The Primary prevention strategy refers to the approaches to prevention and control of Legionella infections in health care facilities with no identified cases. The Guidelines include: 4.b. Legionella grows best in water temperature 77 degrees Fahrenheit -108 degrees Fahrenheit, particularly in water that is not moving or or that does not have enough disinfectant to kill germs. 1.) On 3/27/24 at 09:04 AM Surveyor met with (Maintenance Director) MD-U to review the facility's Water Management Plan. The facility has a closed unit with 23 resident rooms, 1 shower and 4 bathrooms for general use. This unit has been closed for years. This has not been identified in the facility's risk assessment. There is not any documentation of control measures for the water that has not been used. MD-U indicated they do not have a documented plan for the closed unit. The facility Water Management Committee did review their plan on 2/5/24. This plan does not identify the areas closed on the South unit with a verification process. The facility has a plan for the units that are open with unoccupied rooms. For these rooms, there is a plan to flush water and take temperatures. They have a service that comes in to address the ice machines. The water bubblers are in use. On 3/27/24 at 9:58 AM Surveyor shared the water plan concerns regarding the South unit with Administrator-A and Director of Nurses-B. No further information was provided. 46517 2.) On 03/24/24 at 8:45 AM, Surveyor observed Licensed Practical Nurse (LPN)-F prepare to give medications to R38. LPN-F preformed hand hygiene. LPN-F then punched out a Carbidopa-Levodopa 25mg/100mg tablet from a bubble pack. Surveyor observed LPN-F touch the pill with her bare hand prior to placing the pill in the medication cup. Surveyor observed LPN-F continue to prepare the rest of R38's medications the same way: punching the medication out of the bubble pack, touching the pill with her bare hands, and placing the medication in the cup. LPN-F preformed hand hygiene entered R38's room and administered the medications to R38. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/26/24 at 11:32 AM, Surveyor interviewed the Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A and [NAME] President of Success-C. Surveyor relayed the above concern of LPN-F touching pills with her bare hands. Surveyor asked if a nurse should touch pills with her bare hands. DON-B stated no. No additional information was provided.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 38829 Based on interview and record review the Facility did not ensure 8 of 8 staff chosen at random received QAPI (quality assurance performance improvement) training on the elements & goals of the Facility's QAPI program which is required for all direct and indirect staff. This practice had the potential to affect all 78 residents in the facility. The following direct care workers: Certified Nursing Assistant (CNA)-CC, CNA-DD, CNA-EE, CNA-FF, CNA-T, and Licensed Practical Nurse (LPN)-R did not receive the required QAPI training within the required time-frame of date of hire. The following indirect care workers Laundry/Housekeeping (LK)-GG and Dietary Aide (DA)-HH did not receive the required QAPI training. Findings include: The facility's Facility Assessment Tool policy, updated 3/28/24, contained the following information: .List all staff training and competencies needed by type of staff. The list of required training's does not include QAPI training. CNA-CC was hired by the facility on 10/01/17. CNA-DD was hired by the facility on 03/08/22. CNA-EE was hired by the facility on 6/22/20. CNA-FF was hired by the facility on 09/24/19. CNA-T was hired by the facility on 06/22/21. LPN-R was hired by the facility on 10/1/17. LK-GG date of hire is 10/27/18 for this facility. DA-HH date of hire is 2/7/23 for this facility. On 3/29/24 at 2:09 PM, Surveyor reviewed the training's for CNA-CC, CNA-DD, CNA-EE, CNA-FF, CNA-T, LPN-R, LK-GG, and DA-HH. The sampled direct and indirect facility staff did not have documentation of QAPI training. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/29/24 at 3:47 PM, Surveyor shared the concern with Administrator r(NHA-A) and Director of Nursing (DON-B) the concern that CNA-CC, CNA-DD, CNA-EE, CNA-FF, CNA-T, LPN-R, LK-GG, and DA-HH did not receive the required QAPI training. No further information was provided by the facility at this time. On 4/1/24 at 11:37 PM, NHA-A provided additional information for CNA-CC, CNA-DD, CNA-EE, CNA-FF, CNA-T, and LPN-R by email. CNA-CC received QAPI training on 10/21/23, however, based on date of hire, CNA-CC did not receive the QAPI training within the required time-frame based on date of hire on 10/1/17. CNA-DD received QAPI training on 10/31/23, however, based on date of hire, CNA-DD did not receive the QAPI training within the required time-frame based on date of hire on 3/8/22. CNA-EE received QAPI training on 1/26/24, however, based on date of hire, CNA-EE did not receive the QAPI training within the required time-frame based on date of hire on 6/22/24. CNA-FF received QAPI training on 10/7/23, however, based on date of hire, CNA-FF did not receive the QAPI training within the required time-frame based on date of hire on 9/24/19. CNA-T received QAPI training on 10/4/23, however, based on date of hire, CNA-T did not receive the QAPI training within the required time-frame based on date of hire on 6/22/21. LPN-R received QAPI training on 1/3/24, however, based on date of hire, LPN-R did not receive the QAPI training within the required time-frame based on date of hire on 10/1/17. Surveyor did not receive any documentation that LK-GG or DA-HH received the required QAPI training.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 38829 Based on staff interview and record review, the facility did not ensure staff received the annual Compliance and Ethics training. This practice had the potential to affect all 78 residents in the facility. The facility did not provide staff with the required annual Compliance and Ethics training which includes all direct and indirect staff for Laundry/Housekeeping (LK-GG) and Dietary Aide (DA-HH) on an annual basis. Findings include: The facility's Facility Assessment Tool policy, updated 3/28/24, contained the following information: .List all staff training and competencies needed by type of staff. The list of required training's does not include Compliance and Ethics training. LK-GG date of hire is 10/27/18 for this facility. DA-HH date of hire is 2/7/23 for this facility. On 3/9/29 at 2:09 PM, Surveyor reviewed the training's for LK-GG and DA-HH and determined there is no documentation that LK-GG and DA-HH received the required Compliance and Ethics training. On 3/29/24 at 3:09 PM, Surveyor interviewed Dietary Manager (DM-JJ) in regards to the required Abuse training for DA-HH. DM-JJ stated the expectation is that all dietary employees watch a video and then take a test. DM-JJ stated the documentation would show up on the training report as 2 separate events, inservice and test. On 3/29/24 at 3:14 PM, Surveyor interviewed Housekeeping Supervisor (HS-KK) in regards to the required Abuse training for LK-HH. HS-KK is aware there are required training's and stated, Its printing wrong. On 3/29/24 at 3:47 PM, Surveyor shared the concern with Administrator (NHA-A) and Director of Nursing (DON-B) the concern that LK-GG and DA-HH did not receive the required Compliance and Ethics training. No further information was provided by the facility at this time.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 38829 Based on record review and interview, the facility did not ensure direct care staff 5 of 5 Certified Nurse Aides (CNAs)(CNA-CC, CNA-DD, CNA-EE, CNA-FF, CNA-T), Licensed Practical Nurse (LPN-R), and indirect care staff Laundry/Housekeeper (LK-GG), and Dietary Aide (DA-KK) reviewed received behavioral health training to care for Residents diagnosed with mental, psychosocial, a history of trauma, or substance use disorder as indicated on the facility assessment. This deficient practice has the potential for all staff to lack current knowledge to work with the unique challenges mental health illnesses present. The facility did not provide staff with required annual training on the facility's behavioral health services. Findings Include: The facility's Facility Assessment Tool policy, updated 3/28/24, contains the following information: .The facility admits Residents with Psychiatric/Mood Disorders which include Psychosis, Depression, Bipolar, Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions. The facility assessment documents that the facility has an average of 1-10 Residents with behavioral health needs and 2-4 Residents with active or current substance use disorders, and this is increasing. Services and care offered by the facility for mental health and behavior is to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. List all staff training and competencies needed by type of staff and behavioral health training is not listed. The facility requires staff to competent in caring for Residents with mental and psychosocial disorders, as well as Residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions. On 3/29/24 at 2:09 PM Surveyor reviewed the following employee training's: CNA-CC was hired by the facility on 10/01/17 and did not receive Behavioral Health Training. CNA-DD was hired by the facility on 03/08/22 and did not receive Behavioral Health Training. (continued on next page)

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA-EE was hired by the facility on 6/22/20 and did not receive Behavioral Health Training. CNA-FF was hired by the facility on 09/24/19 and did not receive Behavioral Health Training. CNA-T was hired by the facility on 06/22/21 and did not receive Behavioral Health Training. LPN-R was hired by the facility on 10/1/17 and did not receive Behavioral Health Training. LK-GG date of hire is 10/27/18 for this facility and did not receive Behavioral Health Training. DA-HH date of hire is 2/7/23 for this facility and did not receive Behavioral Health Training. On 3/29/24 at 3:47 PM, Surveyor shared the concern with Administrator (NHA-A) and Director of Nursing (DON-B) the concern that CNA-CC, CNA-DD, CNA-EE, CNA-FF, CNA-T, LPN-R, LK-GG, and DA-HH did not receive the required behavioral health training. No further information was provided by the facility at this time.