STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525414	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Health Services	2727 W Mitchell St Milwaukee, WI 53215

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interview and record review the facility did not ensure residents the right to refuse and/or discontinue treatment for 1 of 12 (R33) residents reviewed for choices. * R33 was forced by facility staff to get out of bed against his wishes. Findings include: R33 was admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following Cerebral Infarction, Congestive Heart Failure and Atherosclerotic Heart Disease. R33's Quarterly Brief Interview for Mental Status dated 2/26/24 documents a score of 4, indicating severe cognitive impairment. R33's Quarterly Minimum Data Set (MDS) dated [DATE] documents bed mobility, transfer, dressing and personal hygiene as extensive 2 person physical assist. Section E - Behavior documented: None exhibited. R33's Quarterly MDS dated [DATE] documented: Physical behavioral symptoms directed towards others (e.g. , hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - behavior occurred 1-3 days. R33's Quarterly MDS dated [DATE] documented no behaviors. Surveyor review of a Facility Reported Incident documented on 10/12/23 at 11:00 AM R33 reported to his granddaughter that the night before 2 caregivers sat on him to hold him down. Police were called, did not come out to investigate. Skin assessment OK. Daughter/Physician notified. Residents on assignments of Certified Nursing Assistants (CNA)'s interviewed - no other concerns reported. Roommate reported they were forcing the resident to get up. Re-education initiated with employees on abuse. Employee files were reviewed - neither had been disciplined, both had background checks completed, both had completed orientation education on abuse. The statements from the 2 CNA's indicated they held down the resident to change him and were argumentative with him. Based on these actions, the 2 CNA's are no longer employed with the facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation included the following statements: R33: I was in my bed asleep and the Fat (expletive) [NAME] got on top of me and held my arms down so I couldn't get up. Then the other skeleton looking (expletive) was laughing so I kicked her. She said it didn't hurt so I kicked her again. She lied and said my legs were hanging out of the bed and they were not. I really don't need anyone's help. I can get out of the bed and walk over to the chair on my own. They harass me every night. They come in and wake me up to (expletive) with me. Roommate of R33: On the evening of 10/11 (CNA-I and CNA-J) came into the room and woke (R33) up to get him up into the Broda chair. (R33) told them no, he didn't want to get into the chair because he was sleeping and the aides continued to force (R33) to get up. The roommate stated when (R33) kicked the aide she got mad with him (roommate) and replied what are you laughing at. CNA-I: Observed (R33)'s feet hanging out of the bed, went to get help, CNA-J entered the room. (R33) became verbally abusive calling CNA-J anorexia and CNA-I a [NAME]. CNA-J was kicked by (R33) and responded didn't hurt. (R33) became more upset and agitated, continued to use expletives, CNA-I is holding arm/leg alongside of the bed to prevent (R33) from hitting/kicking. Eventually got resident up into Broda chair, pushed resident outside into corridor. Resident continued with physical and verbal abuse. CNA-J: CNA-I went into (R33)'s room to check on him and he was kicking his legs off the side of the bed and threatening to throw himself on the floor, so CNA-I went and told (nurse) and she said to get him up. As soon as we came in he started cursing us out for no reason. He called me a skinny anorexic .(expletive) and called CNA-I a fat (expletive) [NAME] and said he was going to kick our (expletive). (Nurse) told us to just go ahead and get him up into the Broda chair. I was on the side of the bed nearest the window at the top of the bed and CNA-I was on the other side. (R33) then kicked me three times and I told him that didn't hurt. I told CNA-I to grab his hands so that we can get him dressed. (R33) was trying to punch CNA-I so she held his right arm and leg. We rolled him from side to side to get the sling under him to lift him with the hoyer. He then grabbed onto the Broda chair arm to try and prevent us from transferring him from the bed to the chair. He finally let go and we got him into the Broda chair. On 2/28/24 at 9:07 AM Surveyor spoke with [NAME] President of Excellence-C about the facility self report. VP of Excellence-C reported based on the investigation it was determined action would be taken against the two CNA's and training was provided for all staff on abuse. On 2/28/24 at 2:13 PM Surveyor reviewed the employee files of both CNA-I and CNA-J. No substantiated findings of abuse, neglect or misappropriation on the Wisconsin Caregiver Misconduct Registry. Background checks completed. Surveyor review of the education provided included the facility policy Neglect and exploitation revised 7/15/22, which included definitions of abuse. On 2/29/24 at 8:07 AM Surveyor spoke with Social Services Director-D who reported she was familiar with the incident and investigation involving R33. Surveyor asked about the education provided to staff following the incident. Surveyor noted education included providing the policy on abuse and asked if any other education was completed. Social Services Director-D stated: Yes, we also did an in depth power point presentation in conjunction with providing the policy. It was more specific. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was provided a copy of the power point education provided to all staff following the incident involving R33. The content included reporting allegations, what do I have to report, how do I know if its abuse, who do I tell, who do I call, what happens if I don't report it, etc. Surveyor noted the training provided to staff was not specific to the incident involving R33. No education was provided on dementia, dealing with difficult behaviors, re-approaching at a later time or residents' right to refuse treatment and care. On 2/29/24 at 9:43 AM Surveyor spoke with R33 who was sitting in his Broda chair, well groomed, no odors or signs/symptoms of pain. R33 reported feeling fine today. R33 stated staff treats him fine no-one talks mean to him, they're nice and denied being hit or abused. When asked if he is able to get up when he wants to, R33 replied yes. Surveyor asked if anyone ever makes him get up when he doesn't want to, R33 replied no. Surveyor asked R33 to talk about his care and the staff. R33 stated: They're nice, they help me. On 2/29/24 at 11:28 AM Surveyor advised Social Services Director-D of concern regarding respect and dignity. Surveyor advised of concern regarding R33's right to refuse treatment and the incident involving CNA's forcing him to get out of bed against his wishes. Surveyor acknowledged training was completed on abuse, recognizing and reporting - however training specific to the incident was not completed. Social Services Director-D reported she understood and has power points more specific to the concerns involving the incident with R33. Social Services Director-D thanked Surveyor. On 2/29/24 at 12:55 PM Surveyor verified with Nursing Home Administrator-A that the admission packet provided to residents upon admission includes packet titled Board on Aging and LTC (Long Term Care) Ombudsman Program Advocates for the Long Term Care Consumer [AGE] years of age or older which documents: SELF-DETERMINATION - Every resident has the right to make choices about aspects of their life in the facility that are significant to the resident. This includes choosing activities, schedules and healthcare consistent with personal beliefs, interests, assessments and plans of care. Each resident has the right to participate in planning their care and treatment, including the right to refuse care and treatment. Even residents who are confused or have difficulty expressing themselves should have the opportunity to give input about care and treatments to the extent they are able.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on interviews and record review the facility did not ensure residents the right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 1 (R33) reviewed. * R33 was physically held down by facility staff to get dressed against his wishes. Findings include: R33 admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following Cerebral Infarction, Congestive Heart Failure and Atherosclerotic Heart Disease. R33's Quarterly Brief Interview for Mental Status dated 2/26/24 documents a score of 4, indicating severe cognitive impairment. R33's Quarterly Minimum Data Set (MDS) dated [DATE] documents bed mobility, transfer, dressing and personal hygiene as extensive 2 person physical assist. Section E - Behavior documented: None exhibited. R33's Quarterly MDS dated [DATE] documented: Physical behavioral symptoms directed towards others (e.g. , hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) - behavior occurred 1-3 days. R33's Quarterly MDS dated [DATE] documented no behaviors. Surveyor review of a Facility Reported Incident documented on 10/12/23 at 11:00 AM R33 reported to his granddaughter that the night before 2 caregivers sat on him to hold him down. Police were called, did not come out to investigate. Skin assessment OK. Daughter/Physician notified. Residents on assignments of Certified Nursing Assistants (CNA)'s interviewed - no other concerns reported. Roommate reported they were forcing the resident to get up. Re-education initiated with employees on abuse. Employee files were reviewed - neither had been disciplined, both had background checks completed, both had completed orientation education on abuse. The statements from the 2 CNA's indicated they held down the resident to change him and were argumentative with him. Based on these actions, the 2 CNA's no longer work for the facility. The investigation included the following statements: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33: I was in my bed asleep and the Fat (expletive) [NAME] got on top of me and held my arms down so I couldn't get up. Then the other skeleton looking (expletive) was laughing so I kicked her. She said it didn't hurt so I kicked her again. She lied and said my legs were hanging out of the bed and they were not. I really don't need anyone's help. I can get out of the bed and walk over to the chair on my own. They harass me every night. They come in and wake me up to (expletive) with me. Roommate of R33: On the evening of 10/11 (CNA-I and CNA-J) came into the room and woke (R33) up to get him up into the Broda chair. (R33) told them no, he didn't want to get into the chair because he was sleeping and the aides continued to force (R33) to get up. The roommate stated when (R33) kicked the aide she got mad with him (roommate) and replied what are you laughing at. CNA-I: Observed (R33)'s feet hanging out of the bed, went to get help, CNA-J entered the room. (R33) became verbally abusive calling CNA-J anorexia and CNA-I a [NAME]. CNA-J was kicked by (R33) and responded didn't hurt. (R33) became more upset and agitated, continued to use expletives, CNA-I is holding arm/leg alongside of the bed to prevent (R33) from hitting/kicking. Eventually got resident up into Broda chair, pushed resident outside into corridor. Resident continued with physical and verbal abuse. CNA-J: CNA-I went into (R33)'s room to check on him and he was kicking his legs off the side of the bed and threatening to throw himself on the floor, so CNA-I went and told (nurse) and she said to get him up. As soon as we came in he started cursing us out for no reason. He called me a skinny anorexic .(expletive) and called CNA-I a fat (expletive) [NAME] and said he was going to kick our (expletive). (Nurse) told us to just go ahead and get him up into the Broda chair. I was on the side of the bed nearest the window at the top of the bed and CNA-I was on the other side. (R33) then kicked me three times and I told him that didn't hurt. I told CNA-I to grab his hands so that we can get him dressed. (R33) was trying to punch CNA-I so she held his right arm and leg. We rolled him from side to side to get the sling under him to lift him with the hoyer. He then grabbed onto the Broda chair arm to try and prevent us from transferring him from the bed to the chair. He finally let go and we got him into the Broda chair. On 2/28/24 at 9:07 AM Surveyor spoke with [NAME] President of Excellence-C about the facility self report. VP of Excellence-C reported based on the investigation it was determined action would be taken against the two CNA's and training was provided for all staff on abuse. On 2/28/24 at 2:13 PM Surveyor reviewed the employee files of both CNA-I and CNA-J. No substantiated findings of abuse, neglect or misappropriation on the Wisconsin Caregiver Misconduct Registry. Background checks completed. Surveyor review of the education provided included the facility policy Neglect and exploitation revised 7/15/22, which included definitions of abuse. On 2/29/24 at 8:07 AM Surveyor spoke with Social Services Director-D who reported she was familiar with the incident and investigation involving R33. Surveyor asked about the education provided to staff following the incident. Surveyor noted education included providing the policy on abuse and asked if any other education was completed. Social Services Director-D stated: Yes, we also did an in depth power point presentation in conjunction with providing the policy. It was more specific. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was provided a copy of the power point education provided to all staff following the incident involving R33. The content included reporting allegations, what do I have to report, how do I know if its abuse, who do I tell, who do I call, what happens if I don't report it, etc. Surveyor noted the training provided to staff was not specific to the incident involving R33. No education was provided on dementia, dealing with difficult behaviors, re-approaching at a later time or residents' right to refuse treatment and care. On 2/29/24 at 9:43 AM Surveyor spoke with R33 who was sitting in his Broda chair, well groomed, no odors or signs/symptoms of pain. R33 reported feeling fine today. R33 stated staff treats him fine no-one talks mean to him, they're nice and denied being hit or abused. When asked if he is able to get up when he wants to, R33 replied yes. Surveyor asked if anyone ever makes him get up when he doesn't want to, R33 replied no. Surveyor asked R33 to talk about his care and the staff. R33 stated: They're nice, they help me. On 2/29/24 at 11:28 AM Surveyor advised Social Services Director-D of concern regarding respect and dignity and the right to be free from any physical restraints. Surveyor advised of concern regarding incident involving CNA's holding R33 down to get him dressed against his wishes. Surveyor acknowledged training was completed on abuse, recognizing and reporting - however training specific to the incident was not completed. Social Services Director-D reported she understood and has power points more specific to the concerns involving the incident with R33. Social Services Director-D thanked Surveyor. On 2/29/24 at 12:55 PM Surveyor verified with Nursing Home Administrator-A that the admission packet provided to residents upon admission includes packet titled Board on Aging and LTC (Long Term Care) Ombudsman Program Advocates for the Long Term Care Consumer [AGE] years of age or older which documents: DIGNITY - Every facility resident has the right to be treated as an individual, with courtesy, respect and dignity. The facility must maintain or enhance each resident's dignity and self-worth. no one should humiliate, harass or threaten a resident. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure 1 (R24) of 5 allegations of abuse and injuries of unknown source were reported to the state agency. * On 12/18/23 the nurses note indicate R24 was holding her right wrist and crying out in pain. R24 was unable to say what happened. R24 was transferred to the emergency department for evaluation of the right wrist pain. The hospital x-ray report of the right wrist reveals an acute displaced intra-articular fracture of the distal radius. The facility did not report this injury of unknown source to the state agency. Findings include: The facility's Abuse, Neglect and Exploitation policy dated 7/15/22 indicate: VII. Reporting/response . 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R24 was admitted to the facility on [DATE] with diagnoses of dementia, morbid obesity and osteoporosis. The MDS (minimum data set) dated 11/30/23 indicate R24 has moderate cognitive impairment. The nurses note dated 12/18/23 indicate R24 was holding her right wrist and crying out in pain, requesting to go to the emergency department. The nurses note indicate R24 cannot tell them what happened to cause the right wrist pain. The hospital record dated 12/18/23 indicate R24 told the hospital staff she fell and landed on her outstretched hand. The x-ray result of the right wrist indicate an acute nondisplaced intra-articular fracture of the distal radius. The hospital record also indicate hospital staff called the facility staff to let them know of R24's finding of a new distal radius fracture and R24 will be splinted. On 2/27/24 at 3:00pm during the daily exit meeting with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B, Surveyor explained R24 sustained a right wrist fracture on 12/18/23 and if Surveyor can review the facility investigation into the fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/24 at 7:50 a.m. Surveyor asked NHA-A for the investigation into R24's wrist fracture and NHA-A stated they were gathering the information. On 2/28/24 at 3:15 p.m. NHA-A provided Surveyor with a typed up statement with no date that indicates Upon residents return form the emergency room , discharge notes stated resident fell and landed on her outstretched hand. Resident would not be capable of getting herself off the floor and would require staff assistance. Staff observed resident making multiple attempts to exit building and was banging on the doors which each attempt. Resident has an old healed fracture of the right wrist so wrist was compromised. Surveyor asked NHA-A if this injury was self reported to the state agency and NHA-A stated it was not and that the previous NHA would have been responsible for reporting it to the state agency. On 2/29/24 at 8:00 a.m. Surveyor explained to NHA-A the concern R24 wrist fracture was an injury of unknown source and it was not reported to the state agency. NHA-A understood the concern and had no additional information.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on interview and record review the facility did not ensure 3 (R24, R101 and R20) of 5 residents reviewed had thorough investigations into allegations of misappropriation and injuries of unknown source. * On 12/18/23 R24 was discovered with a wrist fracture and a thorough investigation into the injury was not conducted. * On 11/18/23 R101 was complaining of neck pain and was sent to the hospital for evaluation. While at the hospital they discovered R101 had a hematoma to the scalp. R101 alleges he was injured during a transfer while at the facility. The facility did not conduct a thorough investigation into the hematoma to the scalp. * R20 alleged missing money and a thorough investigation was not conducted. Findings include: The facility's Abuse, Neglect and Exploitation policy dated 7/15/22 indicate: V. Investigation of Alleged abuse, neglect and exploitation A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g not destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegation(s); 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. 1. R24 was admitted to the facility on [DATE] with diagnoses of dementia, morbid obesity and osteoporosis. The MDS (minimum data set) dated 11/30/23 indicate R24 has moderate cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 12/18/23 indicate R24 was holding her right wrist and crying out in pain, requesting to go to the emergency department. The nurses note indicate R24 cannot tell them what happened to cause the right wrist pain. The hospital record dated 12/18/23 indicate R24 told the hospital staff she fell and landed on her outstretched hand. The x-ray result of the right wrist indicate an acute nondisplaced intra-articular fracture of the distal radius. The hospital record also indicate hospital staff called the facility staff to let them know of R24 finding of a new distal radius fracture and R24 will be splinted. On 2/27/24 at 3:00pm during the daily exit meeting with Nursing Home Administrator (NHA)-A and DON-B, Surveyor explained R24 sustained a right wrist fracture on 12/18/23 and if Surveyor can review the facility investigation into the fracture. On 2/28/24 at 7:50 a.m. Surveyor asked NHA-A for the investigation into R24 wrist fracture and NHA-A stated they were gathering the information. On 2/28/24 at 3:15 p.m. NHA-A provided Surveyor with a typed up statement with no date that indicates Upon residents return form the emergency room , discharge notes stated resident fell and landed on her outstretched had. Resident would not be capable of getting herself off the floor and would require staff assistance. Staff observed resident making multiple attempts to exit building and was banging on the doors which each attempt. Resident has an old healed fracture of the right wrist so wrist was compromised. Surveyor asked NHA-A if this statement is the completed investigation, NHA-A stated they have no further information regarding the unknown injury sustained to R24 right wrist. 2. R101 was admitted to the facility on [DATE] with diagnoses of quadriplegia and neurogenic bowel and bladder. The nurses note dated 11/17/23 indicate R101 wanted to go to the emergency department because he had back and neck pain. While at the emergency department, R101 was discovered to have a hematoma to the scalp. R101 alleged the facility staff hitting his head on the headboard and baseboard during transfers. The facility conducted an investigation and reported this allegation of abuse to the state agency. The police were notified. When R101 returned to the facility the previous NHA (nursing home administrator) interviewed R101 regarding him allegeding staff hit his head on the headboard. The investigation indicates R101 stated staff had the bed too high when they transferred him to bed that when staff lowered the bed he hit his head on the headboard. R101 was unable to give a specific day or date and was unable to indicate which Certified Nursing Assistants (CNAs) were involved. The investigation revealed staff were not interviewed regarding how R101 sustained a hematoma to the head. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/24 at 9:07 a.m. Surveyor interviewed NHA-A and [NAME] President (VP) of Excellence-C. Surveyor explained the concern R101 sustained a hematoma to the head during a transfer and there were no interviews with staff regarding this incident. NHA-A stated the previous NHA was responsible for the investigation. VP of Excellence-C stated she would look for more information. As of 2/29/24 the facility had no further information regarding the investigation into R101 hematoma to the head. 38253 3. R20 was admitted to the facility on [DATE] with a diagnosis of cerebrovascular accident affecting the right side. R20's Admission Minimum Data Set (MDS) assessment dated [DATE] indicated R20 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R20 had an activated Power of Attorney (POA). A Facility Reported Incident was submitted to the State Agency with the following information: R20 reported on 12/16/2023 that money was missing from R20's locked drawer on the night of 12/15/2023 or the early morning of 12/16/2023. The facility initiated an investigation at that time by interviewing R20 and the Certified Nursing Assistant (CNA) that R20 reported the missing money to. R20 stated the money had been in the locked drawer of the bedside table with a wheelchair in front of the drawer. There was enough space between the wheelchair and the bedside table that the drawer was able to be opened. R20 stated to the administrator that R20 had forgotten to lock the drawer and the key to the drawer was on a string around R20's neck. R20 indicated the CNA that had worked the night shift was who R20 suspected of taking the money. Surveyor reviewed the investigation file. No other staff members were interviewed that worked the night of 12/15/2023 or the morning of 12/16/2023. The CNA that R20 alleged took the money was not interviewed. No other residents were interviewed to determine if there were any other items or money missing. On 2/28/2024 at 9:37 AM, Surveyor interviewed R20 about the reported missing money. R20 stated the missing money was R20's fault because R20 had forgotten to lock the drawer. R20 had a key visible hanging on a string around R20's neck. R20 stated the facility did not reimburse R20 for the money and stated R20 understood that it is hard to prove someone took anything. R20 stated R20 should have locked the drawer and was not concerned or upset with the outcome of the incident. In an interview on 2/29/2024 at 9:22 AM, Social Services Director (SSD)-D stated the Nursing Home Administrator (NHA) submits the Facility Reported Incident to the State Agency and SSD-D interviews staff that may have information about the incident and interviews residents that may have been affected on the unit where the money had gone missing. Surveyor asked SSD-D where those statements from staff and residents would be found. SSD-D stated all interviews would have been included in the report. Surveyor shared with SSD-D that only one statement from the CNA that R20 reported the missing money to and two interviews with R20 were included in the report. SSD-D stated SSD-D would look for related information. At 10:30 AM, SSD-D provided a statement that R20 found the money in R20's hat. Surveyor shared with SSD-D that the statement provided was dated one month after the reported missing money. SSD-D stated that statement must have been about a different report of missing money. SSD-D did not provide any other interview statements from staff or residents concerning the report of missing money on 12/16/2023. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/2024 at 12:58 PM, Surveyor shared with NHA-A the concern the report filed with the State Agency for R20's report of missing money on 12/16/2023 was not a thorough investigation. The file on the investigation did not include any interviews with staff that were working at the time the money went missing or any interviews with other residents. NHA-A stated NHA-A was not employed at the facility at the time of the report but would look to see if any more information could be found. At 1:36 PM, NHA-A stated no more information was found regarding R20's missing money on 12/16/2023.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38146 Based on observations, interviews, and record review, the facility did not ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and to ensure residents do not develop new pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. This affected 2 of 4 residents (R23 and R12) reviewed for pressure injuries. *R23 was admitted to the facility with hospital discharge documents indicating R23 was being discharged with three stage 3 pressure injuries: one to the left and right buttock and one to the coccyx. The facility did not comprehensively assess these areas upon admission. The facility did not take note of the pressure injuries on R23's buttocks upon admission. The admission evaluation identifies R23 as having a pressure injury on the sacrum - stage 2 - with no comprehensive details of the wound bed or characteristics of the wounds. The sacral wound deteriorated to a facility acquired unstageable pressure injury that became a stage 4 pressure injury due to the continual need for debridement. The facility did not comprehensively assess R23's wounds to show the characteristics of the wound beds or details of the wound(s). The facility did not make timely revisions to R23's care plans to address the ongoing deterioration of R23's sacral pressure injury and to assist in healing. *R12 developed two facility acquired pressure injuries that were not comprehensively assessed. The facility assessed one area to be a stage two pressure injury with the presence of granulation, which would be an incorrect stage. During observations of R12's pressure injury, it was noted R12 had two open areas on the buttocks that were not comprehensively assessed or properly treated. The areas were observed with one large piece of gauze covering both areas, which is not what the physician ordered. Surveyor shared her observation and concerns with facility administration and noted the areas still were not comprehensively assessed or had clarified treatment orders for each of the areas of pressure injury on R12's buttocks. Findings include: The facility policy titled Pressure Injuries and Non pressure Injuries revised 7/20/22 documents (in part) . .This center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. Policy Explanation and Compliance Guidelines: 1. Upon admission: a. A head to toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/Readmission Evaluation UDA. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	If skin is compromised: i. If pressure injury: Initiate the Pressure Injury Weekly Tracker UDA - one per wound. ii. If non pressure: Initiate the Non-Pressure Injury tracker UDA - one per wound. iii. Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. iv. Ensure appropriate treatment orders for each wound area, as needed. 1. R23 admitted to the facility on [DATE] and has diagnoses that include Chronic Kidney Disease stage 3, dependence on renal dialysis, Type 2 Diabetes Mellitus, Thrombocytopenia, and Lymphedema. R23 receives dialysis three times a week. On 2/27/24 at 9:38 AM, Surveyor spoke with R23. He reported he was down at home for 3 days before his neighbor alerted his family and police. He reported he does not remember anything, was in the hospital for weeks, and only remembers waking up in the facility. R23 reported he developed a pressure injury on his butt. R23 stated, It was pretty bad, but they're taking good care of it now. R23 reported he still goes to the wound clinic. When asked how he thought the wound developed, he stated probably from lying in bed. R23 reported he was not sure if the wound developed in the hospital or after admission to the facility. R23's Annual Brief Interview for Mental Status (BIMS) dated 2/10/24 documents a score of 15 indicating no cognitive impairment. R23's Hospital Discharge Summary included documentation dated 1/30/23 of: Stage 3 left buttock, right buttock, coccyx. Facility progress note on 2/3/23 at 22:17 (10:17 pm) documents: Admission Summary Note Text: Resident is alert and orientated, able to make all needs known. Resident is aware of situation and is responsible for self. Resident complains of chronic pain to knees from arthritis. Denies needing pain medication at this time. Resident has pressure sore to coccyx area which the hospital was packing with Dakin's and covered with gauze. Surveyor noted there is no reference to the possible stage 3 areas on R23's left and right buttocks. R23's Admission evaluation dated 2/3/23 documents: - Sacrum. Pressure stage II. There were no measurements or description of the wound and no documentation about the right and left buttock pressure injuries. Surveyor noted the admission evaluation references a sacrum wound vs. the coccyx as noted by facility staff in progress notes. Surveyor also noted the change in staging of the wounds from the hospital discharge summary without a full assessment to show how the wounds were downstaged. R23's ADL (Activities for Daily Living) care plan initiated 2/4/23 indicates R23 requires assist of 2 staff for bed mobility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R23's Admission Minimum Data Set (MDS) dated [DATE] documents: R23 requires substantial/maximal assistance for rolling left and right, sitting to lying requires substantial/maximal assist with helper doing more than half of the effort. The MDS also indicates R23 has a stage 1 or greater pressure injury and is at risk for pressure injuries. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Number of Stage 3 pressure ulcers (2). Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry (2). Unstageable - Slough and/or eschar - Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar (1). Number of these unstageable pressure ulcers that were present upon admission/entry or reentry (1). Surveyor noted the reference to 2 stage three areas is possibly consistent with the hospital discharge summary, however the facility had not assessed the pressure areas on R23's right and left buttocks upon admission to include staging or characteristics of the wounds. Surveyor noted the facility staged R23's sacrum to be a stage 2 on 2/3/23 without measurements or description of the wound bed. The MDS assessment of R23 having an unstageable pressure injury would be considered a decline in a pressure injury possibly since admission and would no longer be a wound present upon admission. This would now be a facility acquired unstageable pressure injury. The facility's Pressure Injury Weekly Tracker dated 2/10/23 is the first documentation of an assessment and measurements of R23's wounds which documented: Sacrum unstageable 4.5 x 2.6 x 0.1 cm (centimeters) 20% gran, 30% slough, 50% necrotic. Right buttock stage 3 - 1.9 x 4 x 0.1 cm. Left buttock stage 3 - 4 x 1.9 x 0.1 cm. Specialty mattress. Surveyor noted there were no details of the tissue type for the right and left buttock pressure injuries despite being stage 3 areas. R23's wounds were followed by the (name of contracted wound group) wound Physician. The (name of contracted wound group) Wound evaluation & management summary dated 2/10/23 documents: Sacrum: Unstageable (due to necrosis) sacrum full thickness 4.5 x 2.6 x 0.1 cm Right buttock: Stage 3 pressure wound of the right buttock full thickness 1.9 x 4 x 0.1 cm. Left buttock: Stage 3 pressure wound of the left upper buttock full thickness 4 x 1.9 x 0.1 cm. Surgical excisional debridement procedure. Remove Necrotic Tissue and Establish the Margins of Viable Tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/30/23, the facility revised R23's ADL care plan to indicate R23 needs the assistance of 1 staff for bed mobility. R23's nutrition care plan dated 3/30/23 included intervention to provide supplements QD (each day) as ordered to aid in wound healing. Surveyor noted R23's nutritional care plan focus area to increase nutritional needs related to wound healing occurred after R23's sacral/coccyx wound had already declined. R23's at risk for skin integrity care plan initiated 3/30/23 indicates R23 is at risk for alteration in skin integrity related to impaired mobility. Goals initiated 3/30/23 include decrease/minimize skin breakdown risks. Interventions initiated 3/30/23 include barrier cream to peri area/buttocks as needed, diet and supplements per MD orders, Encourage fluids, Observe skin condition with ADL care daily, report abnormalities, Pressure redistributing device on bed/chair, Provide preventative skin care routinely and PRN (as needed), Use pillows/positioning devices as needed. On 4/7/23, the (name of contracted wound group) wound Physician evaluation documents: Sacrum: Stage 3 pressure wound 4.3 X 2.5 X 0.2 cm Right buttock: Stage 3 pressure wound 0.5 X 0.5 X 0.1 cm Left buttock: resolved. Surveyor noted there are no details identifying tissue type within the wound or other characteristics of the remaining wounds. Surveyor noted the sacral pressure injury was previously an unstageable area. On 4/20/23, the (name of contracted wound group) wound Physician evaluation documents: Sacrum: Stage 4 pressure wound sacrum full thickness 4 x 1.9 x 0.6 cm. Remove Necrotic Tissue and Establish the Margins of Viable Tissue. Post debridement - stage: 4. Right buttock: Stage 3 pressure wound of right buttock 1.5 x 1 x 0.1 cm. Surveyor noted there are no details describing the wound bed or other characteristics of the wound that would constitute a full assessment of the wound. There are no details identifying the characteristics of the sacral pressure injury prior to debridement. Surveyor noted there were no changes to R23's care plan to address R23 having a stage 4 facility acquired pressure injury. R23's care plan was not updated to reflect R23 having a stage 4 pressure injury until 10/25/23 when the facility initiated a care plan with a focus of: Actual stage IV (4) pressure wound injury to sacrum. Goals initiated 10/25/23 include: will show continual signs of healing, will develop no new areas of skin breakdown, will heal within limits of the disease process, will heal without complication, and resident/representative will perform wound care procedure correctly by discharge date . Interventions initiated 10/25/23 include: Administer treatment per MD orders, Diet and supplements per MD orders, Follow up care with MD as ordered, Obtain labs as ordered and notify MD of results, Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain etc. Notify MD PRN. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted there was no review of R23's support surfaces or assessment of need for repositioning leading to a care plan intervention. The care plan for actual stage 4 pressure wound injury to sacrum care plan was revised on 11/1/23 to include an intervention to add an air mattress to R23's bed and check for proper function/inflation every shift. On 11/22/23, R23's at risk for alteration in skin integrity related to impaired mobility care plan had a revised intervention dated 11/22/23 stating to reposition every 2 hours. Surveyor noted these added interventions to R23's plan of care are months after R23 developed a facility acquired stage 4 pressure injury. Surveyor noted through review of R23's plan of care there is no intervention to address R23 attending dialysis three times a week and the increased risk this may pose to R23's skin integrity. At some point, which the facility was unable to definitively provide, R23 began to be followed by the hospital wound clinic versus the (name of contracted wound group) wound Physician. R23's stage 3 pressure injuries to the right and left buttock healed and only the sacrum pressure injury remains. R23's Outpatient wound care progress note dated 12/28/23 states - Pressure ulcer stage (4) sacrum. Coccyx wound base with moist viable granulation tissue to base today. Some slough visible in wound bed at 12 o'clock debrided today. Still some gray necrosis on underside of undermining at 12 o'clock - this is not visible on examination but through exploratory curetting of the tissue here. Debrided today. Palpates near bone but covered by soft tissue at 12 o'clock. Periwound with dull erythema without warmth. Previous posterior thigh wounds bilateral ischial healed. See back in wound clinic 2 weeks. Outpatient wound care note dated 1/18/24 documents: Sacrum with small opening with undermining circumferentially. 2 x 0.5 x 2.7 cm. Not conducive to bedside debridement. Patient does not appear septic or ill today. Review of R23's plan of care for actual stage 4 pressure wound injury to sacrum initiated 10/25/23 included a revised intervention dated 1/8/24 stating: encourage resident to offload area of pressure injury every 2-3 hours. Roho cushion to wheelchair. R23's 2/10/24 annual MDS indicates R23 is independent at rolling left to right however needs supervision or touching assistance as R23 completes other mobility actions such as sit to lying, lying to sitting on edge of bed etc. Actions that can be related to repositioning. R23's MDS indicates R23 does not demonstrate behaviors including the rejection of care. The MDS indicates R23 does not have a stage 1 or greater pressure injury but is at risk for pressure injuries. The MDS indicates R23 has no unhealed pressure injuries. Review of R23's care plan for at risk for alteration in skin integrity related to: impaired mobility initiated 3/30/23 included an intervention dated 2/12/24 stating: risk vs benefit in place d/t (due to) resident not wanting to reposition self, continue to encourage resident to reposition. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R23's plan of care for actual stage 4 pressure wound injury to sacrum initiated 10/25/23 included a revised intervention dated 2/12/24 stating: risk vs benefit in place d/t (due to) resident not wanting to reposition self, continue to encourage resident to reposition. On 2/27/24 at 2:02 PM, Surveyor spoke with Director of Nursing (DON)-B who reported RN-G does wound rounds with the wound doctor every week. Surveyor asked who is responsible for completing an assessment and measurements of new wounds. DON-B reported all nurses are responsible to assess, measure, and document any new wounds. Surveyor asked what happens if the wound physician is unable to come to the facility for scheduled wound rounds. DON-B reported he sends a replacement. Surveyor was advised R23 currently has only 1 wound, on the coccyx. Surveyor advised unable to locate a comprehensive assessment and measurement of R23's coccyx wound upon admission to the facility on [DATE] and the first documentation was completed on 2/10/23 by the wound physician. DON-B reported she would get the information for Surveyor. DON-B informed Surveyor R23 began going out to the wound clinic a few months ago and is no longer seen by the facility wound Physician. On 2/28/24 at 10:02 AM, Surveyor spoke with DON-B and RN-G. Surveyor asked who is responsible to complete an assessment and measurements on residents that admit with wounds or when wounds are found. DON-B reported the nurse doing the admission is supposed to measure the wound and describe what it looks like. RN-G added: Then we rely on the doctor to stage it. I am not wound certified, and we don't have anyone here that is wound certified, so we have the doctor look at it and go by what he says. Surveyor asked what happens if the doctor doesn't come until the following week. RN-G stated: Well, we have the documentation of the measurements and what it looked like when first seen, so he can see that. I know he (R23) came in with wounds, so he was put on the list to be seen by the wound doctor. Surveyor advised DON-B and RN-G that R23's admission assessment on 2/3/23 documents only the sacral pressure injury as a stage 2 and there was no comprehensive assessment, description of the wound, or measurements. One week later on 2/10/23 the wound Physician documented the unstageable sacral pressure injury and stage 3 pressure injuries to right and left buttock. DON-B reported the assessment and measurements should be on the admission assessment, adding: We'll have to do education with the nurse responsible for doing the admission. I think the admission skin assessment was not accurately completed. DON-B reported it is the expectation the nurses are supposed to measure and describe what the wound looks like, and the doctor will stage it. Surveyor asked when R23's stage 3 buttocks pressure injuries healed. RN-G reported she did not remember, I know his sacral wound got worse and deteriorated really quick, that's when he started to go to the wound clinic. On 2/28/24 at 3:15 PM, Nursing Home Administrator (NHA)-A and DON-B were advised of the concerns related to R23's pressure injury care. No additional information was provided. 2. R12 admitted to the facility on [DATE] and has diagnoses that include hemiplegia and hemiparesis following Cerebral Infarction affecting right dominant side, Gastrostomy, Epilepsy, and Dementia. R12's Brief Interview for Mental Status (BIMS), dated 1/13/24, documented a score of 0 indicating severe cognitive impairment. R12's Care plan focus area revised 3/7/23 documents: Resident is at risk for skin integrity condition, or pressure sores r/t (related to): Impaired mobility, incontinence, thin/fragile skin, dementia, rt (right) side cva (Cerebral Vascular Accident), epilepsy - revised 3/7/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The resident has potential for pressure ulcer development r/t Imp (impaired) mobility; incontinence; dementia - revised 8/22/19. The resident has pressure ulcer right buttock r/t Immobility initiated 1/15/24, revised 1/18/24. Interventions include Administer treatments as ordered and monitor for effectiveness. On 2/27/24 at 9:56 AM, Surveyor observed R12 lying in bed on her back with a pillow under her head. R12's legs were turned toward the left side, she was wearing fuzzy socks on her feet, which were not offloaded. Surveyor observed an air mattress on the bed and the head of her bed was elevated 30 degrees. Facility progress notes dated 1/15/24 at 2:05 AM document: Clinical Follow Up Note Text: Resident is on follow up for 1/14 nights superficial O/A (open area). The current status is Writer received report from pm (evening) nurse that pm CNA (Certified Nursing Assistant) reported the O/A right buttock, but pm nurse didn't proceed with tx (treatment). 1 cm (centimeter) x 1 cm superficial pink wound distal end of Right buttock as well as 2 superficial scratches 1 cm and 2 cm long that are scabbed from self-infliction. Writer left scratches OTA (open to air), cleansed wound with NS (normal saline) applied medihoney on wound, applied skin prep around wound and apply borderline drsg (dressing) over wound. R12's current February 2024 Treatment Administration Record (TAR) documents: Cleanse O/A with NS apply skin prep surrounding skin and apply medi honey to wound, apply borderline drsg (dressing) every 3 days and prn (as needed) one time a day every 3 day(s) for wound Right buttock - start Date 1/15/24, discontinue date 2/7/24. Surveyor noted the (name of contracted wound group) Physician notes dated 1/19/24 documents: Signing off on patient who remains in the facility - no open wound. Surveyor noted although the wound physician documented no open wounds on 1/19/24, the ordered treatment for R12's right buttock pressure injury had been signed out as completed in the TAR through 1/30/24. Surveyor noted R12's current February 2024 TAR documents 9 for 2/2/24 and 2/5/24 which indicates other/see progress notes. There was no documentation in R12's progress notes on these dates related to the right buttock wound or treatment. Facility progress note dated 2/5/24 at 10:28 AM documents: Skin/Wound Note Text: Patient received a bed bath this am shift. Wound to right buttock and gastric tube site remains. There were no new skin issues noted or reported at this time. Will continue to monitor. The Facility Pressure Injury Weekly Tracker dated 2/13/24 documents: Right buttock stage II. 1.5 x 0.5 cm (centimeters) 100% granulation. Surveyor noted this is not correctly staged as a stage 2 pressure injury would not include a wound with granulation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	According to the National Pressure Injury Advisory Panel (NPIAP) the definition of a Stage 2 Pressure Injury is: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). R12's February 2024 TAR included an order: Provide wound care to right buttock as follows: Cleanse wound with soap and water, rinse with water and pat dry. Skin prep peri-wound followed by Medihoney and bordered gauze dressing until healed. Wound care daily and as needed. one time a day for wound care to right buttock. Wound Doctor to assess - start date 2/14/2024 - signed out as completed through 2/28/24. The (name of contracted wound group) Physician note dated 2/23/24 documents: Non-pressure wound of the right buttock etiology (quality) trauma/injury 1 x 4.1 x 0.1 cm. The Facility Skin Review Weekly dated 2/26/24 documents: Pressure injury right and left buttock treatment noted. Surveyor noted there was no comprehensive assessment or measurements of the left buttock pressure injury, and no treatment was ordered or implemented on the TAR. On 2/28/24 at 9:15 AM, Surveyor observed R12's pressure injuries with assistance of Certified Nursing Assistant (CNA)-H. Surveyor observed both of R12's buttock cheeks covered together with the same large white gauze dressing and tape. Surveyor observed an opening at the inferior aspect of the dressing. CNA-H pulled back the dressing revealing 2 separate pressure injuries, 1 on her left buttock and 1 on her right buttock. Surveyor noted there was not a separate dressing on each pressure injury. Both pressure injury wound beds were shallow and pink with no active drainage or signs of infection noted. On 2/28/24 at 10:02 AM, Surveyor spoke with Director of Nursing (DON)-B and Registered Nurse (RN)-G about R12's pressure injuries. RN-G reported she has been doing wound rounds with the wound doctor as of Friday, which was the last time. Surveyor advised of facility progress notes which documented a pressure injury on R12's right buttock was noted 1/15/24. Treatment was implemented for medihoney and border dressing which was signed out as completed through 1/30/24, however wound Physician note on 1/19/24 documented no wounds. RN-G stated: That treatment should have been discontinued. Surveyor advised the treatment was being signed out in the TAR as having been completed. RN-G stated: They're probably just signing it out without reading it, that happens sometimes. Surveyor looked at DON-B and clarified: So you are saying the nurses are signing out treatments in the TAR without having completed them? DON-B stated: Probably. We'll have to do education. Surveyor asked RN-G why the (name of contracted wound group) Physician note on 2/23/24 note documents non-pressure wound of the right buttock etiology (quality) trauma/Injury 1 x 4.1 x 0.1 cm. RN-G stated: I don't know, maybe he was referring to the scratches. Surveyor advised R12's weekly skin review dated 2/26/24 documents pressure injury to right and left buttock with no documentation of an assessment or measurements of the left buttock pressure injury, and no treatment for the left buttock pressure injury implemented on the TAR. (continued on next page)

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	525414	A. Building B. Wing	02/29/2024

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Mercy Health Services	2727 W Mitchell St Milwaukee, WI 53215

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F 0686 Level of Harm - Actual harm Residents Affected - Few	RN-G reported she was only aware of the right buttock pressure injury. Surveyor asked what a border dressing is. RN-G reported it is a 1-piece dressing with gauze in the center and an adhesive border surrounding it. Surveyor advised of observations of R12's pressure injuries, 1 on each buttock covered with 1 large piece of gauze dressing secured with several pieces of tape covering both buttocks with opening at inferior dressing/buttocks cheeks. RN-G stated: So there wasn't a border dressing on each wound? Surveyor replied no. RN-G stated: OK, well that's not right, there should be a border dressing on each one if there is (sic) 2 separate wounds. On 2/28/24 at 3:14 PM, Surveyor advised Nursing Home Administrator (NHA)-A and DON-B of concerns: Nurses signed out treatment for R12's right buttock pressure injury on the TAR as completed after the wound allegedly was healed per Physician, and statement that facility aware nurses sign out treatments without completing them. R12's weekly wound tracker dated 2/26/23 documents pressure injuries right and left buttock. The left buttock pressure injury has no treatment ordered or implemented and there are no comprehensive assessments or measurements of the pressure injury. In addition, Surveyor observed the ordered treatment for R12's right buttock pressure injury was not in place. No additional information was provided. On 2/29/24 at 11:52 AM, Surveyor review of R12's TAR revealed there was still no treatment implemented for her left buttock pressure injury. In addition, there was no documentation of a comprehensive assessment or measurements of the left buttock pressure injury. Surveyor advised the facility. No additional information was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 38253 Based on observation, record review, and interview, the facility did not ensure medications were administered to meet the needs of 1 (R32) of 2 residents observed receiving as needed medications. * R32 was administered Furosemide, a diuretic, with no assessment to determine if the medication was indicated, and the order to administer Furosemide did not have any parameters or physical indicators of when the medication should be administered. Findings: The facility policy and procedure entitled Medication Administration General Guidelines dated 1/2023 states: Documentation: 5. When PRN (as needed) medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site. b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recording effects. R32 had an order on 2/8/2024 for Furosemide 40 mg every 24 hours as needed for edema. The order did not include how to assess R32 for edema or what would indicate the administration of Furosemide. R32 had an order on 2/9/2024 for Furosemide 40 mg twice daily for three days 2/9/2024 through 2/11/2024. On 2/28/2024 at 7:43 AM, Surveyor observed Licensed Practical Nurse (LPN)-F passing medications to R32. LPN-F assembled all the morning medications, including Furosemide 40 mg. LPN-F walked into R32's room, gave some medications orally and some medications crushed and liquified through the gastrostomy tube, and left the room. R32 had a right below the knee amputation. LPN-F did not request to see R32's left leg or R32's right stump. Both extremities were covered. In an interview on 2/28/2024 at 10:02 AM, Surveyor asked LPN-F how often R32 received Furosemide. LPN-F stated R32 gets Furosemide once a day and is a scheduled medication. LPN-F stated LPN-F did not know why R32 was getting Furosemide because R32 was on hospice. LPN-F then stated the Furosemide was a PRN (as needed) medication given for edema to the leg and stump. LPN-F stated R32's leg gets swollen at the ankle and the other leg, even though there is not an ankle, the area below the knee at the stump gets swollen. Surveyor noted LPN-F did not assess R32 for swelling or edema prior to administering the Furosemide. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the Medication Administration Record (MAR) on 2/28/2024 at 10:55 AM and on 2/29/2024 at 7:54 AM. LPN-F did not sign out the Furosemide 40 mg PRN as being administered on 2/28/2024 at 7:43 AM. On 2/28/2024 at 11:21 AM, Surveyor shared with Director of Nursing (DON)-B the observation of LPN-F administering Furosemide 40 mg to R32 at 7:43 AM that morning without assessing R32 for edema prior to giving the diuretic. Surveyor shared with DON-B the concern the medication was not signed out in the MAR and the order did not have specific indicators for use other than edema, which could be interpreted in different ways. DON-B stated DON-B would have to do some education of staff regarding the administration of medications. On 2/28/2024 at 3:08 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern LPN-F administered Furosemide 40 mg PRN to R32 without doing an assessment for edema, and the order did not have any parameters or signs/symptoms to determine if the medication should be administered. No further information was provided at that 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** 38253 Based on record review and interview, the facility did not ensure residents on psychotropic medications have a diagnosis for the use of the medication and is being followed for medication management for 1 (R20) of 5 residents reviewed for unnecessary medications. * R20 had an order for Buspirone, an antianxiety medication, with no diagnosis of anxiety. The order stated the medication was for depressive disorder. R20 was seen on 8/31/2023 at an outpatient mental health clinic and the progress note indicated R20 would not be followed by the clinic physician due to mental health services that were available to R20 at the facility. The facility was not aware R20 was not being seen by the outpatient mental health clinic until Surveyor during the survey brought this to their attention. Findings: R20 was admitted to the facility on [DATE] with diagnoses of cerebrovascular accident affecting the right side, seizures, diabetes, depression, and alcohol and tobacco abuse. R20's Admission Minimum Data Set (MDS) assessment dated [DATE] indicated R20 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and the Care Area Assessment (CAA) for psychotropic medication use stated R20 uses psychotropic medications for mood and behavior sleep disorder and R20 medication use was being monitored by nursing staff with no adverse reactions or complications. R20 had the following orders on admission: -Duloxetine delayed release 120 mg daily for depression. -Trazodone 100 mg daily for antidepressant. -Buspirone 10 mg twice daily for depressive disorder. (Buspirone is an antianxiety medication.) On 8/31/2023 at 4:06 PM in the progress notes, nursing charted R20 was seen at the outpatient mental health clinic and a call was received from the physician regarding R20. The physician had concerns with polypharmacy and would fax over a treatment plan for consideration and agreed to the facility service provider to follow R20 while R20 was a resident of the facility. The physician confirmed the psychotropic medications and dosages and the physician agreed with the current medications. On 9/1/2023, the outpatient mental health clinic faxed over a progress note dated 8/31/2023 from R20's visit with outpatient psychiatry. The note stated R20 had the following diagnoses and problems: anxiety, depression, and alcohol use. The note stated R20 came for follow up due to anxiety issues. R20 had been taking Cymbalta, Buspirone, and Trazodone with the same dosages since the last visit on 7/25/2022. The physician documented R20 should be followed by the facility psychological services to avoid multiple prescribers. The physician made the following recommendations: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Taper down Duloxetine from 120 mg daily to 90 mg daily as this dose might be too high for R20's age and by itself can cause anxiety. -Buspirone can be increased form 10 mg twice daily to 10 mg three times daily for anxiety as it is short acting. -Continue Trazodone 100 mg at bedtime as needed for sleep. On 9/13/2023, R20 had an order to increase Buspirone 10 mg three times daily for depressive disorder. In an interview on 2/29/2024 at 8:57 AM, Surveyor asked Social Services Director (SSD)-D who does medication management for R20. SSD-D stated SSD-D watches the psychotropic medications to be aware of the need for a Gradual Dose Reduction of those medications, but R20 goes to an outpatient psychiatric clinic. Surveyor asked SSD-D how often R20 was seen at the psychiatric clinic. SSD-D stated SSD-D would have to check and get back to Surveyor because R20 is also seen at an outside clinic for physical and occupational therapy so was not sure when R20 was going to what type of appointment. Surveyor shared with SSD-D the outpatient psychiatric clinic note dated 8/31/2023 that R20 was no longer being seen there due to not wanting multiple prescribers. SSD-D checked the list of residents that were being seen by the facility psych services and R20 was not on that list. SSD-D stated SSD-D was not aware R20 was not being seen at the outpatient clinic and would add R20 to the list of residents being seen in-house. Surveyor shared with SSD-D the diagnosis listed for the use of Buspirone was depression, including the medication consent form and the psych note from 8/31/2023 indicated R20 had anxiety yet that is not listed on R20's diagnosis list. SSD-D stated nursing puts in diagnoses for residents so was not sure why that was not listed. At 10:33 AM, SSD-D stated R20 did not have any indication of anxiety as a diagnosis yet that is what Buspirone is used for. SSD-D stated SSD-D would follow up with the psych Nurse Practitioner. In an interview on 2/29/2024 at 11:02 AM, Surveyor asked Director of Nursing (DON)-B how diagnoses were entered into residents' medical charts. DON-B stated MDS nurses enter the diagnoses. Surveyor shared the concern with DON-B that R20 was receiving Buspirone and did not have a diagnosis of anxiety. DON-B stated DON-B was not aware R20 was taking any psychotropic medications. In an interview on 2/29/2024 at 11:11 AM, Surveyor asked Licensed Practical Nurse (LPN) MDS-E where LPN MDS-E gets information for diagnoses that are added to resident records. LPN MDS-E stated LPN MDS-E reviews hospital discharge summaries and then orders and if the medication and indications for use do not match, the physician is called to clarify the proper indication for use of the medication. LPN MDS-E was not employed at the time R20 was admitted to the facility. LPN MDS-E stated R20 was taking Duloxetine for depression, Buspirone for anxiety, and Trazadone for depression and for sleeping. Surveyor agreed those were the medications R20 was taking, but shared with LPN MDS-E that R20 did not have a diagnosis listed of anxiety and the indication for use of the Buspirone was depression. Surveyor shared the psychiatric note from 8/31/2023 listed R20 as having anxiety. LPN MDS-E stated LPN MDS-E will follow up to see why anxiety was not listed as a diagnosis. At 12:21 PM, LPN MDS-E stated LPN MDS-E was not able to find any more information regarding the diagnosis of anxiety with the use of Buspirone. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/29/2024 at 1:00 PM, Surveyor shared with Nursing Home Administrator (NHA)-A the concerns R20 was receiving Buspirone with an inappropriate diagnosis for use of depression when it is an anxiolytic and SSD-D was not aware R20 was not being followed by any psychiatric services until SSD-D was informed by Surveyor. No further information was provided at that time.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38253 Based on observation, record review, and interview, the facility did not ensure the medication error rate was below 5 percent in 1 (R32) of 3 resident observed receiving medications. The facility medication error rate was 6.9 percent. * R32 received a crushed Omeprazole delayed release tablet, making the medication ineffective, and Licensed Practical Nurse (LPN)-F would have administered an inhaler that was ordered for a different resident if Surveyor had not intervened. Findings: The facility policy and procedure entitled Medication Administration General Guidelines dated 1/2023 states: Medication Preparation: 5. b. Long-acting, extended release or enteric-coated dosage forms should generally not be crushed; an alternative should be sought. Medication Administration: 9. Verify medication is correct three (3) times before administering the medication. a. when pulling medication package from med cart; b. When dose is prepared; c. Before dose is administered . 16. Medications supplied for one resident are never administered to another resident. On 2/28/2024 at 7:43 AM, Surveyor observed LPN-F preparing medications for R32's morning medication pass. LPN-F placed oral medications into a med cup. LPN-F placed Omeprazole delayed release 20 mg into a plastic sleeve and crushed the medication. LPN-F placed the crushed Omeprazole into a cup, added water, and administered the medication through R32's gastrostomy tube. LPN-F removed a different resident, R11's Anoro Ellipta 62.5-25 mcg inhaler from the medication cart, took the inhaler out of the package and handed the package to Surveyor to note the medication and dose. Surveyor noted the name on the package was R11 and not R32. Surveyor pointed out the name on the package to LPN-F and LPN-F stated R32's inhaler must not be in the med cart. LPN-F put R11's inhaler back into the package and into the med cart. R32's order read Omeprazole oral suspension 2 mg/ml (liquid): give 10 ml via G-tube two time a day for GERD (gastroesophageal reflux disorder). In an interview on 2/28/2024 at 10:02 AM, Surveyor asked LPN-F to see R32's Omeprazole medication card. LPN-F provided the card and agreed the medication stated delayed release. Surveyor asked LPN-F why the liquid Omeprazole was not used as ordered. LPN-F stated they do not have the oral suspension and will have to call the pharmacy to get R32's inhaler so will ask about the liquid Omeprazole at the same time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/2024 at 11:21 AM, Surveyor shared with Director of Nursing (DON)-B the observation of LPN-F administering R32's medication and the concerns LPN-F was going to administer R11's inhaler to R32 if Surveyor had not intervened and LPN-F crushed R32's delayed release Omeprazole. DON-B stated DON-B will have to do education to the nurses about medication administration. No further information was provided at that time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38253 Based on observation, record review, and interview, the facility did not ensure sanitary practices were maintained during medication pass for 1 (R32) of 3 residents observed during medication pass. Licensed Practical Nurse (LPN)-F touched each medication administered to R32 with LPN-F's bare hands before placing them into a medication cup. Findings: On 2/28/2024 at 7:43 AM, Surveyor observed LPN-F prepare R32's morning medications. LPN-F popped each medication out of the blister pack into LPN-F's bare hand and then placed the medication into the med cup. LPN-F took Senna 8.6 mg stock med bottle out of the cart, opened the bottle, and shook the medications into LPN-F's bare hand, replacing extra doses back into the bottle, and put one pill into the med cup. At 10:08 AM, Surveyor asked LPN-F why LPN-F popped R32's medications into LPN-F's hand instead of directly into the med cup. LPN-F stated LPN-F's hand hurts due to trigger thumb so sometimes it is hard to punch the med out. LPN-F stated LPN-F should be putting the meds into the med cup right from the card. On 2/28/2024 at 11:21 AM, Surveyor shared with Director of Nursing (DON)-B the observation of LPN-F touching each of R32's medications with LPN-F's bare hands during medication pass that morning. DON-B stated DON-B will have to do education with the nurses on medication pass. No further information was provided at that time.