STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525421	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the facility did not ensure a comprehensive person centered care plan was developed for 1 (R297) of 13 residents. * R297's foley catheter was discontinued on 6/7/24. The facility did not develop a urinary care plan after R297's foley catheter was discontinued. Findings include: The facility's policy titled, Comprehensive Person Centered Care Plan and last reviewed 8/10/23 under Procedure documents C. Care Plan shall be reviewed and revised quarterly, upon change of condition, and/or as needed. 1.) R297 was admitted to the facility on [DATE] with a diagnoses that includes depression, benign prostatic hyperplasia, urinary retention, diabetes mellitus, and Alzheimer's Disease. R297's POA (power of attorney) was activated on 4/1/22. R297's admission MDS (minimum data set) with an assessment reference date of 5/31/24 has a BIMS (brief interview mental status) score of 7, which indicates severe cognitive impairment. Yes is checked for indwelling catheter placement for R297. R297's Urinary Incontinence and Indwelling Catheter CAA (care area assessment) dated 6/4/24 under analysis of findings for nature of problem/condition documents BPH (benign prostatic hyperplasia)-Urinary retention-Foley cath (per VA (veterans administration)) Assisted to safely manage and monitor cath (catheter) and output. R297's admit/readmit note dated 5/25/24, at 01:07 (1:07 a.m.) written by Registered Nurse (RN)-BBB documents Bowel and Bladder: Toilet use: Limited assistance. Bladder: Catheter. Continent of Bowel: No. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R297's nursing note dated 5/26/24 at 05:07 (5:07 a.m.) written by RN-ZZ documents: C/O (complained of) neuropathy to hands and legs. PMH (past medical history) of PVD (peripheral vascular disease) noted in patient's MR (medical record). Pedal pulses weak upon assessment. Advised to lay on back and elevate legs. No pain reported at this time. Foley patent with clear yellow urine noted. BP (blood pressure) elevated 178/80. encouraged increased oral hydration. care plan continues. will continue to monitor per facility protocol. R297's nurses note dated 5/28/24 at 04:59 (4:59 a.m.) written by RN-ZZ documents: Patient did not sleep well through night. C/o pain/discomfort to Foley cath (catheter) site at tip of penis. No s/s (signs/symptoms) of injury noted. CNA (Certified Nursing Assistant) reported applying zinc. Foley patent and free of kinks. Will continue to monitor. R297's physician order dated 6/7/24 documents remove foley one time only for removal foley until 6/7/24. R297's nurses note dated 6/7/24 at 22:40 (10:40 p.m.) written by RN-AAA documents: Resident Foley catheter removed, no difficulties noted, resident's output was 1000 ml (milliliter). R297's nurses note dated 6/8/24 at 15:33 (3:33 p.m.) written by RN-AAA documents: Resident is being monitored for Foley removed, PVR (post void residual) 396, some hematuria, encouraged to push fluids, resident BS at am 84 and noon 170, resident refused insulin, stated he feel fine. R297's nurses note dated 6/12/24 at 0817 (8:17 a.m.) written by Licensed Practical Nurse (LPN)-WW documents: Continue to monitored for Foley catheter removal. Resident alert/orient. Skin warm and dry. No issues noted. Resident voiding without difficulties. Denies any pain or discomfort at this time. Will continue to monitor this shift. Surveyor reviewed R297's care plans and noted the following care plans: Potential for decreased activity involvement and socialization initiated 3/12/24 & revised 5/30/24. Potential alteration in nutrition abnormal labs, weight variance, and fluctuating intake initiated & revised 6/3/24. Documented Pressure Ulcer initiated 5/24/24 & revised 5/25/24. Advanced Directives initiated & revised 7/2/24. Resident has limited physical mobility initiated 3/7/24 & revised 3/18/24. Resident has impaired cognitive function/dementia or impaired though process initiated 5/24/24 & revised 5/25/24. Resident wishes to remain at SNF (skilled nursing facility) for long term care initiated 7/2/24. Resident has Diabetes Mellitus initiated 5/24/24 & revised 5/25/24. Resident is high risk for falls initiated 5/24/24 & revised 5/25/24. Resident has constipation initiated 5/24/24 & revised 5/25/24. Resident has an potential for alteration in hematological status initiated & revised 6/4/24. Resident uses antidepressant initiated 5/24/24 & revised 6/4/24. Resident has depression initiated & revised 7/2/24. Resident has potential for pain initiated 5/24/24 & revised 6/4/24. Resident has impairment to skin integrity initiated 5/24/24 & revised 5/25/24. Resident has Indwelling Catheter initiated 5/24/24 & revised 5/25/24. Surveyor noted the facility did not develop an urinary continence care plan after R297's indwelling catheter was discontinued. On 2/18/25, at 7:44 a.m., Surveyor asked Director of Nursing (DON)-B about the facility's care plan process. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON-B informed Surveyor nursing, MDS, therapy, social services, dietary or dietitian are involved in care plans. Surveyor asked if a urinary care plan would be developed after a resident's Foley catheter was discontinued. DON-B replied yes. Surveyor asked DON-B if she knew why the facility did not develop a urinary care plan after R297's Foley catheter was discontinued. DON-B replied I don't know. Surveyor asked who should of developed the new care plan. DON-B replied nursing. Surveyor asked if the floor nurse would develop this care plan. DON-B informed Surveyor the floor nurse wouldn't have done it and it would of been nursing management or MDS. No additional information was provided as to why the facility did not initiate a urinary care plan after R297's foley catheter was discontinued.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review, the facility did not ensure 1 (R297) of 13 residents received treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan and the residents choice. * R297 was admitted to the facility on [DATE] with an order to the left shin which continued until 8/1/24. There is only one skin assessment of this area dated 5/25/24. On 7/22/24 Advanced Practice Nurse Prescriber-FFF progress note documents two dressings on R297 left lower extremity. There are no skin assessments of R297's left lower extremity as to why dressings were applied. On 7/28/24, R297's left forearm was identified as being bruised and red with an indentation from R297's watch being too tight. On 8/1/24 R297's left forearm skin integrity changed from redness to scabbing. There is no skin assessment when R297's skin integrity changed. On 8/13/24 R297's experienced a change of condition which was not comprehensively assessed. Documentation of R297's meal intake for lunch was 0 to 25% which was the first time in the previous two weeks R297 ate only 0 to 25%. Licensed Practical Nurse (LPN)-H indicated when she came on duty R297 was in bed covered with a lot of covers which was unusual for R297 as he was usually rolling around. On 8/13/24 at 3:03 p.m., Nursing Student-CCC created an order for a UA (urinalysis). There is no assessment, including a RN assessment, no vitals signs for R297 prior to this order being created as to why this order was obtained. Approximately three hours later vital signs were obtained for R297 which revealed a temperature of 102.8 F with AMS (altered mental status). Even though R297 had an order for acetaminophen 650 mg (milligrams) every four hours for fever, this medication was not administered to R297 prior to being transported to the hospital. On 8/13/24 at 6:00 p.m., an ambulance company arrived and transported R297 to the hospital. R297 was admitted to the hospital for sepsis, UTI (urinary tract infection). Findings include: The facility's policy titled, Change of Condition and Provider Notification and last reviewed on 8/10/23 under Procedure documents 1. Change of Condition a) Change of Condition (COC) is a deviation from an individual's baseline in physical, cognitive, behavioral, or functional status. Clinically important means a deviation that, without intervention, may result in complications or death. 2. Assessment a) Licensed nurse is involved in the assessment process and contribute to the collection of the data base, the planning of interventions and evaluation of individual's response to condition change. b) A licensed nurse is to complete the initial assessment, and follow-up evaluation as indicated by the complexity and stability of the individual's condition. c) Change of Condition Assessment shall be reviewed by Registered Nurse. 1.) R297 was admitted to the facility on [DATE] with diagnoses that include depression, benign prostatic hyperplasia, urinary retention, diabetes mellitus, peripheral vascular disease, congestive heart failure, anxiety, and Alzheimer's Disease. R297's POA (power of attorney) was activated on 4/1/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R297's admission MDS (minimum data set) with an assessment reference date of 5/31/24 has a BIMS (brief interview mental status) score of 7 which indicates severe cognitive impairment. R297 is assessed as requiring set up for eating, supervision or touch assistance for toileting hygiene, independent for roll left & right, and partial/moderate assistance for chair/bed to chair transfer & toilet transfer. R297 has an indwelling catheter and is always continent for bowel. R297 is assessed as not having any pressure injuries, other ulcers, wounds and skin problems. Application of non surgical dressings (with or without topical medications) other than to feet is checked yes R297's impairment to skin integrity care plan initiated 5/24/24 & revised 5/25/24 documents under the intervention section: Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Initiated 5/24/24 & revised 5/25/25. Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to physician. Initiated 05/24/2024 & revised 5/25/24. R297's nurses note dated 5/24/24 at 22:46 (10:46 p.m.) written by Director of Nursing (DON)-B documents: New admit. resident alert and oriented able to make his needs known to staff. skin warm and dry. abd. (abdomen) soft and non tender with + (positive) BS (bowel sounds) x (times) 4 quads. (quadrants) LCTA. (lungs clear to auscultation) no cough or sob (shortness of breath). no s/s (signs/symptoms) of hypo/hyperglycemia. assist with adls (activities daily living) and transfers. no c/o (complaint of) pain or discomfort. R297's admit/readmit note dated 5/25/24 at 01:07 (1:07 a.m.) written by Registered Nurse (RN)- BBB documents Skin: Skin Color: Normal. Skin Temperature: Warm R297's physician orders dated 5/25/24 documents cleanse left shin with n/s (normal saline) foam border drsg (dressing) every evening shift every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound care. R297's admit/readmit screener dated 5/25/24 under the skin integrity section documents under site 42) left lower leg (front), type documents abrasion and length 0.2, width 0.3, and depth 0.1. There is no further assessment of the left lower leg front and the treatment to R297's left shin continued until 8/1/24. APNP (Advanced Practice Nurse Prescriber)-FFF's note dated 7/22/24 under history of present illness documents [R297's name] 82 Y (year) male is seen in follow up day for increased LLE (lower leg edema). [R297's first name] is seen today in his room. His wife is at the bedside. She is concerned that he has some increased LLE (left lower extremity) edea sic (edema). He does have an order for prn (as needed) Bumex. She is also concerned that he is scratching at his legs. He has multiple scratch marks on his LLE. Some are bleeding. There are two dressings covering areas that were bleeding. His wife is concerned that he will develop open sores/infections from scratching as that has happened in the past. Under exam for skin documents scratch marks on BLE (bilateral lower extremities), some areas of bleeding on LLE (left lower extremity). Under medical decision making documents BLE statis dermatitis Start clotrimazole cream daily x (times) 14 days then Eucerin daily. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted there is no assessment R297's left lower extremity when the two dressings were applied which is identified in APNP-FFF's note dated 7/22/24 nor is there any documentation as to when these dressings were applied. Surveyor noted there are no skin assessments of R297's left lower extremities, other than the admission/readmission screen on 5/25/24, while R297 resided in the facility. R297's nurses note dated 7/28/24 at 21:08 (9:08 p.m.) written by Nursing Student-CCC documents Resident left arm is bruised and red with indication of his watch being too tight on wrist. it appears to be red no edema but look irritated and raw resident stated that he is not in pain. Surveyor was unable to locate a Registered Nurse (RN) assessment of this area when it was identified. R297's nurses note dated 7/29/24 at 05:27 (5:27 a.m.) written by Licensed Practical Nurse (LPN)-H documents Bruise on resident left arm still remains with a purplish color. Resident has no complaints of pain or discomfort. R297's wound care initial evaluation dated 7/29/24 by Wound Nurse Practitioner-O under physical examination documents Left wrist No open wounds noted- area with bruising consistent with shape of a watch. Leave area open to air, avoid wearing watch until bruising resolves. Monitor closely for breakdown. Under assessment documents Traumatic ecchymosis of left wrist. R297's nurses note dated 7/29/24 at 13:03 (1:03 p.m.) written by Director of Nursing (DON)-B documents resident seen by wound GNP for area to LT (left) wrist. no noted pressure injuries to LTV. wrist, area with redness from indentation from wrist watch, wrist to be monitored for changes, watch removed and taken home by wife. R297's nurses note dated 7/31/24 at 00:14 (12:14 a.m.) written by Nursing-DDD documents we continue to monitor for redness to (AL) arm. Redness still remains. Resident denies any pain or discomfort. No bleeding or drainage noted. resident denies area itches. Will continue to monitor. R297's nurses note dated 8/1/24 at 03:17 (3:17 a.m.) written by LPN-EEE documents generalized scabbing of LTV. forearm. no c/o (complaint of) pain when asked. no s/s (signs/symptoms) of infection. T (temperature)96.9. There is no assessment of R297's left arm when R297's skin integrity changed from redness to scabbing. R297's nurses note dated 8/1/24 at 21:09 (9:09 p.m.) written by Nursing Student-CCC documents AL (left) forearm scabbing no s/s of infection or drainage. No c/o of pain or discomfort. R297's nurses note dated 8/4/24 at 00:23 (12:23 a.m.) written by Nursing-DDD documents resident left arm is scabbing. no complaints of any pain or discomfort. no itching noted. will continue to monitor. R297's nurses note dated 8/11/24 at 05:08 (5:08 a.m.) written by LPN-H documents Resident was scratching his left lower legs and reopen scabs that were already there. Leg was clean with NS (normal saline) and bf/b (foam border) was applied to area. Surveyor noted there is no assessment of this area and that there are no nursing notes dated 8/12/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/13/24 there is an order for USA - urinalysis one time only for UT (urinary tract infection). This order was created by Nursing Student-CCC on 8/13/24 at 15:03 (3:03 p.m.). There is no assessment for R297 as to why this urinalysis was ordered nor are their any vital signs prior to this order being created. Surveyor noted under the weights/vital tab on 8/13/24 at 17:52 (5:52 p.m.) R297's temperature was 102.8 F oral, blood pressure 145/70, pulse 55 bpm (beats per minute), and oxygen sats were 91% on room air. R297's respiratory rate was not obtained. The ambulance report documents: received 8/13/024 18:00:44 (6:00 p.m. & 44 seconds), dispatched 8/13/2024 18:00:57 (6:00 p.m. & 57 seconds) at patient 8/13/24 18:18:45 (6:18 p.m. and 45 seconds), transport 8/13/24 18:38:12 (6:38 p.m. and 12 seconds) and at destination 8/13/24 18:41:49 (6:41 p.m. and 49 seconds). The narrative documents [Ambulance company & Number] dispatched with lights and sirens to the listed nursing facility for an 82 y/o (year old) male with an altered mental status. Dispatch notes state not acting himself. Crew donned proper PPE (personal protective equipment) prior to patient contact. When arriving on scene we find our patient lying in bed with his wife at this side. His wife states the patient has been sleeping all day, has a fever, is weak and is hurting from the neck down. She states he has a history of a CVA (cerebral vascular accident) x2 (March 3rd and March 8th). She denies any falls or other trauma. Upon patient contact he presents as alert, A & O (alert and orientated) x 3 which is his baseline due to dementia, pale skin color and unlabored respirations. Patient also feels warm to the touch. Patient states he feels weak today and generally unwell. He states he is having lower back pain as well. He explained to EMS crew that he attempted to stand today to get out of bed and was unable to do so. He states he has a headache and that his vision went out for a few moments this morning. Stroke scale is performed and found to be positive at this time in patient only having a headache. No vision disturbances, facial droop, slurred speech, unsteady gait or unilateral weakness are noted at this time. At this time he is transferred onto EMS cot via draw sheet method and placed in positron of comfort. Baseline set of vitals are obtained and patient is found to be slightly tachycardic and hypoxic. Patient denies any shortness of break at this time. He is placed on 4L (liters) continuous oxygen via nasal cannula, secured x5 with safety straps and loaded in the ambulance. Once in the ambulance an oral temperature is obtained and found to be 102.9. Blood glucose is obtained and noted to be 81. 12-Lead EKG is perform and found to read sinus tachycardia. EKG is transmitted to receiving emergency department. SPO2 is noted to have increased with oxygen therapy. Additional vital signs are obtained and found to remain similar to initial set; with SPO2 having increased. Patient care report is called into receiving emergency department with an ETA (estimated time arrival) of 3 minutes. At this time transport began. R297's nursing note dated 8/13/24 at 21:49 (9:49 p.m.) written by LPN-H documents: Resident was sent out to hospital per POA (Power of Attorney) requested. MD (Medical Doctor) was informed of patients transfer. patient and an fever of 102.8 with altered mental status. Writer called [hospital initials] ER (emergency room) to get an update and patient was admitted to hospital for an UTI (urinary tract) and high fever. R297's physician orders included Acetaminophen Tablet 325 mg (milligram) Give 2 tablet by mouth every 4 hours as needed for elevated temperature; pain. Surveyor noted R297 did not receive this medication when his temperature on 8/13/24 at 17:52 (5:52 p.m.) was 102.8 degree Fahrenheit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R297's amount eaten from 7/30/24 to date of discharge on 8/13/24. Surveyor noted until 8/13/24 R297 ate 76-100% of his meals with the exception of breakfast on 8/6/24 & 8/9/24 and dinner on 8/12/24 when R297 ate 51-75% of his meals. On 8/13/24 two meals are documented as 0-25%. The eINTERACT Change in Condition Evaluation - V 5.1 dated 8/13/24 under status documents errors. The eINTERACT Transfer Form V5 dated 8/13/24 under status documents in progress. The hospital ED (emergency department) care time line dated 8/13/24 documents at 18:45:58 (6:45 p.m and 58 seconds) Arrival Complaint form [Facility's name] with AMS (altered mental status); fever of 102.8 not treated. The ED triage notes dated 8/13/24 at 18:49:25 (6:49 p.m. and 25 seconds) documents Patient arrives from [Facility Name] with complaint of fever and generalized weakness that started yesterday. Vitals at 18:50 (6:50 p.m.) documents 102.2 F (39 C) 108 24 167/78 86 % 81.6 kg (180 lb). The ED provider note dated 8/13/24 at 2051 (8:51 p.m.) documents History Chief Complaint Patient presents with Fever. HPI (history present illness) [AGE] year-old gentleman with past medical history of dementia presents emergency department today with a chief complaint of altered mental status Symptoms started earlier today in the facility reports he has been less active than usual. His wife came to visit him and noticed that he was warm to the touch. Has had prior UTIs as well as pneumonia. On arrival the patient is febrile and unable to provide any additional history and denies any pain or radiation of pain. Additional history limited to secondary to dementia. 2101 (9:01 p.m.) admitted for sepsis, UTI. The ED Notes Nursing Admission Handoff Report at 22:06:10 (10:06 p.m. and 10 seconds) documents Admitting diagnosis: Urinary tract infection with hematuria, site unspecified. The hospital infectious diseases consult dated 8/14/24 under Assessment/Medical Decision Making documents 82 Y male Alzheimer's dementia, COPD, T2DM who presented on 8/13/2024 with high fevers and confusion beyond baseline in addition to hypoxemic respiratory failure. Blood cultures obtained on arrival resulted as MRSA within 12 hours of collection. ID consulted for further evaluation. Exam significant for severe midline low back pain. I am concerned this is a result from MRSA bacteremia. Will order MRI T/L (thoracic/lumbar) spine with contrast to evaluate for osteodiscitis/epidural abscess which may require surgical evaluation. Will order TTE (transthoracic echocardiogram). Will order CT (computed tomography) chest without contrast due to concern for MRSA seeding lungs. Can stop ceftriaxone and azithromycin and continue vancomycin for now. Will follow repeat blood cultures. ID will follow. #Community-onset MRSA bacteremia #New onset back pain #Acute hypoxemic respiratory failure #T2DM #Bilateral LE wounds. The hospital physician death summary note dated 8/20/24 documents Death Summary [R297's name] was pronounced dead at 1908 (7:08 p.m.) on 8/20/24 Primary cause of death: MRSA (methicillin resistant staphylococcus aureus) Bacteremia. Secondary Cause of death: Sepsis secondary to cystitis. Tetiary cause of death: acute hypoxemic respiratory failure. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/14/25, at 1:27 p.m., Surveyor interviewed Advanced Practice Nurse Prescriber (APNP)-FFF regarding R297 on the telephone. Surveyor asked APNP-FFF if she was aware of R297 scratching his legs. APNP-FFF replied I think so and explained R297 had been at the facility one or two times prior for subacute and had this kind of behavior before. Surveyor informed APNP-FFF her 7/22/24 note documents two dressings covering areas that were bleeding and inquired if she ordered these dressings. APNP-FFF informed Surveyor she's honestly not sure. Surveyor informed APNP-FFF R297 had a change of condition on 8/13/24 and asked APNP-FFF if she assessed R297 on this date. APNP-FFF informed Surveyor she was not in the building but remembers a phone call or text about an elevated temperature. Surveyor asked APNP-FFF if she remembers what time the facility contacted her. APNP-FFF replied want to say late afternoon or evening. Surveyor asked if she gave any instructions to the nurse. APNP-FFF informed Surveyor she remembers asking her to obtain a UA and honestly doesn't recall if there was any blood work associated with the UA. Surveyor asked if she was notified R297 was being transferred to the hospital. APNP-FFF replied yes. Surveyor asked on 8/13/24 APNP-FFF if she wrote a note on the day R297 was discharged . APNP-FFF replied I wouldn't of written a note because I didn't do a visit. On 2/17/25, at 9:56 a.m., Surveyor interviewed Licensed Practical Nurse (LPN)-WW, who worked the day shift on 8/12/24 & 8/13/24, regarding R297 on the telephone. Surveyor asked LPN-WW if she remembers being informed of R297 not feeling well or having a fever prior to R297 being transferred to the hospital. LPN-WW replied I can't recall explaining it was so long ago. LPN-WW informed Surveyor R297 was usually okay, didn't have many issues. Surveyor asked LPN-WW if he had any skin impairments on his legs. LPN-WW informed Surveyor R297 had scratches and thought he had cream some time and a bandage with dressing. Surveyor asked LPN-WW if she ever did a treatment for R297. LPN-WW replied of course I did and informed Surveyor she thought it was just allevyn, didn't think he had any kerlix wrap. LPN-WW informed Surveyor it's been awhile and so many people come and go. On 2/17/25, at 10:18 a.m. Surveyor interviewed LPN-H, who worked the evening shift on 8/12/24 & 8/13/24, regarding R297. LPN-H informed Surveyor she sent R297 out on her shift. LPN-H explained R297 had a 100 and something fever and spoke to the NP who decided to send R297 out. LPN-H informed Surveyor she probably came to the facility around 1:30 p.m. and around 2:00 p.m. she saw R297 was in bed with a lot of covers over him he was not himself. LPN-H explained R297 was usually up talking, rolling around, and his wife said he wasn't feel good. LPN-H informed Surveyor she was informed R297 didn't eat breakfast or lunch today. Surveyor asked LPN-H when she took R297's vitals. LPN-H replied she has no clue as the med tech took vitals first as R297 is on Midodrine that was scheduled at 3:00 p.m. LPN-H informed Surveyor when she took R297's temperature it was high, she talked it over with the wife and reached out to the NP who was agreeable to send R297 out. Surveyor asked LPN-H if she assessed R297's respiratory rate or listened to his lung sounds. LPN-H replied no I didn't I went off temperature &altered mental status. He wasn't being himself that's what I reported to the NP I was going to send him. Surveyor asked LPN-H if she called 911 or [Name of] ambulance. LPN-H informed Surveyor she thinks she sent R297 out by [Name] ambulance company. LPN-H informed Surveyor R297 had an elevated temperature and altered mental status, it wasn't like a seizure or heart attack. LPN-H informed Surveyor the ambulance came pretty quickly. Surveyor asked LPN-H how long she thought it took the ambulance to arrive at the facility. LPN-H replied maybe 20 minutes. Surveyor asked LPN-H if she contacted a Registered Nurse. LPN-H replied no. Surveyor asked LPN-H if any of the Certified Nursing Assistants (CNA) reported anything to her about R297. LPN-H replied no and stated she didn't think a CNA went in R297's room. Surveyor informed LPN-H Surveyor noted an order for a UA and asked if she received this order from the NP. LPN-H informed Surveyor she didn't create so Nursing Student-CCC probably got the order. LPN-H informed Surveyor she doesn't remember that order. (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 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/17/25, at 12:59 p.m., Surveyor interviewed Nursing Student-CCC on the telephone regarding R297. Nursing Student-CCC worked the evening shift on 8/13/24. Surveyor asked Nursing Student-CCC if she received anything in report regarding R297. Nursing Student-CCC informed Surveyor she didn't get report and was guessing the past couple of days he was ill. Nursing Student-CCC informed Surveyor R297 wasn't himself that's why she sent him out. Surveyor asked Nursing Student-CCC if she took R297's vital signs. Nursing Student-CCC informed Surveyor she took vital signs when starting med pass and again when R297 was sent out. Nursing Student-CCC informed Surveyor his temperature was really high that's what made her send R297 out. Surveyor asked Nursing Student-CCC if she called APNP-FFF. Nursing Student-CCC replied yes. Nursing Student-CCC informed Surveyor she was actually working under another nurse and there were two of them. Surveyor asked Nursing Student-CCC if the nurse was LPN-H. Nursing Student-CCC replied yes and said she (LPN-H) was kind of doing everything as she just graduated & was fresh out of school. Nursing Student-CCC informed Surveyor she was working under LPN-H and remembers bits and pieces. Surveyor informed Nursing Student-CCC Surveyor noted she created an order for a UA. Nursing Student-CCC informed Surveyor R297 wasn't himself, he wasn't urinating or anything. Surveyor asked if she spoke to APNP-FFF or did she text her. Nursing Student-CCC informed Surveyor she believes LPN-H called her. Surveyor asked Nursing Student-CCC if she spoke to any RN about R297's change of condition. Nursing Student-CCC informed Surveyor she's pretty sure LPN-H communicated with the DON and didn't think there was an RN in the building. Surveyor asked Nursing Student-CCC if any of the CNAs reported anything to her about R297. Nursing Student-CCC replied no not that I recall. Surveyor asked Nursing Student-CCC how she was aware R297 was not urinating. Nursing Student-CCC informed Surveyor she can't recall and doesn't know if LPN-H told her but she remembers something in that nature and thinks R297 told her he wasn't able to go. LPN-H informed Surveyor this is the first time she has sent a patient out. On 2/17/25, at 1:50 p.m., Surveyor interviewed Director of Nursing (DON)-B and asked what the expectation is if a resident has a change of condition and the nurse on the floor is a LPN. DON-B explained they would make their observations and update the MD (medical doctor) to get further orders. Surveyor asked if there would be a RN assessment. DON-B replied there is, they let management know and we will take a look at the resident as well. Surveyor asked DON-B if she remembers R297. DON-B replied slightly. DON-B informed Surveyor what she remembers R297 was a pleasant man, not many complaints, he was diabetic and there wasn't a lot of issues that she was informed of. DON-B informed Surveyor she knows he scratched himself a lot and he had cream ordered for that. Surveyor asked if there was anything ordered other than cream. DON-B replied no. Surveyor asked DON-B if a dressing was applied, would there be an assessment. DON-B replied there should be. Surveyor informed DON-B of APNP-FFF's note on 7/22/24 which documents two dressings. DON-B reviewed R297's record and then informed Surveyor there is no assessment. Surveyor asked DON-B if she was involved with R297's transfer to the hospital on 8/13/24. DON-B replied no. Surveyor asked DON-B if she was contacted regarding R297's change of condition on 8/13/24. DON-B informed Surveyor they would of contacted the on call and doesn't recall being called. Surveyor asked who was the on call RN. DON-B informed Surveyor she doesn't know. Surveyor asked DON-B to look up who was on call the evening of 8/13/24 and get back to Surveyor. DON-B did not provide Surveyor with the name of the on call RN. No additional information was provided.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on observation, record review, and interview, the facility did not ensure 2 (R147 & R350) of 3 residents reviewed with pressure injuries received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new pressure injuries from developing. * R147 developed skin concerns of MASD (moisture-associated skin damage) noted at the facility on 10/28/24. There were no care plan revisions implemented and no comprehensive assessments completed. On 11/04/24, while at the hospital, R147 was found to have an infected sacral wound requiring debridement. After debridement, the wound was classified as a stage 4 pressure injury (PI.) Upon return to the facility on [DATE], the facility failed to comprehensively assess R147's pressure injuries, did not assess the appropriateness of the type of wheelchair cushion and mattress being used, and did not implement interventions to promote healing of PIs. The facility's failure to comprehensively assess and implement an individualized plan of care for R147's pressure injuries created a finding of immediate jeopardy that began on 10/28/24. Surveyor notified the Nursing Home Administrator (NHA)-A, Director of Nurses (DON)-B, and Regional Nurse Consultant (RNC)-N of the immediate jeopardy finding on 2/17/25 at 4:20 PM. The immediate jeopardy was removed on 2/20/25. The deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan and as evidenced by: * R350 was assessed for being at risk for pressure injury. Preventative interventions were not observed being implemented. Findings include: The facility's policy and procedure Pressure Injury Prevention and Managing Skin Integrity dated 12/5/24 documents that preventative measures are put in place to reduce the occurrence of pressure injuries. The procedures include: 2. Identifying Interventions and Care Plan: (a.i.) The care and intervention for any identified skin breakdown or wound is intended to prevent any further advancement of the wound or additional skin breakdown. (a.i.1.) This will be in collaboration with the Interdisciplinary Team regarding the presence of breakdown and the intervention plan. (a.i.3.) The identification of risk factors present or acquired that compromise skin integrity will be considered. (2.b.i.) The Care Plan development will consider: (a.i.2.) Cognitive changes or impairment of the individual. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(a.b.3.) Current state of skin integrity and personal hygiene practices of the individual that impact skin health. 3. Skin Checks: (3.a.) Skin check will be done upon admission, readmission or as clinically indicated. 4. Weekly Wound Rounds: (4.a.) Upon identification of abnormal skin findings, a licensed nurse will complete a skin assessment. Individual with abnormal skin concern(s) will be added to weekly wound rounds. (4.b.iii.) Update the Care Plan with any new interventions as applicable. 1.) R147 was readmitted to the facility from the hospital on 3/8/2024, with diagnoses including diabetes, congestive heart failure, and peripheral vascular disease. care plan related to a closed right ankle fracture initiated on 2/6/24 documents under the Goal section: The resident to remain free from skin breakdown due to incontinence and brief use. The initiated date is 2/6/24, and goal date of 3/11/25, and includes these interventions: - 2/6/24 barrier cream as ordered. - 2/6/24 monitor skin for signs of skin breakdown related to incontinence. - 2/15/24 clean peri-area with each incontinence episode. R147's Alternation in Nutrition due to Inadequate Intake care plan dated as initiated on 3/15/24 documents under the Goal section: Weight to stabilize 190 +- 10# (pounds), wound show signs and symptoms of healing, tolerate diet intake of greater than 75%, labs within MD (Medical Doctor) range, and resident will accept supplements: - 3/15/24 provide regular diet, additional protein via prosource twice a day and 6 ounces mighty shake twice a day, meals in dining room, treatment to wounds, confer with wound team, monitor intake, labs, weight, weigh per policy, staff assist/encourage at meals. R147's Quarterly Minimum Data Set (MDS) assessment completed on 9/13/24 documents that R147 had 1 unstageable pressure injury at the time of the assessment and is at risk for the development of pressure injuries. R147 is frequently incontinent of bowel and bladder and requires staff assist with activities of daily living. R147's skin assessment completed by Wound Nurse Practitioner (WNP)-O on 10/28/24 documents: Chief complaint is wound to the right heel, skin tear to left wrist/hand, wounds to R (right) posterior thigh and L (left) buttock. Subjective assessment the Patient is seen resting in bed. Staff report he has new areas of breakdown to buttocks. He denies pain, fevers or chills. He is eating and sleeping well. Medications electronic health record (EHR) reviewed. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Diagnoses that could affect wound healing are type 2 diabetes, afib (atrial fibrillation), heart failure (HF), hyperlipidemia, hypertension, (peripheral vascular disease) PVD, hypothyroidism, on Warfarin. Interventions in place are heel offloading with heel offloading boots or pillows as tolerated by patient, turn and reposition every 2-3 hours with assistance as needed, dietary collaboration, physical therapy and occupational therapy (PT/OT) collaboration; Physical Examination: +Right posterior heel (stage 3 pressure ulcer) Full thickness wound measuring 4.5 x 2.5 x 0.1 centimeter (cm). 100% granular tissue. Moderate amount of serous drainage noted, no odor. Peri wound without redness or warmth to indicate infection. Wound status: improving. The Plan: Cleanse with normal saline NS or wound cleanser then apply Hydrofera Blue to the base of the wound, cover with ABD (abdominal) pad and secure with kerlix. Change daily and prn (as needed). Continue offloading with Prevalon Boot. +Right thigh moisture associated skin damage (MASD) Full thickness wound measuring 1.5 x 1.5 x 0.1 cm. 100% granular tissue. Scant serosanguineous drainage. Peri-wound is dry, intact. No sign/symptoms (s/sx) infection. Status is a new area. The Plan is happy butt cream three times a day (TID) and as needed (PRN). +Left buttock (MASD) Full thickness wound measuring 0.5 x 0.8 x 0.1 cm. 100% granular tissue. Scant serosanguineous drainage. Peri-wound is moist, fragile, intact. No s/sx infection. Status is a new area. The Plan is happy butt cream TID and PRN. The Wound Assessment Summary is a pressure ulcer of right heel, stage 3 (not new). The new skin impairment areas are irritant contact dermatitis due friction or contact with other specified body fluids. Reviewed medical records. Discussed plan of care with nurse. Protein supplementation per dietary. Continue aggressive offloading, Prevalon boot to be worn at all times (cannot be used with transfers). Discussed results of X-ray and arterial studies with wife previously. At this time she will think about possible referral to vascular as patient with severe peripheral artery disease (PAD) which will compromise healing. Magnetic resonance imagining (MRI) is also recommended as the X-ray cannot exclude osteo - wife would like to hold off on the MRI at this time and think about getting an MRI in the future. Wound care re-evaluation in 1 week. Surveyor noted that there were new skin impairment areas for R147 that were a result of moisture association that were identified in R147's 10/28/24 assessment. Surveyor noted that there is no documentation of any revisions in the plan of care to promote healing. There were no changes to R147's plan of care for skin impairment and bladder incontinence care despite the new skin impairment areas that were identified in the above assessment. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/13/25, at 12:26 PM, Surveyor interviewed WNP-O via telephone. WNP-O assessed R147 on 10/28/24 and did not see any open skin areas. WNP-O stated the skin areas on 10/28/24 were from moisture. WNP-O stated they ordered zinc paste for the moisture areas. WNP-O would expect diligent incontinence care. WNP-O does not personally document in R147's plan of care. WNP-O informed Surveyor that WNP-O was not notified of any open areas prior to 11/4/24. WNP-O informed Surveyor that WNP-O relies on the facility to determine types of wheelchair and air mattresses that residents use for off-loading and pressure relief. Surveyor reviewed WNP-O's wound assessment plans. Surveyor informed WNP-O that there were no documented changes with R147's skin assessment on 10/28/24 and 12/2/24. WNP-O stated there was nothing to change in the plan of care. WNP-O stated R147 can be resistant to positioning and doesn't tolerate turning. WNP-O stated WNP-O goes to various facilities and that WNP-O leaves it up to the facility to determine what type of pressure relief intervention devices are used. Surveyor noted that WNP-O's assessments document just an air mattress (not specifics), continue aggressive off-loading, protein supplement per dietary, and Prevalon boots. WNP-O stated that WNP-O relies on the facility to develop an individualized plan of care. On 2/13/25, at 8:12 AM, Surveyor interviewed Director of Nurses (DON)-B. DON-B stated facility staff observed R147's skin on 10/28/24 with the Wound Nurse. DON-B stated there was not an open area that was observed. DON-B stated facility staff were not aware of an open area before 11/4/24. DON-B stated they would attempt to locate for skin sheets for R147. DON-B provided Surveyor with a Skin Sheet dated 10/15/24. Surveyor noted that there were no Skin Sheet or Skin Evaluations completed between 10/28/24-11/4/24. Despite R147 developing pressure injuries, Surveyor noted that there was no documentation of any changes to R147's dietary plan, no changes to R147's incontinent care/product use, and no changes in R147's turning and repositioning timeframes. R147 went to a scheduled imaging appointment on 11/4/24. At the start of R147's appointment, R147 had a change in condition and was sent directly to the emergency room (ER). While in the ER, a comprehensive assessment was completed. The assessment documented there was a pressure injury on the sacrum of R147 that was odorous, with tan drainage, and appeared infected. R147's hospital records included photographs and pre-debridement measurements of the sacral wound that were 6 cm (centimeters) by 6 cm and staged as a stage 4 pressure injury. The post-debridement assessment documents measurements of 6 cm x 8 cm x 2 cm in the deepest dimension. The assessment documents: Coccygeal ulcer with purulent drainage status post (s/p) debridement - 11/4 superficial coccyx wound culture with multiple organisms isolated and 4+ Bacteroides fragilis group. Acute care surgery consulted for coccyx wound with malodor and necrotic tissue on exam and patient ultimately underwent excisional debridement of sacral decubitus ulcer on 11/5/24; operative note reports tissue from wound bed was excised until healthy bleeding was noted at the wound base; no specimens were collected intraoperatively for culture. 11/14 computed tomography (CT) imaging showed appropriately 3.7 x 3 x 6 cm sacral decubitus ulcer/wound without fluid collection. Inpatient wound care team is following, see photos in chart of wounds. Continue local wound cares regularly. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted that from 10/28/24 to 11/4/24 there is no facility documentation related to the sacrum pressure injury discovered on R147 on 11/4/24 in the ER. R147 remained in the hospital for multiple medical reasons and was readmitted to the facility on [DATE]. R147's Admit/Readmit Screener completed on 11/25/24 documents under the Skin section: - Unstageable pressure injury to the right heel measuring 2 cm x 3 cm x .1 cm. - Stage 4 pressure injury to the sacrum measuring 5 cm x 5 cm x 1 cm. Surveyor noted that the Admit/Readmit screener completed on 11/25/24 did not include any characteristics, along with percentages, describing the two wound bed or periwound areas. Surveyor noted that there is no documentation of any revisions that were completed to R147's plan of care. Surveyor noted that R147's pressure injuries were not comprehensively assessed when R147 was readmitted to the facility, as the above Admit/Readmit screener did not include wound bed characteristics, along with percentages or a description of the periwound areas on R147. On 2/13/25, at 7:29 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-R. LPN-R stated that R147 is a PM bath and that the CNAs fill out a bath sheet and the nurse does a skin evaluation at this time and that bath sheets are scanned into the EHR. LPN-R informed Surveyor that LPN-R saw R147 before they left the faciity on [DATE]. LPN-R stated R147 had a small open area on the sacrum, and it was red. LPN-R stated that the facility was putting zinc on the area and LPN-R described the area to look like a straw opening. LPN-R could not recall the wheelchair that was used for transporting R147 before he left. During this interview, R147's spouse was wheeling R147 into the dining room and informed Surveyor that the wheelchair that R147 was currently in was the wheelchair used to transport R147. Surveyor noted that the wheelchair R147 was sitting in had a wheelchair cushion in place. Surveyor was unable to locate any documentation that R147's pressure injuries were assessed until 12/2/24, or 7 days after R147 was readmitted to the facility, one week after R147 was readmitted to the facility from the hospital on 12/2/24. R147's comprehensive wound assessment dated [DATE] and completed by WNP-O documents: Return from leave assessment, has wound to right heel and sacrum. Subjective assessment: patient is seen resting in bed, recently returned from prolonged hospitalization . During hospitalization , sacral ulcer was debrided on 11/5. Was treated with intravenous (IV) antibiotics for concern for wound infection during hospitalization . R147 is seen resting in bed today. R147 complains of pain with exam. Staff report no fevers, chills or other concerns today. The current Medications in the EHR were reviewed. The diagnoses that could affect wound healing include type 2 diabetes, afib (atrial fibrillation), HF, hyperlipidemia, hypertension, PVD, hypothyroidism, on Warfarin. Interventions in place are heel offloading with heel offloading boots or pillows as tolerated by patient, turn and reposition every 2-3 hours with assistance as needed, dietary collaboration, PT/OT collaboration. Physical Examination: +Right posterior heel (unstageable pressure ulcer) (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Full thickness wound measuring 4.5 x 3.5 x 0.1 cm. 80% slough, 20% granular tissue. Moderate amount of serosanguineous drainage noted, no odor. Peri wound without redness or warmth to indicate infection. This was present on readmission. Plan: Cleanse with NS or wound cleanser then apply saline moistened Hydrofera Blue to the base of the wound, cover with ABD pad and secure with kerlix. Change daily and prn. Continue offloading with Prevalon Boot. +Sacrum (stage 4 pressure injury) Full thickness wound measuring 4 x 3.5 x 3.6 cm. 100% granular tissue. Moderate serosanguineous drainage. Peri-wound is moist, fragile, intact. No s/sx infection. This was present on readmission. Plan: Gently pack with saline moistened hydrofera blue. Cover with bordered foam. Change daily and PRN The Summary Assessment is an unstageable pressure injury on the right heel, stage 4 pressure injury on the sacrum, and moderate protein-calorie malnutrition. Reviewed medical records. Discussed plan of care with nurse. Protein supplementation per dietary. Continue aggressive offloading, Prevalon boot to be worn at all times (cannot be used with transfers). Wound care reevaluation in 1 week. Patient with multiple comorbidities and multiple risk factors for developing and worsening of pressure injuries. Interventions consistent with individual needs, goals and standards of care have been implemented. Revisions to interventions were made as appropriate. Wound is considered unavoidable, and patient is at risk for further worsening or development of additional areas. Surveyor noted that there were no revisions to R147's plan of care that individualized pressure relieving interventions to promote healing. Surveyor was unable to locate any documentation of an assessment that described what an appropriate wheelchair cushion for R147 was to be used due to R147's pressure injury development. Surveyor was unable to locate any documentation of an assessment as to what type of air mattress was appropriate for R147 due to R147's pressure injury development. Despite R147 developing pressure injuries, Surveyor noted that there was no documentation of any changes to R147's dietary plan, no changes to R147's incontinent care/product use, and no changes in R147's turning and repositioning timeframes. R147's Significant Change in Status completed on 12/2/24 documents 1 unstageable pressure injury and 1 stage 4 pressure injury present from R147's readmission to the facility. The MDS documents that R147 is frequently incontinent of bowel and bladder and requires staff assist with activities of daily living. R147's Care Area Assessment for Pressure Injuries documents continue with plan of care-ambitious goal to heal wounds. Immediate goal to keep risk in balance and provide interventions to reduce risk. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted that there were no revisions to the plan of care for nutrition with the new onset(s) of R147's skin impairments. R147's current wound assessment completed by WNP-O on 2/10/25 documents: +Right posterior heel (stage 3 pressure ulcer) Full thickness wound measuring 1.1 x 1.3 x 0.1 cm. 100% granular tissue. Moderate amount of serosanguineous drainage noted, no odor. Peri wound without redness or warmth to indicate infection. The wound status has improved. There is no change in the plan of care. +Sacrum (stage 4 pressure injury) Full thickness wound measuring 3.5 x 2.8 x 2.5 cm. Undermining 9-2, 2 cm @ 12 o'clock. 100% granular tissue. Moderate serosanguineous drainage. Peri-wound is moist, fragile, intact. No s/sx infection. The wound status has declined. There is no change in the plan of care. On 2/10/25 at 9:52 AM, Surveyor observed R147 lying in bed. R147 was on their back with the bed in a semi-Fowler position (head of bed elevated 30-45 degrees.) R147 was on a low air loss mattress set at 10-minute cycles. The bed coverings were over R147's feet. Per the facility pressure injury list that was provided to Surveyor, along with the roster matrix, R147 was reported to have a stage 3 and stage 4 pressure injury. 10 On 2/13/25 at 8:20 AM, Surveyor interviewed R147's Power of Attorney for Healthcare (POAHC)-S. POAHC-S stated R147 had a very small area on their bottom at the facility. POAHC-S stated staff used zinc on it. POAHC-S stated the facility should have treated R147's open area before it got bigger. POAHC-S stated R147 used their current wheelchair for transport and that there is not another wheelchair used by R147. Surveyor observed R147 in his wheelchair in the dining room and Surveyor observed the wheelchair to have a cushion in place. On 2/13/25, at 9:56 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-Q. CNA-Q informed Surveyor that CNA-Q recalls that R147 had a small open area on the buttocks. CNA-Q stated that R147 is a check and change for incontinence. CNA-Q stated R147 can use the urinal at times and ask for a bed pan. CNA-Q could not recall any changes in the air mattress or wheelchair cushion of R147. On 2/11/25, at 10:30 AM, Surveyor interviewed Registered Nurse (RN)-I who completes resident weekly wound assessments with WNP-O. RN-I stated RN-I was on maternity leave from 9/12/24 to 12/10/24. RN-I became the facility's wound nurse when she returned on 12/10/24. RN-I informed Surveyor that with new admissions and readmissions, staff complete the screener information, and that a physical skin check is completed by the admission nurse or floor nurse. RN-I stated that nursing staff will get the discharge orders for any skin concerns and that at the end of the week, RN-I reviews the documentation for wound concerns. RN-I stated that residents with wounds are added to the weekly wound rounds that are completed on Monday with WNP-O. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN-I stated WNP-O documents in the progress notes and that they take a picture of the wounds and generate it into the Point Click Care Skin Evaluation (part of the EHR). RN-I stated that WNP-O documents the initial wound assessment and that RN-I finishes it up. RN-I informed Surveyor that the admission/floor nurse only measures the wounds and makes sure that a treatment is in place. RN-I stated that the admission/floor nurses also put in the initial care plan for any new or readmitted resident. RN-I stated that when a new open skin area on a resident develops, RN-I would update the care plan for that resident. RN-I stated that the facility has weekly meetings to review the plan of care of residents and that all nursing staff can go into the system to update the plan of care for a resident. On 2/11/25, at 2:20 PM, Surveyor observed R147 receive wound care by Assistant Director of Nurses (ADON)-G and Nurse Extern NE-P. R147 was in bed and R147's room had a strong unpleasant odor. The ADON-G is not familiar with the development of R147's pressure injuries. The Nurse Extern (NE)-P assisted in the positioning of R147 in bed. R147 had pressure relief heel boots on, and the air mattress was set to low air loss at 10-minute cycles. Surveyor observed the pressure injury treatment to the right heel was completed as ordered and correlated with wound assessment. The sacrum wound dressing was saturated with urine and drainage. The dressing date was smeared due to the extent of saturation. There was an unpleasant odor. R147 had an incontinence brief on in bed. ADON-G completed the wound treatment as ordered to the sacrum. ADON-G and NE-P provided incontinence care and changed R147's brief. ADON-G stated they had not seen R147's pressure injuries prior to completing the wound treatments. ADON-G is also the Unit Manager for R147. ADON-G stated that residents have weekly skin checks with baths and that skin evaluations are completed and scanned into the EHR. On 2/13/25, at 1:39 PM, Surveyor interviewed Registered Dietitian (RD)-DD. RD-DD stated they have started, and stopped, nutritional supplements for R147 due to weight changes. RD-DD stated the company had a brand change in their protein supplements. RD-DD informed Surveyor that RD-DD has assessed R147's protein needs and feels they are being met. RD-DD stated RD-DD did not change anything when R147 returned from the hospital on 11/25/24 with a stage 4 pressure injury. RD-DD stated R147 did not receive any additional vitamin supplements. RD-DD stated there has been no discussion about vitamins and minerals for wounds for R147. RD-DD informed Surveyor that R147 is already on a multivitamin. Surveyor noted that there were no changes in R147's nutritional management care plan despite R147 developing pressure injuries. WHEELCHAIR CUSHION INTERVENTION On 2/13/25, at 11:18 AM, Facility Service Manager (FSM)-L provided Surveyor the manufacturer recommendations for the wheelchair cushion that is in R147's wheelchair. The wheelchair cushion used by R147 is an Express Comfort Foam Flat. The product information documents it is for comfort and support. The product information does not document use for a stage 4 pressure injury. On 2/17/25, at 8:01 AM, Surveyor interviewed ADON-G about R147's wheelchair cushion. The ADON-G stated the wheelchair cushion is probably from physical therapy. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/17/25, at 9:06 AM, Surveyor interviewed Rehab Director (RD)-T. RD-T stated the wheelchair cushions don't necessarily come from therapy. RD-T informed Surveyor that there is a closet where anyone can take one to use. RD-T stated they will look for an assessment for the wheelchair cushion used in R147's wheelchair. On 2/17/25, at 9:45 AM, RD-T informed Surveyor that therapy does not have an assessment on the wheelchair cushion currently used by R147. On 2/17/25 at 10:02 AM, Surveyor interviewed WN-I. WN-I stated they do not coordinate, or place, the wheelchair cushions used by residents. Surveyor was unable to locate any assessment that described what an appropriate wheelchair cushion for R147 was to be used due to R147's pressure injury development. AIR MATTRESS INTERVENTION On 2/17/25, at 8:01 AM, Surveyor interviewed ADON-G. ADON-G stated the air mattress is programmed by the delivery company. ADON-G stated that the facility does not program the air mattress. On 2/17/25 at 8:24 AM, ADON-G shared with Surveyor that the air mattresses in the facility are programmed by the delivery company. On 2/17/25, at 9:04 AM, ADON-G stated R147's current air mattress was delivered on 8/16/24. The ADON-G provided Surveyor the company invoice of the air mattress delivery. On 2/17/25, at 9:14 AM, Surveyor called the air mattress Contractor-U regarding R147's air mattress. Contractor-U informed Surveyor that upon delivery, they just input the weight of the resident. Contractor-U stated the air mattress delivery staff do not program the minute cycles or anything else. Contractor-U stated the default weight is 150 pounds if there was no weight provided. On 2/17/25 at 10:02 AM, Surveyor interviewed WN-I. WN-I stated they are not involved in setting up air mattresses for residents. WN-I stated that floor staff are supposed to make sure that air mattresses are on and functioning correctly. R147 documented weights in the EHR are: - 8/25/2024: 233.0 Lbs. - 12/1/2024: 189.5 Lbs. - 1/15/2025: 219.4 Lbs. - 2/5/2025: 200.2 Lbs. Surveyor noted that R147's weights have fluctuated. Despite the weight changes in R147, Surveyor was unable to locate any documentation that R147's air mattress was adjusted to accommodate R147's weight changes. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Despite R147 developing pressure injuries, Surveyor noted that there was no documentation of any changes to R147's dietary plan, no changes to R147's incontinent care/product use, and no changes in R147's turning and repositioning timeframes. Surveyor was unable to locate any assessment of what type of air mattress was appropriate for R147 due to R147's pressure injury development. Surveyor noted that there were no revisions to R147's plan of care on 10/28/24 when R147 had increased skin moisture. Surveyor was unable to locate any documentation prior to 11/4/24 that R147's stage 4 pressure injury was assessed and treated by the facility. Surveyor was unable to locate a comprehensive pressure injury assessment upon R147's return to the facility on [DATE]. Surveyor noted that a comprehensive pressure wound assessment was completed 7 days after R147 was readmitted to the facility. Surveyor noted that R147's nutritional management did not change despite R147 being readmitted to the facility with a newly acquired stage 4 pressure injury. Surveyor noted there is no documentation of R147's refusing preventative turning and or repositioning. Surveyor was unable to locate any documentation of revisions to R147's turning/positioning timeframes with R147's onset of pressure injury and increased skin moisture. The facility's failure to comprehensively assess and implement an individualized plan of care for R147's pressure injuries led to serious harm for R147, thus leading to a finding of immediate jeopardy that began on 11/4/24. Surveyor notified the Nursing Home Administrator (NHA)-A, Director of Nurses (DON)-B and Regional Nurse Consultant (RNC)-N of the immediate jeopardy finding on 2/17/25 at 4:20 PM. The immediate jeopardy was removed on 2/20/25, when the facility completed the following interventions: - Resident continues to reside in facility and has resolving pressure injury to right heel and stable stage four PI to sacrum - goals of care are currently being met. - Skin sweep completed 2/17/25 to ensure all skin altercations have been identified, documented and have appropriate treatments and interventions in place. - Care plan sweep completed by 2/19/25 to ensure all interventions are individualized (guided by skin sweep results). - All staff educated on standard skin protocol before next shift to work. This includes skin integrity monitoring and change expectations for nurses, aides, dietary and therapy. - All licensed nurses educated on standard skin protocol, and comprehensive wound documentation expectations - including upon admit and recognition of a new skin altercation the licensed nurse will: alert provider and obtain any needed treatment orders, document comprehensive skin observation, interventions to be placed and documented as appropriate for resident, update DON or designee, update POA if applicable; and complete Risk Management for any new skin altercation - before next shift to work, competency quiz to validate understanding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, record review and interview, the facility did not ensure that residents received adequate supervision and assistance to prevent accidents. The facility did not thoroughly assess falls and accidents for causative factors. The facility did not ensure fall interventions were implemented. This was observed with 6 (R12, R23, R36, R39, R346 and R347) of 6 residents reviewed for accidents. * R12's falls were not thoroughly assessed for causative factors. There was not observations of fall preventative interventions * R23's falls were not thoroughly assessed for causative factors. There was not observations of fall preventative interventions * R36 was observed not to have their call light not in reach per his falls plan of care. * R39's falls were not thoroughly assessed for causative factors. There was not observations of fall preventative interventions * R346 and R347's falls were not thoroughly assessed for causative factors. Findings include: The facility's policy and procedure Falls dated 12/5/24. The policy documents that preventative measures are put in place to reduce the occurrence of falls and risk of injury from falls. The procedures include: - Licensed nurse completes electronic documentation of the Fall Incident Report. - The care plan will be updated with an identified intervention. - Registered Nurse reviews and completes the fall assessment and interventions. - Fall follow-up assessments completed as indicated. - The (Interdisciplinary Team) IDT will review Fall Incident report and utilize root cause analysis to make further recommendations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25, at 3:55 p.m., Surveyor interviewed Director of Nursing (DON)-B regarding the facility's fall process. DON-B informed Surveyor when ever there is a fall the staff check out the resident, ask the resident what happened, what they were trying to do and get statements from the aides as to when the resident was last toileted, what were they doing, were they in bed, and what was going on before the fall. Staff calls the POA (power of attorney), NP (Nurse Practitioner), herself, and the case worker. The resident is placed on the 24 hour board and neuro checks should be charted on. Residents are monitored for three days and if there is any injury they let the NP know and get orders to send them out. Surveyor inquired if anyone reviews the falls. DON-B informed Surveyor the IDT (interdisciplinary team) reviews fall in the morning meeting explaining they read the notes, try to determine what happened. If there is not a clear picture they will ask the resident and follow up with the nurses. DON-B informed Surveyor the nurses are suppose to put in an immediate intervention and they follow up. Surveyor asked if anyone reviews to see if prior interventions were in place. DON-B explained they have a weekly meeting where they go over everything including risk, wounds, injuries. Surveyor asked if anyone follows up with the CNAs. DON-B informed Surveyor they try to follow up and the CNAs shouldn't write they don't know but sometimes its difficult to get a hold of them. 1.) R12's diagnoses includes vascular dementia and is receiving hospice care. R12's significant change MDS (minimum data set) with an assessment reference date of 11/27/24 has a BIMS (brief interview mental status) score of 1 which indicates severe cognitive impairment. R12 is assessed as being dependent for toileting hygiene, roll left & right, chair/bed to chair transfer and toilet transfer. R12 is assessed as being always incontinent of urine and bowel. R12 is assessed as not having any falls since prior assessment. R12's Falls CAA (care area assessment) dated 11/29/24 under analysis of findings for nature of problem documents At risk for fall progressive weakness-recent admit to hospice services-assisted to safely transition surfaces. Daily meds (medication) add to risk potential. Under care plan considerations documents Continue with care plan. Continue to assist to safely transition and reposition. Goal to maintain safety without fall. Falls place at risk for injury. R12's fall risk evaluation dated 8/19/24 has a score of 15. Under instructions documents Assess the resident status below. If the total score is 10 or greater, the resident should be considered HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. R12's fall risk evaluation dated 9/12/24 has a score of 15 which indicates high risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's at risk for falls care plan initiated & revised on 7/12/24 documents the following interventions: PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered or PRN (as needed). Initiated 11/5/23. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 7/12/24 & revised 8/19/24. Ensure that the resident is wearing appropriate footwear (Shoes/socks with nonskid soles) when ambulating, transferring or mobilizing in w/c (wheelchair). Initiated 7/12/24 & revised 8/19/24. The resident needs a safe environment with a working and reachable call light, personal items within reach. Initiated 7/24/24 & revised 8/19/24. Bed in lowest position with floor mat when in bed. Initiated 8/19/24. Staff to assist resident to bed after breakfast if allows. Initiated 8/19/24. Staff to check and change q (every) 2 to 3 hours and prn if allows. Initiated 8/19/24. Body pillow when in bed. Initiated 9/12/24. Transfer bar to assist with bed mobility. Initiated 9/26/24 & revised 12/9/24. Air mattress with bolsters. Initiated 12/11/24 & revised 12/13/24. Air mattress - check function q (every) shift and prn (as needed). Initiated 12/11/24. R12's nurses note dated 9/12/24 at 21:27 (9:27 p.m.) written by Licensed Practical Nurse (LPN)-J documents Nurse went to give resident medication at about 6.30 PM and found resident on the floor by bed. Resident fell on the floor mat and was laying on her left side. Evaluation of all limbs functioning and moving well. Resident had a neuro check and vitals done and will be ongoing. Resident had a bm (bowel movement) and was cleaned up by CNA's and was placed in Hoyer to be put back into bed. No injury noted at the time of the assessment. Surveyor reviewed the facility's fall investigation provided by Director of Nursing (DON)-B for R12's fall on 9/12/24. Surveyor noted the facility investigation does not include whether prior interventions were in place at the time of R12's fall. R12's fall risk evaluation dated 9/26/24 has a score of 13 which indicates high risk. R12's nurses note dated 9/26/24 at 11:36 a.m. written by LPN-HH documents Resident had an unwitnessed fall and was found by med tech at 0635 (6:35 a.m.). Resident was face down on ground. Tech alerted nurse and nurse went to residents room. Nurse assessed resident. Resident c/o (complained of) head and left shoulder pain. Neuro checks started, vitals taken. DON (Director of Nursing), ADON (Assistant Director of Nursing), and NP (Nurse Practitioner), POA (Power of Attorney) notified. NP assessed resident as well. Resident alert as morning progresses and denies any pain in head or shoulder. Pupils reactive, normal ROM (range of motion) as resident had before fall. ADON talked to residents POA about transfer bars. No signs of injuries or bleeding. Surveyor reviewed facility's fall investigation provided by DON-B for R12's fall on 9/26/24. Surveyor noted the facility did not conduct a thorough investigation of R12's fall as there are no staff statements or evidence staff was spoken to as to when was R12 last seen, toileted, what was R12 doing, etc. There is no information as to whether prior interventions such as the body pillow were in place at the time of R12's fall. R12's fall risk evaluation dated 12/11/24 has a score of 13 which indicates high risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's nurses note dated 12/11/24 at 10:45 a.m. written by LPN-WW documents Writer was called into the room around 6:45 this morning to find resident lying on the floor by her bed on her right side. Resident was alert/orient and responsive. Resident was assessed and assisted with Hoyer lift back into bed. Resident has small bump to right side of head. Resident denies any pain or discomfort @ (at) this time. VSS (vital signs stable). ROM (range of motion) per usual. Hospice was called and Nurse [Name] came out to assess pt. as well. NOR (new order received) to D/C (discontinue) neuro check and one time order for dilaudid. Husband was called and updated as well as DON and administrator. Will continue to monitor this shift. Surveyor reviewed facility's fall investigation provided by DON-B for R12's fall on 12/11/24. Surveyor noted the facility did not conduct a thorough investigation of R12's fall as the two day shift staff statements indicates they didn't know when R12 was last toileted or repositioned as this fall occurred shortly after the day shift started. There are no statements or indications the night shift staff was interviewed as to who last saw R12, when was R12 toileted or repositioned. CNA (Certified Nursing Assistant)/Med Tech-KK's statement includes documentation of matt not in place on floor, bed not in lowest position. There is no indication as to whether the prior intervention of the body pillow was in place at the time of R12's fall. On 2/11/25, at 7:17 a.m., Surveyor observed R12 in bed on the right side with the bed in the lowest position and a mat on the floor along the left side of R12's bed. Surveyor observed there isn't a body pillow on the left side. The right side of R12's bed is against the wall. On 2/11/25, at 7:36 a.m. Surveyor observed Certified Nursing Assistant (CNA)-K in R12's room and is wearing gloves. CNA-K placed the wash basin on the over bed table, removed the floor mat, and informed R12 she was going to get her up, dressed, and go down for breakfast. CNA-K raised the height of bed and positioned R12 on her back. CNA-K unfastened the incontinence product which Surveyor observed contained urine. CNA-K informed R12 she was going to wash her peri area and washed R12's inner thighs and frontal perineal area. CNA-K positioned R12 on the right side, and removed the soiled incontinence product and informed R12 she was going to put the brief under her. As CNA-K was attempting to place the incontinence product under R12, R12's knee kept hitting the wall on the right side. CNA-K removed her gloves and left R12's room. Prior to leaving R12's room, CNA-K did not lower R12's bed and did not place the body pillow or mat on the floor. CNA-K reentered R12's room with a sheet, placed gloves on, folded the sheet and placed the sheet under R12 & straightened out the incontinence product by positioning R12 from side to side. CNA-K pulled up the incontinence product between R12's thighs and fastened the product. CNA-K placed pants on R12, removed R12's shirt and placed a Hoyer sling under R12. CNA-K washed R12's upper body, placed a sweater on R12, and stated to R12 she was going to lower her down while she goes to get help. CNA-K lowered the bed down, removed her gloves and left R12's room at 7:51 a.m. CNA-K did not place the body pillow on R12's bed or the mat on the floor prior to leaving R12's room. At 7:53 a.m. CNA-K and CNA-LL entered R12's room, placed gloves on, and transferred R12 from the bed into the broda chair using a Hoyer lift. On 2/11/25, at 7:25 a.m., Surveyor asked CNA-K if they use the body pillow. CNA-K replied yes at night. Surveyor informed CNA-K Surveyor did not observe the body pillow on R12's bed this morning. On 2/11/25, at 8:37 a.m., Surveyor observed R12 sitting in a broda chair along side a table in the dining room. Surveyor observed there is a pillow between R12's knees and a pink U shaped pillow around R12's neck. (continued on next page)

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	525421	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25, at 8:55 a.m., Surveyor observed R12 continues to be along side the table in the dining room. R12 has a spoon in her hand and is eating oatmeal. On 2/11/25, at 9:31 a.m., Surveyor observed CNA-K wheel R12 into her room and left R12's room immediately. On 2/11/25, at 9:51 a.m. Surveyor observed R12 sitting in a broda chair, which is slightly reclined back in her room holding onto a pillow with the pink u shaped pillow on R12's lap. On 2/11/25, at 10:27 a.m., Surveyor observed R12 continues to be sitting in the broda chair in her room and has thrown the two pillows on the floor. On 2/11/25, at 10:43 a.m., Surveyor asked CNA-K if R12 lays down during the day. CNA-K informed Surveyor after lunch she goes back to bed. Surveyor asked CNA-K if R12 lays down after breakfast. CNA-K replied just lunch. Surveyor noted there is a fall intervention to lay down R12 after breakfast. On 2/11/25, at 11:09 a.m. Surveyor asked Registered Nurse/Wound Nurse (RN/WN)-I if a resident has fall interventions like a body pillow should they be in place. RN/WN-I replied they should have a body pillow. Surveyor asked if the intervention is a fall mat should the mat be next to the bed. RN/WN-I replied yes because you don't know what will happen, a fall can happen that quick. Surveyor informed RN/WN-I of the observations of R12's fall interventions not in place. On 2/11/25, at 11:24 a.m., Surveyor observed R12's call light was activated. Surveyor entered R12's room and observed R12 sitting in the broda chair holding onto the call light. Surveyor asked R12 if she put her call light on. R12 put the call light up to her hear stating hello, hello. On 2/11.25, at 2:44 p.m., Surveyor observed R12 awake in bed on her left side. Surveyor observed R12's bed is in the low position with the body pillow along the left side but the mat is not the floor next to R12's bed. Surveyor observed the floor mat is propped up against the recliner in the corner. On 2/11/25, at 3:36 p.m., Surveyor observed R12 continues to be in bed awake on her left side. Surveyor observed the body pillow continues to be propped up against the recliner and is not on R12's bed according to R12's plan of care. On 2/13/25, at 2:18 p.m., Surveyor informed DON-B of Surveyor's concerns of fall interventions observed not in place for R12 and facility's investigation for R12's falls on 9/12/24, 9/26/24, & 12/11/24 were not thoroughly investigated to prevent further falls. 2.) R23's diagnoses includes congestive heart failure, depression, diabetes mellitus, glaucoma, macular degeneration, and atrial fibrillation. R23 receives hospice care. R23's admission MDS (minimum data set) with an assessment reference date of 11/8/24 has a BIMS (brief interview mental status) score of 1 which indicates severe cognitive impairment. R23 is assessed as requiring partial/moderate assistance for toileting hygiene, roll left & right and toilet transfers. R23 is assessed as requiring substantial/maximal assistance for chair/bed to chair transfer. R23 has an indwelling catheter and is frequently incontinent of bowel. R23 is assessed as not having any falls prior to admission or since admission. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23's fall CAA (care area assessment) dated 11/11/24 under analysis of findings for nature of the problem/condition documents Hx (history) syncope due to orthostatic hypotension adm (admission) fall score=10 indicates risk. Decreased vision/vision Dx (diagnosis). At fall risk-assisted to safely transition surfaces. Under care plan considerations documents Proceed to care plan. Maintain safety throughout her stay. Falling places at risk for injury/Fx (fracture). R23's fall risk evaluation dated 11/1/24 has a score of 10. Under instructions documents Assess the resident status below. If the total score is 10 or greater, the resident should be considered HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. R23's high risk for falls care plan initiated & revised on 11/1/24 documents the following interventions: Anticipate and meet the resident's needs. Initiated 11/1/24. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Initiated 11/1/24 & revised 12/9/24. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Initiated 11/1/24. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Initiated 11/1/24 & revised 11/5/24. Ensure that the resident is wearing appropriate footwear non skid socks when ambulating, transferring or mobilizing in w/c (wheelchair). Initiated & revised 11/1/24. Follow facility fall protocol. Initiated 11/1/24. PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered or PRN (as needed). Initiated 11/1/24. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. Initiated 11/1/24. The resident needs a safe environment with: SPECIFY even floors from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, personal items within reach. Initiated 11/1/24. Staff to ensure pillows are arranged on cough sic (couch) as resident allows. Initiated 11/17/24. Call don't fall sign. Initiated 12/10/24. Bedside commode. Initiated 12/13/24. Mattress with bolsters. Initiated 12/13/24. Body pillow when in bed if allows. Initiated 12/14/24. Recliner chair with lever replaced with recliner chair with remote for easier use. Initiated 1/22/25. Recliner chair replaced with chair that does not recline. Initiated 1/23/25. Resident to sit in Broda chair when out of bed when resident allows. Initiated 1/23/25 & revised on 1/24/25. R23's ADL (activities daily living) self-care performance deficit care plan initiated 11/1/24 includes an intervention of Transfer with assist of 1 with gait belt and walker. Initiated & revised 11/1/24. R23's nurses note dated 11/17/24, at 13:41 (1:41 p.m.), written by Licensed Practical Nurse (LPN)-H documents Resident had an UWF (unwitnessed fall) this morning. Upon checking resident was continent of B/B (bowel/bladder) with proper footwear on. Resident denies having any pain. No injuries were found after head/toe observation. Resident was fixing something on her couch when she lost her balance and fell on the floor. She crawled to her recliner chair to push her call light for help. She was then helped off the floor and helped into her recliner chair and was reeducated on calling for help before getting up. Resident son was informed of the fall when he came in to visit this morning, hospice notified and NP (Nurse Practitioner). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor reviewed R23's fall investigation emailed by Director of Nursing (DON)-B on 2/12/25. Surveyor noted there are no statements or interviews with staff as to who last saw R23, what was R23 doing etc. There is no information as to whether previous interventions were in place. On 2/13/25, at 2:20 p.m., Surveyor interviewed DON-B regarding R23's fall on 11/17/24 and inquired if there are any staff statements/interviews. DON-B informed Surveyor she doesn't think she has any. R23's nurses note dated 12/13/24, at 10:17 a.m., written by LPN-HH documents Resident had a witnessed fall while getting up to go take a shower with CNA (Certified Nursing Assistant). Resident got dizzy, fell backward and hit her head on a wood side table. Residents head was bleeding and nurse stopped the bleeding with applied pressure. Resident said her head did not hurt when asked. Nurse called emergency contact and left a message for him to call back. [Name] hospice was notified. Neuro checks started. Surveyor reviewed the facility's fall investigation emailed by DON-B on 2/12/25. The root cause documents resident was being assisted to bathroom by CNA with wheeled walker, got dizzy and lost balance causing her to be lowered to the floor. On 2/13/25, at 2:21 p.m., Surveyor interviewed DON-B regarding R23's fall on 12/13/24. Surveyor asked if R23 was lowered to the floor how did she sustain a hematoma to the back of R23's head and was the CNA using a gait belt according to R23's plan of care. DON-B informed Surveyor she can't say if the gait belt was being used and lowered to the floor was probably a typo. Surveyor asked DON-B to get back to Surveyor with any further information regarding R23's 12/13/24 fall. DON-B did not provide Surveyor with any further information. R23's nurses note dated 12/14/24, at 05:49 (5:49 a.m.), written by Nurse Extern-XX documents Resident had a unwitnessed fall. Resident was trying to get out of bed. Gash noted from previous fall, no bleeding observed. Hospice nurse, POA, NP notified. resident did say she has no pain. Surveyor noted this fall occurred on 12/13/24 at 6:37 p.m. Surveyor reviewed the facility's fall investigation emailed by DON-B on 2/12/25. Surveyor noted there are no statements or interviews with staff as to who last saw R23, what was R23 doing etc. There is no information as to whether previous interventions were in place. On 2/13/25, at 2:24 p.m., Surveyor interviewed DON-B regarding R23's fall on 12/13/24 which was documented on 12/14/24. DON-B informed Surveyor there are not any staff statements. R23's nurses note dated 12/14/24, at 20:27 (8:27 p.m.) written by Nurse Extern-P documents UWF (unwitnessed fall) Resident was lying on the floor in front of bed on her back, assessed resident, resident said she has no pain, took vitals, resident said she is feeling ok. contacted NP, tried to contact son [Name] no answer tried contacting ADON (Assistant Director of Nursing) no answer. Surveyor reviewed the facility's investigation emailed by DON-B on 2/12/25. Surveyor noted the facility did not have a thorough investigation there are no staff statements/interviews as to who last saw R23, was R23 incontinent, what was R23 doing prior and whether prior interventions were in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/13/25, at 2:25 p.m., Surveyor interviewed DON-B regarding R23's fall on 12/14/24. Surveyor informed DON-B there are no staff statements/interviews as to who last saw R23, what was she doing and were prior interventions in place. Surveyor asked DON-B if the body pillow is a current intervention. DON-B informed Surveyor it's on her care plan so it's a fall intervention. Surveyor informed DON-B Surveyor has not observed R23's body pillow. R23's nurses note dated 1/21/25, at 21:20 (9:20 p.m.) written by LPN-H documents Resident was found on her floor in front of her wheelchair face down upon observation she has and large knot above her right eye, Ice was applied to the right eye. Resident had on proper footwear and was continent upon fall. Resident was asked if she would like to go to hospital and she refused, resident isn't on any blood thinners. Family, Hospice, NP and DON were informed. Neuro checks started. Family came up to facility to check on resident will let me know if they would like for her to be sent out to hospital. Surveyor reviewed the facility's investigation emailed by DON-B on 2/12/25. Surveyor noted CNA-YY's statement for time of incident 8:50 p.m. for the question when was the last time you saw the resident and what were they doing documents I saw her at 8:00 PM. She was sitting in recliner watching TV. For the question was the call light on a the time of the fall and was it within reach documents No I was in room at time. Surveyor noted this information is conflicting. On 2/13/25, at 2:26 p.m., Surveyor interviewed DON-B regarding the facility's fall investigation regarding R23's fall on 1/21/25 at 8:50 p.m. Surveyor informed DON-B CNA-YY's statement documents she last saw R23 at 8:00 p.m. but documents the call light was not on because she was in the room at the time. DON-B informed Surveyor she doesn't think she understood the questions. Surveyor asked DON-B if she asked CNA-YY if she was in R23's room when 23 fell . DON-B replied I didn't ask her. R23's Certified Nursing Assistant (CNA) kardex as of 2/11/25 under the transfer section documents Transfer with assist of 1 with gait belt and walker. On 2/10/25, at 1:49 p.m., Surveyor observed R23 sitting in a wheelchair in her room. There is a burgundy colored mat on the floor on the right side of R23's bed. On 2/10/25, at 3:41 p.m., Surveyor observed R23 sitting in a wheelchair facing the bed. Surveyor observed R23's call light is resting on the floor next to R23's bed by the floor mat. On 2/11/25, at 7:14 a.m., Surveyor observed R23 in bed on her back. R23's bed is in the low position, there is a mat on the floor on the right side and the call light is attached to the sheet on the right side hanging down. Surveyor did not observe the body pillow on R23's bed. On 2/11/25, at 8:09 a.m., Surveyor observed R23 continues to be in bed on her back. Surveyor observed there is still not a body pillow on R23's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/25, at 10:36 a.m., CNA-K entered R23's room and placed gloves on. CNA-K informed Surveyor she will put on her socks after she is finished brushing her teeth. Surveyor observed R23 is sitting on the edge of the bed brushing her teeth. At 10:37 a.m. CNA-K placed tubi grips on R23's bilateral lower extremities and then placed gripper socks on. CNA-K asked R23 if she wants to lay down or sit up. R23 informed CNA-K she wants to sit in the wheelchair. CNA-K moved R23's wheelchair closer to the bed, placed the urinary collection bag under R23's wheelchair, held under R23's left arm & back and assisted R23 with standing, R23 took a couple steps to turn and sit in the wheelchair. CNA-K did not use a gait belt according to R23's plan of care. On 2/11/25, at 11:39 a.m., Surveyor asked CNA-K if she ever uses a gait belt when transferring R23. CNA-K replied no, just walker, used to be in care plan but hospice took it out. On 2/11/25, at 2:42 p.m., Surveyor observed R23 sleeping in bed on her back. Surveyor observed the bed is not at the lowest position, there is no floor mat on the right side and the body pillow is not on R23's bed. On 2/11/25, at 3:38 p.m., Surveyor observed R23 continues to be sleeping in bed on her back. Surveyor observed the bed is not at the lowest position, there is not a body pillow on R23's bed and there is not a floor mat on the right side of the bed. On 2/13/25, at 7:27 a.m., Surveyor observed R23 in bed on her back. Surveyor observed the bed is at the lowest position, there is a blue mat floor mat on the right side but there is no body pillow observed. On 2/13/25, at 7:36 a.m., Surveyor asked CNA/Med Tech-KK when R23 is in bed should there be a floor mat on the right side of R23's bed. CNA/Med Tech-KK replied yes. On 2/13/25, at 2:18 p.m., Surveyor asked DON-B if R23 should be transferred with a gait belt. DON-B replied if that is what the care plan says, yes. Surveyor informed DON-B of the observation of R23 being transferred without a gait belt and Surveyor had observed gait belt hanging on the back of R23's door. Surveyor also informed DON-B of other fall interventions, mat on floor and body pillow not being in place. No additional information was provided. 51016 3.) R36 was admitted on [DATE] with diagnosis that includes Spastic Hemiplegia (causing weakness) affecting right dominant side, Cerebral Infarction, Dementia and Chronic Respiratory Failure. R36's Quarterly MDS (Minimum Data Set) with an assessment reference date of 12/4/24 documents a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate intact cognition for R36. Section GG (Functional Abilities and Goals) documents R36's bed mobility to roll left to right as requiring substantial maximal assistance. Section GG documents R36's bed mobility to go from sitting position to lying down as substantial maximal assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section GG documents R36's bed mobility to go from lying position to sitting as substantial maximal assistance. Section GG documents R36's bed mobility to toilet transfer as dependent on staff. Section H documents R36's urinary and bowel incontinence as always incontinent. R36's fall risk care plan dated 8/29/24, revision on 9/6/24, documents, The resident is at risk for falls r/t (related to) confusion, deconditioning. R36's intervention dated 8/29/24, revision on 9/30/24, documents, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. On 02/10/25, at 10:30 AM, Surveyor observed R36 in bed with the call light hanging behind R36's bed. Surveyor asked R36 if R36 could reach the call light. R36 pointed behind R36 and informed Surveyor not at the moment (referring to not being able to reach the call light). On 02/10/25, at 11:49 AM, Surveyor observed R36 in bed with the call light resting over the headboard and behind the mattress of R36's bed and not in reach of R36. On 02/10/25, at 12:30 PM, Surveyor observed R36 in bed with the call light resting over the headboard and behind the mattress of R36's bed and not in reach of R36. On 02/10/25, at 01:45 PM, Surveyor observed R36 in bed with the call light resting over the headboard and behind the mattress of R36's bed and not in reach of R36. Surveyor asked R36 if R36 could reach the call light. R36 informed Surveyor R36 could not reach the call light. On 02/11/25, at 07:32 AM, Surveyor observed R36 in bed with the call light resting over the headboard and behind the mattress of R36's bed and not in reach of R36. On 02/11/25, at 09:00 AM, Surveyor observed staff take a breakfast tray into R36's room and leave after setting up a breakfast tray for R36. Surveyor observed the call light still behind R36 and out of reach. On 02/11/25, at 09:55 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K. Surveyor asked CNA-K if CNA-K worked on the unit routinely. CNA-K informed Surveyor yes. Surveyor asked CNA-K are there any residents in this hallway that cannot use their call light. CNA-K informed Surveyor they all can use their light on this hall. Surveyor asked CNA-K if R36 can use the call light. CNA-K informed Surveyor yes, R36 can use the call light. On 02/11/25, at 10:02 AM, Surveyor observed R36 in bed with the call light resting over the headboard and behind the mattress of R36's bed and not in reach of R36. Surveyor asked R36 if you wanted to call for help or call a nurse, what would R36 do. R36 pointed behind R36, and informed Surveyor use the call light. Surveyor asked R36 could R36 reach the call light if R36 needed to call for help. R36 informed Surveyor not now (referring to not being able to reach the call light). On 02/11/25, at 10:32 AM, Surveyor observed call light behind R36's head and out of reach of R36. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/11/25, at 10:43 AM, Surveyor observed R36's right heel treatment by Licensed Practical Nurse (LPN)-F. On 02/11/25, at 10:56 AM, Surveyor observed LPN-F leave R36's room after completing the treatment on R36's wound. Surveyor observed that LPN-F did not place the call light within reach of R36. On 02/11/25, at 02:34 PM, Surveyor observed R36 in bed with the call light resting over the headboard and behind the mattress of R36's bed and not in reach of R36. On 02/11/25, at 03:05 PM, Surveyor informed Nursing Home Administrator (NHA)-A, Regional Nurse Consultant-N, Assistant Director of Nursing (ADON)-G and Director of Nursing (DON)-B of the above findings. Surveyor informed the facility of Surveyor's multiple observations of the call light not being in reach of R36. Surveyor informed the facility that Surveyor witnessed a food tray be delivered and wound care completed for R36, and in both instances, the call light was not placed by staff within R36's reach. NHA-A informed Surveyor that the call light not being in reach was a concern for the facility as well and that NHA-A would make sure that was taken

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F 0725 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 42037 Based on observation, interview, and record review, the facility did not designate a licensed nurse to serve as a charge nurse on each tour of duty. * The facility did not designate a charge nurse for each tour of duty on each daily nursing schedule. This deficient practice has the potential to affect all 49 residents residing in the facility. Findings include: On 2/11/25, Surveyor requested nursing schedules and nurse staff postings for Quarter 4 (July 1st-September 30th, 2024) due to Payroll Based Journal reporting and 1/20/25-2/10/25. Surveyor was provided with the nursing schedules and nurse staff postings and noted the facility's nursing schedules did not designate who the charge nurse was for each tour of duty. On 2/17/25, at 10:15 AM, Surveyor conducted an interview with Scheduler-HHH. Scheduler-HHH is responsible for coordinating the facility's nursing schedule and preparing the facility's nurse staff postings. Surveyor asked Schedule-HHH if they were aware there was not a charge nurse designated on the facility's nursing schedules for Quarter 4 (July 1st -September 30th, 2024) from 1/20/25-2/10/25. Scheduler-HHH told Surveyor that they were not aware that it is a requirement to designate a charge nurse for each shift on the daily nursing schedule. On 2/17/25 at 2:40 PM, Surveyor informed Nursing Home Administrator (NHA)-A of the concern related to the facility's schedules not designating who the facility charge nurse would be on the facility's nursing schedules for Quarter 4 (July 1st -September 30th, 2024) from 1/20/25-2/10/25 for each tour of duty. The facility did not provide any additional information as to why it did not ensure that the facility designated a charge nurse for each tour of duty.

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	525421	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindengrove Menomonee Falls	W180 N8071 Town Hall Rd Menomonee Falls, WI 53051

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21855 Based on observation, interview and record review, the facility did not ensure food was prepared, and served, in a sanitary manner. This was observed in 2 of 2 food preparation and serving areas and with the meal tray service to resident rooms on 1 (Unit A) of 4 units. * The facility did not ensure the facility kitchen dish machine was functioning to sanitize dishware. * The dietary staff was observed without hair restraints in the 1st floor kitchen preparation and serving area and the main kitchen. * On Unit A resident meal trays items were not covered during delivery to resident rooms. * The facility kitchen dish machine was not monitored, and checked, to ensure appropriate sanitization of dishware. Findings include: On 2/11/25, at 12:16 PM, the Food Service Director (FSD)-W provided policy and procedures to Surveyor. There is no date of review, or revision, on the policy and procedures. The FSD-W does not know the dates and this what they use. The facility's policy and procedure with no date and titled, Hair Restraints documents that all staff entering a kitchen will wear a hairnet/hair restraint, ensuring that all hair is completely covered by the hairnet. The facility's policy and procedure with no date and tilted, Recording Dish Machine Temperatures documents that all staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. The facility's policy and procedure with no date and titled, Manual Dishwashing documents that all flatware, serving dishes, cookware will be washed, rinsed and sanitized after each use. The policy states that the dish machine will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation. 1.) On 2/10/25, at 11:38 AM, Surveyor observed the 1st floor kitchen area. The 1st floor kitchen service area has hairnet boxes by both entrances. There is signs in the doorways to use a hair restraint when entering. The lunch service was being prepped by Dietary Aide (DA) -X and DA-V. DA-V was observed with a medium length beard that was uncovered. DA-V was setting up meal trays and place settings in the dining room. The meal trays were being set-up on the steam table food handling area. On 2/10/25, at 12:10 PM, DA-V brought the hot food cart into the kitchen area. DA-V now is wearing a beard covering. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/10/25, at 12:14 PM, DA-X removed the hot food items from the hot cart and into the food steamer. DA-X was observed with a hairnet on the top portion of their hair bun. DA-X hair on their head itself was uncovered. DA-X placed the hot food items into the serving steam table. DA-X obtained food temperatures of the food items in the steam table. After this was completed, Surveyor queried DA-X regarding hair restraints. DA-X stated they do not have any large enough to cover their entire head. DA-X stated they only cover their top bun. At this time (FSD) -W entered the kitchen area. DA-X requested a larger hairnet from FSD-W. The FSD-W did provide DA-X with a larger hair restraint. On 2/11/25, at 9:10 AM, Surveyor observed Cook-Y in the main kitchen by the food preparation area. Cook-Y has a medium length beard. Cook-Y was wearing a beard hair restraint underneath their beard. DA-V was observed by the dish machine area. DA-V has a medium length beard. DA-V did not have a hair restraint over their beard. On 2/11/25, at 2:05 PM, Surveyor interviewed the Regional Food Service Director (RFSD)-Z and the FSD-W. Both stated staff should be utilizing hair restraints in the kitchen areas. On 2/11/25, at 3:09 PM, at the facility exit meeting, Surveyor shared the hair restraint concerns with Nursing Home Administrator (NHA) -A, Regional Nurse Consultant (RNC)-N and Director of Nurses (DON) -B. 2.) 02/11/25, at 9:54 AM, Surveyor observed Dietary Aide (DA)-V emptying a used meal tray cart. DA-V went over by the dish machine loading area. DA-V stated they typically use a sticker for testing the dish machine. DA-V stated they don't look, or log, the dish machine temperatures. DA-V stated they did not test the dish machine temperature yet. DA-V has not seen the dish machine log sheet. DA-X came and took over emptying the used food carts. DA-X stated they did not know where the temperature logs were. DA-V was observed utilizing the dish machine with dishware. Surveyor requested the dish machine logs from Food Service Director (FSD) -W. The FSD-W also looked around the kitchen for the dish machine logs and could not locate them. The FSD-W stated they will look for them. On 2/11/25, at 11:18 AM, the FSD-W provided Surveyor a clipboard with the dish machine logs. Surveyor noted the dish machine logs do not include temperature documentation for each meal use of the dish machine. The dish machine logs have AM and PM headers with one entry of a temperature test strip for 2/11/25 AM. Surveyor noted there was no dish machine log temperature documentation for September 2024, November 2024, December 2024, January 2025 and February 1 - 10. Surveyor noted the August 2024 dish machine log has no temperature documentation for the following dates in August 2024: 3, 8, 11,12,13,14,15,17 and 31. Surveyor noted that the dish machine logs did have documentation of proper sanitization with use. There is not a additional system to ensure dish ware is being sanitized correctly. On 2/11/25, at 2:05 PM, Surveyor interviewed Regional Food Service Director (RFSD)-Z and FSD-W. Both stated they do not have a backup system to ensure dish machine is sanitizing correctly. There was not additional information for the dish machine logs that were missing monitoring. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/11/25, at 3:09 PM, at the facility exit meeting, Surveyor shared the dish machine sanitizing concerns with Nursing Home Administrator (NHA) -A, Regional Nurse Consultant (RNC) -N and Director of Nurses (DON)-B. 38829 2) Surveyor was provided a Dining, Organization, Staffing, and Service policy and procedure last reviewed 11/29/06. The policy documents: F. Sanitary conditions shall be maintained in the storage, preparation and distribution of food. On 2/11/25, at 8:53 AM, Surveyor observed staff distributing the room breakfast trays. Surveyor observed the tray cart with door left open. Surveyor observed that the hot cereal, cold cereal, and orange in a dish is not covered. Staff take a tray out of the cart and walk 2-3 rooms away from the cart. On 2/11/25, at 12:40 PM, Surveyor observed the room lunch trays have an uncovered cookie and uncovered grated cheese on the trays. On 2/11/25 at 2:19 PM, Surveyor interviewed Regional Food Service Director (RFSD)-Z and Food Service Director (FSD)-W together. Both confirmed that a lid covers the heated plate and then transferred to the covered cart for Resident rooms. The only side item that gets covered would be the soup which would get a disposable lid. On 2/13/25 at 8:49 AM, Surveyor made observations of breakfast trays being delivered to Resident rooms. The cart of breakfast trays is parked at the beginning of the hallway of Unit A. Certified Nursing Assistant (CNA)-FF is delivering the breakfast trays. Surveyor observed CNA-FF going 3 rooms down from the cart. Surveyor observed cereal and the fruit are not covered. CNA-FF delivered breakfast trays to rooms [ROOM NUMBERS]. On 2/13/25, at 8:51 AM, CNA-FF moved the cart to the center of the hallway, and served the first room on the right(106). Side items on the tray were not covered. On 2/13/25, at 8:56 AM, CNA-FF took room(108) tray out of the cart and walked it down to room [ROOM NUMBER] with milk on the tray with no items covered including the milk. Surveyor observed this was 3 rooms down from cart. On 2/13/25, at 9:04 AM, CNA-FF took a tray out of the cart and crossed the hall to room [ROOM NUMBER]. Side items are not covered. CNA-FF placed the tray on top of the isolation cart, put a gown on and delivered the tray. On 2/13/25, at 9:19 AM, Surveyor observed CNA-CC carrying a tray all the way down to the last room on the right. CNA-CC informed Surveyor that CNA-CC got the tray from the dining room kitchenette because the Resident wanted the food to be hot. Surveyor observed the plate was covered, but the cereal and berries were not. Tea was covered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/13/25, at 10:05 AM, Surveyor spoke with RFSD-Z via telephone. RFSD-Z confirmed only the hot meal gets covered to keep the temperature. and goes directly into the covered cart. No other items are covered. RFSD-Z understands the concern that when the cart is parked at the beginning of the hallway and staff is walking the Resident room trays down the hallway with uncovered items. On 2/13/25, at 3:04 PM, Surveyor shared the concern with Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A the concern that items are not covered on the Resident room trays and are delivered down the hallway 2-3 rooms away from the cart. Surveyor explained that food should be covered when traveling a distance (i.e., down a hallway, to a different unit or floor). NHA-A shared that the facility will be getting all new kitchen staff. No other information has been provided at this time. On 2/17/25, at 8:59 AM, Surveyor observed Resident room breakfast trays being distributed. Surveyor observed the the tray cart at the beginning of the Unit A hallway by room [ROOM NUMBER]. CNA-FF carried a tray from the cart down to room [ROOM NUMBER] with uncovered oatmeal and applesauce, placed the tray on the isolation cart, donned a gown and went into the room. On 2/17/25, at 9:06 AM, Surveyor observed CNA-FF carry a room tray from the cart still parked at 102 to room [ROOM NUMBER] and the applesauce is not covered. On 2/17/25, at 9:12 AM, Surveyor observed CNA-EE carry a tray from the cart still parked at 102 with uncovered applesauce to room [ROOM NUMBER]. This is approximately 3 rooms down and across the hallway. On 2/17/25, at 9:13 AM, Surveyor observed CNA-EE carry a tray from the cart still parked at 102 with uncovered cereal and applesauce, put the tray on isolation cart, and donned gown and gloves outside of room [ROOM NUMBER] and took the tray to room [ROOM NUMBER]. No additional information was provided.