STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525424	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Brookfield	18740 W Bluemound Rd Brookfield, WI 53045

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47094 Based on interview and record review, the facility did not ensure the residents received treatment and care in accordance with professional standards of practice, individual assessment, the comprehensive person-centered care plan, and the resident's choices for 2 (R4 and R6) of 9 residents. * R4 was admitted to the facility on [DATE]. There wasn't a comprehensive assessment or monitoring ordered for R4's midline surgical incision. On 10/10/24 R4 went to the hospital for an infection to the midline surgical incision. On 10/15/24 (R4 was not in the facility at the time) a care plan was initiated for R4's midline incision. R4 was readmitted to the facility on [DATE] with treatment orders for the midline incision. R4's care plan was not revised until 10/21/24 and R4's midline treatment/ monitoring orders for the midline incision were not implemented until 10/21/24. On 10/23/24 R4 was sent to the hospital for possible infection to the midline surgical incision. * R6 had a change in condition, the facility did not act upon ordered labs and results accordingly. R6 was admitted to the hospital. Findings Include: The facility policy entitled Wound Management- Wound Prevention and Treatment revised on 10/11/2024 documents: The purpose of this program is to assist the facility in the care, services, and documentation related to the occurrence, treatment, and prevention of pressure as well as no-pressure-related [sic] wounds. PROVISION AND PROCEDURE: . 2. Upon admission, the resident will receive a head-to-toe skin check to identify any skin issues. 4. All residents will have the following nursing care procedures implemented: a. Skin hygiene- - Daily with cleanser and rinse thoroughly. - As needed to keep local areas of skin clean, dry, and free of body wastes such as urine, feces, perspiration, and wound drainage. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- During care, inspect the skin for signs and symptoms of skin breakdown. 5. Daily, during routine care, the certified nursing assistant (CNA) will observe resident's skin. When abnormalities are noted, this will be communicated to the licensed nurse, and the licensed nurse will evaluate and implement a skin event if applicable. The facility policy entitled Change of Condition Process initiated on 3/1/2021 documents: The purpose of this policy is to promptly implement a system for a resident having a change in condition. A change of condition is defined as an improvement or decline in their physical, mental, or psychosocial status. 5. Change of condition documentation will continue until the director of nursing (DON) or IDT (interdisciplinary team) determined there is a resolution of the condition. 1.) R4 was admitted to the facility on [DATE] and has diagnoses that include colon cancer with metastasis to the liver and lung, viral hepatitis C, peritoneal abscess, spinal stenosis, protein-calorie malnutrition, history of cocaine abuse with intoxication, adjustment disorder with anxiety, cognitive communication deficit, and adult failure to thrive. R4's admission minimum data set (MDS) dated [DATE] indicated R4 had intact cognition with a brief interview for mental status (BIMS) score of 15 and the facility assessed R4 requiring moderate assistance with 1 staff member for toileting hygiene and minimal assistance with 1 staff member for personal hygiene. R4 had a right hemicolectomy and was continent of urine. R4 had a right lower back JP drain (drain for excess fluid buildup) and a midline incision above R4's umbilicus where an abdominal abscess was removed while R4 was in the hospital. R4 was admitted to the facility for rehab and wound management. Surveyor reviewed the admission collection and baseline care plan tool dated 10/3/2024 and noted staff documented in the skin condition section: -Abdomen- vertical surgical wound with staples approximated, no S/SX (signs/symptoms) of infection. Surveyor noted there was no care plan initiated or orders initiated to monitor R4's abdominal surgical incision or interventions established. There wasn't a comprehensive assessment documented about how long the incision was, how many staples are present, what surrounding skin looks like. On 10/5/2024, at 7:12 AM, in the progress notes nursing documented follow up abd (abdominal) incision, staples intact, incision open to air. Surveyor noted there are no further assessments or documentation regarding R4's abdominal incision observation or assessments. On 10/10/2024, at 15:30 (3:30 PM), in the progress notes nursing documented writer asked by Certified Nursing Assistant (CNA) to look at resident due to drainage coming from the surgical site. Nursing documented creamy/slightly green drainage coming from incision site above umbilicus site, no drainage noted from JP drain. R4 was sent to emergency room for evaluation. On 10/14/2024, at 13:13 (1:13 PM), in the progress notes nursing documented R4 was admitted to the hospital with abdominal wall abscess and leaking from the abdominal drain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that a care plan was initiated on 10/15/2024 for actual skin impairment to skin integrity related to abdominal surgical wound, right hemicolectomy, small bowel resection, and end ileostomy and drainage of abdominal abscess on 9/17/2024 and a JP drain site on right lower abdomen area. Abdominal incision, PICC site, ostomy right lower abdomen with the following interventions: - Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. - Document skin observation during ADL (activities of daily living) care- report abnormal findings to the nurse. - Educate resident/family/caregivers of causative factors and measures to prevent skin injury. - Encourage good nutrition and hydration in order to promote healthier skin. - Follow facility protocols for treatment of injury - Identify/document potential causative factors and eliminate/resolve where possible. - Implement pressure reducing devices i.e. w/c (wheelchair) cushion, air-mattress, off-loading heels, etc. - Monitor for side effects of the antibiotics and over-the-counter pain medications: . - Monitor/document location, size, and treatment for skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration, etc. to MD (medical doctor). Surveyor notes that R4 was still in the hospital at time the care plan was initiated on 10/15/2024. Surveyor reviewed R4's initial hospital visit note dated 10/15/2024 that documents the following: - Possible surgical wound infection - CT abdomen and pelvis show no drainable abscess Plan/Recommend: - IR (interventional radiology) repositioning/replacement for perihepatic collection - Gauze dressing to abdominal wound, change twice daily - Monitor for staple removal, after drainage incision improves - IV antibiotics (treated with Micafungin and high dose Augmentin based on cultures growing candid glabrata and coli methicillin -sensitive E faecalis) - Likely high output as drainage from incision appears similar to output of JP drain. IR replaced the drain and adjustment on 10/11/2024. (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 10/18/2024, at 1733 (5:33 PM), in the progress notes nursing documented R4 readmitted to the facility . has orders for IV antibiotics including two oral antibiotics. R4's abdominal incision dehisced both above and below the umbilicus. R4 has new wound orders that have been entered into PCC (point click care-healthcare software). A wound evaluation form was completed on 10/21/2024 that stated wound was assessed on 10/19/2024 and documents: Abdominal surgical wound: -Above umbilicus- 4.5 cm x 2.3 cm x 1 cm (length x width x depth), 50% granulation, 50% slough, moderate serosanguineous drainage. - Below umbilicus- 2.3 cm x 1.5 cm x 1 cm, 50% granulation, 50% slough, moderate serosanguineous drainage Surveyor noted that the following wound orders were not implemented on R4's MAR/TAR (medication/treatment administration record) until 10/21/2024: 1. Monitor dressing placement to abdomen to ensure dressing is clean, dry, intact. Replace dressing if soiled or breakthrough drainage noted every shift. 2. Monitor wound to abdomen for signs and symptoms of infections such as pain, swelling, warmth, redness, odor, purulent, and deterioration. Notify MD if s/sx of infection, deterioration noted. 3. Wound care abdomen: Dakin's packing to abdominal wounds (1/2 inch packing strip to superior wound, kerlix to inferior wound). Cover with abdominal pad and secure with tape BID (twice a day) for abdominal incision wound infection. Surveyor noted that R4's abdominal incision care plan was not revised until 10/21/2024 with the following interventions. - Turn and reposition as necessary - Weekly treatment documentation to include measurement of each area of skin breakdown width, length, depth, tissue type and exudate and other notable changes or observations. On 10/23/2024, at 11:44 AM, in the progress notes nursing documented R4 is being transferred out due to post surgical infection. Vital signs: blood pressure 94/57, hear rate 100, temperature 97.8 . Surgical site is purulent drainage and abdominal pad is soaked through. R4 has been complaining of increased abdominal pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/29/2024, at 2:00 PM, Surveyor interviewed unit manager (UM)-M who stated expectations for wound assessments on admission are that two nursing staff observe the wound and document the measurement, and appearance of the wound, treatments are initiated on the medication/ treatment administration record (MAR/TAR) and a care plan is initiated. Surveyor asked UM-M how often staff should have been monitoring and documenting on R4's abdominal incision wound. UM-M stated nursing should document observation of any warmth, redness, swelling, and other signs/symptoms of infection every shift and as needed or as ordered. UM-M stated that it would have been listed on R4's MAR/TAR. Surveyor asked if monitoring of R4's abdominal incision should have been on the MAR/TAR, UM-M stated that it should have been on R4's MAR/TAR to monitor the abdominal incision each shift and is not sure why it was not. Surveyor asked UM-M when are care plans initiated when there are areas of concern observed. UM-M stated that care plans should be initiated or revised as soon the area of concern is observed to get interventions in place. Surveyor asked why R4's abdominal care plan would have been initiated on 10/15/2024 if R4 was not in the facility at the time. UM-M was not sure why it was initiated at that time. On 10/30/2024, at 9:26 AM, Surveyor interviewed director of nursing (DON)-B who stated initially comprehensive assessments were not done for surgical wounds with staples but recently the facility implemented a RN comprehensive assessment for all wounds. Surveyor asked when that would have happened. DON-B stated that on 10/9/2024 R4's wound was assessed but unfortunately DON-B did not get measurements or description of the wound. DON-B stated that the wound MD assessed R4's abdominal incision on 10/9/2024 but would not follow any longer due to R4 seeing outpatient surgery for R4's abdominal wound management. Surveyor asked about wound monitoring for R4's abdominal incision. DON-B stated that CNA staff did daily observations with activities of daily living (ADL) care and would report abnormalities to nursing staff. DON-B stated usually standard to monitor skin with showers that are 1-2 times a week. Surveyor asked how staff would know to monitor wounds if it was not listed on the MAR/TAR or care plan. DON-B stated that there is a 24 hour board and nursing report. DON-B stated R4's abdominal incision was open to air and that monitoring should have been on the MAR/TAR but must have been missed. Surveyor asked if wound care followed R4 at all for R4's incision. DON-B stated R4 would not have been seen due to R4's wound being a surgical wound, but the wound care nurse did see R4 on 10/9/2024 with the wound MD. Surveyor did not see an assessment for R4's abdominal surgical incision for 10/9/2024. Surveyor requested to speak with the wound care nurse, the wound care nurse did not come talk with Surveyor. Surveyor reviewed CNA charting for skin observation for R4 and noted that there wasn't consistent documentation for skin observations for R4. CNAs did not document each shift or document about the incision for R4. Many days on the skin observation task form were left blank. Surveyor reviewed the 24 hour reports for 10/3/2024 - 10/10/2024 and noted there was inconsistent monitoring/mention of R4's abdominal wound or mention that R4 had areas of concern to monitor. Surveyor reviewed a (name of wound care group) note dated 10/9/2024 that documented: -Signing off on patient who remains in the facility. Surgical wound. Surveyor noted there is no wound MD assessment of R4's abdominal wound. Surveyor noted there was no assessment or recommendations etc. regarding R4's incisions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	10/30/2024, at 10:30 AM, Surveyor interviewed licensed practical nurse (LPN)-N who stated when a resident is admitted , any orders get implemented into the MAR/TAR and two nurses assess the resident for any wounds or skin concerns. LPN-N stated wound care will see the resident the next day if there are any concerns and implement any orders. LPN-N stated that R4 was admitted with a drain and staples but could not recall anything else. LPN-N stated if an incision was to be open to air it should still be put on the MAR/TAR so staff are aware and monitoring of the area, but usually wound care will put in those orders when they see them the next day. Surveyor asked if wound care would see residents if the wounds are surgical. LPN-N stated that a request gets put it when the skin observation sheet gets filled out and there are concerns on it so R4 should have seen wound care, but LPN-N stated LPN-N was not quite sure what that process is. Surveyor asked how LPN-N would know or where staff would look if R4 or any other residents had surgical incisions or other skin concerns that had to be monitored. LPN-N stated that it would be on the residents MAR/TAR and care plan with interventions that needed to be done. Surveyor asked where documentation is located for any observations/ monitoring. LPN-N stated there would be a progress note and initials to the MAR/TAR. On 10/30/2024, 12:33 PM, Surveyor shared concerns with nursing home administrator (NHA)-A and DON-B of lack of documented monitoring/ assessments for R4's abdominal incision and R4 had to go to the hospital twice for wound abdominal wound incision infections. Surveyor shared concerns that R4 did not have a care plan initiated until 10/15/2024, when R4 was in the hospital, and that there were no orders for monitoring of R4's abdominal wound. Surveyor shared concerns that when R4 was readmitted to the facility on [DATE] R4's wound care orders/ monitoring was not imitated until 10/21/2024 and R4's care plan was not revised until 10/21/2024 and R4 was sent out to the hospital a second time on 10/23/2024 for potential abdominal incision infection. 42037 2.) R6 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Intestinal Perforation, Urinary Retention, Diabetes Mellitus and Malnutrition. R4's Admission Minimum Data Set (MDS) dated [DATE] indicated R6 had intact cognition with a BIMS score of 13. R6 was discharged from the facility on 10/13/24. Surveyor reviewed R6's closed medical record including progress notes, physician orders, laboratory reports and comprehensive care plan. A progress note by Licensed Practical Nurse (LPN)-Y dated 10/11/24 with a posted time of 11:23 PM documented the following: Resident was c/o (complaining of) emesis x 2 around dinner time, writer checked resident's vitals (stable) and notified NP (Nurse Practitioner). NOR (New Order Received) for CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) and Zofran (An anti-nausea medication) 4 mg every 8 hours as needed. Surveyor requested R6's CBC and BMP lab results from 10/11/24 order. A progress note by LPN-Z dated 10/13/24 at 4:25 PM documented the following: Writer reviewed resident's blood work, writer immediately called on call MD. MD instructed the writer to take a full set of vitals. Vital signs viewed as the patient's baseline besides (sic) low diastolic blood pressure. The writer informed resident that he would be sent out to his hospital of choice for IV fluids and medications . On 10/13/24, R6 was sent to the hospital. R6 has not returned to the facility at this time. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R6's laboratory report from 10/12/24. Surveyor noted the WBC (White Blood Cell) reference range to be 4.0-10.8. p/mL (per milliliter), Sodium reference range of 137-146 mEq/L (milliequivalents per liter) and Potassium reference range of 3.6-5.0 mEq/L. On 10/12/24, R6's laboratory report results were documented as follows: WBC 19.24p/mL .sodium 127 mEq/L .potassium 2.7.mEq/L, On 10/29/24 at 12:35 PM, Surveyor conducted interview with LPN-Z. Surveyor asked LPN-Z what the procedure would be for arranging for laboratory blood draws at the facility. LPN-Z responded that the nurse that obtained the order should notify the laboratory company by faxing a requisition form with the resident's demographic information, diagnostic reason for laboratory test and physician's order. LPN-Z told Surveyor that if the Surveyor was interested in speaking about R6 that the only thing LPN-Z knew was that on 10/13/24 on PM shift, LPN-Z found R6's laboratory results and reported the abnormal lab results to the on call physician. Surveyor asked LPN-Z what they had meant by saying they found R6's laboratory results. LPN-Z responded that R6's laboratory results were at the nurse's station desk located by the 24 hour report board. Surveyor asked LPN-Z what the facility's expectation would be for reporting laboratory results to a physician. LPN-Z responded that abnormal laboratory results should either be reported to a physician by phone or their email at the time that the facility receives the laboratory results via fax or phone from the laboratory. Surveyor asked LPN-Z if they knew why there had been a delay in reporting R6's abnormal laboratory reports as the laboratory results were drawn on 10/12/24. LPN-Z remained silent at this time and did not respond to Surveyor's question. Surveyor concluded interview with LPN-Z at this time. On 10/30/24 at 1:09 PM , Surveyor conducted interview with LPN-Y via telephone. Surveyor asked LPN-Y what the procedure would be for arranging for laboratory blood draws at the facility. LPN-Y responded that the nurse that obtained the order should notify the laboratory company by faxing a requisition form with the resident's demographic information, diagnostic reason for laboratory test and physician's order. Surveyor asked LPN-Y if they recalled receiving the order for R6's laboratory tests from an NP on 10/11/24. LPN-Y told Surveyor that they remembered receiving orders for Zofran and lab work for R6. Surveyor asked LPN-Y if they recalled notifying the laboratory company of R6's physician orders for a CBC and BMP. LPN-Y told Surveyor that they did not recall if they had notified the laboratory company of R6's physician orders for a CBC and BMP. Surveyor asked LPN-Y what the facility's expectation would be for reporting laboratory results to a physician. LPN-Y responded that abnormal laboratory results should either be reported to a physician by phone or their email at the time that the facility receives the laboratory results via fax or phone from the laboratory. On 10/30/24 at 11:15 AM, Surveyor contacted the laboratory company's main telephone line. Surveyor conducted interview with Laboratory Assistant-AA via telephone. Surveyor asked Laboratory Assistant-AA to verify when the Laboratory had received the facility's laboratory requisition for R6's CBC and BMP labs. Laboratory Assistant-AA verified facility's laboratory requisition for R6's CBC and BMP labs was received via fax from facility on 10/12/24 at 4:02 PM. It was noted they were a stat order. Laboratory Assistant-AA told Surveyor that a phlebotomist from the laboratory had collected a blood sample from R6 on 10/12/24 at 5:20 PM. Laboratory Assistant-AA told Surveyor that R6's CBC results were faxed to the facility on [DATE] at 6:05 PM and that R6's BMP results were faxed to the facility on [DATE] at 7:34 PM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/29/24 at 1:15 PM, Surveyor conducted interview with Unit Manager-M. Surveyor asked Unit Manager-M what the procedure would be for arranging for laboratory blood draws at the facility. Unit Manager-M responded that the nurse that obtained the order should notify the laboratory company by faxing a requisition form with the resident's demographic information, reason for laboratory test and a physician's order. Surveyor asked Unit Manager-M what the facility's expectation would be for reporting laboratory results to a physician. Unit Manager-M responded that abnormal laboratory results should either be reported to a physician by phone. Surveyor asked Unit Manager-M if they were aware that R6 had laboratory orders for a CBC and BMP with results on 10/12/24 including an elevated WBC (White Blood Cell) level of 19.24 p/mL, low sodium level of 127 mEq/L and low potassium level of 2.7 mEq/L not being reported to R6's physician until 10/13/24 at 4:20 PM, resulting in R6 being discharged to the hospital. Unit Manager-M told Surveyor when they heard that R6's laboratory results from 10/12/24 were not reported to R6's physician until the following day that they were very concerned and that there must have been a miscommunication among nursing staff. On 10/30/24 at 1:25 PM, Surveyor conducted interview with Acting DON-B. Surveyor asked Acting DON-B what the procedure would be for arranging for laboratory blood draws at the facility. Acting DON-B responded that the nurse that obtains the order should notify the laboratory company by faxing a requisition form with the resident's demographic information, reason for laboratory test and a physician's order. Surveyor asked Acting DON-B what the facility's expectation would be for reporting laboratory results to a physician. Acting DON-B responded that abnormal laboratory results should either be reported to a physician by phone or emailed to the physician on call. Surveyor asked Acting DON-B if they were aware that R6 had laboratory orders for a CBC and BMP with results on 10/12/24 including an elevated WBC (White Blood Cell) level of 19.24 p/mL, low sodium level of 127 mEq/L and low potassium level of 2.7 mEq/L not being reported to R6's physician until 10/13/24 at 4:20 PM, resulting in R6 being discharged to the hospital. Acting DON-B told Surveyor that they had spoken to the facility's medical director after they were made aware of R6's abnormal laboratory results and that if the Medical Director had been on call on 10/13/24 that the medical director would have managed R6's condition at the facility and would have not sent R6 to the hospital. On 10/30/24 at 1:30 PM, Surveyor shared concerns with Acting DON-B that R6's abnormal lab results that were received on 10/12/24 at 6:02 PM and 7:34 PM were not reported to R6's physician until 10/13/24 at 4:20 PM, leading to a delay in treatment for R6 which resulted in R6 being admitted to the hospital. Acting DON-B did not have any further information available for Surveyor at this time. On 10/30/24 at 1:45 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A that R6's abnormal lab results that were received on 10/12/24 at 6:02 PM and 7:34 PM were not reported to R6's physician until 10/13/24 at 4:20 PM, leading to a delay in treatment for R6 which resulted in R6 being admitted to the hospital. The facility did not have any further information available for Surveyor at this time.

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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 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** 20025 Based on observation, interview, and record review, the facility did not ensure 3 of 3 residents (R) reviewed (R1, R2, and R3) had a comprehensive assessment and care plan to prevent and heal pressure injuries. R1 was admitted to the facility on [DATE]. Upon admission, R1 had no open wounds or pressure injuries. R1 was assessed to be at risk for pressure injuries and to need extensive assistance with bed mobility. On 7/12/24, R1 developed a blister to the right heel. An RN assessment was not completed until 7/17/24. On 7/12/24, R1's right heel blister was inaccurately assessed as Stage 1 pressure injury with 100% granulation. The care plan does not indicate heel offloading was an intervention prior to R1 developing a blister to the right heel. The nurse's notes and weekly wound assessments indicate R1 is not compliant with interventions and treatment of the right heel pressure injury. The facility does not have evidence of any discussion with R1 regarding risk and benefits of noncompliance. The noncompliance was also not addressed in the care plan until 9/25/24. R1's pressure injury deteriorated on 9/18/24, which required hospitalization for osteomyelitis. R1 required IV antibiotics and debridement of the wound while hospitalized . R1 returned to the facility on [DATE] with a Stage 4 pressure injury. On 9/25/24, Wound MD-D assessed R1's heel as a Stage 4 pressure injury. On 9/25/24, the facility wound evaluation inaccurately indicated R1's heel is an unstageable pressure injury. The facility's failure to prevent the development of a facility acquired stage 4 pressure injury with infection by ensuring assessment, prevention, and treatment in accordance with current standards of practice created a finding of immediate jeopardy that began on 9/18/24. Surveyor notified NHA (Nursing Home Administrator)-A of the immediate jeopardy on 10/10/24 at 2:55 p.m. The immediate jeopardy was removed on 10/11/2024, however, the deficient practice continues at a scope/severity of G (actual harm/isolated) based upon additional resident examples involving R2 and as the facility continues to implement its action plan. R2 was found with pressure injuries to the plantar area of both feet on 9/30/2024, the care plan was not updated with the relevant intervention until 10/9/2024, a Physician order for treatment was not started until later the next day, and then only on the right foot. When Surveyor observed wound care, one pressure injury was incorrectly staged. There is an additional example involving R3: *The facility did not stage R3's left and right heel pressure ulcers according to standards of practice as observed during wound treatment care on 10-09-24. Facility did not follow skin monitoring interventions listed in R3's care plans. Findings include: The facility's Wound Management-Wound Prevention and Treatment policy revised 5/9/22 documents: 1. The facility will ensure that based on the comprehensive assessment of a resident: (continued on next page)

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	525424	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Brookfield	18740 W Bluemound Rd Brookfield, WI 53045

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a) A resident receives care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and b) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 6. Interventions will be implemented in the resident's care plan to prevent pressure ulcer development when the resident has no areas of concern. 8. Interventions will be implemented in the resident's care plan to prevent deterioration and promote the pressure ulcer's healing. According to the National Pressure Injury Advisory Panel (NPIAP): https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf. NPIAP Pressure Injury Stages - The updated staging system includes the following definitions: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. 1.) R1 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes with diabetic neuropathy, obesity, pain in right hip, idiopathic gout right ankle and foot, localized edema, and spinal stenosis. R1 has an activate healthcare Power of Attorney (HCPOA). The admitting MDS (Minimum Data Set) dated 5/28/24 indicates R1 has a Brief Interview for Mental Status (BIMs) score of 8 indicating R1 has moderate cognitive impairment and needs extensive assistance with bed mobility. The MDS also indicates R1 is at risk for pressure injuries and is free from pressure injuries, R1 did not demonstrate any rejection of care, and R1's ability to understand others may include missing some part/intent of message but comprehends most conversation - usually understands. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 is noted to have a care plan indicating for a focus: the resident is functioning at a cognitively moderately impaired level r/t (related to) observable loss of memory initiated 5/29/24 and revised on 5/29/24. Goals initiated 5/29/24 with a revision on 6/5/24 include resident will participate in the following activities through the next review date of 8/20/24. Interventions different activities/strategies to help R1 participate and remember things cognitively. R1 also is identified as having a communication problem related to being understood by others and usually understanding others appropriately related to her moderately impaired cognition. Interventions dated 5/29/24 include anticipate and meet needs . Ri's Activities of Daily Living (ADL) care plan initiated 5/22/24 and revised on 5/29/24 documents, Focus: The resident has an ADL self-care performance deficit related to being physically deconditioned s/p (status post) recent hospitalization for Spondylopathy of the cervical region and spinal stenosis. Goals include: The resident will maintain current level of function through the review date initiated: 5/22/24, revised 6/5/24, target date 8/20/24. The resident will improve current level of function through the review date initiated 5/22/24, revised on 6/5/24. Interventions include: .Bed Mobility: The resident requires extensive assistance initiated 5/22/24, revised on 5/29/24 . Transfer: The resident requires extensive assistance with chair/bed transfers initiated 5/22/24, revised on 5/29/24. R1 also had a care plan related to diabetes with a focus documenting: The resident had Diabetes Mellitus Type 2 with Neuropathy and utilizes po (by mouth) medication management initiated: 5/29/24, revised on: 5/29/24. Goal: The resident will be free from any s/sx (signs/symptoms) of hypoglycemia through the review date. Initiated: 5/29/24, revised on 6/5/24. Interventions include, Check all of body for breaks in skin and treat promptly as ordered by doctor initiated: 5/29/24 . Surveyor noted the care plan does not specify completion of diabetic foot checks or the frequency at which staff are to check all of R1's body for breaks in skin. The care plan with a focus area of limited physical mobility related to the Spondylopathy of the cervical Region, spinal stenosis initiated 5/22/24, revised 9/2/24 to include a right heel unstageable PU (pressure ulcer/injury). Goal is for the resident to demonstrate the appropriate use of adaptive device(s) to increase mobility through the review date. Initiated 5/22/24, revised 6/5/24, target date: 8/20/24. Interventions include: The resident is weight bearing initiated: 5/22/24, Ambulation: The resident requires extensive assistance with ambulation with the FWW (four wheeled walker) up to 10 feet initiated: 5/22/24, revised: 5/29/24. Provide supportive care, assistance with mobility as needed. Document assistance as needed initiated: 5/22/24. PT (physical therapy), OT (occupational therapy) referrals as ordered, PRN (as needed) initiated: 5/22/24. Surveyor noted there is no revised intervention related to the noted unstageable heel pressure injury that is a focus area of the care plan. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's care plan with a focus on the potential for impairment for skin integrity related to impaired mobility was initiated on 5/22/24 and revised 5/29/24. The goal documents, the resident will maintain or develop clean and intact skin by the review date. This was initiated 5/22/24, revised on 6/5/24 with a goal date of 8/20/24. Interventions dated 5/22/24 include encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, turn and reposition as necessary and provide pressure relieving device(s): Pressure relieving mattress initiated 5/22/24. Revised on 10/9/24: refuses apm (alternating pressure mattress). The facility added to this care plan on 7/15/24, elevate heels off surface of bed using pillows, heels up device or heel lift boots. Surveyor noted prior to 7/15/24, the care plan related to R1 being at risk for skin integrity issues did not include preventative interventions for R1's feet despite R1's risk factors for skin integrity concerns. Surveyor also noted the plan of care was not individualized for R1. Additional review of R1's care plans include a focus initiated 5/29/24 related to kidney function and renal insufficiency that included the intervention to elevate feet when sitting up in chair to help prevent dependent edema initiated 5/29/24. A care plan initiated on 5/29/24 related to impaired circulation related to diabetes and hyperlipidemia initiated 5/29/24 includes an intervention to elevate R1's legs when resting initiated 5/29/24. It is noted R1 also had issues related to edema. Surveyor noted the care plans did not address how to individually care for R1's risk factor to allow elevation to prevent edema while decreasing the risk for the development of pressure injuries. A nurses note dated 7/12/24 documents, Rt heel, discolored filled blister, (Wound MD-D) aware, order to (sic) skin prep. Family at bed side, family aware. The skin impairment/wound evaluation dated 7/12/24 documents R1's right heel blister as, Stage 1 measuring 4.0 cm (centimeters) by 3.0 cm and the wound bed is 100% granulation. Surveyor noted a description of a stage 1 blister would not include the presence of granulation according to standards of practice. Both the nurses note and the wound evaluation are documented by an LPN (Licensed Practical Nurse). A skin issues form dated 7/12/24 prepared by DON-B indicates R1 has a right heel ulcer - new skin area with resident unable to give a description. Immediate action taken indicates PCP (primary care physician,) wound nurse, and DON notified. Treatment ordered for skin prep and to off-load heels. The document indicates R1 is oriented to person, place, and time. Predisposing environmental factors indicate none. Predisposing physiological factors indicate none and behavioral factors - resistive/non-compliant. Predisposing situation factors indicate none. Notes document: IDT (interdisciplinary team) meeting s/p status post resident new skin issue. DON and wound care nurse assessed wound - root cause analysis completed, resident frequently up in wheelchair daily, refuses care and assessment at times. Resident is assist (sic) with transfers and repositioning needs, staff will continue to reposition per facility policy. Nursing intervention - foot boots for heel protection and treatment per wound care MD. Care plan reviewed and updated. There is a document dated 7/12/24 with the front and back outline of a body that includes R1's name and is signed by Director of Nursing (DON)-B. The document has a circled area on the back, right heel stating 4 cm (centimeter) x (by) 3 cm, blister. Surveyor noted there is no description of the blister as to whether it is fluid filled or not and what type of fluid it may be if present. There are also no details describing the surrounding skin to the wound. (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 there were no revisions to R1's skin integrity care plan until 7/15/24 when the facility added the intervention to elevate (R1's) heels off the surface of bed using pillows, heels up device, or heel lift boots. Surveyor also noted the skin issues form indicates behaviors as a factor including resisting cares or noncompliance. Surveyor noted there is no assessment of these behaviors and no care plan interventions to address these behaviors. Surveyor noted R1 has cognitive impairment. The 7/16/24 Wound MD-D assessment indicates the right heel is an unstageable DTI (deep tissue injury) measuring 5 cm by 9 cm, skin intact with purple/maroon discoloration and blood-filled blister. The note also indicates the development of this wound and the context surrounding the development were considered in greater detail today. Counseling offered to optimize wound healing regarding relevant conditions including diabetes, chronic kidney disease. Reviewed off-loading surfaces and discussed surfaces care plan. Recommend upgrading off-loading devices in bed and/or chair. Considered patient behavior as factor is complicating wound healing and discussed it further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Dressing treatment plan: skin prep apply once daily for 30 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. Surveyor noted this does not specify whether the counseling was provided to the facility staff, resident, family, etc. The note does not indicate a discussion of risks and benefits. The facility did not initiate a behavior care plan for any behaviors R1 may display that could impact healing. Wound MD-D's wound evaluation dated 7/23/24 indicates unstageable pressure injury of the right heel, full thickness. Measuring 5cm by 9cm by not measurable cm, depth is unmeasurable due to presence of nonviable tissue and necrosis. 100% thick adherent devitalized necrotic tissue. Exacerbated due to patient non-compliant with wound care. The note also indicates: The progress of this wound and the context surrounding the progress were considered in greater detail today. Counseling offered to optimize wound healing regarding relevant conditions (or possible conditions) including diabetes, anemia, noncompliance. Patient not following repositioning or off-loading recommendations and counseling provided. Reviewed off-loading surfaces and discussed surfaces care plan. Recommend upgrading off-loading device in bed and/or chair. Considered patient behavior as factor that is complicating wound healing and discussed it further with staff and/or family. Discussed wound healing trajectory and expectations with patient and/or family. Primary dressing: betadine apply twice daily for 30 days. Secondary dressing: ABD (abdominal) pad apply twice daily for 30 days; gauze roll (kerlix) 3.4 apply twice daily for 30 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. Surveyor noted this does not specify whether the counseling was provided to the facility staff, resident, family, etc. The note does not indicate a discussion of risks and benefits. The facility did not initiate a behavior care plan for any behaviors R1 may display that could impact healing. The facility's skin impairment/wound evaluation dated 7/23/24 indicates the presence of an unstageable pressure injury: obscured full thickness skin and tissue loss. Measuring 5 cm by 9 cm by UTD (unable to determine) cm. Wound tissue: blister. It also indicates exacerbated due to patient non-compliant with wound care. Surveyor noted there is no indication the facility assessed R1's resistance to wound care interventions and established a plan to address this behavior if it was impacting wound healing. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound MD-D's wound evaluation dated 7/30/24 indicates unstageable (due to necrosis) of the right heel full thickness. Measuring 5 cm by 6 cm by not measurable cm. Depth is unmeasurable due to presence of nonviable tissue and necrosis 50% thick adherent devitalized necrotic tissue and 50% granulation tissue. Primary dressing: Iodosorb gel apply once daily for 30 days. Secondary dressing: ABD pad apply once daily for 23 days; gauze roll (kerlix) 3.4 apply once daily for 23 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. The facility's skin impairment/wound evaluation dated 7/30/24 indicates the same evaluation as Wound MD-D's assessment and continues to indicate exacerbated due to patient noncompliant with wound care. Surveyor noted there is no indication the facility assessed R1's resistance to wound care interventions and established a plan to address this behavior if it was impacting wound healing. The facility's skin impairment/wound evaluation dated 8/6/24 indicates unstageable pressure injury: obscured full thickness skin and tissue loss to right heel. Measuring 6 cm by 6.5 cm by 0.2 cm with 50% granulation 50% eschar and continues to indicate exacerbated due to patient noncompliant with wound care. Wound MD-L's wound evaluation dated 8/9/24 indicates unstageable (due to necrosis) of the right heel full thickness. Measuring 4.5 cm by 6 cm by 0.2cm 50% thick adherent devitalized necrotic tissue and 50% granulation tissue. Primary dressing: iodosorb gel apply once daily for 20 days. Secondary dressing: ABD pad apply once daily for 13 days; gauze roll (kerlix) 3.4 apply once daily for 13 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. Wound MD-L's wound evaluation dated 8/16/24 indicates unstageable (due to necrosis) of the right heel full thickness. Measuring 4.5 cm by 6 cm by 0.2cm 50% thick adherent devitalized necrotic tissue and 50% granulation tissue. Primary dressing: iodosorb gel apply once daily for 13 days. Secondary dressing: ABD pad apply once daily for 30 days; gauze roll (kerlix) 3.4 apply once daily for 30 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. It also indicates remove necrotic tissue and establish the margins of viable tissue. Treatment options-risk-benefits and the possible need for subsequent additional procedures on this wound were explained on 8/16/24 to the patient who indicated agreement to proceed with the procedure(s). Wound MD-L's wound evaluation dated 8/23/24 indicated unstageable (due to necrosis) of the right heel full thickness. Measuring 4.3 cm by 5.5 cm by 0.2cm 40% thick adherent black necrotic tissue (eschar) and 50% thick adherent devitalized necrotic tissue and 10% granulation tissue. Primary dressing: leptospermum honey apply once daily for 30 days. Xeroform gauze apply once daily for 30 days. Secondary dressing: ABD pad apply once daily for 23 days; gauze roll (kerlix) 3.4 apply once daily for 23 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot; antibiotic choice: doxycycline 100mg BID (twice a day) for 7 days. Wound MD-L's wound evaluation dated 8/30/24 indicated unstageable (due to necrosis) of the right heel full thickness. Measuring 3.2 cm by 6.4 cm by 0.3cm 20% thick adherent black necrotic tissue (eschar) and 50% thick adherent devitalized necrotic tissue and 30% granulation tissue. Primary dressing: Sodium hypochlorite solution (Dakin's) apply twice daily for 30 days: 1/2 strength, soaked gauze to pack the wound. Secondary dressing: ABD pad apply once daily for 16 days; gauze roll (kerlix) 3.4 apply once daily for 16 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Wound MD-L's wound evaluation dated 9/6/24 indicated unstageable (due to necrosis) of the right heel full thickness. Measuring 3.2 cm by 5.9 cm by 0.3cm 20% thick adherent black necrotic tissue (eschar) and 50% thick adherent devitalized necrotic tissue and 30% granulation tissue. Primary dressing: Sodium hypochlorite solution (Dakin's) apply twice daily for 23 days: 1/2 strength, soaked gauze to pack the wound. Secondary dressing: ABD pad apply once daily for 9 days; gauze roll (kerlix) 3.4 apply once daily for 9 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. Wound MD-L's wound evaluation dated 9/13/24 indicated unstageable (due to necrosis) of the right heel full thickness. Measuring 3.8 cm by 4.8 cm by 0.3cm 50% thick adherent devitalized necrotic tissue 30% slough and 20% granulation tissue. Primary dressing: Sodium hypochlorite solution (Dakin's) apply twice daily for 16 days: 1/2 strength, soaked gauze to pack the wound; metronidazole sprinkled apply once daily for 30 days. Secondary dressing: ABD pad apply twice daily for 30 days; gauze roll (kerlix) 3.4 apply twice daily for 30 days. Recommendations: float heels in bed; elevate leg(s); pressure off-loading boot. The facility's skin impairment/wound evaluation dated 8/17/24, 8/23/24, 8/31/24 and 9/7/24 reiterates Wound MD-L's wound assessments. There is no documentation of noncompliance from R1. Wound MD-D's wound evaluation dated 9/18/24 indicates unstageable (due to necrosis) of the right heel full thickness. Measuring 6 cm by 7 cm by not measurable cm 80% thick adherent devitalized necrotic tissue and 20% granulation tissue. Wound progress exacerbated due to patient noncompliant with wound care. It also indicates, Patient recommended for transfer to hospital for further care. The hospital record dated 9/18/24 indicates R1 was admitted with osteomyelitis and surgical debridement of the wound was performed. The hospital record indicates a conversation regarding possible amputation was discussed with R1 and R1 adamantly refused amputation. R1 also received IV antibiotics for the osteomyelitis. The medical record indicates R1 returned to the facility on [DATE]. Wound MD-D assessed the right heel at a Stage 4 pressure injury measuring 4 cm by 6.5 cm with 30% necrotic tissue and 70% granulation tissue. Acting DON-B, who is also the 2nd floor unit manager and Wound nurse, documented on 9/28/24, R1's pressure injury as unstageable instead of Stage 4 as assessed by Wound MD-D. The weekly wound evaluations performed by Acting DON-B continue to indicate R1's pressure injury as unstageable instead of Stage 4. The facility's skin impairment/wound evaluations dated 7/23/24 and 7/30/24 and Wound MD-D's 7/23/24 assessment indicate R1 was noncompliant with treatment and interventions to help heal pressure injury. There is no documentation in the nurse's notes indicating R1 is noncompliant with interventions and treatment to heal the pressure injury. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/10/24 at 9:52 a.m., Surveyor interviewed Acting DON-B and NHA-A. Surveyor explained the concern; R1 developed an avoidable, facility acquired unstageable right heel pressure injury which was inaccurately assessed on 7/12/24 and there wasn't a RN assessment until 7/17/24. R1's care plan did not address interventions to prevent the heel wound from developing and R1's pressure injury deteriorated to the point of osteomyelitis and needing surgical debridement along with IV antibiotics in the hospital with discussion of possible amputation. Surveyor also explained the facility continued to assess the wound as unstageable after Wound M-D assessed it as a Stage 4 pressure injury post hospitalization . NHA-A stated R1 would be noncompliant with treatment and interventions. Surveyor explained R1 did not have a care plan addressing this noncompliance until 9/24/24 and there is no documentation that R1 was educated on risk and benefits of her noncompliance. Acting DON-B agreed the 7/12/24 assessment was incorrect and the assessments after R1 returned from the hospital should be assessed as Stage 4 instead of unstageable. On 10/9/24 at 2:27 p.m., Surveyor observed R1's pressure injury treatment. Wound MD-D assessed the wound and stated the wound is improving. The 10/9/24 wound assessment reveals R1 to have a Stage 4 pressure wound to right heel measuring 3.5 cm by 4.5 cm by 0.3 cm with moderate serosanguineous drainage and 100% granulation tissue. On 10/10/24 at 3:00 p.m. during the exit meeting with Acting DON-B and NHA-A, Surveyor explained the deficient practice. NHA-A stated the facility initiated to elevate heels after the discovery of the blister on R1's right heel. Surveyor explained there is no evidence interventions were in place to prevent a pressure injury from developing. On 10/30/24 at 4:20 p.m., Surveyor interviewed R1's son, the HCPOA for R1. R1's son stated he was never notified R1 was non-compliant with the care and treatment of the heel pressure injury. R1's son stated he would ask staff why (R1's) wound was not healing and he was told, Oh, that sometimes it takes a while to heal. R1's son stated Wound MD-D or Wound MD-L did not notify him of anything regarding R1's heel. R1's son stated R1 came to the facility for rehab due to weakness and then was supposed to go home. R1's son stated R1 now can't go back home and has to remain at a skilled nursing facility. The facility's failure to assess R1's risk for the development of pressure injuries and to establish preventative interventions to address R1's risk led to R1 developing a facility acquired, avoidable stage 4 pressure injury with osteomyelitis. R1 was hospitalized because of deterioration in the pressure injury and required surgical debridement and amputation was discussed. The facility consistently stated R1 was noncompliant with wound care and yet did not complete an assessment to show this noncompliance or establish a care plan to work with R1's behaviors. These failures created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The immediate jeopardy was removed as the facility implemented the following action plan: ~Residents at risk for pressure injuries were identified and person-centered care plans were established to ensure preventative measures. ~Education was provided to nursing and IDT prior to the start of their next shift on following the facility's wound management policy including the requirement of a comprehensive RN assessment of any newly identified pressure injuries and updating care plans. (continued on next page)

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Aria of Brookfield	18740 W Bluemound Rd Brookfield, WI 53045

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	~All nursing and IDT staff will be educated prior to the start of their next shift on the importance of implementing person centered care plans for the prevention of pressure injuries. ~All Nursing staff and IDT will be educated prior to the start of their next shift on documentation of Risk vs Benefit conversation and documentation for any non-compliance. ~The facility policy and procedure on wound management and coordination was reviewed with the medical director. Including RN assessment and care plan updates to ensure policy meets current standard of practice. ~IDT will meet weekly to audit residents at risk for pressure injuries to ensure preventative interventions are in place, care plans are updated, and weekly skin checks are documented. ~IDT will review daily in clinical meeting any new admissions assessments, incidents regarding skin, and document on eagle board to ensure proper assessments have been obtained and notifications have been made. ~Ad hoc QAPI is scheduled for 10.11.2024. The immediate jeopardy was removed on 10/11/24, however, the deficient practice continues at a scope and severity of a G (actual harm/isolated) related to the following example regarding R2. 49011 2.) R2 was admitted to the facility on [DATE] with diagnoses which include encounter for palliative care, vascular dementia, bipolar disorder, depression, anxiety disorder, neurocognitive disorder with Lewy bodies, epilepsy, and adult failure to thrive. R2's Quarterly Minimum Data Set (MDS) with an assessment reference date of 9/24/2024 indicated R2 had a Brief Interview for Mental Status score of 00 (severe cognitive impairment). R2 has an activated power of attorney. Per the MDS, R2 rarely or never makes self-understood or has ability to understand others. The behavior of rejection of care was noted to have occurred on 1-3 days during the 7 day look back period, no other behaviors were noted. R2 is noted to be frequently incontinent of bowel and bladder. R2 is assessed to be at risk for pressure injuries. R2 has a care plan for The resident has actual impairment to his skin integrity related to his impaired mobility, Vascular Dementia with Behavioral Disturbances, and a Neurocognitive Disorder with Lewy Bodies 7/14/24-skin tear buttocks

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on observation, interview, and record review the Facility did not ensure proper foot care for 2 (R1 and R3) of 3 Residents. R1 and R3's toenails were very long and in need of trimming. R3 had care planned interventions to monitor feet that was inconsistently implemented. Findings include: 1.) R1 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, obesity and spinal stenosis. The admitting MDS (minimum data set) dated 5/28/24 indicates R1 has moderate cognitive impairment and needs extensive assistance with bed mobility. On 10/9/24 at 2:27 p.m. Surveyor observed wound care on R1's right heel. Surveyor observed R1's toe nails long and in need of trimming. There is no evidence in the medical record R1 was seen by a podiatrist for nail trimming. On 10/10/24 at 9:00 a.m. Surveyor asked Nursing Home Administrator (NHA)-A if the facility has a policy for diabetic foot care. NHA-A stated the facility doesn't have a policy for diabetic foot care. On 10/10/24 at 9:52 a.m. Surveyor interviewed NHA-A and Acting Director of Nursing (DON)-B regarding R1's foot care. Surveyor explained the observation made on 10/9/24 of R1's long toe nails. Acting DON-B stated she understood the concern and would check to see if R1 is on the list to see podiatry. As of 10/10/24 at 3:00 p.m. the facility did not provide any additional information regarding R1's foot care. 51016 2.) R3 was admitted to the facility on [DATE], with diagnoses that includes cerebral infarction with dominant side weakness, end stage kidney disease, peripheral vascular disease, and diabetes mellitus type 2. R3 was discharged to the hospital on 9-23-24. R3's Discharge MDS (Minimum Data Set) documents a BIMS (Brief Interview for Mental Status) score of 15, indicating that R3 is cognitively intact. R3 returned to the facility on [DATE] to hospice. R3's Hospice assessment dated [DATE] documents: Indicate ambulation finding total care, indicate transfer findings total care, indicate bathing findings total care, indicate dressing findings total care. Indicate level of consciousness semi-comatose, indicate assessment finding periods of confusion. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's PVD (Peripheral Vascular Disease) care plan dated as initiated on 7/9/24 documents the following interventions: *Educate resident on importance of proper foot care including proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks, *if resident has thick nails, corns, calluses, refer to podiatrist. *Keep skin on extremities well hydrated with lotion in order to prevent dry skin and cracking of the skin. *Monitor the extremities for s/sx (signs and symptoms) of injury, infection or ulcers. *Monitor/document for excessive edema and encourage resident to elevate legs. *Monitor/document report prn any s/sx of skin problems related to PVD: redness, edema, blistering, itching, burning bruises, cuts, other skin lesions *Monitor/document/report prn any s/sx of complications of extremity, pallor, rubor, cyanosis and pain. Surveyor requested and was informed that the facility does not have a policy regarding diabetic nail care for residents. R3's October 2024 TAR (Treatment Administration Record) documents the following order dated 9/30/24: Diabetic Foot Check: - Inspect toenails and skin issues on bilateral feet. i.e. Calluses, Lesions, Open sores, Redness, Swelling, Etc. - Toenails to be trimmed by nurse or podiatrist only - Notify physician/podiatry of any concerns. Every evening shift disinfect instrument before and after use. Surveyor noted that R3 did not have daily diabetic foot checks documented as completed on the following dates: 10/5/24,10/6/24 and 10/8/24. Surveyor noted that R3 was documented as first receiving diabetic nail care on 10/9/24 by LPN (Licensed Practical Nurse)-G. On 10/9/24 at 12:40 PM, Surveyor observed Acting DON (Director of Nursing)-B perform wound care on R3's heels. During the treatment, Surveyor observed R3's toenails on both feet to be long, thick, and unkempt. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 12:40 PM, during the wound treatment, Surveyor interviewed Acting DON (Director of Nursing)-B regarding R3's diabetic foot care. Surveyor asked Acting DON-B if R3 has had a podiatry consult recently. Acting DON-B informed Surveyor that R3 has not had a podiatry consult recently. Surveyor asked Acting DON-B if R3 has a diabetic foot care plan of care. Acting DON-B informed Surveyor that Acting DON-B would review R3's medical record and would let Surveyor know. On 10/10/24 at approximately 3:00 PM, Acting DON-B informed Surveyor that R3 did not have a diabetic foot care plan of care. Surveyor informed NHA (Nursing Home Administrator)-A and Acting DON-B of the above findings regarding R3 not receiving diabetic foot care. Surveyor requested any additional information regarding R3's diabetic foot care. No additional information was provided as to why R3 did not receive diabetic foot care daily per R3's plan of care.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on observations, interviews, and record review, the facility did not ensure that 1 of 1 resident (R5) reviewed for elopement was provided adequate supervision and interventions to prevent elopement and ensure safety. R5 had a Wanderguard placed on admission for exit seeking behaviors. R5 was assessed as a non-smoker on admission. On 10/8/24, R5 cut his Wanderguard off. A new Elopement Risk Assessment was completed and scored a higher risk for elopement than the assessment on admission, but the facility staff determined that R5 did not require the Wanderguard. Additional supervision was not put in place by the facility. On 10/8/24, Psychiatric Nurse Practitioner (NP)-R documented that R5 was an active smoker and that R5 needed to continue taking Seroquel for agitation and start taking Zoloft for anxiety and depression. The facility did not assess R5 for smoking safety/supervision and did not initiate a care plan for smoking. The facility did not enter the Zoloft medication order and start offering R5 the medication until 10/14/24. R5 refused multiple doses of Seroquel and Zoloft. The facility did not document that NP-R was made aware of multiple refusals of Seroquel and Zoloft after the 10/8/24 visit. On 10/18/24, R5 was seen smoking on the facility grounds at 1 PM. Facility staff did not document seeing or assessing R5 after 1PM on 10/18/24. Licensed Practical Nurse (LPN)-P went to R5's room to give R5 medications at 6:00 PM on 10/18/24. R5 was not in his room. LPN-P returned to R5's room at 8:00 PM. R5 was not in his room. The facility staff began to search for R5. The Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A were notified and a larger search began. On 10/18/24 at 10:40 PM, the police were called. On 10/19/24 at 8:24 AM, a silver alert was placed by the local police department. R5 was found by police on 10/19/24 at 11:00 AM in R5's former apartment, which is 17 miles away from the facility. The facility's failure to provide adequate supervision and interventions to prevent elopement and ensure safety for R5 created a finding of immediate jeopardy that began on 10/8/2024. NHA-A was notified of the immediate jeopardy on 10/30/24 at 3:00PM. The facility removed the immediate jeopardy on 10/31/24. The deficient practice continues at a scope and severity of an E (potential for harm/pattern) as the facility continues to implement their action plan. Findings include: The facility policy titled, Elopement prevention and missing resident policy with a date of 1/5/2021 documents in part: Purpose: to create an environment that is as safe as possible for residents at risk for elopement and develop a plan of action that will ensure a prompt, effective and coordinated response when a resident is reported missing . It is the policy of this facility, while continuing to foster the independence of all residents, will provide support for potential elopement of residents; and to ensure that a plan of action is in place to assist any resident who may wander from the facility . Elopement is defined as a situation where a resident with cognitive impairment who cannot recognize normal danger and hazard outside the facility leaves the facility without knowledge . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessments and Plan of Care: Upon admission or re-admission, all residents will be assessed for elopement risk utilizing the Elopement Risk Assessment form. A comprehensive elopement prevention plan of care will be developed for each resident identified as at risk for elopement. Residents at risk for elopement will be reassessed quarterly and with a significant change of condition . Routine Procedures: .All elopement risk residents will be accompanied by a responsible party when leaving the facility. The responsible party will follow the sign-out procedure before departure. Should an exit alarm sound, staff shall immediately respond and determine the cause of the alarm. If no reason can be found, the Supervisor shall be notified, and an account of all residents identified to be at risk for elopement shall be performed. All staff members are responsible for responding to an exit alarm. Environmental Consideration: Residents who are at risk for elopement shall be provided at least one of the following safety precautions. 1. A WanderGuard device that will notify facility staff when the resident has left the building without supervision. 2. Door alarms on facility exits. 3. Staff supervision either by visual contact or closed-circuit television of facility exits . Elopement Policy: .If any staff member identifies that they cannot find a resident in a place that the resident is anticipated to be, the staff member will alert their supervisor for assistance once affirming that the resident was not signed out of the facility. The Supervisor will assume control of the search and gather all available staff and begin an immediate preliminary search of the area and immediate premises . If the resident is not located in a reasonable amount of time, the Administrator and/or the Director of Nursing, the resident's representative, the Attending Physician, and law enforcement officials will be notified . R5 was admitted to the facility on [DATE] with diagnoses that include Rhabdomyolysis, Metabolic encephalopathy, Dementia, Weakness, Hypertension, Depression, and Anxiety. R5's Admission Minimum Data Set (MDS) Assessment, dated 10/3/24, documents that R5 is understood and usually understands. R5 has a Brief Interview for Mental Status (BIMS) Assessment of 6, indicating that R5 has severely impaired cognition. R5 has a PHQ9 score of 15, indicating R5 has Moderately Severe symptoms of Depression. R5's MDS documents that R5 does not exhibit behaviors of wandering. R5 exhibits rejection of care 4 to 6 days. R5's mobility is independent but when tested for walking 150 feet the MDS documents R5 is dependent. For walking 10 feet on uneven surfaces and doing steps (stairs or curbs) R5 is dependent. R5's Care Area Assessment for Cognition Loss/Dementia and Behavioral Symptoms dated 10/3/24, documents: Resident is alert and oriented with confusion and forgetfulness [related to] Dementia. [R5] verbalizes feeling depressed, difficulty sleeping, feeling tired, poor appetite and difficulty concentrating. [R5] refuses medications and vitals at times [related to] Dementia. [R5] was very weepy during [R5's] interview. Prior to R5's admission to the facility, R5 was hospitalized on [DATE] after being found on the floor of his home. The Hospital's After Visit Summary (AVS) dated 9/26/24, documents, in part: [R5] was diagnosed with Acute toxic metabolic encephalopathy, rhabdomyolysis, heart attack and positive urine drug screen for amphetamines and benzodiazepines. The AVS documents [R5] is unable to explain his urine drug screen and says he only take suboxone . [R5] says [R5] smokes cigarettes but does not do any other recreational drugs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In addition, while hospitalized , R5 was appointed a court-ordered temporary guardian. R5's Elopement Risk Evaluation completed by LPN-P, dated 9/26/24, documents the following: a total score of 2. Category: not at risk. Relevant Diagnosis/Impaired Cognition. No. Communication-Diminished ability to understand others. No. Historical Behavior Pattern-Purposeful exit seeking, frequently searching for home or something familiar. No. Other relevant Behaviors-Grasping at doorknobs or handles without purpose, following visitors closely. No. Mobility status-Independently mobile via ambulation . Yes. New to facility-admitted to facility within 60 days. Yes. Evaluation-Score of 4 or more requires action unless resident is not ambulatory. Is the resident at risk for elopement? Yes. List interventions taken, or reason resident is not at risk if they scored 4 or more. This question was answered with, Wanderguard. On 10/29/23 at 12:33 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-Q who cared for R5 on R5's first day of admission. CNA-Q stated that R5 walks independently without a walker. CNA-Q stated R5 was counting and checking each exit door on the first day R5 was at the facility. CNA-Q stated that R5 would push exit doors to see if they would alarm. CNA-Q stated that R5 was exit seeking from the beginning of R5's stay at the facility and that R5 has continued to exhibit these behaviors. CNA-Q stated that R5 likes to ask everyone if they have a vehicle. On 10/30/24 at 8:25 AM, Surveyor interviewed LPN-P who was the nurse who admitted R5 to the facility. LPN-P stated when R5 arrived at the facility R5 was counting how many doors are in each unit. LPN-P stated that during the nurse-to-nurse report from the hospital staff, LPN-P was told that R5 was an escape seeker. LPN-P indicated that R5 was exit seeking from the beginning of R5's stay at the facility. LPN-P stated that R5's exit seeking behaviors have continued since admission. Because of that, R5 had a Wanderguard put in place on admission. LPN-P indicated that R5 walks independently without a walker. Surveyor noted that R5 has a diagnosis of dementia, R5 had a historical behavior of exit seeking per the hospital staff report, and R5 was counting doors and pushing them to see if they would alarm. These findings were not reflected on the 9/26/24 Elopement Risk Evaluation. R5's limited physical mobility care plan initiated on 9/26/24 documents interventions that include: The resident is NON-weight bearing. The resident is Weight-Bearing. Ambulation: the resident requires extensive assistance with ambulation up to 50 [feet] with the [four-wheeled walker] . Surveyor noted that R5's limited physical mobility care plan does not accurately portray R5. Facility staff stated that R5 is independent and does not use a walker. The care plan has that the resident is both weight-bearing and non-weight bearing. R5's elopement care plan initiated on 9/26/24 documents interventions that include: Monitor exit seeking behavior. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. R5's MD order with a start date of 9/27/24 documents, Wanderguard: Check placement, location, and function [every] shift for elopement risk. Right wrist. Surveyor reviewed R5's Treatment Administration Record (TAR). Surveyor noted that staff documented that R5 was wearing R5's Wanderguard from 9/27/24 through 10/8/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed R5's Medication Administration Record (MAR) and TAR from 9/27/24 through 10/8/24. Surveyor noted nursing staff were not monitoring exit seeking behaviors as outlined in R5's Elopement Care Plan. Surveyor reviewed R5's CNA documentation of wandering and exit seeking behaviors. Surveyor noted that from 9/27/24 through 10/8/24, CNAs documented, None of the above observed. Surveyor noted that CNA-Q informed Surveyor that R5 was exit seeking from the beginning of R5's stay at the facility and that R5 has continued to exhibit these behaviors. Surveyor noted that these behaviors were not documented within R5's medical record. R5's progress note entered by Unit Manager (UM)-M and dated 10/8/2024 at 2:37 PM, documents: Resident has not been exhibiting exit seeking behaviors and has been ambulating with purpose and remaining in the facility without concern. Writer completed an updated elopement assessment and resident is no longer an elopement risk. Wanderguard has been removed and resident remains without a Wanderguard at this time. Resident is no longer exhibiting exit seeking behavior, and no longer needs a Wanderguard in place. R5's Elopement Risk Assessment entered by UM-M and dated 10/8/2024, documents the following: a total score of 4. Category: At risk for elopement. Relevant Diagnosis/Impaired Cognition. Yes. Communication-Diminished ability to understand others. No. Historical Behavior Pattern-Purposeful exit seeking, frequently searching for home or something familiar. No. Other relevant Behaviors-Grasping at doorknobs or handles without purpose, following visitors closely. No. Mobility status-Independently mobile via ambulation . Yes. New to facility-admitted to facility within 60 days. Yes. Evaluation-Score of 4 or more requires action unless resident is not ambulatory. Is the resident at risk for elopement? No. List interventions taken, or reason resident is not at risk if they scored 4 or more. Resident walks around facility but isn't exit seeking. Resident also goes outside in the appropriate courtyard for resident use without exit seeking and returns back inside appropriately. Surveyor noted that R5's Elopement Risk assessment score was higher on 10/8/24 than it was on admission. Despite a higher score, the facility determined that R5's Wanderguard was no longer necessary. Surveyor reviewed R5's Elopement Care Plan and noted no additional supervision intervention was put in place after the Wanderguard was removed. On 10/29/24 at 2:19 PM, Surveyor interviewed UM-M. Surveyor asked when a Wanderguard was typically placed on a resident. UM-M stated that on admission, if a resident scores a 4 or more on the assessment, a Wanderguard is placed. Surveyor asked about R5's behaviors. UM-M stated that R5 can be hostile and become aggressive if R5 is not doing what R5 wants to do. UM-M stated R5 can be stand-offish. Surveyor asked if R5 is exit seeking. UM-M stated that R5 was exit seeking for the first day or two after admission. UM-M stated that R5 was talking or asking about leaving in the beginning but then after that R5 would be wandering the halls but moving throughout the building appropriately. UM-M indicated that R5 cut off R5's Wanderguard on 10/8/24 and R5 would not allow another Wanderguard to be put in place. UM-M stated that after the elopement risk assessment was completed, the facility determined the Wanderguard could remain off R5. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/8/24, an initial Psych evaluation was completed on R5 by Nurse Practitioner (NP)-R. This note documented in part: . [R5] with history of dementia, depression, and anxiety is being seen today for initial psychiatric evaluation. Staff reports patient has been very forgetful, impulsive, longing for home and barricading his door . Smoking Tobacco: Cigarettes: Active: Yes . [R5] is quite resistant with medications. Staff reports that he is very forgetful and is physically impulsive. He has been known to barricade the door to his room. He is not always easily redirected . There may be some underlying psychosis. Patient was admitted with Seroquel 25 mg nightly. Plan: Continue Seroquel for now. Add Zoloft to treat anxiety as well as depression . Surveyor noted NP-R documented R5 as longing for home on the same day the Wanderguard was removed, and no additional care plan intervention was put into place. Surveyor noted NP-R's psychiatric note documented R5 as an active smoker. Surveyor reviewed medical record for a smoking assessment and did not locate a completed smoking assessment for R5. Surveyor reviewed R5's care plans and did not locate a smoking care plan. R5's Orders-Administration note dated 10/9/2024 at 1:51 PM documents: Resident upset after speaking with case manager regarding going home. [R5] is refusing skin check and shower. Surveyor noted staff documented R5 as being upset regarding going home one day after Wanderguard was removed and no additional supervision was put into place. On 10/29/23 at 12:33 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-Q about R5's smoking. Surveyor asked when R5 started smoking. CNA-Q stated that CNA-Q thought R5 had been smoking since admission. On 10/30/24 at 8:25 AM, Surveyor interviewed LPN-P who was the nurse who admitted R5 to the facility. LPN-P stated that LPN-P asked R5 if R5 was an active smoker. R5 told LPN-P that R5 did not smoke. LPN-P noted on the hospital record that he smoked years ago but had quit smoking. Surveyor asked when R5 started smoking at the facility. LPN-P stated R5 started smoking 2 to 3 weeks after R5's admission. LPN-P stated that R5 would get cigarettes from other residents. Surveyor asked if LPN-P knew if other staff had seen or were aware that R5 was smoking. LPN-P stated other staff knew R5 was smoking. On 10/29/24 at 2:53 PM, Surveyor interviewed LPN-G. Surveyor asked when R5 started smoking. LPN-G stated that R5 started smoking sometime after admission. Surveyor asked how often R5 smoked. LPN-G stated R5 goes out to smoke every once in a while. On 10/29/24 at 2:19 PM, Surveyor interviewed UM-M about when R5 started smoking. UM-M stated that UM-M was unsure when R5 started smoking. UM-M stated that R5 was supervised when R5 did smoke. Surveyor asked when a smoking assessment and care plan should be implemented. UM-M stated on admission if a resident is a smoker. Surveyor asked if R5 should have had an assessment and care plan entered after staff knew R5 was smoking. UM-M stated, Ideally, yes. On 10/30/24 at 9:17 AM, Surveyor returned to UM-M; UM-M stated that UM-M had not seen R5 smoke. UM-M stated that R5 went to the courtyard (smoking area) to socialize. Surveyor noted that staff were aware that R5 had started smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor noted NP-R's psychiatric plan for R5 was to continue with Seroquel medication and add Zoloft to treat Anxiety and Depression. R5's MD order with a start date of 9/27/24, documents: Seroquel 25mg. Give 1 tablet by mouth at bedtime for agitation. Surveyor reviewed R5's MAR to confirm that R5 was receiving Seroquel as ordered. R5 took the medication as ordered from 9/27/24 through 10/2/24. Resident refused Seroquel on 10/3, 10/6, 10/8, and 10/9. Staff did not document a refusal or administration of the Seroquel in the MAR for the 10/11 dose. R5 refused Seroquel on the 13th and 14th. Staff did not document a refusal or administration of the Seroquel in the MAR for the 15th. R5 refused Seroquel on the 16th and 17th of October. Surveyor noted that NP-R's psychiatric note on 10/8/24 documented, [R5] is quite resistant with medications indicating that NP-R was aware of previous refusals of medications. Surveyor did not locate any other documentation after 10/8/24 that NP-R was made aware of R5's multiple refusals of Seroquel. R5's MD order with a start date of 10/14/24, documents: Zoloft Oral Tablet 50 MG. Give 50 mg by mouth one time a day for depression, anxiety. [half] tab [every day for] 6 days, then 1 tab every day. Surveyor reviewed R5's MAR to confirm R5 was receiving Zoloft as ordered. R5 refused Zoloft on 10/14 and 10/15/24. R5 took Zoloft on the 16th, 17th, and 18th of October. Surveyor noted that the Zoloft was recommended by NP-R to start on 10/8/24 and was not entered as an order until 10/14/24. Surveyor did not locate documentation that NP-R was made aware that R5's medication did not start until 10/14/24 or that R5 refused the medication on 10/14 and 10/15/2024. On 10/15/24, the facility doctor visited R5. The facility doctor's note documents, in part: .Patient continues to be going out and smoking . Nicotine dependence . Smoking cessation counseling was discussed. Currently not interested. R5's progress note, dated 10/18/24, at 11:07 PM documents: Nurse attempted to administer PM medication after [6:00 PM]. Resident was not present. During second attempt to administer medication nurse observed resident not present in room. PM supervisor and staff began searching facility and surrounding areas for resident. Interim DON and Administrator notified of resident's elopement. Administrator and interim DON arrived at the facility to help facilitate search. Staff searched local businesses and restaurants with no evidence of resident. BPD was called, and statements were given to the officer. MD and guardian was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/29/24 at 10:35 AM, Surveyor interviewed R5. Surveyor asked how things were going at the facility. R5 stated, I'm not supposed to be here. I don't know why I am here. Surveyor asked R5 to explain more. R5 stated that R5 ran away a few weeks ago. Surveyor asked why R5 left the facility. R5 stated, because I don't like it here. Surveyor asked how long R5 had felt that way. R5 indicated that R5 wanted to go home since admission and stated that R5 still wants to go home. R5 stated that the facility is supposed to be working on getting R5 home. R5 stated that R5 had told the facility that he wanted to go home prior to running way, and they didn't listen. R5 indicated that the day R5 left the facility, R5 went outside for a cigarette at the designated area at the back of the building and then walked off. R5 indicated that R5 left the facility around 1200 (noon). R5 stated that R5 walked, hitchhiked, and got a ride from a cop to get home. Surveyor asked if R5 used a walker. R5 indicated, R5 walks independently. R5 stated that it took R5 an hour and a half to get home. R5 indicated that he made it home safely. Surveyor asked when R5 started smoking. R5 stated that R5 smoked most of his life but did quit smoking years ago. Once R5 arrived at the facility, R5 stated R5 started smoking a few days after that. R5 stated that R5 would buy cigarettes from other residents. Surveyor noted the weather on 10/18/24 was reported as sunny with a high of 66 and a low of 41 (at 6 PM). Surveyor reviewed the facility's self-report timeline which documents in part: At 8:30 PM on 10/18/24, staff noticed R5 was not in his room. Staff began to immediately check building and surrounding areas. At 9:30 PM, DON-B was notified and R5's prior apartment was contacted but voicemail was received . At 10:00 PM, NHA-A and DON-B arrived at the building to assist with building and property checks . At 10:40 PM, 911 was called and [R5] was reported missing. R5's guardian was called, and voicemail was left. At 11:15 PM, a police officer arrived at the facility to being an investigation . On 10/19/24, at 8:00 AM, R5's prior apartment was contacted but voicemail was received . At 8:24 AM, a silver alert was placed for resident . At 11:00 AM, [R5] was located in [R5's] old apartment by the police . At 11:42 AM, [R5] returned to the facility. At 12:09 PM, [R5] was sent out to the emergency room for evaluation . The facility collected statements of staff who worked on 10/18/24. CNA-S, LPN-P, LPN-T, and DON-B were among the statements collected. On 10/29/24 at 3:10 PM, Surveyor interviewed CNA-S. Surveyor asked what R5's personality is like. CNA-S stated that R5 is pretty chill. CNA-S stated that R5 wanders a lot and talks about how he is ready to go home. CNA-S stated that R5 will say things like, I'm ready to get out of this place. Surveyor asked when that started. CNA-S stated it has been more in the last couple of weeks but that is started at the beginning of October. Surveyor asked if CNA-S was working on 10/18/24. CNA-S stated yes. Surveyor asked CNA-S to explain what happened. CNA-S stated that CNA-S did not remember seeing R5 during the day. CNA-S stated that R5 would typically come to the nurse's station by CNA-S later in the evening for a snack but did not come to the desk that night. CNA-S stated that CNA-S was alerted around 8PM that R5's room was empty. CNA-S stated that staff checked the building and surrounding area after that and did not find R5. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/30/24 at 8:25 AM, Surveyor interviewed LPN-P. Surveyor asked what R5's personality is like. LPN-P stated R5 is sweet and sarcastic. R5 is laid back, quiet, and sneaky. Surveyor asked LPN-P to explain what happened on 10/18/24 with R5. LPN-P stated that LPN-P worked first shift on the first floor and 2nd shift on the 2nd floor where R5's room is located. LPN-P stated that LPN-P saw R5 at 12 or 12:30 PM. LPN-P stated R5 was taking another resident's sweatshirt that was left outside, back to the resident's room. LPN-P stated that R5 typically walked around the facility in gripper socks and pajamas but on 10/18/24, R5 was wearing clothes, socks, and tennis shoes. LPN-P stated that R5 took the elevator upstairs and that was the last time LPN-P saw R5. LPN-P stated that R5 will typically come out of R5's room and go to the nurse's station between 4 and 6 PM to ask for R5's medications, but otherwise R5 stays in R5's room most of the PM shift. On 10/18/24, R5 did not come to the nurse's station asking about R5's medications. At 6 PM, LPN-P went to R5's room to give medication to R5. R5 was not in R5's room. LPN-P stated that LPN-P asked a coworker if they had seen R5 and the coworker told LPN-P that maybe R5 went downstairs to smoke. LPN-P stated that LPN-P went back to R5's room at 8 and R5 was not in the room. LPN-P stated LPN-P looked downstairs and when LPN-P could not locate R5, LPN-P notified the supervisor and staff began a search. On 10/30/24 at 8:50 AM, Surveyor interviewed LPN-T. Surveyor asked what R5's personality is like. LPN-T stated that R5 refuses a lot of care and most of R5's meds. LPN-T stated R5 can get aggressive toward staff and R5 likes to manipulate situations. Surveyor asked LPN-T to explain what happened on 10/18/24 with R5. LPN-T stated LPN-T and a coworker worked R5's hall during the day on 10/18/24. LPN-T stated that R5 refused the morning medications. LPN-T stated that LPN-T saw R5 at lunch and that was the last time LPN-T saw R5. LPN-T stated R5 was acting normal that day. On 10/30/24 at 9:30 AM, Surveyor interviewed DON-B. Surveyor asked what R5's personality is like. DON-B stated that R5 is a bit intimidating. R5 can be aggressive and has lunged at staff in the past. DON-B stated that DON-B has a great relationship with R5 and R5 will talk to DON-B. R5 has told DON-B that R5 likes that staff are intimidated by R5. Surveyor asked when DON-B saw R5 last on 10/18/24. DON-B stated that DON-B saw R5 smoking a cigarette outside at 1 PM. DON-B indicated that this was the first time DON-B had seen R5 smoke. Surveyor noted R5 was last seen by facility staff at 1 PM on 10/18/24. An initial search for R5 did not start until 8:30 PM, which was 7.5 hours later. On 10/29/24 at 3:10 PM, Surveyor interviewed CNA-S. Surveyor asked how often CNA-S and other staff round on residents. CNA-S stated every two hours. On 10/30/24 at 8:25 AM, Surveyor interviewed LPN-P. Surveyor asked how often LPN-P and other staff round on residents. LPN-P stated every 2 hours. On 10/29/24 at 2:19 PM, Surveyor interviewed UM-M. Surveyor asked how often staff should round on residents. UM-M stated every one to two hours. Surveyor noted that staff did not round on R5 every two hours on 10/18/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor reviewed CNA documentation regarding R5's 10/18/24 meals. Surveyor noted that facility staff did not document any meals given to R5 on 10/18/24. On 10/30/24 at 10:30 AM, NHA-A informed Surveyor that R5's dinner meal tray was dropped off by a CNA and collected by a dietary aide. NHA-A indicated that the facility conducted an audit regarding this concern and concluded that this instance was a one-off issue and not a systemic issue. R5's progress note dated 10/19/24 at 2:36 PM, documents: Resident returned to the facility via [local police department name] at 1145. Resident was instructed by staff that he would need to be sent to the hospital for evaluation. Resident refused to comply with nursing and refused to go to the hospital. Resident's guardian arrived at the facility at 1155. Guardian was able to get the resident to be agreeable to going to the hospital. At 1205, resident was transferred to [Local hospital name] . for evaluation. R5's Hospital AVS dated 10/19/2024, documents a discharge diagnosis of: Problem related to social environment. Surveyor reviewed the hospital documentation and noted that no new injuries were found. While in the hospital R5 refused vitals, labs, and an IV. R5 had to be redirected back to his room after trying to go smoke. Hospital staff had to supervise R5 when R5 went out to smoke. R5's progress note dated 10/19/2024 at 11:45 PM documents, in part: Resident was brought to facility via Bell ambulance on stretcher . Resident jumped off gurney as Bell staff was pushing him down the hall. Once finally getting in his room resident cursed and swore at Bell staff and then slammed his room door . Writer attempted to get a set of vitals and resident refused. Writer placed resident on 15-minute check. Writer called MD on call and let them know that resident had made it back to the facility. Resident resting comfortably in his bed. Surveyor reviewed R5's 24-hour board and noted staff started 1 to 1 supervision and 15-minute checks when R5 returned from the hospital. On 10/19/24, R5's elopement care plan was updated with 2 new interventions: Identify pattern of wandering. Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise. Intervene as appropriate. Assess for fall risk. On 10/20/24, R5's elopement care plan was updated with an intervention: [R5]-refuses Wanderguard, guardian aware. Staff will provide 1:1 supervision and supervised smoke breaks. R5's Elopement Risk assessment dated , 10/20/2024, documents a score of 6. Category: At risk for elopement. Relevant Diagnosis/Impaired Cognition. Yes. Communication-Diminished ability to understand others. No. Historical Behavior Pattern-Purposeful exit seeking, frequently searching for home or something familiar. Yes. Other relevant Behaviors-Grasping at doorknobs or handles without purpose, following visitors closely. No. Mobility status-Independently mobile via ambulation . Yes. New to facility-admitted to facility within 60 days. Yes. Evaluation-Score of 4 or more requires action unless resident is not ambulatory. Is the resident at risk for elopement? Yes. List interventions taken, or reason resident is not at risk if they scored 4 or more. Resident refuses Wanderguard, guardian aware. Requires 1:1 supervision including supervised smoke breaks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R5's MD order with a start date of 10/20/24 documents: Behaviors - resident monitored for the following: restless, anxious, agitated, fearful, repetitive physical, repetitive question, sleeplessness, wandering, exit seeking, refusal of care/hygiene. Document Y for NONE or N if BEHAVIORAL .Choose other chart code and document progress note that includes non-pharmacy and any drug interventions and effectiveness. Every shift. Surveyor reviewed the TAR and noted that nursing staff were monitoring the above behaviors since 10/21/24. On 10/21/24, facility staff completed a smoking assessment for R5 and initiated a smoking care plan. R5's MD order with a start date of 10/22/24, documents: Zyprexa Oral Tablet 5 MG (Olanzapine). Give 5 mg by mouth one time a day for psychosis, exit seeking. Surveyor noted when R5 returned to the facility after eloping, the facility started to regularly monitor R5's behaviors, initiated a 1 to 1 intervention, completed a smoking assessment and smoking care plan with supervised smoking, and started R5 on new medication. On 10/30/24 at 7:00 AM, Surveyor observed the facility's courtyard, which is the designated smoking area. This courtyard is located at the back of the building. Outside there are benches and trash receptacles for the smoking materials. Surveyor observed a sidewalk that leads to a large parking lot at the back of the facility. Behind the parking lot, there is a tree line. The tree line is next to a road with a 25-mph speed limit. If you turn left out of the courtyard, there is a road with a 30-mph speed limit. At the front of the facility is 6 lane road with a 45-mph speed limit. On the inside of the building, there is a door leading out to the smoking area. This door has a box located on the left side. A code must be entered before opening the door or the door will alarm until the code is entered. On 10/29/24 at 12:45 PM, Surveyor observed R5 leave his room. R5 walked independently and without a walker. R5 was followed by CNA-U. CNA-U opened the door to the courtyard and R5 sat on a bench and smoked a cigarette. CNA-U remained indoors but observed R5 through a large window. Surveyor asked how long R5 had been smoking. CNA-U stated that R5 has been smoking since admission. Surveyor asked how the door to the smoking area is supervised. CNA-U stated that anyone who smokes[TRUNCATED]

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview, and record review the facility did not ensure 1 (R5) of 7 residents reviewed received medically related social services to attain their highest practicable mental and psychosocial well-being. R5 was admitted to the facility with moderately severe symptoms of Depression. A care plan with resident centered interventions and monitoring was not developed by the facility. R5's Discharge planning evaluation completed on 10/4/24 documented R5's discharge goal and plan as uncertain and unknown. R5 eloped from the facility on 10/18/24. (Cross-reference F689). R5 reported to Surveyor that R5 left the facility because I don't like it here. Upon return to the facility, R5 still verbalizes R5's desire to leave the facility. The facility has not documented any follow up on the 10/4/24 discharge planning evaluation to determine R5's goal and plan for discharge. Findings include: R5 was admitted to the facility on [DATE] with diagnosis (on admission) that include Rhabdomyolysis, Metabolic encephalopathy, Dementia, Weakness, Hypertension, Depression, and Anxiety. R5's Admission Minimum Data Set (MDS) Assessment, dated 10/3/24, documents that R5 is understood and usually understands. R5 has a Brief Interview for Mental Status (BIMS) Assessment of 6, indicating that R5 has severely impaired cognition. R5 has a PHQ9 score of 15, indicating R5 has Moderately Severe symptoms of Depression. R5's MDS documents that R5 does not exhibit behaviors of wandering. R5 exhibits rejection of care 4 to 6 days. R5's Care Area Assessment for Cognition Loss/Dementia and Behavioral Symptoms dated 10/3/24, documents: Resident is alert and oriented with confusion and forgetfulness [related to] Dementia. [R5] verbalizes feeling depressed, difficulty sleeping, feeling tired, poor appetite and difficulty concentrating. [R5] refuses medications and vitals at times [related to] Dementia. [R5] was very weepy during [R5's] interview. A referral was made to psych to evaluate R5 for depression. R5 has a court-ordered temporary guardian in place. On 10/29/24 at 10:35 AM, Surveyor interviewed R5. Surveyor asked how things were going at the facility. R5 stated, I'm not supposed to be here. I don't know why I am here. Surveyor asked R5 to explain more. R5 stated that R5 ran away a few weeks ago. Surveyor asked why R5 left the facility. R5 stated because I don't like it here. Surveyor asked how long R5 had felt that way. R5 indicated that R5 wanted to go home since admission and stated that R5 still wants to go home. R5 stated that the facility is supposed to be working on getting R5 home. R5 stated that R5 had told the facility that he wanted to go home prior to running way, and they didn't listen. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's discharge care plan initiated 9/26/24 documents a focus of: The resident would like to discharge home or community. Goal: The resident and/or family representative will verbalize communicate an understanding of the discharge plan and describe the desired outcome by the review date. Interventions include: Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress. Evaluate the resident's motivation and ability to safely return to the community. Evaluate/record the resident's abilities and strengths, with family caregivers/IDT. Determine gaps in abilities which will affect discharge. Address gaps by making community referral, pre-discharge [physical therapy/occupational therapy] or internal referral. Surveyor reviewed R5's medical record and did not locate a care plan to address R5's depression. No individualized interventions to monitor depression or non-pharmacological interventions for R5's depression was located. Surveyor noted that R5 was not on an antidepressant medication on admission. R5's Discharge Planning evaluation entered by Social Worker (SW)-X, dated 10/4/24 documents: Anticipated length of stay: uncertain. Other: Guardian. Select on for resident's overall goal established during assessment process: unknown or uncertain. What determination was made by the resident and the care planning team regarding discharge to the community: Determination not made. List concerns about returning home: uncertain. Does resident have family or support network to provide assistance post-discharge: No. Who will be primary caregiver: Facility staff. Potential treatment needs: Uncertain. Additional home supports required: Unknown at this time. Overall Summary of potential for discharge. Discharge plans uncertain. Surveyor noted that the Discharge planning evaluation was vague and did not establish any goals or plans for R5's discharge. On 10/8/24, an initial Psych evaluation was completed on R5, by Nurse Practitioner (NP)-R. This note documented, in part: . [R5] with history of dementia, depression, and anxiety is being seen today for initial psychiatric evaluation. Staff reports patient has been very forgetful, impulsive, longing for home and barricading his door . [R5] is quite resistant with medications Staff reports that he is very forgetful and is physically impulsive. He has been known to barricade the door to his room. He is not always easily redirected . There may be some underlying psychosis. Patient was admitted with Seroquel 25 mg nightly. Plan: Continue Seroquel for now. Add Zoloft to treat anxiety as well as depression . Surveyor noted that even after a new antidepressant medication was added to R5's medication list, a care plan addressing R5's depression was not initiated by the facility. On 10/18/24, R5 eloped from the facility and returned to the facility on [DATE]. On 10/29/24 at 3:10 PM, Surveyor interviewed CNA-S. Surveyor asked what R5's personality is like. CNA-S stated that R5 is pretty chill. CNA-S stated that R5 wanders a lot and talks about how he is ready to go home. CNA-S stated that R5 will say things like, I'm ready to get out of this place. Surveyor asked when that started. CNA-S stated it has been more in the last couple of weeks but that is started at the beginning of October. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 8:50 AM, Surveyor interviewed LPN-T. Surveyor asked what R5's personality is like. LPN-T stated that R5 refuses a lot of care and most of R5's meds. LPN-T stated R5 can get aggressive toward staff and R5 likes to manipulate situations. LPN-T stated that LPN-T was working at the facility when R5 returned to the facility after eloping. LPN-T stated that when police returned R5 back to the facility R5 was aggressive and tried to leave again. LPN-T stated that the Social Worker tried to stop R5 and R5 hit the Social Worker. LPN-T stated that after R5's guardian came to the facility, R5 calmed and agreed to be evaluated at the local emergency room . When LPN-T worked the following day, LPN-T stated that R5 was still exit seeking and talking about wanting to go home. Surveyor reviewed R5's medical record and did not locate any documentation that R5's discharge plan was reviewed or revised since the 10/4/24 evaluation. On 10/30/24 at 2:34 PM, Surveyor interviewed Social Services Director (SSD)-W. Surveyor asked what the plan was for R5's discharge. SSD-W stated that R5 has a court appointed temporary guardian. SSD-W stated that on Wednesday, October 23rd, SSD-W listened to support R5 while R5 had a Court hearing via zoom. SSD-W stated that family was found for R5 and initially were agreeable to becoming R5's guardian. During the hearing, R5's family did not proceed with the guardianship proceedings. SSD-W stated that the court ordered temporary guardian will have another hearing on November 12th to determine permanent guardianship. Surveyor asked if a plan for R5 to go home was discussed. SSD-W stated that the guardian wants R5 to remain at the facility. SSD-W stated that the guardian has discussed Family Care to help with services and possibly an assisted living setting. Surveyor asked if R5 has protective placement. SSD-W stated that SSD-W would have to call the guardian. SSD-W indicated that he remembers someone mentioning it in the past but was not sure if the protective placement went through or not. On 10/30/24 at 2:50, SSD-W returned to Surveyor. SSD-W informed surveyor that SSD-W had left a message with R5's guarding asking about protective placement. Surveyor asked SSD-W about the 10/4/24 discharge evaluation completed by SW-X. SSW-D informed surveyor that SW-X is only working on an as needed basis and is not regularly at the facility. Surveyor asked if SSW-D follows up on assessments done by SW-X. SSW-D stated that SSW-D is aware of R5's situation and R5's guardian wants R5 to remain at the facility. Surveyor informed SSW-D of the concern that R5 does not like it at the facility and asked if any referrals have been made. SSW-D stated that no referrals have been made to other facilities because the guardian wants R5 here. Surveyor informed SSW-D of the concerns that R5 is verbalizing the desire to leave the facility and facility staff are not listening to R5, the discharge planning evaluation completed on 10/4/24 was inconclusive and vague and has not been followed up on since. On 10/30/24 at 3:10 PM, NHA-A was informed of the concerns that R5 had a discharge planning evaluation completed on 10/4/24 and most of the answers were marked as uncertain. There has been no follow-up documented since that evaluation. R5 is currently stating that R5 does not like the facility and does not want to be here. NHA-A stated that R5's guardian wants R5 to remain at the facility and that is why referrals have not been made. Surveyor informed NHA-A of the concern that the facility is not listening to R5's requests. No further information was provided as to why the facility did not ensure R5 received medically related social services to attain their highest practicable mental and psychosocial well-being.

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Aria of Brookfield	18740 W Bluemound Rd Brookfield, WI 53045

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49435 Based on interview and record review the Facility did not ensure 1 (R5) of 3 residents were free from significant medication errors. R5 was seen by Psychiatric Nurse Practitioner (NP)-R on 10/8/24. NP-R documented that R5 needed to continue taking Seroquel (an antipsychotic medication) for agitation and start taking Zoloft (an antidepressant medication) for anxiety and depression. The facility did not enter the Zoloft medication order and start offering R5 the medication until 10/14/24. R5 refused multiple doses of Seroquel and Zoloft. The facility did not document that NP-R was made aware of multiple refusals of Seroquel and Zoloft after the 10/8/24 visit. R5 was sent to the emergency room (ER) on 10/19/24 for evaluation. R5 returned to the facility on the same day. The hospital After Visit Summary (AVS) documented that R5 should start doing blood sugar tests and start taking insulin medication. The facility did not acknowledge the AVS instructions and did not address the instructions with the resident's doctor. Findings include: The undated facility policy titled, Medication Administration General Guidelines documents, in part: Policy-Medications are administered as prescribed in accordance with good nursing principles and practices . Refusals of Medication . Medication refusal must be reported to the prescriber after (XX) number of doses are refused and there must be documentation of prescriber notification of such . Documentation . If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time . the space provided on the front of the MAR (Medication Administration Record) for that dosage administration is initialed and circled. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR system. An explanatory note is entered on the reverse side of the record. If [XX consecutive doses] of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. Surveyor noted the facility policy did not designate how may doses of medication refusals are allowed before notification to a provider. R5 was admitted to the facility on [DATE] with diagnoses (on admission) that include Rhabdomyolysis, Metabolic encephalopathy, Dementia, Weakness, Hypertension, Depression, and Anxiety. R5's Admission Minimum Data Set (MDS) Assessment, dated 10/3/24, documents that R5 is understood and usually understands. R5 has a Brief Interview for Mental Status (BIMS) Assessment of 6, indicating that R5 has severely impaired cognition. R5 has a PHQ9 score of 15, indicating R5 has Moderately Severe symptoms of Depression. R5's MDS documents that R5 does not exhibit behaviors of wandering. R5 exhibits rejection of care 4 to 6 days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Care Area Assessment for Cognition Loss/Dementia and Behavioral Symptoms dated 10/3/24, documents: Resident is alert and oriented with confusion and forgetfulness [related to] Dementia. [R5] verbalizes feeling depressed, difficulty sleeping, feeling tired, poor appetite and difficulty concentrating. [R5] refuses medications and vitals at times [related to] Dementia. [R5] was very weepy during [R5's] interview. A referral was made to psych to evaluate R5. R5 has a court-ordered temporary guardian in place. R5's care plan with an initiation date of 9/26/24 documents: the resident has an active order for psychotropic medication for a diagnosis of Agitation: Quetiapine (Seroquel). Interventions include: Administer psychotropic medications as ordered by physician. Educate the resident/family/caregivers about risks, benefits, and the side effect and/or toxic symptoms. Monitor/document/report [as needed] any adverse reactions of psychotropic medications . R5's MD order with a start date of 9/27/24, documents: Seroquel 25mg. Give 1 tablet by mouth at bedtime for agitation. On 10/8/24, an initial Psych evaluation was completed on R5, by NP-R. This note documented, in part: . [R5] with history of dementia, depression, and anxiety is being seen today for initial psychiatric evaluation. Staff reports patient has been very forgetful, impulsive, longing for home and barricading his door . [R5] is quite resistant with medications Staff reports that he is very forgetful and is physically impulsive. He has been known to barricade the door to his room. He is not always easily redirected . There may be some underlying psychosis. Patient was admitted with Seroquel 25 mg nightly. Plan: Continue Seroquel for now. Add Zoloft to treat anxiety as well as depression . Surveyor reviewed R5's MAR to confirm that R5 was receiving Seroquel as ordered. R5 took the medication as ordered from 9/27/24 through 10/2/24. Resident refused Seroquel on 10/3, 10/6, 10/8, and 10/9. Staff did not document a refusal or administration of the Seroquel in the MAR for the 10/11 dose. R5 refused Seroquel on the 13th and 14th. Staff did not document a refusal or administration of the Seroquel in the MAR for the 15th. R5 refused Seroquel on the 16th and 17th of October. From 10/18 through 10/21/24, the MAR documents that R5 did not receive any Seroquel. The Seroquel was discontinued on 10/21/24. Surveyor noted that NP-R's psychiatric note on 10/8/24 documented, [R5] is quite resistant with medications indicating that NP-R was aware of previous refusals of medications. Surveyor did not locate any other documentation after 10/8/24 that NP-R was made aware of R5's multiple refusals of Seroquel. R5's MD order with a start date of 10/14/24, documents: Zoloft Oral Tablet 50 MG. Give 50 mg by mouth one time a day for depression, anxiety. [half] tab [every day for] 6 days, then 1 tab every day. Surveyor reviewed R5's MAR to confirm R5 was receiving Zoloft as ordered. R5 refused Zoloft on 10/14 and 10/15/24. R5 took Zoloft on the 16th, 17th, and 18th of October. From 10/19/24 through 10/30/24, Zoloft was documented as administered two times. It was administered on 10/20/24 and 10/28/24. Surveyor noted that the Zoloft was recommended by NP-R to start on 10/8/24 and was not entered as an order until 10/14/24. Surveyor did not locate documentation that NP-R was made aware that R5's medication did not start until 10/14/24 or that R5 refused the medication on 10/14 and 10/15/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 9:30 AM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked how many times a resident can refuse a medication before it is reported to the MD. DON-B stated that the doctor should be notified the first time. If a resident continues to refuse the medication, it should be documented in a progress note or in the MAR. Surveyor informed DON-B that Seroquel was refused multiple times and Surveyor could not locate documentation that the NP-R was updated after the initial visit on 10/8/24. DON-B stated DON-B would look into that. Surveyor asked why there was a 6-day delay in entering the Zoloft order and administering the medication to the resident. DON-B stated that DON-B would have to look into that. Surveyor reviewed R5's hospital After Visit Summary (AVS) dated 9/26/24. Surveyor did not locate a diagnosis of Diabetes, documentation of R5's blood sugar being tested , or documentation that R5 was receiving insulin. On 10/18/24, R5 eloped from the facility. R5 returned to the facility on [DATE] and was sent to a local ER for evaluation. R5 was readmitted to facility on 10/19/24. The hospital After Visit Summary dated 10/19/24, documents, in part: . Take these medications: Insulin pen needle .use with insulin injections 4 times daily at mealtimes and at bedtime. Onetouch Delica Lancets . testing frequency 4 times daily before meals and at bedtime. Onetouch Verio [with] device kit. 1 Kit 4 times daily. Ask your doctor about these medications .Insulin Aspart 100 unit/[milliliter] pen injector . use based on dosing chart. Max daily dose 78 units . Lantus Solostar 100 unit/[milliliter] pen injector. Inject 12 units subcutaneously nightly. The AVS documents a past medical history diagnosis of Type 2 diabetes mellitus. Surveyor noted a handwritten note on the 10/19/24 AVS. The note documents, Noted 10/23/24. The initials underneath the handwritten note were illegible. Surveyor reviewed R5's electronic medical record and did not locate any documentation of a diagnosis of Type 2 Diabetes, the need for insulin or any results from blood sugar testing. Surveyor did not locate any documentation that staff had notified R5's primary physician to inquire about the diagnosis, the need for insulin or the instructions for testing blood sugars. On 10/30/24 at 8:25 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-P, who was the nurse who admitted R5 to the facility on [DATE]. Surveyor asked if LPN-P had ever checked R5's blood sugar. LPN-P stated No. Surveyor asked if LPN-P had ever given insulin to R5. LPN-P stated No, R5 is not a diabetic. LPN-P stated that when R5 was admitted to the facility on [DATE], LPN-P reviewed the AVS and Diabetes was not listed as a diagnosis. On 10/30/24 at 8:50 AM, Surveyor interviewed LPN-T. Surveyor asked if LPN-T received the hospital paperwork when R5 was admitted back to the facility on [DATE]. LPN-T stated the night shift received the paperwork. Surveyor asked what the process if for reviewing hospital AVS and/or discharge instructions. LPN-T stated that the nurse should review it to see if new orders need to be entered or if new medications are ordered. The nurse who receives the hospital paperwork should then enter any new orders. The nurse will then report off to the next nurse if anything needs to be followed up on. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 9:17 AM, Surveyor interviewed Unit Manager (UM)-M. Surveyor asked what the process is when a resident returns to back to the facility from the ER with an AVS. UM-M stated that the Unit Secretary (HUC) is the first to look at the AVS and instructions. The HUC will enter orders. The nurse will review the AVS and activate the order and will look to verify that everything is entered. The unit manger will review the AVS if a nurse has any questions or concerns. On 10/30/24 at 9:30 AM, Surveyor interviewed Acting Director of Nurses (ADON) -B. Surveyor asked what the process is when a resident returns to back to the facility from the ER with an AVS. ADON-B stated that the nurse is required to review the AVS and enter any new orders. ADON-B indicated management will then review the AVS and new orders to verify. Surveyor asked if R5 had every received blood sugar checks or insulin since being admitted to the facility. ADON-B stated that R5's AVS on initial admission (9/26/24) did not document a diagnosis of diabetes or the need for blood sugar checks or insulin. Surveyor informed ADON-B that the AVS from R5's 10/19/24 ER visit documents a medical history diagnosis of Type 2 Diabetes and instructed R5 to take blood sugars 4 times a day and ask the doctor if insulin is needed. ADON-B stated that this is something that ADON-B would need to look into. ADON-B stated that maybe the nurse spoke to the doctor about it. Surveyor asked where that would be documented. ADON-B stated it would be documented in a progress note. Surveyor asked if ADON-B recognized the initials on the AVS. ADON-B listed off a few names and then stated that ADON-B would get back to Surveyor. Surveyor reviewed R5's progress notes and did not locate documentation that a nurse had a conversation with the doctor about the diabetes diagnosis or treatment. On 10/30/24 at 3:45 PM, Surveyor informed Nursing Home Administrator and ADON-B of the concerns that the facility did not enter the Zoloft medication order and start offering R5 the medication until 10/14/24, which was 6 days after NP-R had recommended the medication be started. R5 refused multiple doses of Seroquel and Zoloft. The facility did not document that NP-R was made aware of multiple refusals of Seroquel and Zoloft after the 10/8/24 visit. R5's AVS from 10/19/34 documented that R5 should start doing blood sugar tests and taking insulin medication. The facility did not acknowledge the AVS instructions and did not address the instructions with the resident's doctor. No further information was provided as to why the Facility did not ensure R5 was free from significant medication errors.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51016 Based on record review, observations and interviews, the facility did not ensure the coordination of services between hospice and the facility for 2 (R3 & R2) of 2 residents reviewed for hospice care. * R3 did not have hospice services coordinated so that R3 received consistent and professional services for the treatment of R3's pressure injury. * Hospice visit notes were not updated in R2's medical record or in R2's hospice binder until Surveyor requested the information. Hospice was not aware of pressure injuries to R2's bilateral feet. Findings include: The facility's hospice contract 4/14/23 and titled, General Inpatient and Respite Care Skilled Nursing Facility Agreement documents in section 3.3, The facility should designate an IDG (interdisciplinary group) member who is to work with hospice staff to coordinate care provided by the hospice staff. 1.) R3 was admitted to the facility on [DATE], with diagnoses that includes cerebral infarction with dominant side weakness, end stage kidney disease, peripheral vascular disease, and diabetes mellitus type 2. R3 was discharged to the hospital on 9-23-24. R3's Discharge MDS (Minimum Data Set) documents a BIMS (Brief Interview for Mental Status) score of 15, indicating that R3 is cognitively intact. R3 returned to the facility on [DATE] to hospice. R3's hospice care plan dated as initiated on 9/27/24 does not document a facility staff person designated as the IDG member to work with hospice care. R3's hospice care binder and notes does not document a facility staff person as the IDG point person for hospice services. R3's hospice care communication forms dated 9/30/24 and 10/10/24 documents Registered Nurse (RN)-L as the name of the facility staff that would be the point of contact between the facility and hospice services. On 10/9/24 at 10:45 AM, Surveyor interviewed LPN (Licensed Practical Nurse)-E regarding when R3 would receive wound care as Surveyor was unable to locate in R3's hospice binder when R3 received wound care. LPN-E informed Surveyor that R3 usually receives wound care from hospice every other day but could not tell Surveyor what days exactly R3 received wound treatment. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 12:40 PM, Surveyor asked acting DON (Director of Nursing)-B who usually completes R3's wound treatments. Acting DON-B informed Surveyor that hospice completes R3's wound treatments on Monday and Friday and that the facility assesses and measure R3's wounds on Wednesday. On 10/09/24 at 12:40 PM, Surveyor observed LPN (Licensed Practical Nurse)-F complete R3's wound treatment. Surveyor asked if LPN-F normally completed R3's wound treatments. LPN-F informed Surveyor that she completed R3's wound treatments if hospice cannot complete them. Surveyor asked LPN-F how hospice communicates with facility staff. LPN-F informed Surveyor that acting DON-B usually communicates with hospice. On 10/09/24 at 12:40 PM, Surveyor observed LPN-F and acting DON-B complete a wound treatment on R3. Surveyor asked acting DON-B where it was documented that hospice services would provide wound care for R3. Acting DON-B informed Surveyor that orders are kept in a hospice binder. On 10/9/24 at 1:40 PM, Surveyor interviewed acting DON-B about the difference between MD (Hospice Medical Doctor)-H orders and MD (Wound Medical Doctor)-D orders for R3's wound treatments. Acting DON-B informed the Surveyor that MD (Hospice)-H is keeping MD (Wound)-D's orders. Surveyor asked, where the orders for R3's wound treatment are found. Acting DON-B informed surveyor that DON-B would find that out and get back to the Surveyor. Surveyor noted during record review that in MD Wound-D's notes dated 10/2/24 wound care was deferred to hospice team. On 10/09/24 at 9:34 AM, Surveyor asked RN Hospice-I and RN Hospice-J how changes to R3's wound would be communicated from hospice to facility staff. RN Hospice-I informed Surveyor that R3's wound changes would be communicated to facility staff via a verbal consult. On 10/09/24 at 9:34 AM, Surveyor inquired if RN Hospice-I observed the new gluteal fold ulcer, new right foot heel ulcer, and new great toe skin tear. RN Hospice-I informed Surveyor that RN Hospice-I observed the gluteal fold and the buttocks ulcers on 10/8/24. RN Hospice-I informed Surveyor that RN Hospice-I was not aware of the right heel ulcer or right great toe skin tear. Surveyor asked RN Hospice-I how the Facility was updated on wound changes. RN Hospice-I replied a facility nurse had changed the dressings while he observed. Surveyor was informed by RN Hospice-I he was unable to remember the name of the nurse. Surveyor asked RN Hospice-I where hospice orders are found and how does the nursing staff know where to find them. RN Hospice-J informed Surveyor orders and notes are located in the hospice computer medical record and are printed out and faxed to the facility. RN Hospice-J informed Surveyor that when RN Hospice-I comes into the facility the hospice notes and orders are put into the hospice binder. On 10/09/24 at 9:53 AM, Surveyor informed Acting DON-B of the above findings. Acting DON-B informed Surveyor that DON-B was unable to find the name of the nurse whom assisted RN Hospice -I during wound care on 10/8/24. Acting DON-B informed Surveyor that DON-B felt that RN Hospice-I completed the dressing changes on R3 on her own and felt that RN Hospice-I was not being truthful about having a facility nurse assist with R3's wound care. No additional information was provided as to why the facility did not ensure that R3 had hospice services coordinated so that R3 received consistent and professional services for the treatment of R3's pressure injury. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49011 2.) R2 was admitted to the facility on [DATE] with diagnoses which include encounter for palliative care, vascular dementia, bipolar disorder, depression, anxiety disorder, neurocognitive disorder with Lewy bodies, epilepsy, and adult failure to thrive. R2's Quarterly Minimum Data Set (MDS) with an assessment reference date of 9/24/2024 indicated R2 had a Brief Interview for Mental Status score of 00 (severe cognitive impairment). R2 has an activated power of attorney. Per the MDS, R2 rarely or never makes self-understood or has ability to understand others. The behavior of rejection of care was noted to have occurred on 1-3 days during the 7 day look back period, no other behaviors were noted. R2 is noted to be frequently incontinent of bowel and bladder. On 10/10/2024, at 10:50 am, Surveyor requested the hospice communication for R1 as there was nothing in the electronic medical record related to hospice visits. Nursing Home Administrator (NHA)-A stated they would go get information for Surveyor. On 10/10/2024, at 1:09 pm, Surveyor reviewed the hospice binder. Multiple Visit Note Report sheets were added to the binder with a fax date of 10/10/2024 at 10:58 am on the top of each page. Surveyor notes this was faxed the same day, after the information was requested. On 10/10/2024, at 1:09 pm, Surveyor reviewed the Visit Note Report forms that were added and for the visit dates of 10/1/2024, 10/4/2024 and 10/7/2024 it is stated that patient is free from exacerbations of integumentary status since last visit. Surveyor notes that on 9/30/2024 pressure injuries to the left and right plantar area of feet were discovered on R2. The Skin Issues form completed by the Acting Director of Nursing (ADON)-B has a note that on 9/30/2024 hospice was notified. Surveyor notes the Facility had treatment orders from the wound physician at (name of wound physician group). No documentation was found that hospice was actively involved in the wound care or assessments. On 10/9/2024, at 9:34 am, Surveyor interviewed a hospice staff member from (name of hospice group), R2's hospice provider, and asked if R2's pressure wounds had been observed yet. The hospice staff member stated R2 has no pressure wounds. Surveyor asked if there were wounds on R2's feet or buttocks and was told R2 has no pressure wounds that I know of. The Visit Note Report from hospice on 10/10/2024 has note that caregiver stated that patient has obtained blisters on both feet. Potentially from shoes being too small or from patient putting shoes on wrong feet. On 10/10/2024, at 1:23 pm, Surveyor interviewed Acting Director of Nursing (ADON)-B and asked who the caregiver was that shared pressure wound information with hospice. ADON-B stated it is a certified nursing assistant on R2's floor. Surveyor asked if hospice just found out today about the pressure wounds and was told that on 9/30/2024 the hospice on call was notified. Surveyor told ADON-B about interview from 10/9/2024 that hospice denied pressure wounds on R2. ADON-B stated not knowing why hospice would not know of pressure wounds. Surveyor notes the communication forms were not available to the Facility until faxed on 10/10/2024 so no review was completed to know hospice was not aware of pressure wounds. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024, at 1:57 PM, Surveyor let the ADON-B know of the concern that hospice was unaware of R2 having pressure injuries to the planter area of both feet. ADON-B stated having no disagreement with these findings. No further information was provided at this time.