STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor	803 S University Ave Beaver Dam, WI 53916

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on observation, interview, and record review, the facility did not ensure 3 of 3 residents (R16, R26, R41) with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections and provide dignity for residents. R16, R26, and R41 were observed with their catheter drainage bag uncovered. Evidenced by: The facility's policy titled Resident Rights Policy last reviewed on 2/28/24, states in part .Dignity and Respect: a. This facility will care for each of its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. b. We will promote their right to receive care and treatment in a manner and in an environment that maintains or enhances their dignity and respect in full recognition of their individuality . Example 1 R16 was admitted to the facility on [DATE] with diagnoses that include Parkinson's Disease, benign prostatic hyperplasia with lower urinary tract symptoms (a prostate gland enlargement that can cause problems with urination), depression, anxiety, and type 2 diabetes mellitus. R16 has a urinary catheter drainage system. On 11/11/24 at 9:29 AM, Surveyor observed R16 sitting in his wheelchair, in his room with his catheter bag uncovered and the door open. On 11/11/24 at 11:48 AM, Surveyor observed R16 sitting in his wheelchair in the hallway with his catheter bag uncovered. On 11/14/24 at 4:13 PM, Surveyor interviewed R16 and FM W (Family Member). Surveyor asked R16 if he would prefer to have his catheter bag covered, R16 stated yes. FM W reported that R16's catheter bag is uncovered most of the time and that they would prefer for it to be covered when R16 is taken out of the facility. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Hillside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S University Ave Beaver Dam, WI 53916	

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/14 at 2:29 PM, Surveyor interviewed CNA U (Certified Nursing Assistant). Surveyor asked CNA U if they typically put a dignity bag over catheter bags, CNA U stated that if they have them available and that sometimes they don't have them. On 11/12/24 at 2:33 PM, Surveyor interviewed CNA V. Surveyor asked CNA V if she got R16 up for the day, CNA V reported that she did get R16 up. Surveyor asked CNA V if she put a dignity bag over his catheter bag, CNA V reported that they never put them on and that she was unaware that the facility had them. 50228 Example 2 R26 was observed with urinary drainage bag uncovered. R26 was admitted to facility on 8/30/24 with foley catheter for assist in wound healing. On 11/12/24 at 7:52 AM, Surveyor observed R26's urinary drainage bag hanging from the side of the bed nearest the door. The drainage bag was not covered and was visible from the hallway. 50285 Example 3 R41 was observed with urinary drainage bag uncovered. R41 was admitted to facility on 2/16/22 with foley catheter for urinary retention. On 11/11/24 at 2:14 PM, Surveyor observed R41's urinary drainage bag hanging from the side of his garbage can, uncovered. On 11/14/24 at 4:22 PM, Surveyor observed R41's urinary drainage bag hanging from the side of his garbage can. At this time, the urinary drainage bag was covered by a dignity bag. Surveyor asked R41 if his urinary drainage bag was normally covered. R41 replied no, it was not normally covered. On 11/14/24 at 1:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she would expect residents with catheter bags to have the bags covered, DON B reported that the facility's policy is that if a resident is out of their room, the bag should be covered. Surveyor asked DON B if a resident is sitting in their room with the door open, should their catheter bag be covered, DON B stated that it is general practice that they should be covered.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42038 Based on interview and record review the facility failed to immediately consult with physician when needing to alter treatment for 1 (R37) of 3 residents reviewed for physician notification. R37 had an unwitnessed fall on 9/6/24. The facility did not call the on-call physician when R37 reported increased complaints of pain. R37 was found to have a distal clavicle fracture. Evidenced by: The facility's policy titled Resident Change in Condition Policy last reviewed on 12/12/23, states in part .The Nursing Staff will update the resident's attending physician when: .c. There is a need to alter the resident's treatment .f. Deemed necessary or appropriate in the best interest of the resident . R37 was admitted to the facility on [DATE] with diagnoses that include dysphasia (difficulty swallowing) following a cerebral infarction (stroke), congestive heart failure (chronic condition where the heart doesn't pump blood as well as it should), major depressive disorder, history of falls, and vascular dementia. R37's most recent Minimum Data Set (MDS) dated [DATE] states that R37 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R37 is cognitively intact. R37's Minimum Data Set (MDS) also stated that she is dependent on staff for bed mobility and all transfers. Fall documentation states: 9/6/24 at 6:18 PM: .Resident was in her recliner and was walking/ standing when she fell .Posey alarm was sounding but was very soft and this writer could not hear it until almost in the room .Resident was found on the floor by CNA (Certified Nursing Assistant) and alerted this writer that she was on the floor, and she was bleeding. Resident laying on her right side with her head almost underneath the bed. Noted she has a large laceration to the right side of her head with bruising already appearing. Held pressure to area. Resident laying on right side almost in a perpendicular position from her bed. Laying on her right shoulder and right hip. Denies pain, however, does state that right shoulder is sore' with attempts to move. 911 called to transport resident to ER (emergency room) for further evaluation . emergency room documentation dated 9/6/24 at 7:05 PM states in part: .Procedure: laceration repair note. Location: right temple. Anesthesia: 1% lidocaine with epinephrine. Laceration length/ type: 2.5cm. Suture type/ size: Surgical staples. Number of sutures: 3 . It is important to note that the emergency room did not x-ray R37's shoulder. Nurse's notes state the following: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/7/24 at 2:02 AM: PRN (as needed) Med Given: Acetaminophen 325mg tablet given for pain/ discomfort. Pain level before med: 5. Location: head. 9/7/24 at 3:49 PM: PRN Med Given: Acetaminophen 325mg tablet given for pain/ discomfort. Pain level before med: 3. Location: head. 9/9/24 at 5:38 PM: PRN Med Given: Acetaminophen 325mg tablet given for pain/ discomfort. Pain level before med: 6. Location: right shoulder, right hip. 9/13/24 at 9:39 PM: Resident complained of right shoulder pain, ice applied and scheduled Tylenol given. Bruising noted from most recent fall. Winces with movement of arm toward midline. Action: Continue to observe. Fax sent to: [Nurse Practitioner] regarding continued complaints of pain to right shoulder since fall. It is important to note that 9/13/24 was a Friday. 9/14/24 at 6:14 AM: Complaints of right shoulder pain when asked. 9/15/24 at 4:54 AM: Complaints of pain to right shoulder, ice pack applied. NP (Nurse Practitioner) updated via fax. 9/15/24 at 5:55 AM: Fax sent to: 9/15/24 [Nurse Practitioner] regarding update on right shoulder pain. 9/15/24 at 7:39 AM: Right shoulder discomfort after returning from outing with family. Action: Continue to observe. 9/16/24 at 7:24 AM: Orders received: Obtain x-ray of right shoulder (3 views): dx (diagnosis): recent fall; right shoulder pain. 9/17/24 at 8:19 AM: X-ray impression showed probable distal clavicle fracture. On 11/14/24 at 1:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if a resident is experiencing an increase in pain, would she expect nurses to call the on-call physician, DON B stated yes. Surveyor discussed with DON B that nurses sent 2 faxes during the weekend of 9/13/24- 9/15/24 regarding R37's pain. Surveyor asked DON B if she would expect staff to call the on-call physician when a resident has an increase in pain over a weekend after a recent fall; DON B stated yes, they should be calling.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50228

Based on interview and record review, the facility did not develop a comprehensive, person-centered care plan for 1 (R26) of 15 residents reviewed for care plans.

R26's care plan does not include a problem, goal, and interventions for pain or anxiety.

Evidenced by:

The facility's Psychotropic Medication Use/Chemical Restraints policy, dated 12/14/23, states, in part: . 3.1 Physicians / providers must order psychotropic medications only when all other attempts at redirection and non-pharmacological interventions have failed and are documented.3.7 The Care Plan will be developed with assistance of the interdisciplinary team, resident, and family members. The Care Plan will define the behavior as well as the goals for the resident. 3.8 Each care plan will also provide specific and individualized instructions for staff to follow to assist with behavior concerns.

The facility's Comprehensive Person-Centered Care Planning and Interdisciplinary Care Plan Conference policy, dated 12/20/23, states, in part: .2.2 Definitions .Care Plan: outlines the care to be provided to a resident to ensure that the resident reaches the highest physical, mental, and psychosocial well-being. Purpose Statement: To define the purpose and use of an individualized Person-Centered Care Plan. An interdisciplinary Care Plan Conference exists to identify resident needs and establish obtainable goals. An appropriate plan of action is designed to ensure optimal levels of activity and independence for all residents. 3.1 Each resident will have a Care Plan that is current, individualized, and consistent with the medical / nursing regimen.

R26 was admitted to the facility on [DATE] with diagnoses that include, in part: Non-pressure chronic ulcer of back with unspecified severity; Major depressive disorder; adult failure to thrive; contusion of left lower leg; gout due to renal impairment (a type of inflammatory arthritis that causes pain and swelling in the joints); other chronic pain; low back pain, unspecified; pressure ulcer of right buttock; pressure ulcer of left buttock; unilateral primary osteoarthritis, left knee; primary osteoarthritis, right shoulder.

R26's physician orders include, in part:

-Allopurinol 300 mg daily for gout

-Colchicine 0.6 mg daily as needed for gout

-Diclofenac sodium 1% gel 2-gram dose apply to left knee and right shoulder four times daily for osteoarthritis

-Acetaminophen 325 mg (2) three times daily as needed for pain

-Hydrocodone-acetaminophen 10mg-325 mg tablet three times daily for pain

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Hillside Manor	803 S University Ave Beaver Dam, WI 53916

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hydrocodone-acetaminophen 10mg-325mg tablet daily as needed at 2:00 AM for pain -Fentanyl 12 mcg/hr. 72 hour transdermal (pain medication absorbing through the skin into the bloodstream) every 3 days for chronic pain -Lorazepam 2mg/ml -1mg dose=0.5mg every 4 hours as needed for anxiety R26's care plan does not include a problem, goal, and interventions for pain. R26's care plan does not include a problem, goal, and interventions for anxiety. On 11/14/24 at 11:02 AM, Surveyor interviewed DON B (Director of Nursing) and asked if residents receiving fentanyl and hydrocodone-acetaminophen should have a care plan regarding pain. DON B stated yes. Surveyor asked if residents receiving lorazepam should have a care plan for anxiety. DON B stated yes. Surveyor asked if R26 had care plans for pain and anxiety which list non-pharmacological interventions for staff to perform. DON B stated no. Surveyor asked if R26 should have care plans for pain and anxiety which list non-pharmacological interventions. DON B stated yes.

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F 0689

Level of Harm - Actual harm

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 42038

Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 3 of 4 residents reviewed (R37, R12, and R36) for accidents. R37 and R12 are being cited at severity level 3 (actual harm) R36 is being cited at severity level 2 (potential for more than minimal harm).

R37 has a history of multiple falls, primarily from her lift chair. Facility staff did not implement fall interventions. R37 had one fall that resulted in a fracture of her right elbow and a laceration to forehead requiring staples, and another fall that resulted in fracture of her clavicle and a laceration to her head requiring staples.

R12 had a history of falls, 26 falls in the past year, one of which resulted in a laceration and fracture of maxillary sinus. The facility did not complete a thorough root cause analysis on several of the falls or ensure that appropriate interventions were in place and included in R12's care plan. R12 had a fall with laceration and fracture.

R36 is edentulous and wears an upper denture. R36 has not had a lower denture since admission to the facility. On 11/10/24 R36's upper denture was missing. On 11/11/24 ST C (Speech Therapist) recommended R36's diet order be changed (from Level 6) to International Dysphagia Diet Standardisation Initiative (IDDSI) Level 4 (pureed). On 11/13/24 Surveyor observed R36 eating a whole banana at breakfast that was slightly green and firm. Surveyor observed R36 coughing while eating the banana. PSM G (Patient Services Manager) stated R36 should not be served banana on a Level 4 diet. PSM G stated, it is important for R36 to receive the correct Level 4 to avoid a health hazard, safety hazard, and choking hazard. PSM G stated, the Dietary Department has not received R36's updated diet recommendation from the facility or from ST C. Subsequently, R36's meal ticket and IDDSI level was not updated.

Evidenced by:

The facility's policy titled Fall Prevention and Management Procedure last reviewed on 5/6/24 states in part . 3.2 Prevention Interventions/ Strategies: a. Environment Safety: All staff will work together to create a safe environment. b. Medications will be reviewed by Pharmacists as necessary. c. Recommendations will be provided as appropriate. d. Interdisciplinary care plans will provide interventions for each resident to assist with keeping resident safe. e. Therapy screens will be sent with potential for therapy and review of interventions .f. All residents will have: Nonslip footwear during transfers and ambulation .Assess elimination need, assist as needed .3.5 Fall Prevention and Management Interventions: a. Low bed b. Restorative program for ambulation c. Reminder signs in room d. Toileting schedule .i. Activities j. Hip protectors k. Elbow/ knee pads .m. Dycem .

Example 1

R37 was admitted to the facility on [DATE] with diagnoses that include dysphasia (difficulty swallowing) following a cerebral infarction (stroke), congestive heart failure (chronic condition where the heart doesn't pump blood as well as it should), major depressive disorder, history of falls, and vascular dementia.

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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 0689

Level of Harm - Actual harm

Residents Affected - Few

R37's most recent Minimum Data Set (MDS) dated [DATE] states that R37 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R37 is cognitively intact. R37's Minimum Data Set (MDS) also stated that she is dependent on staff for bed mobility and all transfers.

R37's care plan states in part: .3/26/24: Problem: I am independent with the use of remote for recliner to assist in adjusting my position due to chronic phlegm/emesis. I have been observed raising my chair too high my family is aware of this activity and potential for injury associate with this, but I request I continue to have control of remote .9/23/24: Problem: I have suspected clavical [sic] fracture s/p (status post) fall. I have ortho consult pending for further evaluation .Interventions: 9/28/23: posey alarm to wheelchair, recliner, bed. 8/9/24: wedge to right side under right body pillow .

Documentation is as follows:

9/27/23 at 5:15 PM: .At 17:15 (5:15 PM) writer called to unit due to unwitnessed fall. Resident laying on the floor on right side in front of lounge chair (remote controlled lift recliner). Small amount of blood noted on the floor next to resident. Upon assessment, resident with scrape/ skin tear to right temple, quarter sized bump. Hematoma open and bleeding above right eye, golf- ball sized bump to forehead. Complaints of pain to head. Right elbow skin tear approx. (approximately) 0.5 in (inches). Resident had several stories regarding how she fell including picking up a watch, something about witch craft and other nonsensical sentences . Orders received to send to ER (emergency room) .Footwear worn: Barefoot/socks .To prevent future falls: Discussed with POA (Power of Attorney), will think about further and will decide if posey alarms would be effective and to discuss resident using lounge chair while having increased confusion .PT (Physical Therapy) screen placed, OT (Occupational Therapy) screen placed .Morse Fall Risk Assessment: Risk Score 90 .

emergency room documentation dated 9/27/23 at 8:43 PM states in part: .No acute intracranial hemorrhage . Skin tears are not able to be closed with suture. Bacitracin and steri- strips applied by the nurse .

9/29/23 at 7:47 AM: Measures to reduce reoccurrence: Posey alarm to chairs and bed.

10/20/23 at 6:05 PM: .Alarm activated- staff at nurses [sic] station responded to find resident lying face down on floor perpendicular to lounge chair with head towards the window and feet towards bed; pillow under right leg (as was on footrest of recliner). Recliner in semi raised position. Writer summoned- writer observed moderate active bleeding from head. Writer directed another RN (Registered Nurse) to call 911 due to bleeding and body placement limiting ability to assess extent of injury. Appears resident hit head on floor . While awaiting EMS (Emergency Medical Services) arrival, blood pool tripled in size with blood clots noted . Writer observed skin tear to right elbow medial to previously noted skin tear- also moderately bleeding at time of incident .Footwear worn by resident: Barefoot/ socks- barefoot at time of incident .To prevent future falls: to be assessed upon return from ER .

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

emergency room documentation dated 10/21/23 at 1:19 PM states in part: .XR (X-ray) Elbow Complete Right Findings: Mildly displaced fracture of the proximal ulna, involving the olecranon process (pointed tip of the elbow) .Procedure: Laceration repair .Location: Side of forehead at the scalp line. Total length of repair: 1 cm (centimeter). Anesthesia: 2 ml (milliliters) of 1% lidocaine with epinephrine. Description: Was thoroughly cleaned and irrigated. The wound was closed with 2 staples with good wound approximation. Emergency Department Splint Procedure Note: Injury: Olecranon fracture on the right .Splint was placed to ensure immobilization and adequate pain control. Adequate gauze padding was placed, and the splint was secured with ACE bandage .

10/23/23 at 8:14 AM: Measures to reduce reoccurrence: pending PT eval given new elbow fracture .

1/30/24 at 7:00 AM: .Resident with confusion and was acting on belief that she needed to ready for a trip. Resident was observed sitting on her legs on right side of bed. Back resting on bed .Interventions in place: low bed, posey alarm, body pillow bilaterally .To prevent future falls: Resident has posey alarm in place. She has increased confusion with disease progression and goal is to prevent injuries from fall .

It is important to note that the facility did not implement a new fall intervention.

3/25/24 at 8:15 PM: .CNA (Certified Nursing Assistant) staff members assisting other residents in their bathrooms. Resident must have elevated chair. Another alert resident going past room, heard alarm going off and seen that the resident was on the floor. She told another resident and other resident yelled for help. CNA staff heard yelling of resident and immediately went to room of fallen resident. Alerted charge RN. Writer also noted at that time. Entered room. Lounge chair in complete upright position. Resident lying on her right-side facing chair with her head towards entry door. Charge RN already assessing, Resident noted to have right side head injury. Moderate amount of blood noted to shirt and floor. Noted to have a small bump with skin tear to right side of forehead. Skin tear measures 3cm x 3cm .No external rotation or shortening. Resident placed back in lounge chair via med-lift per agency protocol. Area to forehead cleansed by writer and 4 large steri- strips applied to area .Footwear worn by resident: barefoot/ socks .To prevent future falls: family continues to want resident to have lounge chair controller .

It is important to note that the facility did not implement a new fall intervention.

9/6/24 at 6:18 PM: .Resident was in her recliner and was walking/ standing when she fell .Posey alarm was sounding but was very soft and this writer could not hear it until almost in the room .Resident was found on the floor by CNA and alerted this writer that she was on the floor, and she was bleeding. Resident laying on her right side with her head almost underneath the bed. Noted she has a large laceration to the right side of her head with bruising already appearing. Held pressure to area. Resident laying on right side almost in a perpendicular position from her bed. Laying on her right shoulder and right hip. Denies pain, however, does state that right shoulder is sore' with attempts to move. 911 called to transport resident to ER for further evaluation .

emergency room documentation dated 9/6/24 at 7:05 PM states in part: .Procedure: laceration repair note. Location: right temple. Anesthesia: 1% lidocaine with epinephrine. Laceration length/ type: 2.5cm. Suture type/ size: Surgical staples. Number of sutures: 3 .

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

After repeated complaints of pain by R37, the facility obtained an order for an x-ray to R37's right shoulder on 9/16/24. The x-ray results states in part: .Impression: 1. Probable distal clavicle fracture .

It is important to note that the facility did not implement a new fall intervention.

On 11/13/24 at 2:34 PM, Surveyor interviewed CNA R (Certified Nursing Assistant). Surveyor asked CNA R how she knows what fall interventions are in place for each resident, CNA R reported that they have a binder with each resident's care plan and interventions. Surveyor asked CNA R what interventions are in place for R37, CNA R stated that she did not know. Surveyor asked CNA R how she would find out what interventions are in place, CNA R stated that she would ask the nurse and other CNAs.

On 11/14/24 at 1:30 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what fall interventions were put in place for each of R37's falls, DON B reported that for 9/27/24 the posey alarms were implemented. Surveyor asked if R37 should have been wearing gripper socks at the time of the fall, DON B stated that there is no way to know what she was wearing. Surveyor asked about the interventions for the fall on 10/27/23 and if the PT screen was for R37's fractured elbow or falls, DON B reported that it was potentially for both. Surveyor asked about the intervention related to R37's fall on 1/30/24, DON B stated the intervention was to reinforce the previous interventions. Surveyor asked DON B about the intervention related to the fall on 3/25/24, DON B reported that there was no new intervention. Surveyor asked DON B what the intervention implemented after R37's fall on 9/6/24, DON B reported that they reiterated the family's preference to allow R37 to have the remote to the recliner. Surveyor asked DON B with the facility's documented increased confusion with R37, did they increase supervision, DON B stated that she could not find that they did. Surveyor asked DON B if she would have expected that staff check on R37 more often, DON B stated yes. Surveyor asked DON B if the facility has completed a safety assessment for R37's ability to use a remote-controlled recliner, DON B reported that they have been looking for evidenced based practice related to screening for recliner safety. Surveyor asked DON B if R37 was ever placed on a toileting schedule, DON B reported that on 10/16/24, she was placed on last round toileting. Surveyor asked DON B if they have documentation regarding the risks vs. benefits related to R37's recliner use indicating the potential poor outcomes that was signed by the family, DON B stated no.

It is important to note that R37 has been on warfarin (blood thinner) since admission to the facility.

50285

Example 2

R12 was admitted to the facility on [DATE] with diagnoses that include, in part: repeated falls, pain in left hip, age-related osteoporosis, overactive bladder, chronic pain syndrome, depression unspecified, mild cognitive impairment of uncertain or unknow etiology, age related cataract, sensorineural hearing loss, and nausea.

R12's most recent MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 11/5/24, indicates R12 has a BIMS (Brief Interview of Mental Status) of 5 out of 15, indicating R12 has severe cognitive impairment.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525447	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Hillside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S University Ave Beaver Dam, WI 53916	

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 0689

Level of Harm - Actual harm

Residents Affected - Few

R12's fall care plan, includes, in part:

--Problem: I have a history of falls due to my choice to transfer/ambulate without staff assistance. I am aware that I require assistance to maintain my safety, but often do not ask for help. I have weakness and impaired judgement. My son has requested Posey alarm placement due to continued self-transfer attempts. We do not see eye to eye on this subject, and I frequently turn off my alarms prior to self-transfers. My son has been educated on the risk of falls, along with potential for major injury . January 2023: frequent falls, resident failing to call and await staff assistance. Resident fall and behavior pattern does not demonstrate a patter of effectiveness of alarms - does not halt nor stop her attempts at independent ability. POA (Power of Attorney) has been educated on multiple occasions as to the risk of injury with resident behaviors and circumstances regarding falls and resident refusal to participate in therapy services. Recommendations continue to require assistance with all mobility. POA agrees with removal of alarms at this time as they are not altering resident pattern of behaviors and falls . Date: 1/30/24.

--Goal: I will maintain the ability to transfer and the ability to ambulate with 1 assist. Date 8/11/21.

--Goal: I will be free of injury from falls. Date 2/28/25.

--Interventions include, in part: Low bed (Date 3/15/22). Right body pillow (Date 1/31/24). Do not leave alone in bathroom when using toilet (Date: 1/23/22). Keep wheelchair placed on bathroom side of bed when resident is in bed (Date 6/5/24).

On 9/10/23 at 9:40 AM, R12 had an unwitnessed fall in her room. Root cause of fall: resident states walked from chair to nightstand across room to adjust radio. Measures to prevent reoccurrence: continue interventions as per comprehensive CP (care plan). No injuries.

On 9/22/23 at 7:50 PM, R12 had a witnessed fall in her room. Root cause of fall: poor decision making. Measures to prevent reoccurrence: Continue with reminders and reinforcement of the need for staff to assist with needs. No injuries.

Of note, R12 has severe cognitive impairment.

On 10/9/23 at 1:15 AM, R12 had an unwitnessed fall in her bathroom. Root cause of fall: Resident reports transferring self from toilet to wheelchair in front of toilet that was placed there and locked by staff who had to exit room to attend another resident in safety situation. Measures to prevent reoccurrence: none listed. Injuries: hit head, neurological checks initiated per protocol.

On 11/6/23 at 5:15 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident reports was walking self with walker and reported feeling dizzy. Measures to prevent reoccurrence: none listed. Noted no ongoing safety concerns, resident choosing to not call nor wait for staff assistance with mobility needs. No injuries.

On 11/10/23 at 10:15 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident slid out of wheelchair while attempting to self-transfer back to bed. Staff had not previously assisted resident into wheelchair, so resident had transferred self into wheelchair prior (which is parked in bathroom). Measures to prevent reoccurrence: none listed. No injuries.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/16/23 at 2:15 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident reports taking self from bathroom with walker and bent over to reach for slippers on floor. Resident had taken self from recliner to bathroom. Measures to prevent reoccurrence: Refer to mobility CP for full list of interventions. No injuries. On 12/1/23 at (no time listed), R12 had an unwitnessed fall in her bathroom. Root cause of fall: Poor safety awareness. Measures to prevent reoccurrence: none listed. No injuries. On 12/5/23 at (no time listed), R12 had an unwitnessed fall in her room. Root cause of fall: Poor decision making - consistently is getting up without asking for assistance and losing her balance. Measures to prevent reoccurrence: Multiple attempts at education along with therapy and restorative programs are in place in an attempt to keep the resident safe. No injuries. On 12/12/23 at 11:10 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident self-transferred from bed to wheelchair - transferring without staff assistance or assistive device. Measures to prevent reoccurrence: Multiple attempts at education along with therapy and restorative programs are in place in an attempt to keep the resident safe. No injuries. On 12/14/24 at 7:00 PM, R12 had a witnessed fall in her room. Root cause of fall: Resident was sitting at edge of bed looking for TV remote leaning back and forth and slid off bed. Measures to prevent reoccurrence: none listed. No injuries. On 12/19/24 at 10:00 AM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident self-transferred from bed to wheelchair - transferring without staff assistance or assistive device. Measures to prevent reoccurrence: none listed. No injuries. On 12/20/23 at 3:30 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident ambulating in room without assist or assistive device. Measures to prevent reoccurrence: none listed. No injuries. Noted no ongoing safety concerns with poor judgement and disregard for need for staff assistance. On 12/21/23 at 8:30 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident attempted to get out of low bed independently resulting in slide out of bed onto floor. Measures to prevent reoccurrence: none listed. No injuries. On 1/31/24 at 7:30 PM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident attempted to crawl over body pillow to attempt to get out of low bed to either turn light off or get bed control (resident inconsistent with reports). Measures to prevent reoccurrence: Removed body pillow from bathroom side of bed as resident continues to climb over this which may increase risk of fall trying to overcome obstacle. Injuries: bump on head, neurological checks initiated. On 2/6/24 at 9:30 AM, resident had an unwitnessed fall in her room. Root cause of fall: Resident was reaching for TV remote while sitting on walker resulting in fall. Measures to prevent reoccurrence: none listed. No injuries. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/6/24 at 7:30 PM, R12 had a witnessed fall in her room. Root cause of fall: Resident had taken self from bed to the bathroom, using wheelchair upon completion of using bathroom, left wheelchair in bathroom and walked back into room using furniture as a support. Staff walked by room to find resident using bed and recliner as support as knees appeared to be buckling and staff assisted resident to be lowered to floor. Measures to prevent reoccurrence: Continue with toileting schedule, anticipating resident needs, rounding, keep items within reach. Resident continues to get up by self even after these interventions without staff assistance and/or appropriate AD (Assistive Device). No injuries. On 2/20/24 at 1:00 PM, R12 an unwitnessed fall in her room. Root cause of fall: Resident was reaching from wheelchair/slide off wheelchair. Measures to prevent reoccurrence: Refer to prior investigations/current mobility/ADL (Activities of Daily Living)/urinary CP. Injuries: Bruise to elbow. On 2/22/24 at 5:00 AM, R12 had an unwitnessed fall in her bathroom. Root cause of fall: Poor decision making related to safety needs. Measures to prevent reoccurrence: All measures have been attempted without success. No injuries. On 3/26/24 at 1:35 AM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident attempted to transfer self from low bed to w/c (wheelchair). Measures to prevent reoccurrence: Reinforcement of need for assistance with ADL's/toileting. No injuries. On 3/31/24 at 8:15 AM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident was in bed reaching for bed controller causing resident to roll OOB (out of bed). Measures to prevent reoccurrence: Please refer to comprehensive mobility, ADL, and toileting CP for all interventions. Injuries: bruising (location not listed). On 4/11/24 at 11:00 AM, R12 had an unwitnessed fall in her room. Root cause of fall: Resident was reaching from chair for oxygen. Measures to prevent reoccurrence: As per comprehensive care plan. No injuries. On 6/8/24 at 2:00 PM, resident had an unwitnessed fall in her room. Root cause of fall: Resident was standing to close bathroom door and stepped back for clearance and foot caught on walker wheel causing fall. Measures to prevent reoccurrence: Continue interventions as per comprehensive care plan. Resident is now in single occupancy room which allows her more space - this may be contributing to decreased number of falls recently. No injuries. On 7/11/24 at (time not listed), R12 had an unwitnessed fall in her room. Root cause of fall: Poor safety awareness. Resident and family member have been educated on the potential for injury with continued poor decision making related to safety. Measures to prevent reoccurrence: Continue with reminders, rounding. No injuries. On 7/22/24 at 11:02 AM, R12 had an unwitnessed fall in her room. Root cause of fall: Poor safety decision. Measures to prevent reoccurrence: Multiple interventions attempted in the past. PT (physical therapy) evaluation placed. No injuries. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/24/24 at (no time listed), R12 had an unwitnessed fall in her room. Description of event: Resident was pulling her bathroom door open and lost her balance. Resident was transferred to the hospital for further evaluation. Result of ER (emergency room) visit noted to be laceration of face and fracture of maxillary sinus. Root cause of fall: Poor safety decisions and awareness. Resident continues to put self at risk of injury with independent transfers and ambulation. Measures to prevent reoccurrence: Continue with reminders and interventions per care plan. Injuries: laceration and fracture of maxillary sinus. Son/POA was updated with the transfer and is aware of resident's poor safety awareness and risk for injury. R12's ER notes on 7/24/24 state in part: Patient presents to ER for unwitnessed fall earlier today. Patient has laceration to left lateral forehead. Four sutures placed. CT (computed tomography) scan completed of head and neck. Diagnostic details: Left inferior anterior maxillary wall fracture with hematoma in the left maxillary sinus. On 8/23/24 at 1:00 PM, Resident had an unwitnessed fall in her room. Root cause of fall: Resident standing on own and used overbed table for assistance which is on wheels and it rolled away. Measures to prevent reoccurrence: Reminders to resident combined with all previous interventions - refer to fall CP and previous fall assessments. No injuries. On 11/13/24 at 9:02 AM, Surveyor observed R12 sitting in her recliner with a sign placed on the wall in front of her hanging under the TV that states, Please call for assistance. No other fall interventions observed in room. On 11/13/24 at 4:30 PM, Surveyor interviewed DON B (Director of Nursing) regarding R12's multiple falls. DON B indicated that prior to the fall with fracture on 7/24/24, the facility had been encouraging R12 to undergo a therapy evaluation for recommendations on preventing falls, but both R12 and her son/POA Power of Attorney) did not want to have therapy. DON B stated that they had also tried alarms, but they were ineffective. DON B stated the staff have put items closer within reach for R12, ensure she is wearing appropriate footwear while awake, anticipate her needs, offer her snacks and a sweater, and put her on a toileting schedule. DON B acknowledged that many of R12's falls revolved around her desire to maintain her independence and self-transfer. DON B stated that it was her expectation that staff follow the care planned interventions to prevent R12 from having repeated falls and injuries. DON B indicated that the care plan interventions would be on the CNA (Certified Nursing Assistant) Kardex/Group List. Of note: the only fall interventions listed on R12's Kardex/Group List are: Low bed, Transfer with 1 assist and walker, and right body pillow. Toileting schedule is listed every two hours. On 11/14/24 at 12:38 PM, Surveyor asked CNA M, (Certified Nursing Assistant) who stated that she was a new employee. CNA M showed Surveyor the Kardex/Group List. Surveyor asked CNA M if she knew anything about keeping items within reach, anticipating needs, offering snacks or a sweater, or appropriate footwear, as these are not listed on the CNA Kardex/Group List. CNA M stated she was not aware of these interventions. On 11/14/24 at 12:41 PM, Surveyor interviewed RN N (Registered Nurse) what fall interventions were in place for R12. RN N replied that R12 has a low bed, body pillows, wearing shoes or slippers while awake, and to keep her walker or wheelchair close by. RN N stated that R12 still self-transfers at least daily. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/14/24 at 12:47 PM, Surveyor interviewed LPN K (Licensed Practical Nurse) who stated that R12 transfers without assistance multiple times per day. LPN K stated that fall interventions for R12 included anticipating her needs. On 11/14/24 at 12:55 PM, Surveyor interviewed CNA O who stated that R12 self-transfers daily, and that she will see her walking unassisted in her room when she walks by. CNA O stated that the sign to call for assistance in R12's room was a fall intervention, as well as repeatedly reminding R12 verbally to wait for assistance. The facility failed to create a robust fall care plan that included appropriate fall interventions and to ensure that the fall interventions were adequately communicated to the frontline care staff. R12 had multiple falls, one which resulted in a fracture and head laceration requiring sutures. 30992 Example 3 The facility follows IDDSI (International Dysphagia Diet Standardisation Initiative). IDDSI Level 4 Pureed Food for Adults: What is this food texture level. Level 4 - Pureed Foods - Area usually eaten with a spoon - Do not require chewing - Have a smooth texture with no lumps - Hold shape on a spoon - Fall off a spoon in a single spoonful when tilted - Are not sticky - Liquid (like sauces) must not separate from solids Why is this food texture level used for adults: Level 4 - Pureed Food may be used if you are not able to bite or chew food or if your tongue control is reduced. Pureed foods need the tongue to be able to move forward and back to bring the food to the back of the mouth for swallowing. It is important that puree foods are not too sticky because this can cause the food to stick to the cheeks, teeth, roof of the mouth or in the throat. Pureed foods are best eaten using a spoon. How do I test my food to make sure it is Level 4 Pureed: It is safest to test Pureed Food using the IDDSI Fork Drip Test and the IDDSI Spoon Tilt Test. IDDSI Fork Drip Test: Liquid dos does not dollop, or drip continuously through the fork prongs. A small amount may flow through and form a tail below the fork. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	IDDSI Spoon Tilt Test: Sample holds its shape on the spoon and falls of fairly easily if the spoon is tilted or lightly flicked. Sample should not be firm or sticky. R36 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dysphagia, cerebral infarction (stroke), diabetes mellitus type 2, and vascular dementia. R36 has an APOAHC (Activated Power of Attorney for Health Care). R36's comprehensive care plan, dated 5/24/21, indicates, in part, as follows: Monitor me for any increased difficulty with my chewing and/or swallowing ability. R36 care plan documents he receives a Level 6 Diet. On 11/8/24 R36's Dietary Assessment documents the following: Resident is currently on a General with IDDSI Diet: Level 6 foods - Soft & bite sized with bread products allowed, and Level 0 liquids-Thin. Divided plate with Dycem mat and No straws. Supplements: 240 ml Ensure Plus High Protein BID (Twice Daily) Involuntary weight loss of 10% in 6 months. Nutrition Interventions: Medical food supplements added Ensure Plus BID at 1000 and 1900 to help stop weight loss. Writer is also monitoring food intake, fluid intake, weights, skin integrity, tolerance to mechanically altered diet, tolerance of nutritional supplement (Ensure Plus). Will proceed. The plan is to revise/update care plan long term placement so we will Continue with current nutritional interventions, with the addition of Scheduled nutritional supplement. Ensure Plus at 1000 and 1900 to help stop weight loss, and we will Encourage fluids with each encounter, and MDS (Minimum Data Set) completed. On 11/10/24 R36's top denture went missing. Of note, R36 is edentulous and does not have a bottom denture. On 11/10/24 at 4:29 PM, staff entered the following note: Therapy Screen Request: Please Screen: Upper denture is missing, please screen for safety with chewing swallowing with current diet. On 11/11/24 at 10:30 AM, Surveyor spoke to R36 and his APOAHC (Activated Power of Attorney). R36 and his APOAHC stated that R36's denture was lost on 11/10/24. On 11/11/24 at 12:07 PM, Surveyor observed R36 eating ranch chicken (bite size pieces), mashed sweet potatoes, and milk. R36 started coughing while eating the chicken and then vomited. Staff took him out of the dining room and back to his room. On 11/11/24 at 12:09 PM, Surveyor observed R36 with no signs of coughing or watering eyes. R36 stated he was not having any difficulty breathing and was feeling fine. (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 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/11/24 at 12:16 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor relayed that while R36 was eating lunch that he coughed on ranch chicken and vomited the chicken back up. Surveyor shared with DON B possible concern for aspiration. The facility assessed and monitored R36 for the next 24 hours. On 11/11/24 at 12:31 PM, Surveyor spoke with LPN K (Licensed Practical Nurse). LPN K stated that R36 has occasional nausea induced by coughing, and swallowing problems. LPN K stated, R36 takes Reglan (to treat gastroesophageal reflux disease) and omeprazole (to treat heartburn and damaged esophagus). LPN K stated, it doesn't happen all the time but if he eats really fast food will come back up. Surveyor asked LPN K, has this been worse over the last day. LPN K stated, no. LPN K stated, we completed an incident report for R36's missing dentures and SW J (Social Worker) is working on it. LPN K added, she updated R36's APOAHC on 11/10/24. LPN K stated, R36's APOAHC will talk with SW J about getting the dentures replaced. Surveyor asked LPN K was R36's diet modified. LPN K stated, we put in for a ST (Speech Therapy) consult yesterday but i [TRUNCATED]

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50228 Based on interview and record review, the facility did not ensure the medication regimen of each resident was reviewed at least once a month by a licensed pharmacist for 1 of 5 residents reviewed for unnecessary medications (R26). R26 did not have a monthly medication review conducted by a pharmacist. This is evidenced by: The facility's Role of the Pharmacist in Long Term Care Procedure policy, dated 7/8/24, states, in part: .2.2 Definitions . Monthly Medication Regimen Review: The process by which a consultant pharmacist analyzes a LTC (long term care) resident's medical chart, medication administration record, and pharmacy software on a monthly basis in order to prevent, identity, report, and resolve medication-related problems, medication errors, and other irregularities.3.1 The consultant pharmacist will perform the following: a. The consultant pharmacist will perform a drug regimen review for each HSM (Hillside Manor) resident by the end of each calendar month and as needed. 3.2 The consultant pharmacist will create a separate, written report with the resident's name, relevant drug, and irregularity. If no irregularities are found, the consultant pharmacist will note this in the resident's chart on the medication regimen review form. R26 was admitted to the facility on [DATE]. R26's Monthly Medication Regimen Review form indicates pharmacist review occurred on 9/26/24. Surveyor requested monthly pharmacy review for R26 for October 2024 and the facility was unable to provide any documentation that R26's medications and medical chart had been reviewed by a pharmacist for October 2024. On 11/14/24 at 11:02 AM, Surveyor interviewed DON B (Director of Nursing) regarding monthly medication regimen reviews. DON B indicated that reviews are completed monthly by the hospital's pharmacist with documentation completed in the resident's hard chart on the Medication Regimen Review form. Surveyor informed DON B of documentation for 9/26/24 with no subsequent review documented. DON B stated she would look for additional documentation. On 11/14/24 at 1:53 PM, DON B stated that there was no additional documentation, and she would have expected the review to be completed monthly.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on interview and record review the facility did not ensure Residents (R) receiving a psychotropic medication, were free from unnecessary medications for 1 of 15 Residents (R52). R52 receives antidepressant and antipsychotic medications. The facility is not monitoring for side effects of antidepressant and antipsychotic medications. This is evidenced by: Facility policy titled Mood/Behavior Policy dated 11/28/22 with last revision date 12/14/23, states in part: .The (Facility Name) Behavioral Program will include a systemic care process to assure that assessments are accurate and timely; interventions are implemented, monitored, and revised as appropriate. (Facility Name) will provide appropriate care and services . Facility policy titled Comprehensive Person-Centered Care Planning and Interdisciplinary Care Plan Conference Policy, dated 1/3/22 with last revision date 12/20/23, states in part: . Each resident will have a Care Plan that is current, individualized, and consistent with the medical/nursing regimen . R52 was admitted on [DATE] with diagnosis that include Anxiety Disorder, Depression unspecified, Major depressive disorder, single episode with severe psychotic features, and Insomnia unspecified. R52's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/23/24 indicates R52 is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15 out of 15. R52's Care Plan states in part: --Problem: Mood and coping related to recent hospitalization for CABGx3 (Coronary Artery Bypass Grafting: a surgical procedure that improves blood flow to the heart by rerouting blood around blocked arteries) and need for rehab stay. I am able to communicate my feelings freely to staff and family. I am generally pleasant and cooperative. However, I can get upset if I cannot leave. I like to socialize with others. MD (Medical Doctor) indicates I have a longstanding mood disorder characterized by paranoia, depression, and insomnia. I have a long history of paranoia and occasional hallucinations. Date: 10/22/24. --Goal: My depression will be controlled by current medications/interventions. Goal 9/6/24. --Intervention: Assess for reason for behavior/confusion, e.g. infection, pain. Date 9/13/24. --Intervention: Monitor me for side effects and update provider as needed. Date 9/6/24. R52's November 2024 Physician orders include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Hillside Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 803 S University Ave Beaver Dam, WI 53916	

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Sertraline HCl 100 mg tablet by mouth ***200 mg dose*** at bedtime (8:00 pm) for depression. Therapeutic Goal: See Behavior Monitoring or Care Plan (Resident Specific). Start Date: 10/4/24. *Seroquel (Quetiapine Fumarate) 25 mg tablet by mouth daily at bedtime (8:00 pm) for psychosis and agitation. Therapeutic Goal See Behavior Monitoring or Care Plan (Resident Specific). Start Date 10/26/24. R52's November MAR (Medication Administration Record) indicates in part: *Drug: Sertraline HCl 100 mg tablet by mouth *200 mg dose* daily 8:00 pm for depression. Side effects: (blank). Therapeutic Goal: See Behavior Monitoring or Care Plan (Resident Specific). *Drug: Quetiapine Fumarate 25 mg tablet at 8:00 pm for anxiety and agitation due to dementia. Side effects: (blank). Therapeutic Goal: See Behavior Monitoring or Care Plan (Resident Specific). (Of note: R52 does not have a dementia diagnosis listed in his diagnosis list). R52's CNA Kardex/Group List does not have any side effect monitoring listed. R52's MAR/TAR (Medication Administration Record/Treatment Administration Record) does not have any side effect monitoring or what side effects R52 should be monitored for. R52's Mood and Behavior monitoring does not list side effects or indicate what side effects should be monitored for R52. On 11/13/24 at 3:53 PM, Surveyor interviewed CNA Q (Certified Nursing Assistant) about R52's behaviors and monitoring of side effects with antipsychotic and antidepressant medications. CNA Q was not able to tell Surveyor what side effects they would monitor for. On 11/14/24 at 10:41 AM, Surveyor interviewed CNA R. Surveyor asked CNA R what side effects of medication R52 would be monitored for. CNA R stated she did not know. On 11/14/23 at 11:13 AM, Surveyor interviewed CNA/Med Tech S (Medication Technician) what side effects of the antipsychotic and antidepressant medications she would be monitoring R52 for. CNA/Med Tech S answered Surveyor with a list of R52's behaviors, not medication side effects. Surveyor asked CNA/Med Tech S again about the medication side effects. CNA/Med Tech S replied that she would ask the nurse. On 11/14/24 at 3:39 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B if she expected her staff to be monitoring side effects for residents who take antipsychotic or antidepressant medications. DON B answered yes. Surveyor reviewed with DON B the care plan and documentation of R52 and asked what side effects the staff would be monitoring for. DON B answered they are listed on the medication consents that are stored in the paper charts in the nurse station cupboard, as well as all the nurses have access to medication drug books, which list side effects. R52's comprehensive care plan and documentation did not indicate what side effects of antipsychotic or antidepressive medication R52 should be monitored for, nor was there any documentation to indicate that R52's side effects were being monitored by staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42038 Based on observation, interview, and record review, the facility did not ensure it was free of medication error rates of 5% or greater. There were 8 errors in 25 opportunities that affected 1 resident (R39) out of a sample of 6 residents observed for medication administration. This results in an error rate of 32%. R39's medications were scheduled for 8:00 AM and R39 received her medications at 10:02 AM. Evidenced by: The facility's policy titled Basic Medication Administration Policy last reviewed on 12/11/24, states in part: .3. 4 General Medication Administration: .c. All medications must be given within 1 hour before or 1 hour after scheduled time . On 11/11/24 at 10:02 AM, Surveyor observed RN I (Registered Nurse) during medication administration. Surveyor observed RN I give the following medications to R39: Systane eye drops- 1 drop into both eyes QID (four times a day), Senna- s 50/8.6mg (milligrams) 2 tablets daily, Vitamin C 500mg daily, Miralax 17 g (grams) 3 times a week, Calcium + Vitamin D 1 tablet daily, and Eliquis 2.5 mg. On 11/13/24 at 8:52 AM, Surveyor interviewed RN I. Surveyor asked RN I what time the medications for R39 were administered on 11/11/24, RN I stated that she did not know. Surveyor reported that the observation was made at 10:02 AM. Surveyor asked RN I what the facility's policy is for medication administration, RN I stated that medications should be administered within1 hour before and 1 hour after their scheduled times. Surveyor asked RN I if she notified R39's provider that the medications were administered late, RN I stated no. On 11/13/24 at 8:58 AM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what the facility's policy was for administering medication, DON B stated medications should be administered within 1 hour before and 1 hour after their scheduled times. Surveyor asked DON B what steps staff should take if medications are administered late, DON B stated that nurses should be contacting the provider to notify them and documenting the actual administration time in the MAR (Medication Administration Record).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50698 Based on observation, interview, and record review the facility did not ensure drugs and biologicals are labeled in accordance with currently accepted professional standards for 2 of 2 medication carts reviewed for medication storage. The medication cart on Swan hall contained an expired bottle of Atropine 1% eye drops for R40. The medication cart on Monarch hall contained a Combivent Respimat inhaler that was not labeled or dated. As evidenced by: Facility policy entitled, Basic Medication Administration Policy dated 3/4/2024 states, in part .3.4 Medication Storage .c. All medication not contained in an automated dispensing cabinet (ADC) or carousel: Medications for individual resident use will be labeled and stored in resident specific bins or drawers and labeled with a room number .f. Expiration dates of all medications and vaccines will be checked one [sic] a month .3.5 General Medication Administration .u. A revised expiration date will be written on the inhaler once opened from the foil package, using the common medication expiration list provided by pharmacy . Example 1 On 11/12/24 at 9:07 AM, Surveyor conducted medication storage observation of the medication cart on Swan hall with RN H (Registered Nurse). Surveyor observed R40's bottle of Atropine 1% eye drops with an expiration date of 11/3/24. On 11/12/24 at 9:07 AM, Surveyor interviewed RN H about expired medications. RN H indicated expired medication should not remain on the medication cart and removed R40's expired Atropine 1% eye drop bottle from the cart. Example 2 On 11/12/24 at 9:29 AM, Surveyor observed the medication cart on Monarch hall with RN I. Surveyor observed a Combivent Respimat inhaler which was not labeled or dated. There was no resident name or room number on it. On 11/12/24 at 9:29 AM, Surveyor interviewed RN I about the unlabeled Combivent inhaler. RN I indicated she does not know which resident the inhaler belonged to since it was not labeled. RN I indicated the inhaler should be labeled. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:37 PM, Surveyor interviewed DON B (Director of Nursing) regarding medication storage and expiration dates. DON B indicated medication in storage should be dated when opened, labeled with a resident's name, and expiration date, DON B stated expired medications should not be in use once expired.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285 Based on observation, interview and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect the total census of 52 residents. Residents (R) voiced concerns of food not being served at a desirable temperature (R32, R41, R46, and R28). 2 of 2 test trays were observed to not be served at desirable temperatures. Evidenced by: The facility policy, titled Food and Nutrition - Trayline Taste and Temperature Log Procedure, dated 10/15/24, includes in part: . The purpose of Menu Works Daily Service Patient/Resident Taste and Temperature Log is to monitor taste and temperatures on the service line for Patient/Resident food service . Standard Temperatures . Hot Entrees >= 140 degrees Fahrenheit . Hot Vegetables >= 140 degrees Fahrenheit . Hot soup, sauces, gravies, hot beverage and cereal >= 140 degrees Fahrenheit . Cold items <= 41 degrees Fahrenheit or less . Example 1 R32 admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/17/24 indicates R32 has a moderate cognitive impairment with a BIMS (Brief Interview of Mental Status) score of 11 out of 15. On 11/11/24 at 10:40 AM, Surveyor interviewed R32 who indicated that she usually eats in her room, and that the food is not hot enough. R32 stated that this morning breakfast was practically cold. Example 2 R41 admitted to the facility on [DATE]. His most recent MDS with an ARD of 10/8/24 indicates his cognition is intact with a BIMS score of 15 out of 15. On 11/11/24 at 2:16 PM, Surveyor interviewed R41 who indicated that he usually eats in his room and that the food is often not hot and needs to be warmed up by staff. Example 3 R46 admitted to the facility on [DATE]. Her most recent MDS with an ARD of 10/30/24 indicates her cognition is intact with a BIMS score of 13 out of 15. On 11/11/24 at 2:33 PM, Surveyor interviewed R46 who indicated that she usually eats in the dining room. R46 stated that this morning the eggs were cold, and the bacon was so hard she couldn't bite into it. R46 stated that the food comes with covers on, but it doesn't keep the food warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 4 R28 admitted to the facility on [DATE]. Her most recent MDS with an ARD of 10/1/24 indicates her cognition is intact with a BIMS score of 15 out of 15. On 11/11/24 at 2:47 PM, Surveyor interviewed R28 who indicated that she usually eats in her room. R28 indicated that the food is not always hot, especially breakfast, which is typically not as hot as it should be. R28 stated that breakfast is the first meal of the day and it's important to have something hot to give you the energy you need to get going. Example 5 On 11/12/24 at 9:29 AM, Surveyor received a test tray most of the dining room trays had been served, (there were 6 trays remaining on the dining room cart). Of note, the plates for the room trays and dining room are set on plate warmers and are covered by either a thin plastic cover that has a hole in the top center of it, or a solid plastic cover. Surveyor took the temperatures of the food that was served, including a breakfast sandwich with poached egg, ham slice and provolone cheese on a croissant, oatmeal, hashbrowns, diced peaches, and orange juice. Surveyor noted that all the items were in the temperature danger zone. The temperatures were as follows: poached egg 107.8 degrees Fahrenheit (F), ham slice 107.4 degrees F, hashbrowns 100.9 degrees F, oatmeal 114.6 degrees F, diced peaches 60.8 degrees F, orange juice 61.9 degrees F. The provolone cheese on the breakfast sandwich appeared to have melted and then hardened again, the croissant was soggy in the middle and hard on the outside, the oatmeal was congealed in the center with a ring of water around it in the bowl and the orange juice appeared to have separated in the glass. This test tray was not palatable. Example 6 On 11/14/24 at 11:40 AM, Surveyor received a test tray after all the hall trays had been delivered. Surveyor took the temperatures of the food that was served, including rice with tomatoes and spinach, peas, roast pork with gravy, mixed fruit, milk, coffee, and peach crisp. Surveyor noted that many of the items were not at the appropriate temperatures, including rice with tomatoes and spinach at 130.6 degrees F, peas at 112.3 degrees F, roast pork with gravy at 117.5 degrees F, mixed fruit at 58.6 degrees F and milk at 43.3 degrees F. This test tray was not palatable. On 11/14/24 at 11:48 AM, Surveyor interviewed ADFN E (Associate Director of Food and Nutrition). ADFN E stated that the inpatient rooms at the hospital are served first, then the residents in the community. ADFN E stated that she has noticed that the trays will sit on the carts waiting for the residents to come into the dining room, which can sometimes be a long time. Surveyor asked ADFN E if she would expect the food that is served, even at the end of meal service, to be at the desired temperatures. ADFN E replied yes, that would be her expectation. ADFN stated that she knew that cold food was a concern.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992 Based on observation, interview, and record review the facility did not provide food that accommodates resident preferences; appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice for 1 of 1 sampled resident's (R36). R36 was not being served the menu items of their preferences or offered appealing options of similar nutritive value. As evidenced by The facility policy, Food and Nutrition-Patient Menus Selections Procedure, revised 10/15/24, documents in part, as follows: Purpose statement: Patient food preferences are respected, and appropriate dietary substitutions are made. Develops an alternative menu, which is a list of standard options which the Food Service Associate can offer within the limits of the diet order. Contact Food and Nutrition Services upon receiving patient request for alternate/additional food or when patient has refused food served. R36 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dysphagia, cerebral infarction (stroke), diabetes mellitus type 2, and vascular dementia. R36 has an APOAHC (Activated Power of Attorney for Health Care). R36's comprehensive care plan, dated 5/24/21, indicates, in part, as follows: Monitor me for any increased difficulty with my chewing and/or swallowing ability. R36 care plan documents he receives a Level 6 Diet. On 11/8/24 R36's Dietary Assessment documents the following: Resident is currently on a General with IDDSI (International Dysphagia Diet Standardization Initiative): Diet: Level 6 foods - Soft & bite sized with bread products allowed, and Level 0 liquids-Thin. Divided plate with Dycem mat and No straws. Supplements: 240 ml Ensure Plus High Protein BID (Twice a day) Involuntary weight loss of 10% in 6 months. Nutrition Interventions: Medical food supplements added Ensure Plus BID at 1000 and 1900 to help stop weight loss. Writer is also monitoring food intake, fluid intake, weights, skin integrity, tolerance to mechanically altered diet, tolerance of nutritional supplement (Ensure Plus). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Will proceed. The plan is to revise/update care plan long term placement so we will Continue with current nutritional interventions, with the addition of Scheduled nutritional supplement. Ensure Plus at 1000 and 1900 to help stop weight loss, and we will Encourage fluids with each encounter, and MDS (Minimum Data Set) completed. On 11/11/24 at breakfast ST C (Speech Therapist) screened R36 and made the following recommendation that was entered into ECS (Electronic Charting System) at 12:15 PM: Would suggest diet downgrade to IDDSI level 4 pureed solids. Oatmeal is ok. If resident continues to request more solid foods with absent dietician, ST intervention is warranted to address safe texture/solids in a case-by-case basis. On 11/13/24 at 12:06 PM, Activity Lead-Patient Care Support D, asked R36 if he would like mashed potatoes and gravy to eat as his tray was not delivered. R36 stated, yes. Activity Lead-Patient Care Support D asked R36 if he would like shepherd's pie. R36 stated, no. Activity Lead-Patient Care Support D, did not offer any other main meal or protein options to R36. On 11/13/24 at 12:18 PM, Surveyor observed Dietary staff bring a tray to the dining room for R36 with 1 scoop of mashed potatoes with gravy, lemon pudding, pureed pineapple, and milk. R36 ate 100% of the mashed potatoes with gravy and lemon pudding. R36 did not eat the pureed pineapple. On 11/14/24 Surveyor attempted to speak with Activity Lead-Patient Care Support D, however, she was not available. On 11/14/24 at 11:50 AM, Surveyor spoke with DON B (Director of Nursing) Surveyor asked DON B, if a resident declines the main meal being served what should staff do. DON B stated, they should offer the resident the always available menu for other options available. Surveyor shared the observation above with DON B. Surveyor asked DON B, what is your expectation for Activity Lead-Patient Care Support D's next steps. DON B stated, she should have offered the always available menu to R36 for additional options available.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50285 Based on observation, interview and record review, the facility did not store and prepare food in accordance with professional standards for food service safety. This has the potential to affect all 52 residents. Surveyor observed items opened and undated in the refrigerators and coolers. Surveyor observed food items unsealed and/or unmarked in the freezers. Surveyor observed boxes stored on the floor of the freezer. Surveyor observed the facility's meat slicer to be stored uncovered and mixer to be unclean. Surveyor observed a scoop in the powdered sugar container in the food preparation area. Surveyor observed dietary staff touch dirty dishes and then ready to eat food items without performing hand hygiene. Evidenced by: Example: Opened and undated items Facility policy, entitled Food and Nutrition - Food Handling Guidelines dated 6/20/22 states in part, . Food is handled using Hazard Analysis and Critical Control Point (HACCP) process in accordance with regulatory guidelines. Proper handling procedures and techniques are visually monitored on an ongoing basis . On 11/11/24 at 9:03 AM, during initial tour of the kitchen, Surveyor observed items opened and not dated in the facility's refrigerators and coolers, including lettuce, breadcrumbs, grapes, cucumbers, blueberries, and cartons of milk. Surveyor interviewed ADFN E (Associate Director of Food and Nutrition) who indicated that the produce was undated because it would be used next. Surveyor asked ADFN E if those items would be used within the next 24 hours. ADFN E stated that she wasn't sure. Surveyor asked ADFN E how long milk was good for after it was opened. ADFN E replied that milk was good until the expiration date on the carton. Example: Unsealed and unmarked items On 11/11/24 during initial tour of the kitchen, Surveyor observed items opened and not sealed in the facility's freezer, including pound cake, angel food cake, green beans, peas, hamburger patties, chicken strips and chicken patties. Surveyor interviewed ADFN E and asked if items should be properly sealed or tied closed once they are opened in the freezer. ADFN E agreed that they should be closed properly to prevent freezer burn. Example: Food improperly stored (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/11/24 during initial tour of the kitchen, Surveyor observed several boxes of food sitting on the freezer floor. Surveyor interviewed ADFN E who stated they were not supposed to be sitting on the floor but that they were working with a skeleton crew over the weekend. Example: Meat slicer and mixer On 11/11/24 during initial tour of the kitchen, Surveyor observed the facility's meat slicer stored uncovered in the kitchen, with the blades and other parts stored on a rolling cart, also uncovered. Surveyor interviewed ADFN E who stated she was unaware that it needed to be covered. On 11/11/24 during initial tour of the kitchen, Surveyor observed the facility's mixer to have dried food on various parts of the mixer. ADFN E stated she had not noticed that and thanked Surveyor for helping her see areas of the kitchen that needed improvement. Example: Scoop in the food On 11/11/24 during initial tour of the kitchen, Surveyor observed a scoop in the powdered sugar bin in the food preparation area. ADFN E indicated that the scoop should not be stored in the food. Example: Unclean hands/Hand hygiene Facility policy, entitled Hand Hygiene Policy, dated 9/23/24, includes in part: . The purpose of this policy is to ensure . staff is aware of the principles and practice of good hand hygiene. Transmission of microorganisms can easily occur via the contaminated hands of HCWs (Healthcare Workers) . On 11/12/24 at 9:05 AM, Surveyor observed CNA T (Certified Nursing Assistant) bring a resident into the dining room and begin feeding him without putting on gloves or performing hand hygiene. On 11/12/24 at 9:39 AM, Surveyor interviewed CNA T and asked her if she would have done anything differently regarding hand hygiene during dining service. CNA T replied that she should have performed hand hygiene, using the wipes provided on the table, before starting to assist the resident with feeding. On 11/12/24 at 9:13 AM, Surveyor observed DA P (Dietary Aide) picking up dirty trays and dishes in the dining room. Surveyor observed DA P then go to the kitchenette and touch the bread to make a resident some toast without washing hands or performing hand hygiene. On 11/12/24 at 9:17 AM, Surveyor interviewed DA P and asked him if he would have done anything differently regarding hand hygiene during dining service. DA P stated that he would not. Surveyor asked DA P if he performed hand hygiene after he touched the dirty plates and before he touched the bread. DA P replied that he had done hand hygiene and that he always does hand hygiene. (Of note, two Surveyors observed DA P picking up dirty dishes and then touching the bread without performing hand hygiene.)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50228 Based on interview and record review, the facility did not ensure accurate reporting of the mandatory submission of staffing information based on payroll data to the Centers for Medicare & Medicaid Services (CMS). This has the potential to affect all 52 residents residing within the facility. The facility failed to enter accurate data in their Payroll Based Journal (PBJ) reporting and triggered for one fiscal year quarter for one star staffing rating, excessively low weekend staffing, no RN hours, and failure to have licensed nursing coverage 24 hours a day. Evidenced by: The facility's Payroll Based Journal Entry Procedure policy, dated 11/15/24, states, in part: . 3.6 Data submission will be verified for accuracy prior to the reporting deadline by the designated HSM (Hillside Manor) scheduler/employee. a. Prior to the deadline for quarterly submission, the administrator will verify the data uploaded into the PBJ is accurate and complete. The CMS PBJ Staffing Data Report for fiscal year quarter 3 2024 (April 1-June 30), includes: No RN Hours. Infraction dates: 4/6, 4/7, 4/17, 5/4, 5/5, 5/16, 5/18, 5/19, 5/25, 5/26, 5/27. The CMS PBJ Staffing Data Report for fiscal year quarter 3 2024 (April 1-June 30), includes: Failed to have Licensed Nursing Coverage 24 Hours/Day. Infraction dates: 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28, 5/29, 5/30, 5/31. On 11/14/24 at 11:59 AM, Surveyor observed the facility staffing postings and nursing schedules for April and May 2024. Each day had at least 8 hours of RN coverage and 24 hours/day licensed nursing coverage. On 11/14/24 at 12:34 PM, Surveyor interviewed NS L (Nurse Scheduler) and DON B (Director of Nursing). NS L indicated she is responsible for completing the PBJ reporting. NS L indicated that the process for gathering and transmitting data had not been changed for April and May. NS L indicated that CMS was contacted when the error was noted, and facility was told that CMS had received a file, but the data was invalid. DON B indicated the data may have been encrypted or sent with the wrong file type. DON B indicated that the cause of the issue was still unknown to the facility, but facility was working on processes to ensure proper reporting. DON B stated she did expect facility to submit accurate data.