STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525461	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Glacier Valley	1900 American Eagle Dr Slinger, WI 53086

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on observation, staff and resident interview, and record review, the facility did not ensure a call light was within reach for 1 resident (R) (R1) of 25 sampled residents. R1 was dependent on staff for mobility and other cares. During an observation on 11/10/24, R1's call light was not within reach. Findings include: From 11/10/24 to 11/12/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including traumatic brain injury (TBI), non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, pain, and dysphagia (difficulty swallowing). R1's Minimum Data Set (MDS) assessment, dated 10/18/24, had a Brief Interview for Mental Status (BIMs) score of 15 out of 15 which indicated R1 was not cognitively impaired. The MDS indicated R1 was dependent on staff for mobility and transfers. R1 had alteration in vision due to a TBI. R1 was legally blind and relied on staff to help with items R1 needed. R1's plan of care indicated staff should to explain to R1 where R1 could feel for the call light when clipped near R1, explain where R1's fluid cup was, and keep and explain where R1's phone was so R1 could access the phone on R1's own. A behavior symptoms care plan contained an intervention, dated 12/28/17, to familiarize R1 with new staff and familiarize new staff with R1 and R1's routine. On 11/10/24 at 6:51 PM, Surveyor entered R1's room and was told by R1's roommate (R54) that R1 needed R1's phone. Surveyor observed R1 in a Broda chair at the foot of R1's bed. Surveyor noted R1's phone was on the night stand which was next to the head of the bed. R1's call light pad was also on the nightstand. R1 confirmed R1 could not reach the phone or the call light. Surveyor had to step over a garbage can to get to the night stand which was approximately three feet from R1's Broda chair. R1 indicated staff usually clipped the call light to R1's pants and stated, He (staff) didn't give it (call light) to me. Surveyor noted a male agency Certified Nursing Assistant (CNA) (CNA-Y) was assigned to R1's wing with a female CNA (CNA-CC). Upon Surveyor's request, CNA-CC provided R1 with the phone and call light. On 11/10/24 at 6:57 PM, Surveyor interviewed CNA-CC who confirmed R1 could not reach the call light on R1's own. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/10/24 at 8:58 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated CNA-Y was an agency staff and believed it was CNA-Y's first time working in the facility. NHA-A confirmed call lights should be within reach of residents.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure a grievance was thoroughly investigated and resolution was provided for 1 resident (R) (R7) of 25 sampled residents. R7 told staff that R7 was missing items from laundry. Staff did not follow the facility's grievance process or follow-up with R7. Findings include: The facility's Missing Items policy, with a review date of 6/9/23, indicates: .5. When personal items are missing, the resident/responsible party is responsible to inform staff immediately and will complete a complaint/grievance form. From 11/10/24 to 11/12/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and muscle weakness (generalized). R7's Minimum Data Set (MDS) assessment, dated 9/11/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R7 was not cognitively impaired. On 11/10/24 at 12:05 PM, Surveyor interviewed R7 who indicated R7 was missing a purple cat T-shirt and a blanket with polka dots. R7 indicated the items were meaningful to R7 because the cat T-shirt reminded R7 of R7's cats whom R7 missed and the blanket was given to R7 by a friend. R7 indicated R7 told staff about the missing items a couple of weeks ago. R7 indicated staff wrote a note and indicated they would give it to the laundry supervisor, however, R7 had not heard anything yet. On 11/11/24 at 12:55 PM, Surveyor interviewed Laundry Supervisor (LS)-X who indicated LS-X was new to the facility and still learning. LS-X indicated that since LS-X had started, LS-X had not seen any grievances for missing clothing. LS-X was not aware that R7 was missing anything and had not received a note regarding R7's missing items. LS-X showed Surveyor a cart that contained missing items and said residents and families can search through the items if they are missing anything. On 11/11/24 at 1:04 PM, Surveyor interviewed Laundry Aid (LA)-W who delivered laundry in the facility. LA-W indicated LA-W had not heard that R7 was missing clothing but thought LA-W saw a blanket with polka dots. LA-W and Surveyor checked the lost and found but did not find the blanket. LA-W pointed to a yellow sticky note pinned to the bulletin board in the laundry room and indicated if residents are missing items, staff write a note and put it on the bulletin board. LA-W indicated LA-W had not seen a grievance form and had not filled out a grievance form for missing laundry. On 11/11/24 at 1:58 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware R7 was missing items from laundry. NHA-A indicated R7 had a lot of belongings and still had belongings at a previous facility. NHA-A indicated if NHA-A had been aware of R7's missing items, NHA-A would have first checked R7's inventory to see if the items were logged on the inventory sheet. NHA-A then would have searched laundry. NHA-A confirmed a grievance form should be filled out for missing laundry items. NHA-A indicated Social Worker (SW)-V was the facility's Grievance Officer. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/24 at 2:22 PM, Surveyor interviewed SW-V who was not aware that R7 was missing any items. SW-V indicated that not all of R7's belongings came with R7 from a previous facility. SW-V checked R7's inventory log which did not contain the specified items. SW-V indicated there was not much on R7's inventory log, however, R7 ordered items online and a few inventory sheets contained R7's online orders. SW-V indicated if SW-V had been aware of R7's missing items, SW-V would have done a room search (with R7's permission), searched laundry, determined if the missing items required a self-report or a grievance form, and would have called R7's family members to see if they took the items home. SW-V indicated all grievances go through SW-V so they can be distributed to the correct departments for follow-up. Surveyor informed SW-V that laundry staff indicated they do not see grievances, do not fill out grievance forms when they hear about missing items, and that Certified Nursing Assistants (CNAs) write notes and put them in the laundry area if a resident is missing an item. SW-V indicated missing items should be turned into grievances so SW-V can track them and provide follow-up. On 11/12/24 at 11:25 AM, Surveyor interviewed Med Tech (MT)-T who indicated R7 told MT-T about a week and a half ago that R7 was missing a T-shirt and a polka dot blanket. MT-T indicated MT-T wrote a note and gave it to the supervisor on duty. On 11/12/24 at 3:32 PM, Surveyor interviewed NHA-A and informed NHA-A that staff knew about R7's missing items but the information was not received by laundry staff. NHA-A confirmed a grievance should have been completed for R7's missing items.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42423 Based on observation, staff and resident interview, and record review, the facility did not ensure 6 residents (R) (R11, R17, R50, R12, R30, and R26) of 25 sampled residents who required the assistance of staff for activities of daily living (ADLs) were provided care in a timely and consistent manner. On 11/10/24, R11 activated R11's call light for assistance to bed. Certified Nursing Assistant (CNA)-Y turned off the call light and left the room without assisting R11. On 11/10/24, R17 activated R17's call light for assistance to bed. CNA-Z turned off the call light and left the room without assisting R17. On 11/10/24, R50 activated R50's call light for an evening snack. Licensed Practical Nurse (LPN)-F turned off the call light without providing a snack. R12 stated call light response times were lengthy and R12 was not given a bedpan or a bed change when requested. R30 was not given a bedpan or provided assistance to the toilet in a timely manner. R26 did not receive scheduled showers on a consistent basis. Findings include: The facility's Staff Education Policies/Procedures Competency: Showers, with a revision date of 7/1/13, contained sign-offs for the following areas: 1. Encourages participation where appropriate .12. Document appropriately. The facility did not provide a shower/bathing policy. 1. From 11/10/24 to 11/12/24, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), cervical spondylosis (painful condition of the spine due to degeneration), chronic obstructive pulmonary disease (COPD), stage 4 chronic kidney disease, and venous insufficiency. R11's Minimum Data Set (MDS) assessment, dated 10/10/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R11 was not cognitively impaired. The MDS indicated R11 required substantial/maximal assistance of staff for transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/24 at 6:40 PM, Surveyor observed R11 enter the hallway from R11's room via wheelchair. R11 was visibly upset and stated, For cripes sake, he turned my light off and said he needs to find a lift, but the lift is sitting right there. Surveyor noted a mechanical lift in the hallway near R11's room. R11 explained to Surveyor that a male CNA had entered R11's room, turned off the call light which R11 had activated for assistance, and then went to help a resident across the hall and did not return. R11 indicated the lift R11 needed to transfer had been sitting in the same spot for 15 minutes but that was the excuse why R11 was not assisted. R11 stated, I am not dumb. R11's roommate (R57) then exited the room and stated to CNA-Y, You guys need to realize when they (residents) turn their lights on it is because they need someone to help them and you should not turn it (call light) off. R11 indicated call lights are frequently turned off and cares are not provided timely on the weekends. On 11/10/24 at 6:47 PM, Surveyor interviewed CNA-Y who confirmed CNA-Y turned off R11's call light even though CNA-Y did not provide R11 assistance. CNA-Y indicated CNA-Y needed another staff to assist with R11's transfer and another staff was not available. 2. From 11/10/24 to 11/12/24, Surveyor reviewed R17's medical record. R17 was admitted to the facility on [DATE] and had diagnoses including COPD, pressure injury, muscle weakness, insomnia, and obstructive sleep apnea. R17 received Hospice services. R17's MDS assessment, dated 10/28/24, had a BIMS score of 14 out of 15 which indicated R17 was not cognitively impaired. The MDS indicated R17 was dependent on staff for transfers. On 11/10/24 at 7:20 PM, Surveyor noted R17's call light was activated. Surveyor interviewed R17 who was sitting in a recliner and indicated R17 wanted to go to bed. R17 indicated the call light had been on for an hour now. On 11/10/24 at 7:21 PM, Surveyor observed CNA-Z turn off R17's call light and exit the room. Surveyor also observed CNA-Z turn off a call light across the hall and exit the room. Surveyor interviewed CNA-Z who confirmed CNA-Z turned off R17's call light without providing assistance and indicated CNA-Z needed to get a lift. Surveyor observed CNA-Z go to the 500 wing and start to move a lift in the hallway. As Surveyor walked in the opposite direction, CNA-Z stopped moving the lift and went to do something else. On 11/10/24 at 7:31 PM, Surveyor observed R17 still sitting in the recliner. R17's head was down and R17 appeared asleep. R17 had not been assisted to bed yet. 3. From 11/10/24 to 11/12/24, Surveyor reviewed R50's medical record. R50 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder and generalized anxiety disorder. R50's MDS assessment, dated 10/15/24, had a BIMS score of 12 out of 15 which indicated R50 had moderate cognitive impairment. On 11/10/24 at 7:23 PM, Surveyor observed LPN-F turn off R50's call light without providing assistance. Surveyor interviewed LPN-F who indicated R50 wanted a snack but LPN-F was an agency staff and did not know where the snacks were located. On 11/12/24 at 3:40 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed NHA-A expects staff to complete residents' requests before turning off their call lights. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43361 4. From 11/10/24 to 11/12/24, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had diagnoses including obesity, overactive bladder, chronic kidney disease (CKD), and chronic peripheral venous insufficiency. R12's MDS assessment, dated 8/23/24, had a BIMS score of 15 out of 15 which indicated R12 was not cognitively impaired. On 11/10/24 at 12:17 PM, Surveyor interviewed R12 about care at the facility. R12 stated call light response times ranged from ten minutes to one hour. R12 indicated R12 asked for a bedpan which an unnamed CNA would not provide. R12 stated R12 thought the refusal was cruel and inhuman treatment. R12 also indicated R12 asked staff to hold down a bed pan while R12 turned to get off the bed pan. R12 said the CNAs didn't do it which caused the bed pan to spill. R12 indicated sometimes staff didn't change R12's bedding and R12 had to lay on wet bedding for a half hour until night shift staff arrived. On 11/11/24 at 11:39 AM, Surveyor interviewed NHA-A who was not aware of the incidents and indicated NHA-A would start an investigation. 5. From 11/10/24 to 11/12/24, Surveyor reviewed R30's medical record. R30 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, chronic pain syndrome, diabetes type 2 with diabetic polyneuropathy, obesity, and anxiety. R30's MDS assessment, 8/21/24, had a BIMS score of 14 out of 15 which indicated R30 was not cognitively impaired. On 11/10/24 at 11:46 AM, Surveyor interviewed R30 regarding care at the facility. R30 stated an unnamed CNA on the PM shift refused to give R30 a bedpan which caused R30 to be incontinent of urine. R30 refused to name the CNA due to fear of retribution. On 11/10/24 at 2:46 PM, Surveyor observed a CNA enter R30's room and turn off the call light. The CNA did not toilet R30. On 11/10/24 at 3:36 PM, Surveyor interviewed R30 who indicated R30 needed assistance to the bathroom, but the CNA turned off the call light and left to get another staff and a lift. R30 indicated it was the fourth call R30 had made since 12:00 PM; the first and second calls were on the AM shift and the third and fourth calls were on the PM shift. R30 did not know the CNAs' names. R30 indicated R30 was incontinent of a small amount of urine due to the wait. R30 stated R30 felt like a second-class citizen. On 11/10/24 at 3:40 PM, Surveyor observed Medication Technician (MT)-T enter R30's room, ask about R30's concern, and turn off R30's call light to address another resident's fall. On 11/11/24 at 11:39 AM, Surveyor interviewed NHA-A who was not aware of the incident and indicated NHA-A would start an investigation. 6. From 11/10/24 to 11/12/24, Surveyor reviewed R26's medical record. R26 was admitted to the facility on [DATE] and had diagnoses including muscle weakness, difficulty in walking, unsteadiness on feet, and pain. R26's MDS assessment, dated 11/8/24, had a BIMS score of 14 out of 15 which indicated R26 was not cognitively impaired. The MDS assessment indicated R26 was dependent on staff for showering/bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/24 at 12:44 PM, Surveyor interviewed R26 who indicated R26 was supposed to receive two showers per week but did not consistently receive them. On 11/11/24, Surveyor requested R26's shower documentation for the past three months. Surveyor received R26's shower documentation which was in the form of weekly skin checks (some did not state that R26 had a shower) and shower sheets that were not consistently completed and didn't always indicate if R26 had a shower or a bed bath. Surveyor also reviewed R26's medical record which contained inconsistent bathing documentation. R26's progress notes sometimes indicated whether R26 received a shower or bed bath or refused. Documentation indicated showers were given or refused on 10 of 26 opportunities since 8/1/24. The other missed documentation showed the following: ~ A weekly skin assessment on 8/1/24 did not note if a shower was given. ~ R26 received a bed bath on 8/15/24 but staff did not document if R26 refused a shower. ~ A progress note, dated 8/23/24, indicated R26's Power of Attorney for Healthcare (POAHC) was updated on R26's new schedule for twice weekly showers on Wednesdays and Saturdays. ~ Documentation indicated R26 received a partial bed bath on 8/24/24 but did not indicate if R26 refused a shower. ~ Documentation indicated R26 received a bed bath on 9/4/24 but did not indicate if R26 refused a shower. ~ A weekly skin assessment on 9/11/24 did not indicate if R26 had a shower. ~ A shower sheet, dated 9/21/24, was checked bath/shower; however the area that indicated if R26 received a bed bath or shower was not filled out. ~ A shower sheet, dated 9/28/24, was signed by the nurse but was not filled out. ~ A weekly skin assessment, dated 10/5/24, was completed but did not indicate if R26 had a shower. ~ A shower sheet, dated 10/9/24, was signed by the nurse but was not filled out. ~ There was no documentation on 10/16/24 or 10/19/24. ~ A bed bath was documented on 10/23/24 but did not indicate if R26 refused a shower. ~ There was no documentation on 10/26/24, 10/30/24, 11/2/24, or 11/6/24. On 11/11/24 at 4:04 PM, Surveyor interviewed CNA-O who showed Surveyor the shower schedule. Surveyor noted R26 was on the schedule on Wednesday and Saturday. CNA-O indicated shower sheets should be filled out and showers should be documented in residents' medical records. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 3:32 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated showers were a problem for awhile but the facility had been working to restructure them. DON-B indicated DON-B expects CNA staff to complete shower sheets and nurses to complete weekly skin observations in residents' medical records. DON-B indicated audits were being done to ensure weekly skin observations were being completed. DON-B confirmed shower sheets should be filled out completely and refusals should be documented. DON-B indicated the facility was going trial a shower aid the following week.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff, resident and family interview, and record review, the facility did not ensure 3 residents (R) (R67, R17 and R1) of 5 sampled residents reviewed for pressure injuries received the necessary care and services to promote healing and/or prevent pressure injuries from developing. R67 had a pressure injury on the right heel. R67 did not have interventions in place that were recommended by the wound care provider. In addition, R67's care plan did not contain the wound care provider's recommendations. R17 developed a pressure injury from oxygen tubing that was not padded. R1 had a self determination care plan that indicated R1 chose to have a urinal propped against R1's scrotal area. R1's care plan did not contain an intervention to monitor for or prevent potential skin injury to R1's scrotal area. Findings include: The facility's Wound care Policies and Procedures, with a revision date of 6/1/15, indicates: Evaluation is the formal process in which wound characteristics, underlying conditions and contributory medical history are identified/quantified. Evaluation should result in treatment approaches including elimination or compensation for causative factors and a prognosis for healing. 3. Evaluation results are communicated to the members of the care team through documentation, care plan meetings, and care planning. The National Pressure Injury Advisory Panel released the 2nd version (6/23) of the Standardized Pressure Injury Prevention Protocol Checklist (SPIPP-Adult) 2.0 which directs the care provider to: Assess risk factors for pressure injury to guide risk-based prevention: .Use a structured assessment approach (e.g. Braden or other validated risk tool) on admission; Reassess risk every shift and with significant change in condition; Patient/family informed of pressure injury risk and prevention plan; Assess skin/tissue for signs of skin damage and pressure injury; Assess skin (comprehensive, visual, palpation) upon admission and every shift for erythema, discoloration, edema, and temperature; Assess skin under medical devices every shift; Inspect heels every shift. 1. From 11/11/24 to 11/12/24, Surveyor reviewed R67's medical record. R67 was admitted to the facility on [DATE] and had diagnoses including dementia and a stage 2 pressure injury to the right heel. R67's Minimum Data Set (MDS) assessment, dated 8/4/24, indicated R67 was severely cognitively impaired. On 11/10/24 at 11:44 AM, Surveyor observed R67 sleeping in a wheelchair in R67's room with shoes on. Surveyor noted heel boots on R67's bed. R67's medical record indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A care plan, initiated on 9/18/24, indicated R67 had a pressure injury on the right posterior ankle related to immobility, pain, diabetes mellitus type 2, anemia, and muscle weakness. The care plan contained an intervention (initiated on 9/18/24) to use pressure relieving boots to relieve pressure on the heels. ~ A wound note, dated 11/5/24, indicated R67 was seen by the wound care team and wound Nurse Practitioner (NP). R67 had a right posterior ankle wound. The wound bed was yellow with no drainage. The note indicated the wound could be left open to air with no shoe on the right foot. An order for Betadine 3 times per week was initiated. ~ A wound note, dated 11/12/24, indicated to protect R67's heels with 2-3 pillows/offloading boots. The note indicated the wound could be left open to air with no shoe on the right foot. On 11/11/24 at 12:01 PM, Surveyor observed R67 in the dining room in a Broda chair with shoes on. R67 was not wearing heel boots. On 11/11/24 at 4:02 PM, Surveyor observed R67 in the lobby with shoes on. R67 was not wearing heel boots. On 11/12/24 at 11:35 AM, Surveyor interviewed Medication Technician (MT)-T who indicated R67 usually wore shoes during the day and wore heel boots when R67 was in bed. On 11/12/24 at 12:32 PM, Surveyor interviewed Registered Nurse (RN)-U who did wound rounds with the wound care provider. Surveyor informed RN-U of Surveyor's observations of a shoe on R67's right foot and no heel boots. Surveyor also informed RN-U that R67's care plan did not indicate that R67 should not wear a shoe on the right foot. RN-U confirmed wound care provider interventions should be added to care plans and communicated to staff. RN-U confirmed R67 should not have been wearing a shoe on the right foot and should have had heel boots on. 45943 2. From 11/10/24 to 11/12/24, Surveyor reviewed R17's medical record. R17 received Hospice services and had diagnoses including chronic obstructive pulmonay disease (COPD), congestive heart failure (CHF), chronic kidney disease (CKD) stage 3, and recurrent and persistent hematuria (blood in the urine). A Braden scale assessment, dated 11/10/24, had a score of 14 which indicated R17 was at moderate risk for pressure injury development. R17 had a physician's order for 1-6 liters per minute (LPM) of oxygen per nasal cannula. On 11/10/24 at 10:38 AM, Surveyor observed R17 receiving oxygen at 2 liters per nasal cannula via a concentrator. Surveyor observed redness and irritation behind R17's left ear under the unpadded oxygen tubing. Surveyor interviewed R17 who indicated staff had looked at R17's ear but did nothing about it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R17's skin assessments through 11/6/24 and noted the skin assessments did not contain documentation of redness or irritation behind R17's ear. A skin assessment, dated 11/10/24, documented a new reddened area behind the top of R17's left ear due to pressure from R17's oxygen tubing. Surveyor noted R17's care plan, dated 4/4/23, did not contain an intervention to inspect behind R17's ears due to the oxygen tubing. On 11/12/24 at 10:43 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated if a resident is on oxygen staff should check placement of the oxygen tubing and assess skin integrity every shift. DON-B indicated staff should also ensure the oxygen tubing does not have kinks and provides appropriate airflow. DON-B indicated if there is irritation behind a resident's ear, staff should initiate some kind of protection such as foam ear protectors. 42423 3. From 11/10/24 to 11/12/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including traumatic brain injury (TBI), non-pressure chronic ulcer of skin of other sites limited to breakdown of skin, pain, and dysphagia (difficulty swallowing). R1's MDS assessment, dated 10/18/24, had a Brief Interview for Mental Status (BIMs) score of 15 out of 15 which indicated R1 was not cognitively impaired. The MDS also indicated R1 was dependent on staff for mobility and transfers. On 11/11/24 at 9:40 AM, Surveyor interviewed R1's Power of Attorney (POA-J) who indicated R1's Family Member (FM-K) visualized R1's skin (including R1's scrotal area) over the weekend and noted an area below the penis that looked reddened and ring-like. (According to the facility's visitor login, FM-K visited R1 on 11/9/24 from 11:48 AM to 1:41 PM.) POA-J also indicated a nurse told POA-J that a urinal was being left underneath R1's perineal area so R1 did not get wet (from urine). R1 was present at the time of the conversation and stated staff remove the urinal after R1 urinates, empty the urinal, and then put it back. POA-J indicated FM-K spoke with Registered Nurse (RN)-E and told RN-E to stop placing the urinal between R1's legs because it was causing a sore to the penile area. On 11/11/24 at 11:45 AM, Surveyor interviewed POA-J and DON-B. DON-B indicated placing the urinal between R1's legs was care planned as a request from R1. DON-B indicated staff completed skin checks regularly for R1. DON-B indicated DON-B was unaware of a reddened area on R1's penis and would check R1's medical record. On 11/11/24 at 1:30 PM, DON-B provided Surveyor with R1's self-determination care plan that indicated: Problem: R1 prefers to have urinal placed/propped between legs whenever uses urinal and at bedtime. Approach: Education provided in regards to skin integrity as R1 wishes to have the urinal placed/propped between legs at night. Long Term Target Date: 10/1/24, Skin integrity will remain intact. An evaluation note on the care plan indicated: 2/21/23, Seen by wound care NP (Nurse Practitioner)-L. NP-L was concerned about high risk of developing pressure injury to the scrotum/penis due to preference of urinal placement. R1 understood and stated R1 knows the risks of developing a pressure injury. R1 prefers to keep urinal placed between R1's leg while in bed. Last reviewed/revised: 7/8/24 by Assistant Director of Nursing (ADON)-M. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 10:13 AM, DON-B informed Surveyor that ADON-M assessed R1's skin on 11/11/24 after DON-B was notified of R1's perineal area and noted no reddened areas or sores to R1's scrotum. DON-B indicated R1 had a treatment order for buttock areas on the wound log (initiated on 11/7/24). On 11/12/24 at 12:52 PM, Surveyor interviewed RN-E who indicated RN-E worked regularly on R1's unit but was not aware of a sorer on R1's penis. RN-E indicated RN-E worked the 11/3/24 night shift into the morning of 11/4/24. As recent as that shift, RN-E indicated R1 demanded the urinal be placed between R1's legs. RN-E indicated R1's regularly-scheduled Certified Nursing Assistants (CNAs) placed the urinal between R1's legs per R1's request. RN-E indicated if staff do not place the urinal between R1's legs or if there is a new staff who is not aware of R1's request, R1 calls out repeatedly, activates R1's call light, and/or calls the nursing station by phone and demands the urinal be placed between R1's legs. RN-E indicated R1 wants the urinal there. RN-E indicated R1's regular CNAs know to check every two hours and empty the urinal. RN-E indicated FM-K told staff on 11/9/24 to stop putting the urinal between R1's legs. RN-E verified R1 did not request that staff stop placing the urinal between R1's legs. RN-E indicated R1 abides by R1's family's wishes for awhile and then goes back to what R1 wants. A skin check, dated 10/19/24, indicated R1's skin was checked by a CNA during a bath/shower and was also checked by Licensed Practical Nurse (LPN)-R. The skin check contained a body diagram with two small circles drawn on the front of the body below the stomach/top of groin. The comments section contained a hand-written note that indicated R1 had small red areas to the groin. A skin check, dated 10/22/24 with CNA and nurse signatures/initials, indicated R1 had no skin areas noted. An undated skin check form which was placed between the 10/22/24 skin check and the 11/3/24 skin check and signed by LPN-R contained a hand-written note in the comment section that indicated R1 had red areas on the groin. The body diagram contained the same marked areas as the 10/19/24 skin check. A Skin Focused Observation note, dated 10/27/24, indicated R1 had no new areas of concern, no open areas, and R1's buttocks were not red. A Skin Focused Observation note, dated 10/29/24, indicated R1 had no new skin issues. A Skin Focused Observation note, dated 11/1/24, indicated R1 had no new skin areas and a previous red area on the groin. Skin checks, dated 11/3/24 and 11/5/24, were signed by a nurse and a CNA and noted no marks on the diagram or comments related to skin areas. A Skin Focused Observation note, dated 11/5/24, contained no documentation related to the groin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition to the previously mentioned self-determination care plan, Surveyor reviewed an untitled care plan with a problem start date of 11/10/22 that indicated: R1 is at risk for skin breakdown related to a Braden score of 16, generalized weakness and need for staff to assist with repositioning, frequent incontinence, morbid obesity, high risk for shearing, contracture and tightening of joints, desire to hang on to items such as cell phone when in bed, rosacea, history of choric/recurring MASD (moisture-associated skin damage) under skin folds and between gluteal crease, redness of buttocks, lymphedema .R1 demands that a urinal be propped between legs when in bed with a pillow against it which pushes the urinal even tighter against R1's skin. If staff do not do this, R1 will keep calling the facility or yelling out for help until it is done. The care plan had a long term goal target date of 10/1/24 which was: R1 will have interventions to prevent skin breakdown. The care plan contained the following interventions: Assess R1's skin daily during bathing, especially over bony prominence; Licensed nurse to do a weekly skin check. The care plan did not contain an intervention to monitor for skin issues related to the urinal placement between R1's legs with the pillow against it which pushed the urinal tighter against R1's skin. On 11/12/24 at 2:02 PM, Surveyor interviewed LPN-D who indicated LPN-D gave R1 a shower that day. LPN-D indicated LPN-D did not observe any skin issues or reddened areas on R1's scrotum. LPN-D indicated R1 had small raised bumps on R1's lower abdomen approximately two weeks ago which were getting better. LPN-D indicated two scratched areas were observed on R1's coccyx on 11/7/24. LPN-D indicated LPN-D called POA-J with no answer, called FM-K with no answer, and called POA-J a second time and left a voicemail regarding the skin areas. LPN-D did not receive a return call. On 11/12/24 at 2:17 PM, Surveyor received R1's permission to view the area of concern. LPN-D and CNA-BB pulled R1's incontinence brief down and Surveyor observed two dark pink rings/creases on R1's scrotum. R1's skin was intact with no open areas. LPN-D indicated R1 used the bedpan, was incontinent at times, and wore a brief. LPN-D indicated LPN-D was not aware that R1 used a urinal. On 11/12/24 at 2:24 PM, Surveyor interviewed CNA-BB who indicated R1 requests staff prop a urinal on a towel and then notifies staff when R1 is finished urinating. When Surveyor asked about propping the urinal versus holding the urinal, CNA-BB indicated R1 prefers to have the urinal propped. CNA-BB indicated R1 asks staff to keep the urinal between R1's legs and usually calls staff shortly after. On 11/12/24 at 2:25 PM, Surveyor interviewed DON-B regarding the red marks on R1's scrotal area. DON-B indicated DON-B first heard about the red marks on 11/11/24 during the interview with POA-J and Surveyor. DON-B had ADON-M assess R1's skin which ADON-M indicated contained no open areas on the scrotum. DON-B also indicated R1's regular AM shift CNA (CNA-S) did not notice any red marks on 11/11/24. DON-B indicated R1 was reassessed after lunch on 11/12/24 and staff noted a u-shaped mark on R1's scrotal area. DON-B indicated RN-U obtained an order for zinc. DON-B indicated CNA-S told DON-B that R1 was placed on the urinal last night and CNA-S removed the urinal this morning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 2:37 PM, Surveyor interviewed ADON-M who indicated ADON-M viewed R1's skin that morning and noted two bright red creases which, upon reassessment after lunch, appeared diminished and pink (versus red). ADON-M noted the potential causes for the marks which included incontinence while sitting in R1's Broda chair and use of the urinal. ADON-B confirmed staff rest the urinal between R1's legs per R1's request. ADON-M was unsure if R1 made the request that day. ADON-M confirmed regular staff place the urinal between R1's legs and new staff learn to do it when R1 demands they place the urinal there. ADON-M indicated R1's medical record confirmed the risks were explained to R1 and indicated an order for zinc was requested. On 11/12/24 at 2:45 PM, Surveyor interviewed DON-B who confirmed R1's care plan did not include prevention and/or monitoring of the skin for damage due to R1's request of the urinal placement.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff and resident interview and record review, the facility did not ensure the appropriate care and services were provided to increase and/or prevent further decrease in range of motion for 3 residents (R) (R14, R6, and R7) of 3 sampled residents. R14 did not receive restorative therapy per therapy discharge recommendations. Staff did not correctly enter the recommendations in R14's medical record, therefore, R14's Minimum Data Set (MDS) assessment was not coded correctly. R6 did not consistently receive restorative therapy. R7 did not consistently receive range of motion (ROM) per R7's orders and care plan. Findings include: On 11/11/24, Surveyor requested the facility's policy for restorative services. The facility provided a training that was titled Restorative Nursing Program Quick Start from Fundamental Clinical and Operational Services, LLC 2024 which contained educational slides for the restorative nursing program (RNP). The training indicated: .Care planning: specific detail approaches, and periodic evaluation. Daily documentation 1. From 11/10/24 to 11/12/24, Surveyor reviewed R14's medical record. R14 was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and muscle weakness (generalized). R14's MDS assessment, dated 9/11/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R14 was not cognitively impaired. The MDS assessment indicated R14 did not have a restorative program but had limited ROM. On 11/10/24 at 12:05 PM, Surveyor interviewed R14 and noted an exercise sheet on R14's wall. When Surveyor asked if staff did exercises with R14, R14 said no and wondered if R14 should be doing them on R14's own. On 11/11/24 at 12:35 PM, Surveyor interviewed Occupational Therapist Registered (OTR)-Q who indicated R14 had a restorative program from 7/22/24 that was posted in R14's room. OTR-Q indicated R14 should be doing the exercises with staff. OTR-Q indicated when a resident is discharged from therapy, therapy provides a sheet with information with what should be done. OTR-Q indicated OTR-Q also trains staff and posts exercises in residents' rooms. OTR-Q provided Surveyor with R14's therapy communication form, dated 7/22/24, that indicated: 1. Range of motion program daily prior to donning right resting hand splint-see attached. 2. R14 to wear right resting hand splint at night, for 8 hours daily, or per R14's tolerance. 3. R14 may wear left wrist splint up to 4 hours during AM or PM as requested for left wrist pain. Surveyor noted the restorative program was not in R14's care plan. Surveyor also noted there was no documentation on R14's restorative program in R14's medical record. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/24 at 2:52 PM, Surveyor interviewed Minimum Data Set Coordinator (MDSC)-I who indicated MDSC-I was responsible for restorative therapy. MDSC-I indicated another nurse put in the the order for R14's restorative care when it was sent from therapy, however, the staff entered the order under R14's physician orders and did not attach it to R14's Medication Administration Record (MAR) or Treatment Administration Record (TAR). MDSC-I indicated the staff also did not add the order to R14's care plan or to the Certified Nursing Assistant (CNA) tasks in R14's medical record. MDSC-I confirmed those steps should have been taken so staff knew R14 had a restorative program that they should complete and document. Because staff did not document or complete restorative therapy for R14, MDSC-I indicated MDSC-I did not code R14's MDS correctly to indicate that R14 had a restorative program. 2. From 11/10/24 to 11/12/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including multiple sclerosis, muscle weakness, and abnormal posture. R6's MDS assessment, dated 8/21/24, had a BIMS score of 15 out of 15 which indicated R6 was not cognitively impaired. A care plan, dated 6/19/23, indicated R6 received passive range of motion (PROM) and active range of motion (AROM) and required splint brace assistance once per day. On 11/10/24 at 11:46 AM, Surveyor interviewed R6 and noted R6 was leaning in R6's chair and somewhat contracted. When asked if staff assisted R6 with exercises, R6 indicated sometimes they did. On 11/11/24 at 12:35 PM, Surveyor interviewed OTR-Q who confirmed R6 had a maintenance program for restorative therapy. OTR-Q provided Surveyor with a therapy communication form, dated 6/28/23, that indicated: PROM to left and right shoulder flexion. Elbow flexion/extension. Wrist flexion/extension and digit and thumb extension 11 reps. Bilateral lower extremity range of motion for ankle dorsiflexion, hip abduction, and knee extension 10 reps daily. OTR-Q also indicated splint assistance should be provided. Surveyor reviewed documentation on R6's restorative programming from 8/1/24 through 11/11/24 and noted the following: R6's Splint/Brace Assistance Restorative Program: In August 2024, there was no charting on 17 out of 31 days. In September 2024, there was no charting on 18 out of 30 days. In October 2024, there was no charting on 18 out of 31 days. In November 2024, there was no charting on 5 out of 10 days. R6's Active Range of Motion Restorative Program: In August 2024, there was no charting on 17 out of 31 days. In September 2024, there was no charting on 16 out of 30 days. In October 2024, there was no charting on 16 out of 31 days. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In November 2024, there was no charting on 5 out of 10 days. R6's Passive Range of Motion Restorative Program: In August 2024, there was no charting on 7 out of 31 days. In September 2024, there was no charting on 3 out of 30 days. In October 2024, there was no charting on 13 out of 31 days In November 2024, there was no charting on 4 out of 10 days. On 11/11/24 at 12:35 PM, Surveyor interviewed MDSC-I who confirmed staff should consistently document on restorative programs, including refusals. MDSC-I indicated MDSC-I used the information to code residents' MDS assessments accurately. 32768 3. From 11/10/24 to 11/12/24, Surveyor reviewed R7's medical record. R7 was admitted to facility on 6/30/15 and had diagnoses including multiple sclerosis, anxiety disorder, muscle weakness, abnormal posture, osteoporosis, and contracture of muscle and joint. R7's MDS assessment, dated 10/16/24, indicated R7 required substantial maximal assistance with bathing and upper dressing and was dependent on staff for toileting, lower dressing, and transfers. R7 had functional limitation with range of motion and impairment to the upper and lower extremities. A BIMS score indicated R7 was not cognitively impaired. A care plan, dated 10/16/23, indicated: Passive range of motion to bilateral lower extremities 4 to 7 days a week. dorsiflexion bilateral feet 2 times a day, toe passive range of motion 2 times a day, hip passive range of motion 2 times a day, lower trunk rotation, knee rocks 2 times a day, hip abduction/adduction 2 times a day. On 11/10/24 at 1:31 PM, Surveyor interviewed R7 who indicated staff were not doing R7's ROM anymore. R7 indicated ROM was supposed to be done in the morning and afternoon. R7 indicated there was only one CNA who assisted R7 with ROM. On 11/12/24, Surveyor reviewed R7's medical record for lower extremity ROM documentation from 8/1/24 to 11/11/24. The documentation was inconsistent and noted the following: On 8/1, 8/3, 8/4, 8/5, 8/6, 9/2. 9/10, 10/8, 10/13, 10/22, 10/27, 11/6, and 11/10, R7 missed both sessions. On 8/2, 8/9, 8/13, 8/16, 8/20, 8/27, 8/30, 8/31, 9/1, 9/4, 9/5, 9/8, 9/9, 9/14, 9/17, 9/22, 9/24, 10/7, 10/9, 10/11, 10/12, 10/14, 10/15, 10/18, 10/19, 10/20, 10/26, 10/28, 11/3, and 11/8, R7 missed 1 session On 11/12/24 at 12:22 PM, Surveyor interviewed MDSC-I who indicated if a resident's point of care history indicates ROM was not performed then ROM was not completed for that shift or day.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45943 Based on observation, staff interview, and record review, the facility did not provide the necessary care and services to prevent a urinary tract infection (UTI) for 1 resident (R) (R17) of 4 residents reviewed for catheter care. On 11/10/24, R17's uncovered catheter drainage bag was observed on the floor. Findings include: The facility's Catheter-Urinary Catheter, Cleaning and Maintenance Policy and Procedure taken from the Lippincott Nursing Procedures 9th edition (Copyright 2023 with complete revision: May 5, 2023) indicates: Don't place the drainage bag on the floor to reduce the risk of contamination and subsequent catheter-associated urinary tract infection (CAUTI). From 11/10/24 to 11/12/24, Surveyor reviewed R17's medical record. R17 received Hospice services and had diagnoses including chronic kidney disease (CKD) stage 3 and recurrent and persistent hematuria (blood in the urine). R17 had a physician order for an indwelling Foley catheter for acute urine retention (dated 10/18/24) and an order for a privacy bag in place every shift (dated 10/18/24). On 11/10/24 at 10:28 AM, Surveyor observed R17 in a recliner with catheter tubing that ran down R17's right pant leg and drained light clear yellow urine into an uncovered collection bag that was laying on the floor. On 11/10/24 at 10:53 AM, Surveyor interviewed Infection Preventionist (IP)-C who verified R17's uncovered catheter bag was on the floor. IP-C indicated the catheter bag should not touch the floor and should be covered for infection control and privacy. On 11/11/24 at 8:45 AM, Surveyor interviewed Registered Nurse (RN)-H who verified R17's uncovered catheter bag was secured to R17's bed frame. On 11/12/24 at 10:40 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed catheter drainage bags should be covered and not in contact with the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45943 Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R17) of 25 sampled residents received the necessary care and treatment related for oxygen therapy. During an observation on 11/10/24, R17's oxygen tubing did not contain a date or initials to indicate when the tubing was last changed. Findings include: The facility's Oxygen Administration policy, with a revision date of 2/12/24, indicates: Nasal Cannula: Change weekly, when soiled, and on an as needed basis or per state regulations. From 11/10/24 to 11/12/24, Surveyor reviewed R17's medical record. R17 received Hospice services and had diagnoses including chronic obstructive pulmonary disorder (COPD), congestive heart failure (CHF), and chronic kidney disease (CKD) stage 3. R17 had a physician order for 1-6 liters per minute (LPM) of oxygen via nasal cannula. The facility's general nursing orders, dated 7/29/24, indicated: Equipment Oxygen: Change oxygen tubing/nasal cannula/mast/humidification system weekly once a day on Tuesday from 10:00 PM to 6:00 AM. On 11/10/24 at 10:38 AM, Surveyor observed R17 using oxygen at 2 liters per nasal cannula via a concentrator. Surveyor noted the tubing was not labeled with initials or the date the tubing was last changed. On 11/12/24 at 10:43 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated nursing orders to change oxygen tubing are scheduled for the Sunday night (NOC) shift. DON-B indicated oxygen tubing should be labeled with the date and initials of the staff who changed the tubing. DON-B indicated improvement was anticipated because there was now more regular staff on the NOC shift.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 32768 Based on observation, staff and resident interview, and record review, the facility did not ensure sufficient staffing was provided to meet the needs of 5 residents (R) (R30, R11, R17, R50, and R26) of 25 sampled residents with the potential to affect additional residents. The facility had low staffing on 4/14/24, 5/11/24, 5/12/24, and 6/23/24. On 11/10/24, R30 activated R30's call light for assistance with toileting on multiple occasions. Staff turned off R30's call light without providing assistance. On 11/10/24, R11 activated R11's call light for assistance to bed. Certified Nursing Assistant (CNA)-Y turned off R11's call light and left the room without assisting R11. On 11/10/24, R17 activated R17's call light for assistance to bed. CNA-Z turned off R17's call light and left the room without assisting R17. On 11/10/24, R50 activated R50's call light for an evening snack. Licensed Practical Nurse (LPN)-F turned off R50's call light and left the room without providing a snack. R26 did not consistently receive scheduled showers. Findings include: The facility's Staffing Policy, dated 5/5/23, indicates: The facility will implement strategies to mitigate staffing shortages during times of illness, pandemic, or additional situations that may lead to decreased numbers of available staff. The facility will adjust staffing needs to include day, evening, and night shifts based on changes in the resident population .1. The facility will collaborate with Human Resources and regional personal to implement staffing strategies to mitigate staffing shortages in any department. 2. The facility will attempt to ascertain reasons or root causes for staff unavailability for work and address as practicable and able. Low Staffing: The facility calculates the number of CNAs and Registered Nurses (RNs) by the following formula: 3.08 times the census = total hours to schedule per day divided by 8 = number of staff to schedule per shift On 11/12/24, Surveyor reviewed the facility's staffing schedules from 4/1/24 to 6/30/24. Surveyor identified 4 weekend days in April, May, and June where the facility was low on staff. On 4/14/24, the facility had a census of 78 and required 240 staffing hours for the day. The facility had 199.8 hours scheduled and was down 4 CNAs due to call-ins and/or no-shows. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/11/24, the facility had a census of 73 and required 224 staffing hours for the day. The facility had 186.4 hours scheduled and was down 4 CNAs due to call-ins and/or no-shows. On 5/12/24, the facility had a census of 72 and required 221 staffing hours for the day. The facility had 201.8 hours scheduled and was down 3 CNAs due to call-ins and/or no-shows. On 6/23/24, the facility had a census of 77 and required 237 staffing hours for the day. The facility had 192.5 hours scheduled and was down 2 CNAs due to call-ins and/or no-shows. On 11/12/24 at 3:08 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility had low staffing on the above mentioned days and couldn't get coverage. NHA-A indicated the facility tries to call agency, other staff, or have nurse managers cover, but they couldn't find anyone on those days. Call Lights: On 11/10/24 (Sunday) at 2:46 PM, Surveyor observed a CNA enter R30's room, turn off the call light, and exit the room. On 11/10/24 at 3:36 PM, Surveyor interviewed R30 who indicated R30 activated the call light to use the bathroom, but a CNA turned off the call light and left to get another staff and a lift. R30 indicated it was the fourth call R30 had made since 12:00 PM; the first and second calls were on the AM shift and the third and fourth calls were on the PM shift. R30 did not know the CNAs' names. R30 indicated R30 was incontinent of a small amount of urine due to the wait and felt like a second-class citizen. On 11/10/24 at 3:40 PM, Surveyor observed Medication Technician (MT)-T enter R30's room, ask about R30's concern, and turn off R30's call light to address another resident's fall. On 11/10/24 at 6:40 PM, Surveyor observed R11 enter the hallway from R11's room in a wheelchair. R11 was visibly upset and stated, For cripes sake, he turned my light out and said he needs to find a lift, but the lift is sitting right there. Surveyor observed a mechanical lift in the hallway near R11's room. R11 indicated a male CNA entered R11's room, turned off R11's call light, went to help a resident across the hall, and did not return. R11 indicated the lift needed to transfer R11 had been in the same spot for 15 minutes, however, that was the excuse given why R11 was not assisted. R11 stated, I am not dumb. R11's roommate (R57) then exited the room and stated to CNA-Y, You guys need to realize when they (residents) turn their lights on it is because they need someone to help them, and you should not turn it (call light) off. R11 indicated staff frequently turn call lights off and don't provide timely care on the weekends. On 11/10/24 at 6:47 PM, Surveyor interviewed CNA-Y who confirmed CNA-Y turned off R11's call light without assisting R11. CNA-Y indicated CNA-Y needed a second staff to assist with the transfer and a second staff was not available. On 11/10/24 at 7:20 PM, Surveyor observed R17 in a recliner and noted R17's call light was activated. Surveyor interviewed R17 who stated R17 wanted to go to bed. R17 said R17's call light had been on for an hour now. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/10/24 at 7:21 PM, Surveyor observed CNA-Z turn off R17's call light and exit the room. Surveyor also observed CNA-Z turn off a call light across the hall and exit the room. Surveyor interviewed CNA-Z who confirmed CNA-Z turned off R17's call light without providing assistance because CNA-Z needed to get a lift. Surveyor observed CNA-Z go to the 500 wing and start to move a lift in the hallway. When Surveyor turned to leave, CNA-Z stopped moving the lift and went to do something else. On 11/10/24 at 7:31 PM, Surveyor observed R17 still sitting in the recliner. R17's head was down and R17 appeared to be asleep. R17 had not been assisted to bed yet. On 11/11/24 at 11:39 AM, Surveyor interviewed NHA-A who was not aware of the incidents and indicated NHA-A would start an investigation. Showers: On 11/10/24 at 12:44 PM, Surveyor interviewed R26 who indicated R26 was supposed to receive two showers per week but did not consistently receive them. Surveyor reviewed R26's shower documentation for the past three months which was in the form of weekly skin checks and shower sheets that were not consistently completed and didn't always indicate if R26 had a shower or a bed bath. Documentation indicated showers were given or refused by R26 on 10 of 26 opportunities since 8/1/24. On 11/12/24 at 3:32 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated showers were a problem for awhile and the facility was working to restructure them. DON-B indicated the facility was going trial a shower aide the following week. Staff Interviews: On 11/11/24 at 10:34 AM, Surveyor interviewed CNA-DD who indicated staffing was a concern at times and CNA-DD sometimes had to care for a wing of 13 residents. CNA-DD indicated when the census is low on the rehab unit, there is no CNA on the night (NOC) shift. CNA-DD indicated CNA-DD has found that residents were not changed during the night. On 11/11/24 at 10:41 AM, Surveyor interviewed RN-E who indicated the facility had enough staff to care for residents unless there was a call in. RN-E indicated call light response times become longer when many residents make requests at the same time. On 11/11/24 at 10:49 AM, Surveyor interviewed Med Tech (MT)-G who indicated there were not enough staff to care for residents and indicated the facility did not find replacements for call ins. MT-G indicated there was turnover at the facility because CNAs quit when they felt they could not give good care. On 11/11/24 at 10:53 AM, Surveyor interviewed CNA-AA who indicated it is hard to find a replacement if someone calls in. CNA-AA indicated residents frequently complain about call light response times especially on the PM and NOC shifts.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on observation, staff interview, and record review, the facility did not ensure all drugs and biologicals were stored in accordance with the facility's policy. One of five medication carts was observed unlocked and unattended in a resident hallway. One of two medication storage rooms contained expired medication and medical supplies. A prescription label on a medication card was not labeled according to the provider's order for 1 resident (R) (R33) observed during medication administration. This practice had the potential to affect more than 4 of the 72 residents residing in the facility. On [DATE], a medication cart on the 600 wing was unlocked and unattended. In addition, a cup that contained medication was on top of the cart and a computer screen that contained residents' personal information was open. The medication storage room on the long-term care unit contained expired medication and medical supplies. A medication card for R33 was not labeled according to the physician's order. Findings include: The facility's Medication Storage Policy, dated [DATE], indicates: Proper medication storage is a standard of practice. The pharmacy fills medications using a specially packaged administration system designed to assist facilities in reducing medication errors .Expired and/or discontinued medication should be stored separately from other medication and disposed of in a timely manner .Medication carts and cabinets should be locked when unattended .It is the qualified staff member's responsibility to maintain the possession of the keys and security of the medication cart. The medication cart always needs to be securely locked when it is out of the qualified staff member's visual sight. 1. On [DATE] at 3:24 PM, Surveyor noted a medication cart on the 600 wing was unlocked and unattended. In addition, a cup that contained medication was on the top of the cart and a computer screen that contained resident's information was open. Licensed Practical Nurse (LPN)-F returned to the cart at 3:28 PM. On [DATE] at 3:28 PM, Surveyor interviewed LPN-F who indicated it was not LPN-F's usual practice to leave the medication cart unlocked and unattended. LPN-F also indicated it was not LPN-F's usual practice to leave medication unattended on the cart and residents' information exposed. LPN-F indicated LPN-F was called away for a fall on another wing. LPN-F indicated LPN-F was an agency nurse and should not have to deal with all of this. On [DATE] at 3:10 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should lock medication carts and medication when unattended and should turn off or shut down computer screens when unattended. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On [DATE] at 2:14 PM, Surveyor observed the medication storage room on the long-term care unit with Registered Nurse (RN)-E and noted the following items: ~ Acetaminophen suppositories with an expiration date of ,d+[DATE] ~ Asper creme lidocaine with an expiration date of ,d+[DATE] ~ Oyster shell calcium 250 milligrams (mg) with an expiration date of ,d+[DATE] ~ A Drug buster drug disposal system (3 containers) with expiration dates of ,d+[DATE] ~ Twenty nine 18-gauge syringes with expiration dates of ,d+[DATE] ~ Forty five pic line caps with expiration dates of ,d+[DATE] ~ One female luer lock cap with an expiration date of ,d+[DATE] ~ Multiple heparin lock flushes with expiration dates of ,d+[DATE] and ,d+[DATE] (75% of floor stock) On [DATE] at 2:30 PM, Surveyor interviewed RN-E who was not aware who was responsible for maintaining medications and supplies in the medication storage rooms. On [DATE] at 3:10 PM, Surveyor interviewed DON-B who indicated DON-B expects staff to dispose of expired medication and supplies. DON-B indicated pharmacy staff check the medication carts and storage rooms monthly and completed an annual quality review on ,d+[DATE]. 45943 3. On [DATE] at 8:10 AM, Surveyor observed RN-H administer two bumetanide (Bumex) 2 mg tablets to R33. The pharmacy medication label stated bumetanide 2 mg (1 tab once a day to give with 1 mg to equal 3 mg total). On [DATE] at 8:15 AM, Surveyor asked RN-H about the discrepancy. RN-H verified the label was incorrect and indicated there was a new order for Bumex 4 mg daily in R33's Medication Administration Record (MAR). Surveyor verified R33's current order was for Bumex 4 mg daily.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 49563 Based on observation, staff and resident interview, and record review, the facility did not ensure preferences for dietary needs were met for 1 resident (R) (R276) of 25 sampled residents. R276 did not receive consistently receive the dietary preferences that R276 specified to dietary staff. Findings include: Surveyor requested the facility's policy on food preferences and received a Facility Module User Guide for Matrixcare Meal Tracker, dated October 2024. The User Guide indicated how to enter residents' preferences/special requests in the system. On 11/10/24, Surveyor reviewed R276's medical record. R276 had diagnoses including surgical aftercare on digestive system, hyperkalemia, protein calorie malnutrition, and colon cancer. R276's Minimum Data Set (MDS) assessment, dated 11/3/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R276 was not cognitively impaired. R276's plan of care contained interventions to honor food preferences as feasible. R276 disliked oatmeal, bacon, sausage, and meats not in deli slice form. R276 liked fruit, sandwiches with plain white bread, hard-boiled eggs, deli meat, yogurt, and cottage cheese with fruit. A dietary note, dated 11/5/24, indicated R276 worked with speech therapy in 2006 following facial surgery to remove a tumor and R276's swallow ability was as good as it's gonna get. R276 had a removable plate on the roof of the mouth. R276 had difficulty swallowing meats that were not in thin deli meat form. R276's protein preferences were updated. R276 liked hard-boiled eggs, deli meat, yogurt, and cottage cheese with fruit. On 11/10/24 at 10:43 AM, Surveyor interviewed R276 who indicated the food at the facility was good for regular people, however, with R276's digestive and swallowing issues, R276 was unable to eat most of the food served. R276 met with the Dietitian and provided food preferences. R276 was unaware of an alternative menu. R276 indicated R276 informs staff who deliver meal trays, but nothing is done or offered as an alternative. R276 indicated R276's family has been bringing in food for R276. On 11/11/24 at 11:29 AM, Surveyor observed lunch service from the dining room steam table. R276's lunch meal ticket indicated: House diet - Deli meats only, no beef, pork, chicken, turkey entrees. R276's actual meal ticket indicated: 1 each deli sandwich, mashed potatoes, broccoli, roll, bread pudding, and a beverage. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/11/24 at 11:42 AM, Surveyor observed Dietary Aid (DA)-P put meatloaf on R276's plate. DA-P then covered the plate and put R276's meal ticket on the tray. When Surveyor stopped DA-P and indicated R276's meal ticket indicated R276 should get a deli sandwich, DA-P confirmed R276 should get a deli sandwich instead of meatloaf. DA-P asked another staff to make R276 a deli sandwich. At 11:44 AM, staff returned with a deli sandwich made with wheat bread. DA-P then added broccoli and mashed potatoes and sent the tray to R276's room. On 11/11/24 at 12:14 PM, Surveyor interviewed R276 who indicated R276 picked at the deli meat but was unable to eat the wheat bread. R276 indicated R276 was unable to eat the broccoli because it wasn't soft enough for R276's digestive/swallowing needs. R276 ate approximately 20% of the mashed potatoes. R276 stated R276 was frustrated that the facility was not able to meet R276's dietary preferences. On 11/12/24 at 8:05 AM, Surveyor observed R276's breakfast tray and noted R276 received a baked omelet, a hard-boiled egg, a banana, and a muffin. On 11/12/24 at 8:05 AM, Surveyor interviewed R276 who indicated R276 was able to eat the hard-boiled egg and one bite of the muffin. R276 was unable to eat the omelet and the banana. R276 was frustrated with the banana because R276 was told the day before that R276's potassium level was too high and required medication. R276 stated, I do not trust anything staff put on meal tray. A progress note, dated 11/11/24 at 12:26 PM, indicated that lab notified the facility of a critical potassium result. An order was initiated for an immediate dose of Lasix 20 mg. R276's potassium level was to be drawn again on 11/12/24. On 11/12/24 at 11:41 AM, Surveyor observed R276's lunch tray which contained a lettuce salad topped with cheese and tomatoes, refried beans, and Fritos. Surveyor interviewed R276 who indicated the only thing R276 would eat was the tomatoes. When Surveyor asked if R276 met with the Dietitian or Dietary Manager, R276 indicated R276 met with the Dietitian shortly after R276 was admitted . R276 indicated R276 needs vegetables cooked softly and will only will eat certain vegetables. R276 indicated R276 can only eat white bread but gets wheat bread. When asked about the cake on R276's tray, R276 indicated R276 wouldn't eat the cake but would eat Jell-O or peaches for dessert. When Surveyor asked if R276 was aware of an alternative menu, R276 indicated R276 was not aware of an alternative menu or that R276 could let the kitchen know what R276 wanted ahead of time. R276 again expressed frustration with not receiving R276's preferences at meal times. On 11/12/24 at 2:00 PM, Surveyor informed Dietary Manager (DM)-N of the contents of R276's lunch tray on 11/11/24. DM-N confirmed staff should have reviewed R276's meal ticket. DM-N also indicated DM-N had not met with R276 and had not heard that R276 was unhappy with R276's food. DM-N indicated the Dietitian met with R276 and gave DM-N a note about R276's meal preferences last week. Surveyor reviewed the hand-written note that indicated: Breakfast - No oatmeal, send banana, HB (hard-boiled) egg, yogurt. Lunch - No meat - sides only, white bread without anything on it, sandwich with deli meat. Dinner - cottage cheese with fruit, white bread with deli meat, send sides. DM-N indicated DM-N had not entered the information on R276's meal ticket yet, however, the information was posted in the kitchen at the steam table. When Surveyor pointed out that R276 was served from the steam table in the dining room, DM-N confirmed staff serving food would not have known R276's preferences. DM-N confirmed DM-N wanted R276's preferences to be honored and followed.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43361 Based on staff interview and record review, the facility did not designate a person to serve as the food and nutrition services director who was a certified dietary manager, had a national certification for food service management and safety from a national accrediting body, or had an associates or higher level degree in food service management or hospitality. This had the potential to affect all 72 residents residing in the facility. Dietary Manager (DM)-N did not have an approved dietary manager or food service manager certification course or other related education. Findings include: During an initial kitchen tour on 11/10/24 at 10:33 AM, Surveyor interviewed DM-N who indicated DM-N had been at the facility for a short time and did not have a dietary manager certification. DM-N indicated DM-N had a ServSafe certification, but was not yet enrolled in an approved course. DM-N also indicated the facility used a part-time Dietitian. On 11/12/24 at 1:41 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed DM-N did not have an approved certification course for dietary or food service management. NHA-A indicated DM-N was new and the facility's dietitian had sent NHA-A a couple of options for courses. NHA-A indicated the facility was in the process of reviewing the courses for DM-N and other kitchen staff. NHA-A verified NHA-A had not yet enrolled DM-N in a certified dietary manager course.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49563 Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable disease and infection for 1 resident (R) (R275) of 25 sampled residents. R275 was on enhanced barrier precautions (EBP). R275 did not have EBP signage outside of R275's room to inform staff of infection prevention precautions needed during the provision of care. Findings include: The facility's Infection Prevention and Control Policies and Procedures, dated 5/15/23, indicates: Enhanced Barrier Precautions (EBP): 1. EBP expand the use of personal protective equipment (PPE) (gowns and gloves) during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. A. EBP will be implemented for all residents with the following: .2) Wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status .F. The facility will post clear signage on the door or wall outside the room indicating the type of precautions and required PPE (gown and gloves) .H. The facility will provide gowns and gloves immediately outside of the resident's room and position a trash can inside the resident's room near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room. On 11/10/24, Surveyor reviewed R275's medical record. R275 was admitted to facility on 11/8/24 with right lower leg venous ulcers with copious amounts of drainage and had diagnoses including chronic venous hypertension with ulcer and inflammation of right lower extremity, congestive heart failure, and chronic kidney disease. R275's Minimum Data Set (MDS) assessment, dated 11/10/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R275 was not cognitively impaired. R275 required daily and as needed dressing changes. On 11/10/24 at 10:25 AM, Surveyor noted EBP signage was not posted outside R275's room. On 11/11/24 at 9:30 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-D who indicated EBP signage was assigned by the Infection Preventionist (IP). LPN-D indicated if the IP was not working, nursing staff were responsible for posting signage outside residents' rooms. LPN-D verified R275 did not have EBP signage posted outside R275's room and indicated signage should be posted to inform staff of the necessary precautions. On 11/12/24 at 10:24 AM, Surveyor interviewed Infection Preventionist (IP)-C who verified R275 required EBP signage related to a wound with copious drainage. IP-C indicated nurses are the first level to determine if residents need EBP. On 11/11/24 at 3:10 PM, Surveyor interviewed Director of Nursing (DON)-B who verified EBP should be assigned for residents with wounds. DON-B verified there was no signage posted outside R275's room to alert staff that R275 was on EBP.