STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525466	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Health and Rehab Center	S830 - Westland Dr Spring Valley, WI 54767

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. 48793 Based on observation, interview and record review, the facility did not ensure prescription medications were administered by qualified staff. Surveyor observed Certified Nursing Assistant (CNA) apply prescribed Nystatin powder to a resident's (R) skin for 1 of 1 observation. (R187) Findings include: On 07/30/24 at 8:56 AM, Surveyor observed Nystatin powder sitting on bedside table in R187's room. Surveyor asked R187 what the powder was on the bedside table and if it was stored in R187's room regularly. R187 indicated that it is antifungal powder for R187's abdominal folds. R187 indicated that the CNAs usually apply this when CNAs get R187 out of bed. On 07/30/24 at 10:01 AM, Surveyor observed morning cares being performed for R187 by CNA H and CNA Q. Surveyor observed a cup of Nystatin powder located on R187's bedside table. CNA Q picked up the Nystatin powder and handed the powder to CNA H. CNA H applied Nystatin powder to R187's abdominal folds bilaterally and placed Nystatin powder in R187's groin area. On 07/31/24 at 11:16 AM, Surveyor interviewed CNA H and asked what the expectation is for Nystatin powder to be administered by CNAs. CNA H indicated that CNA H has always applied Nystatin powder for the nurses. Surveyor asked if CNA H had any training or experience with applying Nystatin powder. CNA H indicated that no, CNA H has not had any formal training. Surveyor reviewed R187's medical record and identified the following physician's order, dated 07/18/24: Nystatin powder; 100,000 unit/gram; amt: to abdominal folds; topical Two Times A Day. On 07/31/24 at 3:49 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is of CNAs applying nystatin powder to R187. DON B indicated that expectation would be that only nurses administer Nystatin powder to R187. DON B indicated that CNA H should not have administered Nystatin powder to R187.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observations, interviews and record reviews, the facility did not provide spinal precautions and treatment by professional standards of practice to maintain a resident's highest practicable level of physical well-being for 1 of 18 residents (R21) reviewed. Staff did not follow spinal precautions to manage R21's T11 fracture by not providing log rolling during repositioning while R21 was in bed. Staff did not follow physician orders to keep back brace on R21 when head of bed is over 30 degrees. Findings include: R21 was admitted on [DATE]. R21's diagnoses include fracture of T9-T10 vertebra, fracture of first lumbar vertebrae, fracture of second lumbar vertebrae, fracture of third lumbar vertebrae, fracture of fourth lumbar vertebrae, concussion without loss of consciousness, and traumatic brain injury. R21's Minimum Data Set (MDS) assessment, completed on 07/17/24, confirmed R21 scored 12 during a Brief Interview for Mental Status (BIMS), indicating moderate impaired cognition. R21 requires total substantial maximal assistance with rolling from side to side. R21 does not get out of bed. R21's care plan was initiated on 01/05/24, and included the following interventions: Activities of Daily Living: -Bed Mobility: Assist of 2 log roll as much as able, remind resident to keep straight as possible. -Head of Bed below 30 at all times if resident does not have thoracic-lumbar-sacral orthosis (TLSO) brace on. May go above 30 degrees if she has TLSO brace on or is out of bed. Resident is on bed rest. R21's physician orders on 01/04/24 include: -Bed rest at all times every shift for lumbar fractures. -Do not elevate head of bed over 30 degrees every shift for lumbar fractures. R21's physician orders on 05/29/24 include: -Specialist has to decide discontinuation of back brace. Continue back brace as ordered. R21's physician orders on 07/08/24 include: -Adjust current TLSO brace. -Continue with restrictions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Follow up with brace and CT scan. On 07/30/24 at 2:34 PM, Surveyor interviewed R21. Surveyor asked R21 why R21 was admitted to the facility. R21 indicated that R21 was in a motor vehicle collision and is on spinal precautions. Surveyor asked what spinal precautions indicated for R21. R21 indicated that R21 is to be log rolled while in bed, on bedrest and R21 should be wearing R21's back brace. R21 indicated that R21 has been losing weight and the brace is uncomfortable so R21 has not been wearing the brace for a while now. Surveyor observed back brace lying on a box on the floor across the room with papers and bags stored on top. On 07/31/24 at 6:39 AM, Surveyor observed R21 lying in bed supine with head of bed at a 45-degree angle sleeping. Surveyor did not observe R21's back brace (TLSO) on R21. Surveyor observed back brace lying on a box on the floor across the room with papers and bags stored on top. On 07/31/24 at 8:20 AM, Surveyor observed R21 lying in bed supine with head of bed at a 45-degree angle sleeping. Surveyor did not observe R21's back brace on R21. Surveyor observed back brace lying on a box on the floor across the room with papers and bags stored on top. On 07/31/24 at 8:51 AM, Surveyor observed Certified Nurse Assistant (CNA) K and CNA N provide cares. CNA N grabbed behind R21's back of shoulders and R21's hip area and rolled R21 to the left towards CNA K. Surveyor observed R21's right leg cross over R21's left leg and R21's left leg bent backwards. Then after CNA N completed peri cares on R21, CNA K placed hands underneath R21's waist and upper shoulders and rolled to the right towards CNA N. Surveyor observed R21's left leg cross over R21's right leg and R21's right leg bent backwards slightly. Surveyor did not observe CNA K and CNA N log roll R21 as ordered, and care planned during R21's cares. Surveyor did not observe any spinal precautions in place for rolling R21. On 07/31/24 at 12:45 PM, Surveyor observed R21 lying in bed with head of bed at almost 90-degree angle with lunch tray in front on bedside table. Surveyor did not observe R21's back brace on R21. Surveyor observed back brace lying on a box on the floor across the room with papers and bags stored on top. On 07/31/24 at 3:40 PM, Surveyor interviewed CNA I and CNA O and asked CNA I and CNA O how R21 is moved while in bed. CNA I and CNA O indicated that R21 is a log roll since on spinal precautions while in bed. CNA O indicated that R21 does not get out of bed as R21 is on bed rest per provider orders. Surveyor asked CNA I and CNA O where staff find the transfer status and mobility in bed for R21. CNA I indicated that CNAs follow the Kardex for R21. Surveyor asked CNA I and CNA O to show Surveyor the documentation of the Kardex. CNA I pulled the Kardex up for R21 and showed Surveyor that the Kardex did not have specifications on bed mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 3:49 PM, Surveyor interviewed Director of Nursing (DON) B and asked about expectation for bed mobility with R21. DON B indicated that bed mobility for R21 is log rolling due to R21 being on spinal precautions. DON B indicated that all staff are to follow the spinal precautions for R21. Surveyor asked how staff were to know that R21 is on spinal precautions and has staff been educated on how to properly perform log rolling. DON B indicated that it should be in R21's Kardex that staff follow and going forward DON B would be educating staff immediately on performing only log rolls with R21. Surveyor asked DON B if DON B was aware that R21's head of the bed has been up as high as 90 degrees during observations. DON B was unaware that R21's head of bed has been up this far and stated that it shouldn't be that high. Surveyor reviewed physician orders that indicate the head of bed shouldn't be any higher than 30 degrees. DON B indicated that DON B would educate R21 on the head of the bed being elevated and the restrictions that R21 has in place for spinal protection. On 07/31/24 at 4:08 PM, DON B provided documentation to Surveyor showing that R21's Kardex indicated under Activities of Daily Living (ADL) that Bed Mobility stated, Assist of 2 log rolls as much as able, remind resident to keep as straight as possible. DON B indicated that through review of the specialist orders R21's head of bed is not supposed to exceed 20 degrees without applying the TLSO brace. DON B indicated that DON B would be fixing the order right away, educating staff, and R21. DON B also indicated that back in May a nurse requested that the TLSO brace be discontinued, and the provider wrote orders back to continue TLSO brace and that it was the specialist decision to discontinue or not. DON B confirmed the nurse had discontinued the TLSO brace without proper orders from a physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 48793 Based on observation, interview and record review, the facility did not ensure that 2 of 4 residents (R) reviewed for pressure injuries (PI) (R2 and R187) received care consistent with professional standards of practice to promote healing of existing PIs. R2 developed an unspecified injury stage PI to the left heel on 05/30/23 and an ulcer to the great right toe. On 07/09/24, the PI reoccurred to the left heel and the right great toe. On 07/09/24, a new PI occurred to the left great toe. The care plan for PI interventions was not updated since 08/14/23. R2 was not repositioned or encouraged as needed for pressure relief as instructed on the PI care plan. R187 was admitted to the facility with a stage 3 PI to the left posterior thigh. The facility did not ensure R187's buttocks/thighs were protected, did not reposition R187, and inconsistent assessments of the wounds were noted. This is evidenced by: Guidelines from the National Pressure Injury Advisory Panel (NPIAP) 2016, Pressure Injury Prevention Points, accessed 07, March 2024, Prevention Points | National Pressure Ulcer Advisory Panel (npiap.com), states in part: Turn and reposition all individuals at risk for pressure injury, turn the individual into a 30-degree side-lying position and use your hand to determine if the sacrum is off the bed, ensure that the heels are free from the bed, use heel offloading devices for high-risk pressure injuries. The facility policy entitled, Pressure Ulcer/Skin Integrity, stated in part, .1. Upon admission, and thereafter, residents will be assessed for the potential risk for skin breakdown resulting from bony prominences. -2. Skin inspection upon admission, and thereafter, a skin inspection will be completed to identify pre-existing, or potential areas of skin breakdown over bony prominences. It is recommended that assessments be completed as soon as reasonably but not to exceed 24 hours after admission. -4. Wound identification: i. Differentiate the type of wound. ii. Determine wound stage. iii. Describe and monitor the wounds characteristics. iv. Monitor for progress toward healing. vii. Monitor dressings and treatments. -5. Treatment/ Management: residents will receive services treatment/services include: ii. Pressure relieving equipment. iii. Repositioning or off-loading. -6. Documentation: b. Wound documentation is more detailed than routine skin documentation and shall include information related to the wound based on a clinical assessment. -7. Care Planning: b. Comprehensive resident-centered care pans will be developed per the RAI/Care plan timelines and reviewed/revised thereafter . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 1 R2 was admitted on [DATE]. R2's diagnoses include pressure ulcer to the left heel, pyogenic arthritis, emphysema, anemia, and type 2 diabetes mellitus. R2's Minimum Data Set (MDS) assessment, completed on 05/30/24, confirmed R2 scored 15 during a Brief Interview for Mental Status (BIMS), indicating intact cognition. R2 requires partial to moderate assistance with rolling from side to side and transferring from bed to wheelchair. R2's care plan was initiated on 05/10/23 and revised on 11/06/23, and included the following interventions: Activities of Daily Living: -Transfers: Assist of one. Skin Integrity: -Assist/encourage pressure relief as needed/accepted. R2's physician orders on include: -Left great toe-aqualcel and mepilex, right great toe mepilex, monitor heels, float heels as much as possible, every 48 hours for wound care. -Encourage to elevate feet frequently throughout the day, wear Podus boots or float heels on pillow while in bed, encourage to remove shoes when in recliner four times a day for pressure reduction measures. -Offload plan: Frequent position changes independently or with assistance. Custom orthotics and/or insoles per orthotist evaluation. Removing shoes when at rest and not ambulating, floating the heel off the bed by applying pillow under calves and custom booties to be worn while in bed to off-load heels every shift. - Assess skin and complete skin assessment form, and document, one time a day every Wed for ongoing monitoring. The care plan has no new PI interventions since 11/06/23. Surveyor reviewed documentation and found no Braden Score identifying R2 as a risk for pressure injuries. Review of nursing documentation on 07/09/24 showed left great toe 1st lateral toe had measurements L 0.7 cm W 0.5 cm, D 0.2 cm. No documentation about the PI care or comprehensive assessment of the PI on R2's left great toe. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing documentation on 07/16/24 showed left posterior heel had circular reddened area measures L1 cm W 1 cm, and D 0. Right toe No skin problems of right foot, and left great toe 1st lateral toe had serous drainage measuring L 0.6 cm W 0.5 cm, D 0.1 cm. Review of nursing documentation on 07/30/24 showed left posterior heel had circular reddened area measures L1 cm W 1 cm, and D 0. Right toe No skin problems of right foot, and left great toe 1st lateral toe had serous drainage measuring L 0.5 cm W 0.4 cm, D 0.1/0.1 cm. No further documentation about PI care or the comprehensive assessment of the PI on R2's left heel, left great toe, and right great toe was found on the medical record until 07/09/24. No documentation of updates about the PI to R2's physician was found on the medical record during that time frame. No documentation of dressing changes to wounds were found nor any other measurements and condition of the wound bed of the left and right great toe wounds. The orders for wound care during that time frame were for wound care every two days. On 07/30/24 at 1:27 PM, Surveyor observed R2's shoes on while in recliner with feet lying flat against recliner footrest, no pillow underneath to float heels. Surveyor did not observe Podus boots applied to R2 while in recliner and the Podus boots were observed located across the room stored on spare chair. On 07/30/24 at 2:58 PM, Surveyor observed R2's shoes on while in recliner with feet lying flat against recliner footrest, no pillow underneath to float heels. Surveyor did not observe Podus boots applied to R2 while in recliner and the Podus boots were observed located across the room stored on spare chair. On 07/31/24 at 1:51 PM, Surveyor observed R2's shoes on while in recliner with feet lying flat against recliner footrest, no pillow underneath to float heels. Surveyor did not observe Podus boots applied to R2 while in recliner and the Podus boots were observed located across the room stored on spare chair. On 07/31/24 at 10:58 AM, Surveyor observed Registered Nurse (RN) C enter R2's room. RN C indicated that wound dressing changes were performed yesterday on 07/30/24 but RN C would remove dressings and redress R2's wounds so Surveyor could see wounds on R2's feet bilaterally. RN C took R2's shoes and socks off and placed to the side. Surveyor assessed no dressings on R2's left foot or right foot. Surveyor assessed a dime size reddened opened circle area on R2's left great toe on top side of foot and a small reddened area with a small pen dot size scab to the right great toe area. On 07/31/24 at 11:08 AM, Surveyor interviewed RN C and asked why there was not a dressing in place if wound care was completed yesterday on 07/30/24. RN C indicated that RN C was unsure why dressing was not in place. RN C indicated that R2 is supposed to have aquacel applied with a mepilex in place on the left great toe and just a meplix applied to the right great toe. Surveyor asked RN C if R2's wounds were pressure related. RN C indicated that R2 has had bad edema a lot but that R2 wears R2's loafers all the time and it appears to look like pressure is causing the redness on the outer sides of the great toes bilaterally causing R2's great toes to break open. Surveyor asked RN C if R2 takes breaks from wearing loafers to prevent the pressure from occurring. RN C indicated that staff is supposed to encourage R2 to elevate legs and take loafers off when in recliner or in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/24 at 2:10 PM, Surveyor interviewed Director of Nursing (DON) B and asked what expectation was for wound management and assessing R2's wounds on bilateral feet. Surveyor indicated that R2 did not have proper assessment completed for the new and old wounds that have opened back up on R2's feet. Surveyor stated to DON B that Surveyor could not find any documentation on when R2's left heel wound was healed and reoccurred. DON B indicated that DON B understands the facility is not completing weekly assessments adequately on R2. Example 2 R187 was admitted on [DATE]. R187's diagnoses include atrial fibrillation, edema, chronic obstructive pulmonary, morbid obesity, and peripheral vascular disease. Review of R187's baseline care plan initiated on 07/18/24 indicated: -Weekly skin check. -Review skin concerns with MD. -Pressure reduction cushion in wheelchair. -Pressure reduction mattress on bed. R187's physician orders on include: .-Apply triad paste over open slits to posterior thighs twice a day for skin breakdown, open slits. -May receive barrier cream of choice applying to the skin as indicated for preventative wound care as well as for the treatment of open areas every shift to peri area. -Pressure redistribution mattress low air loss every shift. -Skin management: Braden Scale-Admission. Weekly x4, Monthly one time a day every 4 weeks on Thursday. -Skin management: Braden Scale-Admission. Weekly x4, Monthly one time a day every Thursday. -Skin management: Weekly Body Observation and form to be completed 1x week every day shift every Saturday for prevention -weekly skin check tool . Surveyor reviewed documentation from an outside wound clinic R187 was attending before being admitted to the facility that noted stage 3 wound to the left posterior thigh full thickness measuring Length 4.6 cm, Width 2 cm, and Depth 0.1 cm. Recommendations suggest off-loading wound, low air mattress, reposition per facility protocol, turn side to side in bed every 1-2 hours. Review of nursing documentation on 07/18/24 showed left buttock open area no specification of type of injury with measurements containing length 1 cm and width 1 cm. (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 documentation on 07/20/24 Braden Scare completed with score of 15 high risk of skin breakdown. Summary findings indicate R187 requires assist with bed mobility admitted with open area to buttock. No further documentation about PI care or a comprehensive assessment of the PI on R187's buttocks was found on the medical record since admission on 07/18/24. No documentation of updates about the wound to R187's physician was found on the medical record during that time frame. On 07/31/24 at 6:43 AM-8:07 AM, Surveyor observed R187 lying in bed with head of bed positioned sitting upright at a 90-degree angle directly applying pressure to the buttocks. On 07/31/24 at 8:07 AM, Surveyor observed R187 being turned from side to side by staff for peri cares. Surveyor observed scattered open areas to the posterior sides of thighs and buttocks bilaterally. Surveyor also observed a dime size open sore that was pink/red in color located on R187's right posterior thigh/buttock area. R187 indicated to staff that R187's bottom hurts and itches. R187 asked CNA H to itch the area when CNA H applied Triad cream. Surveyor asked CNA H when these wounds were opened. CNA H indicated that CNA H is unsure, but they apply barrier cream as much as they can. On 07/31/24 at 2:10 PM, Surveyor interviewed DON B and asked what expectation was for wound management and assessing R187's posterior thigh/buttocks PIs. Surveyor indicated that R187 did not have proper assessment completed for the new wounds that have opened on R187's posterior right thigh and buttock. Surveyor indicated to DON B that Surveyor cannot find proper assessments completed weekly for measurements, and condition of the wounds to the buttocks. DON B indicated the staff are not completing weekly assessments adequately on R187. DON B indicated the documentation of skin issues has not been completed to its entirety. DON B confessed this is a facility wide issue and the facility will be incorporating new measures and interventions in place to fix the issue. DON B indicated the expectation is that a head-to-toe skin assessment is completed upon admission and documented. Thereafter weekly skin assessments and Braden score assessments are to be completed by a registered nurse.

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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** 40181 Based on observation, interview, and record review, the facility did not ensure the residents' environment remains as free of accident hazards as possible. Two of four residents (R) reviewed for falls with history of falls (R26 and R31) did not have post fall assessments, care plan interventions updated after falls, and had subsequent falls with major injuries. R26 and R31 are being cited at actual harm. R6 and R2 did not have post fall assessments and care plan updates after falls. One resident (R14) did not have a safety assessment or care plan for leaving facility campus and traveling on a busy highway with power wheelchair. R2, R6, and R14 are being cited at severity level 2 (potential for more than minimal harm). Observations of wet floors with no wet floor signs in place to prevent accidents occurred for R21, R13, R1, R187, and R186. Findings include: Facility policy and procedure entitled Accidents/Falls, last reviewed 11/2023, states in part: .5. Resident care plans should be evaluated and updated with each fall with a new and applicable intervention based on root cause. The focus is to be on prevention and maintaining a safe environment .Each incident/accident or fall must be investigated and/or assessed to determine the root cause of the episode to prevent any further injury .10. The resident's individualized care plan is to be updated with any changes or new interventions post fall/incident/accident, communicated to appropriate staff, and implemented . Example 1: R26 was admitted to the facility on [DATE] with the following diagnoses, in part, age-related osteoporosis without current pathological fracture, unspecified symptoms and signs involving cognitive functions following cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, history of falling, anxiety disorder, and difficulty in walking. On 07/30/24 at 9:08 AM, Surveyor interviewed R26 who stated they fell sometimes and had a fall that resulted in a right shoulder fracture. Review of R26's medical record identified a fall risk assessment dated [DATE] that indicated R26 had 1 to 3 falls in the past 3 months and was assessed at risk for falls. R26's medical record identified R26 had an unwitnessed fall in the bathroom on 03/22/24. R26 reported hitting the back of head on the toilet during the fall. The fall risk screening tool completed after R26's fall on 03/22/24 identified R26 at risk for falls. The Interdisciplinary Team (IDT) Post Fall Review, dated 03/28/24, states in part, .Describe new fall prevention interventions to be implemented as a result of the assessment: resident is not to be left in the bathroom unattended . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R26's Safety/Falls care plan and did not identify any updated interventions to include not leaving R26 unattended in the bathroom. Surveyor identified an incident note dated 04/25/24 that indicated R26 had an unwitnessed fall in the bathroom that resulted in a laceration on left eyelid, laceration on right side of chin, and moderate amount of bleeding from nose. R26 was transferred to the hospital for evaluation. Surveyor was unable to identify an Interdisciplinary Team (IDT) post fall review completed after the fall on 04/25/24. The hospital discharge summary dated 04/30/24, states in part, .suffered a mechanical fall resulting in a right shoulder fracture on 04/25/24. Patient underwent ORIF [Open Reduction Internal Fixation surgery] on 04/25/24 . On 08/01/24 at 12:30 PM, Surveyor interviewed Director of Nursing (DON) B and asked if R26's Safety/Falls care plan was updated after the fall on 03/22/24. DON B reviewed the documents and stated the IDT review recommended resident is not left alone in the bathroom to prevent future falls after the fall on 03/22/24. DON B reviewed R26's care plan and stated it did not look like it was updated with this new intervention after R26's fall on 03/22/24. DON B stated they could not locate a post fall IDT review of R26's fall on 04/25/24. DON B stated R26's Safety/Falls care plan should have been updated with the IDT recommendation after the fall on 03/22/24 to try to prevent future falls. 43352 Example 2: R31 was admitted to the facility on [DATE] and has diagnoses that include anxiety disorder, hypertension, depression, and congestive heart failure. On 05/08/24, a fall risk assessment was completed. R31 was marked as being a fall risk, reason general weakness related to recent hospitalization . On 05/30/2024 at 1:43 PM, a nurse progress note read, Resident has had two falls today. First fall was at 9am resident received a skin tear consistent with partial degloving of right forearm, area was cleansed and skin was reapproximated and steri stripped, covered with gauze and wrapped with kerlix. Resident assisted to go to exercise per her request. Resident vitals stable after fall. Did not hit head as fall was witnessed. Resident then fell at 1300, unwitnessed. Complained of right shoulder and hip pain, bleeding from right great toe skin tear to left hand and bleeding noted in her mouth. Resident was not moved from the floor. 911 was called. Unable to obtain BP due to complaints of pain 97.7-18-106 95%. Resident left facility at 1330 via ambulance in c-collar due to unwitnessed fall. Resident did receive ativan this am per request for anxiety. Hospital discharge summary, dated 05/30/24, read in part, Diagnoses: compression fracture of C7 vertebra and multiple skin tears. On 08/01/24 at 9:43 AM, Surveyor asked DON B for fall investigations. (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 08/01/24 at 10:28 AM, DON B brought in what they had and indicated there is no fall investigation or interventions that were put into place after R31's fall on 5/30/24 at 9:00 a.m. R31 then fell again at 1:00 p.m. and sustained a compression fracture of C7. 47807 Example 3: R6 was admitted to the facility on [DATE] and has diagnoses that include hypertension, neurogenic bladder, dementia, depression, and cataracts. R6's most recent Minimum Data Set (MDS) indicated that R6 has had two or more falls since admission to the facility. R6's care plan related to falls states: At Risk for Complications with OR falls R/T current medical / physical status. Has meds/dx that can/may affect fall risk. On 06/11/24 at 9:00 AM, a nurse progress note related to R6's fall read that the writer was paged to resident's room for a fall. Writer was informed that a CNA was using the sit to stand with R6 when R6 tried to pull himself all the way up, which caused the sling to become unattached. The Certified Nursing Assistant (CNA) stayed and was able to lower R6 to the ground. Registered Nurse arrived to assess and help. R6 stated they did not know how that happened. On 08/01/24 at 2:20 PM, Surveyor asked DON B for fall investigations. On 08/01/24 at 2:38 PM, DON B brought in what they had and indicated there was no evidence of an IDT review and care plan update after the fall occurred, only the initial assessment found after the fall took place. 48793 Example 4: R2 was admitted on [DATE]. R2's diagnoses include pressure ulcer to the left heel, pyogenic arthritis, emphysema, anemia, and type 2 diabetes mellitus. R2's MDS assessment, completed on 05/30/24, confirmed R2 scored 15 during a Brief Interview for Mental Status (BIMS), indicating intact cognition. R2 has impairment to lower extremities bilaterally. R2 needs partial to moderate assistance during transfers from bed to wheelchair. Surveyor reviewed R2's medical record and documentation indicated that R2 had falls on: -08/07/23 R2 had an unwitnessed fall in the bathroom. R2 had no injuries, physician was notified. -02/06/24 R2 had an unwitnessed fall in R2's room next to R2's bed. R2 had no injuries, physician was notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-06/16/24 R2 had unwitnessed fall in the hallway. R2 suffered several skin tears to the scalp, face, and right knee. -06/30/24 R2 had unwitnessed fall in R2's room in front of wheelchair. R2 had no injuries, physician was notified. Review of R2's medical record identified a fall risk assessment dated : -11/29/23 R2 had 1 to 3 falls in the past 3 months and was assessed at risk for falls. -02/10/24 R2 had 1 to 3 falls in the past 3 months and was assessed at risk for falls. -03/01/24 R2 had 1 to 3 falls in the past 3 months and was assessed at risk for falls. -04/30/24 R2 had 1 to 3 falls in the past 3 months and was assessed at risk for falls. -06/17/24 R2 had 1 to 3 falls in the past 3 months and was assessed at risk for falls. Review of R2's medical record identified the Interdisciplinary Team (IDT) Post Fall Review, dated 07/02/24, stated in part, .Describe new fall prevention interventions to be implemented as a result of the assessment: Remind [R2] to use call light and wait for staff to assist with transfers to prevent falls/injuries . No other IDT reviews were found for previous falls. Surveyor reviewed R2's Safety/Falls care plan and did not identify any updated interventions after: -08/07/23 -02/06/24 -06/16/24. R2's care plan noted fall interventions placed on 04/05/24 for assistive device bilateral grab bars on bed to aid in bed mobility. R2's care plan noted fall interventions placed on 06/25/24 for call light positioned for easy access. Has visual reminders in room to use call light. Surveyor identified an incident note dated 04/25/24 that indicated R26 had an unwitnessed fall in the bathroom that resulted in a laceration on left eye lid, laceration on right side of chin, and moderate amount of bleeding from nose. Surveyor was unable to identify an IDT post fall review completed after the fall on 04/25/24. On 08/01/24 at 8:47 AM, Surveyor asked DON B for fall investigations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/01/24 at 10:28 AM, DON B brought in what they had and indicated there is not much documentation on R2's falls and only one IDT review was found. DON B indicated that staff will be educated on fall preventions and to correctly document falls and interventions put into place. Example 5: On 07/31/24 at 8:12 AM, Surveyor observed Housekeeper P cleaning R21's room. Surveyor observed Housekeeper P mopping R21's floor. Housekeeper P did not place wet floor sign outside R21's room to show the floor was still wet. Housekeeper P walked down hallway to the next room. On 07/31/24 at 8:16 AM, Surveyor observed Housekeeper P cleaning R13's craft room. Surveyor observed Housekeeper P mopping the floor. Housekeeper P did not place wet floor sign outside of the craft room to show the floor was still wet. Housekeeper P walked down hallway to the next room. Surveyor observed R13 wheel into R13's craft room in wheelchair. On 07/31/24 at 8:42 AM, Surveyor observed Housekeeper P cleaning R1's room. Surveyor observed Housekeeper P mopping R1's floor. Housekeeper P did not place wet floor sign outside R1's room to show the floor was still wet. Housekeeper P walked down hallway to the next room. On 07/31/24 at 9:31 AM, Surveyor observed Housekeeper P cleaning R187's room. Surveyor observed Housekeeper P mopping R187's floor. Housekeeper P did not place wet floor sign outside R187's room to show the floor was still wet. Housekeeper P walked down hallway to the next room. On 07/31/24 at 9:40 AM, Surveyor observed R187 wheel electric wheelchair in room. Surveyor observed floor still to be wet. On 07/31/24 at 9:45 AM, Surveyor observed Housekeeper P cleaning R186's room. Surveyor observed Housekeeper P mopping R186's floor. Housekeeper P did not place wet floor sign outside R186's room to show the floor was still wet. Housekeeper P walked down hallway to the next room. On 07/31/24 at 9:46 AM, Surveyor interviewed Housekeeper P and asked what expectation is for placing yellow wet signs out after mopping resident rooms and common areas. Housekeeper P indicated that Housekeeper P never was really told if wet signs should be placed or not. Surveyor asked Housekeeper P how Housekeeper P would prevent residents or staff from slipping or injuring themselves if there was not a yellow wet sign out to warn them that the floor is potentially wet. Housekeeper P indicated that Housekeeper P would start placing wet floor signs out after mopping rooms and common areas. On 07/31/24 at 2:10 PM, Surveyor interviewed DON B and asked what expectation was for Housekeeper P utilizing wet floor signs after mopping. DON B indicated that after mopping anywhere in the facility, a yellow wet floor sign should be placed in visible view to all traffic to prevent residents, family members, and staff from slipping and falling on wet floors. DON B indicated that Housekeeper P should have been using yellow wet floor signs after mopping all areas. Example 6: Facility policy and procedure entitled Resident Leave of Absence, last revised 11/22, stated: When a resident leaves the facility, it will be documented as to the intent of the resident's absence, when the resident left, with whom, and the expected time of return. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R14 was admitted to the facility on [DATE] with the following diagnoses, in part, stage 4 pressure injury to the sacral region, type 2 diabetes mellitus, morbid obesity, and paraplegia as a result of traumatic spinal cord injury. On 07/31/24 at 11:21 AM, Surveyor asked CNA E where R14 was, so Surveyor could observe R14's safety with smoking. CNA E stated R14 had checked out smoking materials a while ago. CNA E stated that R14 was going to Subway for lunch and was probably still gone from the facility. Surveyor asked CNA E how R14 gets to Subway. CNA E stated R14 travels down there in the power wheelchair. Surveyor noted Subway was slightly over one mile from the facility, and R14 must travel on a busy state highway with a hill and curve in the road to get to Subway. Surveyor was unable to find any safety assessments or safety care plan or any documentation on R14's medical record that addressed R14 leaving the facility campus and traveling down the highway in a power wheelchair to Subway. On 08/01/24 at 8:06 AM, Surveyor interviewed Nursing Home Administrator (NHA) A about R14 leaving facility campus and traveling to Subway in a power wheelchair. NHA A was not aware that this was occurring. NHA A did not know if any safety assessments had been completed related to R14 leaving the campus and traveling down the highway in the power wheelchair. NHA A did not think this was a safe practice and would look into it. On 08/01/24 at 8:15 AM, Surveyor interviewed CNA E who reported R14 signed out on a clipboard kept at the medication cart when going out to smoke or to Subway, and then signed back in upon return. Surveyor asked CNA E if there was any kind of safety assessment completed or a safety care plan related to R14 leaving the facility campus to go to Subway. CNA E did not know if a safety assessment was done or if there was a safety care plan related to R14 traveling down the highway in the power wheelchair. On 08/01/24 at 9:30 AM, Surveyor interviewed DON B and asked if a safety assessment was completed and safety care plan in place related to R14's leaving the campus to go down the highway in a power wheelchair to Subway. DON B was not sure due to being new to the facility but did not think there was a care plan or safety plan or agreement in place for this situation. DON B would look to see what was completed related to this situation. Surveyor asked if the facility had a policy and procedure related to Leave of Absence (LOA) for residents that would apply to this situation. DON B stated they probably have a policy but did not think it was implemented in R14's situation. On 08/01/24 at 10:11 AM, Surveyor interviewed Registered Nurse (RN) D who stated there was no formal safety assessment completed related to R14's safety to leave the campus and travel down the highway to Subway. RN D stated they did get a flag for the wheelchair but did not know if the flag was on the wheelchair. RN D stated someone viewed R14 traveling down the road in the wheelchair and R14 did travel on the correct side of the road and was viewed as safe to do this, but no formal assessment had been done. Surveyor asked RN D if they had developed a safety agreement or plan related to R14 leaving the facility campus and traveling down the busy state highway in a power wheelchair. RN D stated nothing like that had been done. RN D stated, I suppose it should be care planned, but [R14] does sign out when leaving the building. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 08/01/24 at 11:25 AM, Surveyor observed R14 exit the building to smoke. R14 did not have a flag on the power wheelchair.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on record review and interview, the facility did not ensure acceptable parameters of nutritional status to maintain usual body weight. This occurred for 1 of 1 resident reviewed for nutritional status. Resident (R) R21. R21 was not weighed weekly to assess if she was maintaining her usual body weight. R21 had significant weight loss that were not assessed appropriately. This is evidenced by: R21 was admitted on [DATE]. R21's diagnoses include fracture of T9-T10 vertebra, fracture of first lumbar vertebrae, fracture of second lumbar vertebrae, fracture of third lumbar vertebrae, fracture of fourth lumbar vertebrae, concussion without loss of consciousness, and traumatic brain injury. R21's Minimum Data Set (MDS) assessment, completed on 07/17/24, confirmed R21 scored 12 during a Brief Interview for Mental Status (BIMS), indicating moderate impaired cognition. R21 requires total substantial maximal assistance with rolling from side to side. R21 does not get out of bed. R21's care plan included the following interventions: Nutrition/Hydration care plan was initiated on 01/05/24: -Record weights a minimum of monthly or per MD/RDN. -Set up meal per resident direction and assist with eating as/if needed. -Elevate head of bed no more than 30 degrees without brace, may be up higher with brace on. -Amount eaten requires documentation. -Eating requires documentation. -Snack requires documentation. -Weight requires documentation. -Fluids requires documentation. -Record Mid Arm Circumference to measure weight/nutritional status initiated on 07/25/24. R21's physician orders on 01/05/24 include: -Weights daily x3, weekly x4, monthly one time a day for weights for 3 days and one time a day every Friday for weights for 4 weeks and one time a day every 4 weeks on Friday for weights thereafter. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R21's physician orders on 03/28/24 include: -Remeron 7.5 mg start for appetite stimulant R21's physician orders on 04/28/24 include: -Increase Remeron to 15mg for appetite stimulant. R21's physician orders on 06/04/24 include: -House supplement 4mg TID. The only weight charted was: -01/05/24 209 pounds from Hospital admission discharge paperwork. No other weights were obtained from 01/05/24- 08/01/24. R21's food and fluid intake was only found documentation recorded from 06/25/24- 08/01/24. Ranges from refusals to 100% eaten for each meal. Staff could not provide any other history of R21's food intake over the course of the last 6 months. Surveyor reviewed progress notes that indicate: -On 1/18/2024, Dietician indicated that R21 nutrition admission assessment: diet order reads as: general/standard/regular diet, soft & bite sized/chopped texture, thin/regular liquids consistency. No nutrition supplements at this time. Decreased appetite noted in progress notes dated 1/5. Poor appetite noted on 1/6. Current weight for ARD 209.0# on 1/5/24. Estimated nutritional needs based on 209#: 1900-2375 kcal (20-25 kcal/kg), 76-95 g protein (0.8-1.0 g/kg r/t CKD3), 2375-2850 ml fluids (25-30 ml/kg). Would recommend obtaining order for health shakes and to monitor resident's weights on a weekly basis to determine if the health shakes are warranted. Will proceed to care plan. Will continue to monitor quarterly/PRN and follow POC. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 3/20/2024, dietician indicated that writer notified of weight loss, poor appetite. Description provided to writer: resident is bedbound r/t multiple fractures. Facility is unable to obtain her weight r/t bedbound status but using resident's TLSO brace as a point of reference that is custom fitted, it is reported that this is now too big on her. Noted very poor appetite, zofran is being scheduled twice daily for nausea. Resident being offered health shakes three times daily, but barely drinks 50% of them. Progress notes from the past 7 days reviewed - discusses the poor intakes and visual weight loss. Family is aware, has tried bringing in some of resident's favorites, with little success in good intakes. Health shakes was noted in recent progress notes - recommend obtaining physician's order TID. Last known weight 209.0# on 1/5/24, height 65, BMI at that time was 34.8 kg.m^2. It is not that resident can't eat, but rather she won't eat. Seems as though she has lost all interest in food. Tube feeding placement recommendation is not appropriate at this time. Adding more and more nutrition supplements above and beyond the three daily that is already her goal would likely not [NAME] as successful. Writer would recommend at this point that an appetite stimulant may be of benefit to turning resident's appetite around mirtazapine (remeron) is one possibility. Will continue to monitor at high risk and follow POC. -On 4/17/2024, dietician indicated resident receiving a regular, mechanically altered soft & bite sized/chopped textures with thin liquids. Orders for House Supplement three times daily. Per MAR, drinking 0-100% of the supplement three times daily during ARD. PO intakes of meals remains quite variable, refuse-100%, mostly 1-25%, drinking 100-480 ml/meal. Mirtazapine had been implemented at 7.5 mg on 3/28. Dosage was increased to 15 mg/day on 4/3 as an appetite stimulant and to help with resident's mood. This medication can take up to 4 weeks to see a significant improvement in calorie intake. Often times, the 15 mg dose is adequate for appetite stimulation. Unfortunately, resident remains bed-bound, unable to obtain weight. Writer would imagine with her poor intake and inability to participate in any significant physical activity, resident likely has experienced muscle atrophy and overall weight loss. Continue to encourage PO intakes of food/fluids/snacks/supplements. Will review/update care plan. Will continue to monitor at nutritional high risk and follow POC. -On 05/31/24, R21's weights continue to be unable to be obtained due to resident's medical condition. Facility is still monitoring her mid arm circumference to monitor her weight status/nutrition status. Reviewed progress notes. Note on 5/28 indicates the MAC measurement has decreased in size. Was 12.5 cm on 4/26/24 and now measures 11.5 cm on 5/28/24. It is also reported in progress notes that her TLSO brace continues to be too big, another weight loss indicator, and facility has sent a request in to have it discontinued as it is now causing more harm than good, causing skin impairments. Resident does have orders for nutrition supplement three times daily. Per MAR, acceptance is variable, but rarely refuses it. -On 07/25/24, dietician indicated that R21 is being supplemented with house supplement three times a day. R21 has mirtazapine 15mg daily for appetite stimulant/ R21 is unable to be weighed related to spinal precautions. Mid arm circumference was one way to track R21's overall weight status. Dietician will request updated measurement as last updated measurement was 11.5 cm on 05/28/24, which was a decrease in size compared to April. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/30/24 at 2:35 PM, Surveyor interviewed R21 and asked R21 had any concerns with R21's recent weight loss. R21 indicated that R21 is steadily losing weight. R21 indicated that R21 doesn't have much of an appetite but that R21 tries to eat and is unsure why R21 does not have an appetite after the accident. On 08/01/24 at 8:22 AM, Surveyor interviewed Registered Nurse (RN) R and asked how R21 is weighed to manage R21's weight loss. RN R indicated that right now facility cannot weigh R21 as R21 is on spinal precautions. RN R indicated that staff are using a measurement sometimes called Mid-Arm Circumference (MAC). On 08/01/24 at 10:03 AM, Surveyor interviewed Director of Nursing (DON) B and asked expectations for R21's weight loss and managing nutrition for at risk residents. DON B indicated that DON B was made aware yesterday on 07/31/24 that R21 had lost a significant amount of weight 45-50lbs since admission. Surveyor asked how staff knew that R21 had lost this much weight as Surveyor could not find any weights being completed through R21's entire stay at the facility. Surveyor indicated the only weight known in medical record was from the prior hospitalization at discharge. DON B was unsure as it was told to DON B yesterday that weighing R21 at facility can't be completed till R21 is on the gurney that transports R21 to doctor appointments. DON B indicated that R21 is going to doctor appointment today and facility will know more then about R21's weight once R21 leaves the facility. Surveyor asked DON B to explain the process for using MAC as a formal measurement of R21's weight loss. DON B indicated that DON B did not realize that is how staff are measuring weights. DON B indicated that DON B was unsure the exact process for that, and DON B could not find any documentation or order to utilize the MAC practice as a standard of practice. DON B indicated that expectation for residents with weight gain or loss and at risk is an ongoing thorough assessment with steps set forth. DON B stated that DON B would expect to review medication changes increase or decrease in appetite, review diagnosis, re-check weights often weekly and even daily if needed. DON B indicated that dietician would be notified to assess for interventions to implement along with notifying the provider. DON B indicated that staff have not been properly measuring weights on R21 and that staff have not weighed R21 at all during R21's entire stay since admitted [DATE].

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not ensure 2 of 5 residents (R16, R31) were free from unnecessary medications. R16 and R31 were prescribed lorazepam as needed (PRN), beyond the 14-day limit, without a documented rationale. Findings include: R16 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease and heart failure, anxiety disorder, and schizophrenia. R16's most recent MDS assessment completed on 04/10/24 confirmed R16 scored 12/15 during Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. On 07/31/24, Surveyor reviewed R16's physician orders which included lorazepam Oral Tablet 0.5 MG, give 0.5 mg by mouth every 4 hours as needed for anxiety until end date 10/03/2024. The start date was 04/04/2024 for the lorazepam. On 07/31/24, Surveyor reviewed R16's medication administration record (MAR), and noted PRN lorazepam was administered in June and was administered twice (06/01/24, 06/02/24). On 07/31/24, Surveyor reviewed monthly pharmacy reviews, which indicated no irregularities related to lorazepam. On 07/31/24, Surveyor reviewed a physician fax to R16's physician that included communication to the physician with a question from the facility. On 04/03/24, formerly employed RN raised the concern stating, Has PRN order for lorazepam .5mg Q40 PRN may we continue this order through October 3rd, 2024. The physician did not give a response or a reason, only a signature that was signed on 04/03/24. On 08/01/24, Surveyor was not presented with a rationale for the PRN Lorazepam prior to exit of facility. 43352 Example 2 R31's physician orders included lorazepam PRN every 2 hours for anxiety until 12/09/24. On 08/01/24, Surveyor asked DON B for a rationale for use of lorazepam beyond 14 days. On 08/01/24, DON B brought Surveyor a prescription for lorazepam with a diagnosis of anxiety. Surveyor was unable to find documentation in R31's record to confirm a rationale was provided. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/24 at 9:00 AM, Surveyor interviewed Director of Nursing (DON) B. DON B stated she looked though R16's documentation as well and could not find a rationale other than anxiety for R16's PRN lorazepam. When asked what DON B would expect to see for the use of a PRN medication like lorazepam, they said they would not have expected that rationale from the physician and they would have called back and gathered a better rationale to have on record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility did not ensure that food that was opened was thrown out according to policy. The facility did not cover food as it was being distributed in the hallways. The facility did not ensure staff used proper hand hygiene when distributing food and that hair nets were in place. This has the ability to affect all 33 of 33 residents residing in the facility. Findings include: Example 1 Expired/undated food The facility policy entitled, Food Storage, dated year 2021 states, 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days of discarded as per the 2017 Federal Food Code. On [DATE] at 8:30 AM, Surveyor performed initial tour of kitchen where they noted items in the refrigerator that were leftovers having open dates of: Diced pineapple dated [DATE] Diced potatoes dated [DATE] Pudding [DATE] Poke cake [DATE] Ham [DATE] Lobster meat was not dated On [DATE] at 8:59 AM, Surveyor interviewed Culinary Director (CD) G regarding policy for food that was opened and the storage of that food. CD G said they would expect that all foods that have been opened should be dated with the open date and throw out at a maximum of five days later. Surveyor then showed CD G the items in the fridge to which they said they would have expected those foods to be thrown out. Example 2 Uncovered food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:17 PM, Surveyor observed orange sherbert being distributed to residents eating in their own rooms that were not covered when being walked down the hallway of the facility on trays. The food items were open to the air around them. R28, R5, R13, R20, and R21 were all served the uncovered sherbert after it was walked down the hallways in the facility past the rooms of other residents. This had the potential to contaminate the sherbert. On [DATE] at 11:47 AM, Surveyor interviewed CD G regarding their expectations of food being covered when distributing to residents' rooms. CD G would expect that all foods that will be traveling outside of the dining area would be covered, and we have been working on that. There was no policy received regarding the covering of foods while being distributed to residents who choose to eat in their rooms. 43352 Example 3 The facility policy, entitled Employee Sanitary Practices states in part, All employees wear hair restraints to prevent to prevent hair from contacting exposed food. On [DATE] at 8:26 AM, Surveyor observed Dietary Aide (DA) F serving breakfast on [NAME] household. DA F had a hair net on that did not completely cover all DA F's hair. DA F's bangs and hair around frame of face was not covered with the hair net. On [DATE] at 8:57 AM, Surveyor observed Certified Nursing Assistant (CNA) H in kitchenette preparing a breakfast tray. CNA H had their hair pulled back but not in a hair net. On [DATE] at 9:22 AM, Surveyor interviewed Culinary Director (CD) G and asked if they require all hair to be covered by a hair net. CD G indicated yes. Example 4 The facility policy, entitled Bare Hand Contact with Food and Use of Plastic Gloves, reads in part Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed. On [DATE] at 8:30 AM, Surveyor observed DA F put on gloves; no hand washing was observed prior to donning gloves. DA F grabbed bread from bag, put in toaster, pressed the lever down with same gloved hands, then opened up milk, poured a glass of milk, grabbed meal ticket, grabbed toast from toaster, buttered toast, cut toast in half on the cutting board, then removed gloves, washed hands and with bare hands picked up buttered toast and put it on a plate. CNA H said to DA F, You forgot to put gloves on. DA F said, Yeah I know I just washed my hands. On [DATE] at 8:41 AM, Surveyor observed DA F put on gloves; no hand washing was observed prior to donning of gloves. DA F grabbed bread out of bag with same gloved hands, put bread in the toaster, pushed the lever down, touched plastic covered menu, then went to the toaster, grabbed the toast with same contaminated gloved hands. DA F put butter and jelly on the toast holding on to it with the same gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:22 AM, Surveyor told CD G about the above observations. CD G said, I see where that is going. Surveyor asked CD G if DA F did the above properly. CD G indicated no.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on interview and record review, the facility did not establish an Infection Control Program under which it investigates, controls, and prevents infections in the facility, and a system for recording incidents identified under the facility's Infection Control Program, including corrective action in a timely manner, for both residents and staff. This has the potential to affect all 33 residents in the facility. -The facility did not a have a clear water management process or plan in effect to prevent transmission of Legionella infection. This has the potential to effect 33 of 33 residents reviewed. -The facility did not have a tracking program in place for the early detection of infected and exposed residents (R) and staff for COVID-19 and Norovirus during an outbreak. -Observations were made of the facility not implementing Enhanced Barrier Precautions (EBP) for 2 of 3 sampled residents (R187, R186) on EBP. -Certified Nurse Assistants (CNA) were observed not wiping down Hoyer lifts after leaving an EBP room. -Registered Nurse (RN) did not follow appropriate infection control practices during wound care for 2 of 4 (R2, R7) sampled residents. This is evidenced by: Example 1 The facility policy entitled, Water Management Program, dated 11/2022, states in part: Infection Control - . #2. Develop a description of the facilities water system, including narrative description and a process flow diagram . #3. Risk Assessment - will be conducted by water management team annually to identify where legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. #4. Establish control measures, control limits, and control measures monitoring plan . #6. The measures shall be specified in the water management program action plan. The Center for Disease Control and Prevention (CDC) guidelines entitled, Controlling Legionella in potable water systems, last reviewed March 15, 2024, states in part: Flush low-flow piping runs and dead legs at least weekly and flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as-needed to maintain water quality parameters within control limits. On 08/01/24 at 8:04 AM, Surveyor reviewed the facility's Water Management Plan (WMP) and did not find a record of maintenance, inspections, or flushing of areas of concerns that required flushing. Surveyor did not observe the updated version of water management plan being utilized. Surveyor did not observe the flow diagram or WMP updated with locations of hot spots/stagnation areas deemed high risk areas of Legionella growth. Surveyor did not observe an annual risk assessment completed at all. Surveyor observed that the water management plan was copied and printed from CDC recommendations but was not individualized specific to the facility water systems. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/01/24 at 10:03 AM, Surveyor interviewed RN D, the Infection Control Nurse, who indicated that RN D and maintenance are responsible for the water management plan in the facility. Surveyor interviewed RN D and asked to walk Surveyor through the WMP. RN D indicated the current WMP that the facility is using does not show distinct quality measures on the flow diagram or where stagnation/hot spots are located throughout the facility. RN D indicated that nothing has specified locations, and the flow diagram shows just description such as water heater, fountain, etc. but not where these items are located through the building and what is being assessed. RN D indicated the WMP was printed directly from the CDC and not individualized. RN D indicated there were no audit logs being completed by the facility. Example 2 Surveyor reviewed Infection Control (IC) surveillance logs and found the facility identified the facility had an outbreak of Norovirus in April 2024. Line lists did not consist of any other information. Surveyor could not distinguish when outbreak began and when outbreak ended and how many residents and staff were affected by the outbreak. Surveyor observed data logs to be inconsistent and missing residents' identifiers and room numbers. Surveillance logs were observed missing information identifying onset of symptoms, when precautions were implemented, any testing, last well date, when symptoms ended, when precautions ended, and if provider was notified. Surveyor reviewed IC 2023-June 2024 data line lists for residents and staff. Surveyor noted that all line lists from January 2023-June 2024 were inconsistent and missing data. Surveyor reviewed and noted line lists were missing the infection site, pathogen, signs and symptoms, residents' or staff's location, last well date, any summary and analysis of the number of residents and staff who developed infections. Line lists had incomplete data. On 08/01/24 at 10:03 AM, Surveyor interviewed RN D who confirmed there was another outbreak of COVID-19 but that no documentation was found. RN D indicated that RN D could not find any information or line lists pertaining to the COVID-19 outbreak. RN D could not confirm who all was affected by the outbreak and what measures the facility did to mitigate the spread of COVID-19. Surveyor asked RN D if there was any other information that RN D could provide Surveyor pertaining to the documentation of the COVID-19 outbreak. RN D indicated that RN D had no other information as the COVID-19 outbreak was not surveilled as it should have been. Surveyor asked RN D about the process for tracking surveillance of resident infections and sicknesses. RN D indicated that line lists were incomplete throughout the whole year last year in 2023 and into June of 2024. Example 3 The facility policy entitled, Enhanced Barrier Precautions, dated 04/1/24, states in part: . EBP precautions will be applied for any resident high contact care activities involving residents who have wounds, indwelling medical devices, and infections. Precautions include use of gown, gloves and will be used with any high contact activities including dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting care . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/30/24 on 9:37 AM, Surveyor observed CNA H and CNA Q enter R187's room. R187 is on EBP due to chronic open wounds on the buttocks. CNA H and CNA Q entered the room without applying Personal Protective Equipment (PPE). CNA H and CNA Q performed peri cares on R187 and then transferred R187 with Hoyer to R187's wheelchair. CNA H and CNA Q pushed Hoyer lift out of R187's room without wiping down the Hoyer lift and exited R187's room. CNA H and CNA Q sanitized hands after walking to soiled room to dispose of soiled trash. Example 4 On 07/30/24 at 2:56 PM, Surveyor observed CNA J, CNA L, and CNA M don PPE before entering R186's room to provide cares. R186 is on EBP due to having a catheter. On 07/30/24 at 2:59 PM, Surveyor observed CNA M walk out of R186's room and down the hall wearing full PPE from R186's room. CNA M was observed walking down hall in full PPE and entering clean linen closet to obtain clean linens. Surveyor observed CNA M walk back down the hallway with full PPE and back into R186's room. On 07/30/24 at 3:07 PM, Surveyor observed CNA J, CNA L, and CNA M walk out of R186's room with PPE on and park the Hoyer lift outside in hallway. CNA J, CNA L, and CNA M doffed their PPE in the hallway where R186's PPE trash can is located. CNA J, CNA L, and CNA M walked down the hallway and into a storage break room. Surveyor did not observe hand sanitizing performed. Example 5 On 07/30/24 on 9:37 AM, Surveyor observed CNA H and CNA Q enter R187's room, who is on EBP. CNA H and CNA Q performed peri cares on R187 and then transferred R187 with Hoyer to R187's wheelchair. CNA H and CNA Q pushed Hoyer lift out of R187's room without wiping down the Hoyer lift and exited R187's room. CNA H and CNA Q sanitized hands after walking to soiled room to dispose of soiled trash. CNA H and CNA Q did not return to sanitize the lift. Example 6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/31/24 at 10:58 AM, Surveyor observed RN C enter R2's room. RN C washed hands for 5 seconds and dried hands with paper towels. RN C applied gloves and placed new paper towels on floor next to R2 to create a barrier on the floor. RN C took R2's shoes and socks off and placed to the side. RN C opened a blue gown with contaminated gloves and placed blue gown on. RN C gathered supplies out of closet drawer where wound supplies were stored with contaminated gloved hands. RN C laid them on the paper towels on the floor. RN C changed gloves and reapplied a pair of gloves without performing hand hygiene in between glove use. RN C proceeded to grab the wound care solution bottle and spray gauze and then wash the surface of the right great toe wound. RN C then grabbed mepilex dressing and applied the dressing to the right great toe wound. RN C took gloves off and reapplied another pair of gloves without performing hand hygiene in between glove use. RN C proceeded to grab the wound care solution bottle, spray gauze and then wash the surface of the left great toe wound. RN C stated, I forgot the scissors. RN C walked over to the dresser drawer and grabbed the scissors out with the contaminated gloves, then grabbed the sterile pack of Aquacel, opened the package and grabbed the whole sheet of Aquacel out of the package. RN C cut the length needed for dressing change and then laid supplies on the paper towel surface on floor. RN C then opened Mepilex package and grabbed the piece of Aquacel and applied the Aquacel to R12's left great toe. Surveyor observed RN C place the plastic film side of the Aquacel directly on R2's wound. RN C then took Mepilex dressing and applied to R2's left great toe wound. RN C then grabbed the Aquacel pad and readjusted the big piece of supplies and placed it back in the packaging and rolled the top down. RN C picked up all the supplies with the right contaminated gloved hand. While RN C held the supplies in the right hand, RN C picked up the trash on the dirty paper towels on floor and threw in the trash. RN C then grabbed the supplies with the contaminated left hand and placed the supplies back into the wound supply drawer. RN C took gloves off and exited R2's room. Surveyor did not observe RN C perform hand hygiene after exiting R2's room. On 07/31/24 at 11:08 AM, Surveyor interviewed RN C and asked about hand hygiene practices during wound care. RN C indicated that RN C used gloves often and sanitized as needed. RN C admitted to not washing hands or using hand sanitizer between glove changes. Interviews On 08/01/24 at 10:03 AM, Surveyor interviewed DON B and asked about Infection Control (IC) management through the building. DON B indicated that IC is lacking in many ways as there has been huge turn over with staff and going forward DON B will be implementing new measures and will be involved with managing IC. On 08/01/24 at 11:10 AM, Surveyor interviewed RN D and asked about hand hygiene practices. RN D indicated that expectation is that hands are to be sanitized between glove changes and before or after leaving a resident's room. Surveyor indicated to RN D that Surveyor had observations of staff not utilizing PPE in EBP rooms and exiting EBP rooms with PPE still on. Surveyor also indicated that equipment being used in EBP rooms was not being wiped down appropriately. RN D indicated that it is expectation that all staff follow the EBP policy through the whole facility and don and doff PPE according to EBP policy. RN D indicated that any equipment that is utilized in EBP rooms is to be wiped down thoroughly with sanitizing wipes if equipment is used for other residents. 40181 Example 6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy and procedure entitled Handwashing, last revised 11/22, stated in part: .Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Alcohol based hand sanitizer should be used: Immediately before touching a patient .before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal . Resident (R) 7 was admitted to the facility on [DATE] with diagnoses including, in part, malignant neoplasm of endometrium, unspecified wounds left lower leg, local infection of the skin and subcutaneous tissue, and cellulitis of left lower limb. On 07/30/24 at 10:07 AM, Surveyor interviewed R7 who stated they had wounds on lower legs and the nurse changed bandages daily. Surveyor asked if R7's wounds were infected. R7 stated they had recently been on antibiotics for infection in the leg wounds, but they were better now. Surveyor reviewed R7's medical record and identified the following physician orders: 07/10/24 Apply hydrofera blue to Left Ankle wound, cover with 4x4 Mepilex dressing. Change daily. (& prn to keep ulcer covered) may wrap to reinforce dressing(s). one time a day Left Ankle ulcer. 07/10/24 Right & left medial ankle - open areas. cleanse, dry, Aquacel overtop & beyond open areas, followed by mepilex dressing. Change daily & prn. may wrap legs to reinforce dressings. one time a day for open areas right lower leg/ ankle & left medial ankle. 01/23/24 Cover left ankle ulcer &/or right medial thigh PRN excessive drainage. per hospice. Use mepilex or ABD pad & tape, use nurse judgement as needed for excess drainage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/31/24 at 9:49 AM, Surveyor observed RN C provide wound care for R7's lower leg wounds in R7's room. RN C used Alcohol Based Hand Rub (ABHR) at the doorway of R7's room and donned gown and gloves upon entering the room. With gloved hands RN C pushed R7 in the wheelchair directly in front of a dresser in the room. With gloved hands RN C opened the bottom drawer of the dresser which was filled with dressing supplies. RN C removed the old dressing from the left outer ankle and threw it in the waste basket beside the dresser. With the same gloves on, RN C reached in the drawer and took several gauze pads out of a package, picked up a bottle of wound wash, wet the gauze pads, and washed the wound on R7's left outer ankle. RN C disposed of the gauze pads used to wipe the wound. With the same gloves on, RN C reached in the drawer and took a piece of hydrofera blue dressing out of an opened package in the drawer. RN C cut the blue dressing with a scissors from the drawer. RN C placed the remaining blue dressing back in the opened package in the drawer and placed the scissors on the bottom of the drawer. RN C did not sanitize the scissors before or after use. With the same gloves on and while holding the cut blue dressing in one hand, RN C opened the second drawer on the dresser and took out a package with an ABD pad, opened the package and placed the blue dressing on the ABD pad. RN C placed the ABD pad and blue dressing in their lap while squatted down in front of R7's wheelchair. With the same gloves on, RN C took a piece of Aquacel dressing out of an opened package in the drawer and cut it with the scissors. RN C did not sanitize the scissors before or after use. RN C placed the remaining Aquacel dressing back in the opened package in the drawer. While holding the Aquacel dressing in one hand, RN C reached in the second drawer and took out a second ABD pad, took it out of the package, and placed the Aquacel dressing on top of the ABD pad. RN C then placed the ABD on top of the other ABD pad in their lap. With the same gloves on, RN C removed the old dressing from R7's left inner ankle and threw it in the trash. With the same gloves on, RN C took some gauze pads out of the opened package in the drawer, picked up the wound wash bottle, and wet the gauze pads. RN C wiped the wound on R7's left inner ankle and threw the gauze pads in the trash. With the same gloves on, RN C took a package of roll gauze out of the drawer and opened it. RN C placed the ABD pad with the hydrofera blue dressing on the left outer ankle and the ABD pad with the Aquacel dressing on the left inner ankle and then wrapped the roll gauze around the dressings to hold them in place. RN C cut the roll gauze with the scissors from the drawer and placed the remaining roll and scissors back in the drawer. RN C took tape out of the drawer and taped the roll gauze in place. With the same gloves on, RN C removed the old dressing from R7's right ankle and threw it in the trash. With the same gloves on, took several gauze pads out of the opened package in the drawer, picked up the bottle of wound wash and wet the gauze pads. RN C wiped R7's wound on the right ankle with the wet gauze pads. RN C threw the gauze pads in the trash. With the same gloves on, RN C took a mepilex dressing out of the drawer and opened the package. While holding the mepilex dressing in one hand, RN C took the Aquacel dressing out of the opened package in the drawer and cut a piece with the scissors from the drawer. RN C placed the remaining Aquacel dressing back in the open package in the drawer and placed the scissors back in the drawer. RN C placed the cut piece of Aquacel dressing over the wound on R7's right ankle and covered it with the mepilex dressing. RN C removed gloves and gown and threw away. RN C did not use ABHR or wash hands after removing gown and gloves. RN C took a pen out of uniform pocket and wrote on the dressings. RN C placed supplies back in the drawers and closed the drawers. RN C put on clean gloves without using ABHR or washing hands and took the plastic bag liner out of the trash can, tied it, and set it on the floor. RN C placed a new plastic bag in the trash can. RN C picked up the tied bag with gloved hands and left resident room. R7 asked Surveyor a question as RN C was leaving the room, so Surveyor did not observe RN C after they left the room with the trash bag and gloves on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525466	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Health and Rehab Center	S830 - Westland Dr Spring Valley, WI 54767

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Surveyor noted RN C did not change gloves or sanitize hands or scissors at any time during the wound care procedure. RN C touched multiple dressing supplies and surfaces with contaminated gloves during the wound care procedure. RN C did not sanitize or wash hands after removing gown and gloves and before putting clean gloves on. On 07/31/24 at 11:52 AM, Surveyor interviewed RN C about the above observation and asked what the facility procedure was for glove use, glove change, and hand hygiene during wound care. RN C stated they should wash hands or use ABHR before putting on gloves and when they change gloves. Surveyor asked if RN C changed gloves or used ABHR at any time during the wound care procedure. RN C said they used ABHR before putting on the gown and gloves prior to providing wound care. Surveyor asked RN C if they should change gloves and use ABHR after removing old dressings and cleaning wounds, and before touching or cutting new dressings. RN stated they probably should do that but did not do that today during R7's wound care. On 07/31/24 at 12:12 PM, Surveyor interviewed Director of Nursing (DON) B and reviewed the above wound care observation performed by RN C. Surveyor asked DON B what the expectation would be for hand hygiene, and glove changes during wound care procedures. DON B stated RN C should use ABHR or wash hands before starting, and every time they change gloves. DON B stated RN C should remove gloves, use ABHR, and put on clean gloves after removing old dressings, cleaning wounds, and before touching clean dressings. DON B stated the scissors used to cut dressings should be sanitized with an alcohol wipe before use. DON B stated RN C should wash hands with soap and water after removing gown and gloves when wound care procedure is completed. DON B stated RN C did not perform appropriate infection control procedures during this wound care observation and education would be provided.