STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review the facility did not ensure that 6 (R2, R12, R33, R35, R39, & R46) of 13 Residents reviewed for a room change within the facility, were provided with prior written notice, including reason for the room change. *R2 transferred to another room on 4/12/24 and did not receive prior written notice, was not given a choice or rooms, and did not meet potential roommate prior to the transfer. There is no documentation that R2's guardian was provided written notice. *R12 transferred to another room on 2/28/24 and did not receive prior written notice, was not given a choice or rooms, and did not meet potential roommate prior to the transfer. There is no documentation that R12's guardian was provided written notice. *R33 transferred to another room on 4/9/24 and did not receive prior written notice, was not given a choice or rooms, and did not meet potential roommate prior to the transfer. *R35 transferred to another room on 4/30/24 and did not receive prior written notice, was not given a choice or rooms, and did not meet potential roommate prior to the transfer. *R39 transferred to another room on 4/10/24 and did not receive prior written notice, was not given a choice or rooms, and did not meet potential roommate prior to the transfer. There is no documentation that R39's activated Health Care Power of Attorney(HCPOA) was provided written notice. *R46 transferred to another room on 4/15/24 and did not receive prior written notice, was not given a choice or rooms, and did not meet potential roommate prior to the transfer. There is no documentation that R46's unactivated HCPOA was provided written notice. Findings Include: Surveyor reviewed the facility's Change of Room or Roommate policy and procedure dated 3/7/23 and notes the following: (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Policy Explanation and Compliance Guidelines: 4. Prior to making a room change or roommate assignment, all person involved in the change/assignment, such as Residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the Resident and representative understands and will include the reason(s) why the move or change is required. 6. The social service staff can assist the Resident to adjust to the new room or roommate by: a. Informing the Resident and family as soon as possible of the room or roommate change. b. Involving the Resident in the decision and selection of a room or roommate when possible. c. Allowing the Resident to ask questions about the move. d. Showing the Resident where the room is located. e. Introducing the Resident to his/her new roommate and sharing information about the new roommate while maintaining confidentiality regarding medical information in order to help the Resident become acquainted. f. Introducing the Resident to employees who will be providing care. g. Explaining to the Resident why the change is necessary; reassuring the Resident his/her personal possessions will be safeguarded. 7. The Social Service designee or Licensed Nurse should inform the Resident's sponsor/family in advance of a change in the Resident's room or roommate. 8. A Resident has the right to refuse a transfer to another room within the facility. On 5/9/24 at 11:05 AM, Surveyor met with a group of Residents for the group interview to complete the Resident Council task during the surveyor process. R2 and R35 informed Surveyor that R2 and R35 had been transferred to another room without giving permission, was not given prior knowledge of the transfer, was not given choices of potential options for a new room, and was not provided opportunity to meet any potential new roommate. R2 and R35 informed Surveyor that a lot of room changes had been completed in the past couple of months. On 5/13/24 at 11:09 AM, Surveyor requested a list of Resident room changes from Social Services Director(SSD-H). Surveyor completed an electronic medical record(EMR) audit and notes the following Residents had a room change and did not receive advance written notice, and there is no documentation that the Residents/representative gave consent. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) R2 was admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis, Type 2 Diabetes Mellitus, Hemiplegia, Affecting Right Dominant Side, Chronic Kidney Disease, Mild Intellectual Disabilities, Major Depressive Disorder, and Dementia. R2 has a legal guardian. R2's Quarterly Minimum Data Set(MDS) dated [DATE] documents R2's Brief Interview for Mental Status(BIMS) score to be a 15, indicating R2 is cognitively intact for daily decision making. On 5/9/24 at 11:05 AM, R2 informed Surveyor that R2 did not give permission to transfer to another room. R2 stated R2 did not want to move. R2 informed Surveyor that they walked in R2's room and stated R2 is transferring to another room, and R2 moved that same day to a new room. R2's EMR documents R2 transferred rooms on 4/12/24. R2's EMR contains no documentation that R2/representative was provided advance written notification of the room change, the reason for the room change, the opportunity to choose from a selection of roommates, and that R2 was provided the opportunity to meet any new potential roommates. Surveyor notes there is no documentation that R2/representative gave consent for the room transfer. Surveyor also notes there is no follow-up documentation to indicate how R2 was adjusting to the room transfer. On 4/12/2024 LPN-Q documents in R2's EMR: Tolerating room change well. 2) R12 was admitted to the facility on [DATE] with diagnoses of Hemiplegia and Hemiparesis following Cerebrovascular Disease Affecting Left Non-Dominant Side, Epilepsy, Major Depressive Disorder, and Delusional Disorders. R12 has a legal guardian. R12's Quarterly Minimum Data Set(MDS) dated [DATE] documents R12's Brief Interview for Mental Status(BIMS) score to be a 1, indicating R12 is severely impaired for daily decision making. R12 is non-interviewable. R12's EMR documents R12 transferred rooms on 2/28/24. R12's EMR contains no documentation that R12/representative was provided advance written notification of the room change, the reason for the room change, the opportunity to choose from a selection of roommates, and that R12 was provided the opportunity to meet any new potential roommates. Surveyor notes there is no documentation that R12/representative gave consent for the room transfer. Surveyor also notes there is no follow-up documentation to indicate how R12 was adjusting to the room transfer. 3) R33 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Human Immunodeficiency Virus, Unspecified Cirrhosis of Liver, Restlessness and Agitation, and Anxiety Disorder. R33 is his own person. R33's primary language is Spanish. R33's Quarterly Minimum Data Set(MDS) dated [DATE] documents R33's Brief Interview for Mental Status(BIMS) score to be a 15, indicating R33 is cognitively intact for daily decision making. R33 was not available for interview. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's EMR documents R33 transferred rooms on 4/9/24. R33's EMR contains no documentation that R33 was provided advance written notification of the room change in a language R33 could understand, the reason for the room change, the opportunity to choose from a selection of roommates, and that R33 was provided the opportunity to meet any new potential roommates. On 4/10/24 Registered Nurse(RN-O) documented in R33's EMR: Monitoring due to 4/9/24 room change. No issues noted. Seems okay with room change. 4) R35 was admitted to the facility on [DATE] with diagnoses of Chronic Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Venous Insufficiency, Major Depressive Disorder, and Anxiety Disorder. R35 is his own person. R35's Quarterly Minimum Data Set(MDS) dated [DATE] documents R35's Brief Interview for Mental Status(BIMS) score to be a 15, indicating R35 is cognitively intact for daily decision making. On 5/9/24 at 11:05 AM, R35 informed Surveyor that they came and told me I was moving with no knowledge. R35 informed Surveyor that R35 did not give permission to transfer rooms. R35 stated they just said you are moving. R35 stated that R35 had to transfer rooms that same day. R35 states R35 now has to share a bathroom. R35's EMR documents R35 transferred rooms on 4/30/24. R35's EMR contains no documentation that R35 was provided advance written notification of the room change, the reason for the room change, the opportunity to choose from a selection of roommates, and that R35 was provided the opportunity to meet any new potential roommates. On 5/1/2024 Licensed Practical Nurse documented in R35's EMR: Moved from wing 6 and is adjusting. 5) R39 was admitted to the facility on [DATE] with diagnoses of Chronic Pulmonary Embolism, Bipolar Disorder, Anxiety Disorder, Dementia, and Schizophrenia. R39 has an activated HCPOA. R39's Annual Minimum Data Set(MDS) dated [DATE] documents R33's Brief Interview for Mental Status(BIMS) score to be a 0, indicating R39 is severely impaired for daily decision making. R39 is non interviewable. R39's EMR documents R39 transferred rooms on 4/10/24. R39's EMR contains no documentation that R39 was provided advance written notification of the room change, the reason for the room change, the opportunity to choose from a selection of roommates, and that R39 was provided the opportunity to meet any new potential roommates. On 4/11/2024 RN-O documents in R39's EMR: R39 seems okay with 4/10/24 room change to wing 4 6) R46 was admitted to the facility on [DATE] with diagnoses of Malignant Neoplasm of Unspecified Ovary, Bipolar Disorder, and Schizophrenia. R46 is currently her own person. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R46's Quarterly Minimum Data Set(MDS) dated [DATE] documents R46's Brief Interview for Mental Status(BIMS) score to be a 11, indicating R46 is moderately impaired for daily decision making. R46 is non interviewable. R46's EMR documents R46 transferred rooms on 4/15/24. R46's EMR contains no documentation that R46 was provided advance written notification of the room change, the reason for the room change, the opportunity to choose from a selection of roommates, and that R46 was provided the opportunity to meet any new potential roommates. On 4/19/2024, LPN-Q documented in R46's EMR: R46 is being monitored for room change. room change well. Resident is safe and continue to observe. On 5/13/24 at 11:09 AM, Surveyor interviewed SSD-H in regards to the room transfers . SSD-H stated the facility got verbal consent from the Residents for the room transfers and the expectation would be that it should be documented in the Residents' progress notes. SSD-H stated the reason for all the room transfers was to move the more independent Residents in the front of the facility so that is what people saw when you first walked into the facility. SSD-H stated the facility moved all the dependent Residents with hoyers to the back of the facility. SSD-H informed Surveyor that Residents were moved due a dignity issue. SSD-H stated there is no written form that the Resident/representative is provided prior to the room transfers and that the Resident/representative consent to the room transfer would be documented in the Residents' EMR. SSD-H recalls giving advance notice for the room transfers but the facility could not guarantee the day of the room transfer that the room decided on would be the actual room the Resident transferred to. On 5/13/24 at 3:20 PM, Surveyor shared the concern with Administrator(NHA-A) and RN Consultant(RNC-C) the concern that R2, R12, R33, R35, R39, & R46 were transferred to another room and were not provided advance written notice with an explanation of why the room transfer is required. Surveyor also shared there is no documentation that R2, R12, R33, R35, R39, & R46/representative gave consent for the room transfer. No further information was provided by the facility at this time.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50742 Based on record review and interview, the facility did not ensure that 2 (R47 &R322) of 7 facility reported incidents investigations reviewed were reported to the State Survey Agency, within 5 working days of the incidents, after the initial reporting and with the results of the investigations of each alleged violation. Findings include: The facility's policy with no date and titled Abuse, Neglect and Exploitation documents: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes . B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1. R47 was readmitted to the facility on [DATE] with a diagnosis that included of Unspecified Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety. R47's MDS (Add Date and type) documents a BIMS (Brief Interview for Mental Status) score of 0, indicating that R47 is severely cognitively impaired. Section E0100 (Potential Indicators of Psychosis) documents that R47 experiences hallucinations and delusions. Section GG0115 (Functional limitation in range of motion) no impairment to lower and upper extremities. The facility's self-report submitted to the State Agency dated 4/5/24 documents: It was reported to the Administrator of a possible resident to resident altercation during a scheduled activity; Factual findings revealed: Through a detailed investigation, including resident statements, both residents were attending an activity in the activity room with activity staff present. Resident A was being very vocal that triggered resident b to become agitated. She kicked at him and made contact with his wheelchair. Resident B swung back as a reaction. Neither resident was physically or emotionally harmed due to the interaction. Staff statement: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Today at the beginning of our 10 am activity, R47 told resident to shut up as she was talking loudly. She then yelled back at him and kicked the side of his chair. At this point, resident was pulling R47 back and staff was pulling away to de-escalate the situation. Both residents were cussing and yelling. While being separated, R47 made contact with the leg of resident. The facility's follow up report was submitted on 4/15/24. Surveyor noted that the subsequent investigation was not reported to state agency within 5 working days after the initial report. On 5/9/24 at 1:35 PM, Surveyor informed Nursing Home Administrator (NHA-A) of the above findings. Surveyor asked NHA-A why the facility had not submitted the above self-report to the state agency within 5 working days after the initial reporting on 4/5/24. NHA- A informed Surveyor that she was unsure why the facility did not report to the state agency within 5 working days of the initial reporting on 4/5/24 but that she would review the self-report and let Surveyor know. On 5/14/24 at 8:32 AM, NHA- A informed Surveyor that the facility attempted to follow the resident-to-resident altercation flow chart and was confused as to if the actions that were reported were willful or not. NHA-A informed Surveyor that the facility should have reported to the state agency within 5 working days of the initial report of 4/5/24. NHA-A informed Surveyor that going forward the facility would follow the reporting guidelines for investigations. No additional information as to why the facility did not report to the State Agency, within 5 working days of the incidents, after the initial reporting and with the results of the investigations of each alleged violation. 42037 2.) On 5/8/24 at 12:25 PM, Surveyor reviewed a Facility self-report with a report submitted date of 3/20/24. The Facility's self-report described an allegation of staff for potential misappropriation of $60 from R322 that occurred on 3/11/24. On 5/8/24 at 3:15 PM, Surveyor conducted interview with NHA-A. Surveyor asked what staff members at the facility would be responsible for submitting self-reports of abuse, neglect or misappropriation allegations to the state agency. NHA-A responded that Facility's administration would be responsible for submission of self-reports. Surveyor noted the facility's self-report was submitted to the state agency on 3/20/24 at 1:18 PM. On 5/9/24 at 3:22 PM, Surveyor asked NHA-A about the self-report regarding R322's allegations of potential misappropriation of $60 and why it was not submitted within 5 days as required by the State Agency. NHA-A responded that there had been a misunderstanding as NHA-A was previously working in a different state that had different reporting requirements. NHA-A reported that they have since acclimated themselves to the state agency's reporting requirements. On 5/9/24 at 3:30 PM, Surveyor shared concerns with NHA-A that R322's allegation of suspected misappropriation that occurred on 3/11/24 was not reported to the state agency until 3/20/24 at 1:18 PM. No additional information was provided by the facility at this time.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and interview, the facility did not incorporate the recommendations from the Preadmission Screen and Resident Review (PASARR) Level 2 determination and evaluation report into a Resident's assessment, care planning, and transitions of care for 1 (R52) of 1 Resident reviewed with PASARR level 2 recommendations. *R52's PASARR dated 7/21/21 determination states R52 needs specialized services to address R52's developmental disability needs. Findings Include: Policy Review: Specialized Rehabilitative Services (date implemented- blank, Date reviewed- blank, Date revised- blank) Policy: The facility shall provide or obtain services from an outside resource for specialized rehabilitative services if required by the resident's comprehensive assessment and care plan to assist them to attain, maintain or restore their highest practicable level of physical mental functional and psycho- social well-being, as well as ensure that residents with Mental Disorder (MD), Intellectual Disability (ID) or related conditions receive services as determined by their Preadmission Screening and Resident Review (PASARR). Policy Explanation and Compliance Guidelines: (includes) 1. Specialized rehabilitative services include but are not limited to the following: a. Physical therapy b. Speech-language pathology c. Occupational therapy d. Respiratory therapy e. Specialized services for mental illness or intellectual disability (those services to be provided by the State in accordance with the PASARR report) 2. Specialized rehabilitative services will be provided under the written order of a physician by qualified personnel. 4. The care plan for individuals receiving specialized rehabilitative services will be monitored and revised as indicated by a licensed professional. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R52 was originally admitted to the facility on [DATE] with diagnosis that included Cerebral palsy, Asthma, Blindness Right Eye, Major Depressive Disorder, Bipolar Disorder, Developmental Disorder, Anxiety and Seizures. On 7/21/21, the Level 2 Preadmission Screen and Resident Review (PASARR) was completed by a Qualified Intellectual Disabilities Professional (QIDP). The determination was that R52 is appropriate for placement in a nursing home and has both an intellectual/ developmental disability needs. It was determined that R52 needs specialized services to address his/ her developmental disability needs. The decision was based primarily on the following: R52 needs specialized services. The focus of the Specialized Services is to maintain or improve his current level of functioning. SPRS should include a thorough assessment of his unique capabilities, functional limitations, and behaviors, if any, by a QIDP. He requires full assistance with monitoring his own health status and administering medications. He requires assistance with activities of daily living. He is lacking independent living skills. Staff should encourage his involvement in activities of daily living and allow extra time when learning new skills. A review of R52 individual plan of care indicates that R52 requires Specialized Services. Resident has Impaired Mobility r/t (related to) Cerebral Palsy. Decreased Range of Motion due to contractures Date Initiated: 07/30/2021. Created by: (Licensed Practical Nurse) Revision on: 11/03/2023 o Resident will have ADL needs met with Staff assistance Date Initiated: 08/02/2021 Created on: 08/02/2021 o Bed mobility/Repositioning: Total assist for all ADL completion. Mod assist of 1 to roll-log roll technique. Date Initiated: 07/30/2021 o R52 continues needing Specialized Services. All of his posters have been updated on his door and wall. I love going down the hallway and listening to his Christmas music and hearing staff sing along with him. R52 will remember everyone's voices and say their name each time upon saying Hello. Smart guy! And very happy when staff sings his favorite music with him. The [NAME] was a perfect addition to his room! Date Initiated: 09/30/2022 o R52 continues needing specialized services. He is a happy guy who sings a lot of music!! He has the [NAME] in his room that he loves!! He knows how to use it now (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and can verbalize [NAME] to play whatever music he wants. His favorite is Christmas music. When knocking on the door to announce who is coming in, all you have to do is say Hi R52 and he knows exactly who is coming in just by their voice. Smart guy. He has been accepted to a group home and will be leaving in the next week or two. Date Initiated: 12/29/2021 Surveyor conducted a review of the most recent full MDS, annual, dated 8/25/23. The MDS indicates that R52 has the following in place: PASARR level 1- yes PASARR level 2- serious mental illness- yes PASARR level 2 conditions- Intellectual Disability- NO PASARR level 2 conditions- other related conditions- no On 05/13/24 at 12:50 p.m., Surveyor made an observation of R52's room. Surveyor did not observe any posters in R52's room. There was a sign by closet stating to keep head of bed elevated at 30 degrees at all times. In addition, there was a sign on closet door- do not use R52's supplies for other residents. These are his own personal supplies. Surveyor did observe an [NAME] device on the end table . On 05/14/24 at 08:25 a.m., Surveyor interviewed Director of Social Services (DSS)- H DSS- H stated that she had worked at the facility for approximately 1 year. DSS-H stated that she has not worked with Residents who are in need of Specialized Services before. There is a total of 3 residents who receive specialized services in the facility. DSS- H stated that she was involved in making the plan of care and the use of sensory items such as stuffed animals. Surveyor asked if DDS- H has reviewed R52's needs for Specialized Services. DSS- H stated that the team will re-evaluate as needed. If R52 becomes more behavioral, may need to make changes. The music and stuffed animals help with behaviors. DSS- H I understand that the music plan is more to treat the behaviors. I'm not aware of what to add to care plan for the Specialized Services. Surveyor went over the plan of care and asked about the intervention of posters being placed in R52's room. DSS-H stated ,I'm not even sure what they were or what they said or used for. Surveyor shared observations of R52's room and there were no posters on the walls. DSS- H stated that she will need to have help moving forward to write the plan of care for Specialized Service needs for R52. As of the time of exit, the facility did not provide additional evidence that they had developed a plan for R52 to address his needs for specialized services. The facility was unable to state why they have not reevaluated R52's needs for Specialized Services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49011 Based on record review, observation and interview, the facility did not ensure a complete baseline care plan was developed and addressed all of the resident's needs within 48 hours of admission for 1 (R371) of 2 sampled residents for new admission. R371's baseline care plan did not address R371's enabler bar usage on the baseline plan of care. Findings include: The facility policy titled, Baseline Care Plan, with implementation date, February 2023, states in part: Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b.Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i.Initial goals based on admission orders. ii.Physician orders . 2 b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury . ii. Any identified needs for supervision . iii. Any special needs such as IV therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented in the designated format . R371 was admitted to the facility on [DATE] from the hospital with a primary diagnosis of paraplegia, complete; and other diagnoses which include, in part, morbid obesity, chronic respiratory failure, local infection of the skin and subcutaneous tissue, fibromyalgia, and osteoarthritis. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R371's Admission Minimum Data Set (MDS) with an assessment reference date of 5/5/24 indicated R371 had a Brief Interview for Mental Status score of 15 (fully intact memory). R371 is able to make decisions for themselves. R371's MDS showed that upper extremities have no impairment and lower extremities have impairment on both sides. R371 uses a wheelchair for mobility. R371 has a physician order for enabler bars to assist with self positioning dated 4/29/2024. On 05/08/24 at 09:49 AM, Surveyor notes observing enabler bars on R371's bed. R371's baseline care plan with admitted [DATE] has no mention of the enabler bars under the Focus, Goal or Interventions sections. On 5/9/2024 a Screening Tool form was completed by Evolve Therapy Services with a note stating Patient does have ability to utilize assist bar on bed to improve bed mobility. Surveyor notes this was completed on the same day that the assessment information was requested from the facility, 10 days after physician order and admission. Surveyor noted that R371 did not have a baseline care plan upon admission. On 05/13/24 at 03:19 PM, Surveyor informed Nursing Home Administrator-A and Regional Nurse-C of the above concerns On 05/14/24 at 10:30 AM, Surveyor spoke with Regional Nurse-C who agreed that enabler bars should have been placed on the baseline care plan for R371. No additional information was provided as to why the facility did not ensure a complete baseline care plan was developed and addressed within 48 hours of admission for R371.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observations, interviews, and record review, the facility did not ensure 1 (R32) of 1 Resident reviewed for communication with the use of hearing aides, received proper treatment and assistive device to maintain R32's hearing abilities. Findings Include: R32 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Type 2 Diabetes Mellitus, Hypo-osmolality and Hyponatremia, and Gastro-Esophageal Reflux Disease. R32 has an activated health care power of attorney(HCPOA). R32's Significant Change Minimum Data Set(MDS) dated [DATE] documents R32's Brief Interview for Mental Status(BIMS) score to be a 0 indicating R32 demonstrates severely impaired skills for daily decision making. R32 has no behaviors documented. R32's Patient Health Questionnaire(PHQ-9) score is 8 indicating mild depression. R32 has no range of motion(ROM) impairment on upper extremities, and does have ROM impairment on bilateral lower extremities. R32's MDS documents R32 is dependent for dressing, mobility and transfers. R32's MDS documents that R32 has moderate difficulty for hearing and does not have hearing aides. R32 usually understands and usually is understood. R32's Certified Nursing Assistant(CNA) care card does not document that R32 has bilateral hearing aides. R32 has the following care plan in place for having difficulty with hearing: The resident has a communication problem r/t progressive neurological disease and hard of hearing 5/8/23 Resident will be able to make basic needs known on a daily basis through the review date. Encourage resident to see audiologist on next visit, she has previously declined the service. 5/8/23 Anticipate and meet needs. [CNA] 5/8/23 Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express. 5/8/23 Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed. 5/8/23 Refer to Audiology for hearing consult as ordered 5/8/23 R32 also has a care plan documenting that R32 has impaired cognitive function/dementia or impaired thought processes due to diagnosis 11/14/23 with the following intervention: (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Identify yourself at each interaction. Face R32 when speaking and make eye contact. Reduce any distraction-turn off television, radio, close door. R32 understands consistent, simple, directive sentences. Provide R32 with necessary cues. 11/14/23 Surveyor notes there is no documentation in R32's electronic medical record(EMR) that R32 has refused to have the hearing aides put in on a daily basis. On 5/8/24 at 9:27 AM, Surveyor observed R32 in bed and did not have R32's bilateral hearing aides in. On 5/9/24 at 8:27 AM, Surveyor observed R32 watching television and R32 informed Surveyor that R32 did not have any hearing aides in. On 5/9/24 at 12:58 PM, Surveyor notes that R32's television is very loud, and R32 is having difficulty hearing Surveyor. R32 informed Surveyor that R32 has not been wearing hearing aides for a long time. On 5/13/24 at 8:55 AM, R32 informed Surveyor that R32 does not know if R32 has hearing aides. Surveyor observed the hearing aide charger on R32's bedside table. R32 was seen by the audiologist on 7/17/23. The audiologist documented that speech had to be loud for R32 to hear audiologist. With the hearing loss, R32 will miss all of conversational speech and that R32 has severe sesorineural hearing loss in both ears. On 9/7/23, documentation from the audiologist stated that the new hearing aides fit well, included 1 charger, cleaning tool and user manuals. Audiologist documented that television volume went from 36 without hearing aides to 5 with the hearing aides. It is also documented to store the hearing aides on the charger at night, keep charger plugged into wall outlet, wipe down hearing aides daily with a dry cloth and for R32 to wear daily. On 4/17/2024, the audiologist documented that R32's hearing aides fit well and for the nurse to store the hearing aides in the charger at night. The audiologist documents that R32 requires assistance with insertion and removal of hearing aides daily. To store the hearing aides on the charger at night and keep charger plugged into wall outlet. On 4/17/2024 Social Worker(SW-R) documented that R32 was seen by Audiology. Change wax filter monthly or PRN; R32 requires assistance with insertion and removal of hearing aids daily. Store hearing aids on charger at night, and keep charger plugged into wall outlet. Hearing Aids worn daily. On 5/13/24 at 3:20 PM, Surveyor shared the concern with Administrator(NHA-A) and RN Consultant(RNC-C) that R32 has not been wearing R32's hearing aides during the survey process. No further information was provided by the facility at this time. On 5/14/24 at 9:23 AM, Surveyor interviewed RN-E in regards to R32's hearing aides. RN-E informed Surveyor that R32 should have hearing aides, but stated, something must have happened to them because they are not in the medication cart. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1:53 PM, NHA-A and RNC-C were informed by Surveyor that R32's hearing aides could not be located by RN-E.

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F 0686 Level of Harm - 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** 38146 Based on observation, interview, and a comprehensive record review, the facility did not ensure that a resident with pressure injuries received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new injuries from developing for 1 of 3 (R13) residents reviewed for pressure injuries. R13 developed a facility acquired Suspected Deep Tissue Injury (SDTI) on the left heel. Subsequent staging of the pressure injury included staging of the pressure injury as unstageable and a stage 3. While on survey, Surveyor had observations of R13's care plan interventions not implemented, including offloading of R13's heel. Findings include: R13 admitted to the facility on [DATE]. R13's face sheet documents diagnoses that include Paraplegia, Chronic Obstructive Pulmonary Disease, neuromuscular dysfunction of bladder, heart failure, chronic Atrial Fibrillation, pressure ulcer of sacral region stage 4, major depressive disorder, unspecified open wound left foot, colostomy, autonomic dysreflexia, hypertension, and acquired absence of right leg above knee. R13's History and Physical dated 12/25/22 includes diagnoses of Peripheral Vascular Disease, severe protein calorie malnutrition, and osteomyelitis. The facility policy titled Pressure Injury Prevention Guidelines and dated as implemented on 2/14/23 documents: .To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. 1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 2. The goal and preferences of the resident and/or authorized representative will be included in the plan of care. 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. Preventative Skin Care: 1. Inspect skin while providing care, paying close attention to bony prominences. 3. Avoid positioning the resident on an area of redness whenever possible. Repositioning: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1. Reposition all residents at risk of, or with existing pressure injuries, unless contraindicated due to medical condition. Utilize small shifts in repositioning, if otherwise contraindicated. 2. Routine repositioning schedule: Every 2-3 hours, using both side-lying and back positions. Reposition when in bed and out of bed. Repositioning techniques: a. Avoid positioning the resident on bony prominence's/turning surfaces with existing pressure injuries, including stage 1. f. Ensure that heels are floated off the surface of the bed, using pillows or devices that elevate and offload the heel in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon. g. When in chair, provide adequate seat tile to prevent sliding forward. Ensure the feet are properly supported. Pressure Re-Distribution Devices: 1. Support surfaces do not eliminate the need for turning and repositioning. 2. Pillows and wedges may be utilized to maintain proper positioning. 3. Apply heel suspension devices according to the manufacturer's instructions: a. For prevention, stage 1 or stage 2: Use pillows or heel suspension devices. If using heel protectors, will still need to utilize pillows for floatation. b. For stage 3, 4, unstageable or deep tissue injury: Place foot and leg into a heel suspension boot that elevates the heel from the surface of the bed, completely offloading the pressure injury. Check the skin each shift and PRN (as needed) for signs of redness or skin breakdown related to the boot. R13's Annual Minimum Data Set, dated dated dated [DATE] documents: Functional Limitation in Range of Motion: Lower extremity (hip, knee, ankle, foot) - impairment on 1 side. Mobility: Roll left and right - substantial/maximal assistance. Is this resident at risk of developing pressure ulcers? Yes. Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? Yes. Brief Interview for Mental Status score: 15, indicating no cognitive impairment. Rejection of Care - Presence & Frequency: Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Behavior not exhibited. Surveyor was able to view R13's care plan in Point Click Care (PCC) but was unable to view all revisions. The facility provided a printed copy of R13's care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Self-care deficit r/t (related to) decreased mobility, generalized weakness - initiated 6/8/21. Interventions include Bed Mobility: Assist of 1. Uses trapeze over bed and enabler bars x 2. Resident has Potential for impaired skin integrity r/t: Altered nutritional status, assist needed with turning and/or repositioning, decreased mobility, dry skin, History of pressure injuries - 10/24/23. Interventions include: Cushion in wheelchair - 2/10/23 Encourage side to side positioning- 12/11/23 Float heels while in bed - 10/24/2023 Assist to reposition side to side approximately q 2-3 hours and prn - 10/24/23 Elevate feet while in wheelchair - 11/7/23 Wheelchair cushion - 10/24/23 Weekly skin assessment - 10/24/23 Resident has Impaired Skin integrity. Pressure Injury Sacrum, Heel, Ischium initiated 6/9/21, revised 5/9/24. Interventions include: Float heels - 6/9/21 Soft boots on in bed - 6/9/21 Specialty air mattress - 6/9/21 (Resolved) encourage to turn and reposition every 2-3 hours - 6/9/21 (Resolved) ensure ROHO cushion is inflated and fill if not - 6/30/21 Resident may be up as he prefers, encourage to lay down after 2 hours - 4/18/22 Ensure proper footwear while up in chair - 8/4/22 Foot buddy to wheelchair - 7/11/23 Heel lift cushion placed between foot board and patient's feet. Foot board extension - 8/29/23 Soft boot Left foot on in bed at all times; float heels - 10/24/23 Shoes/slippers on to left foot when up - 10/24/23 Encourage side to side positioning (resident needs encouragement as resident often refuses)- 1/19/24 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R13's June 2023 TAR (Treatment Administration Record) documents: Check skin and edema weekly with shower day Wednesday AM shift. Foot checks every HS (hour of sleep) one time a day - 6/21/23. Surveyor asked for a list of residents with pressure injuries. R13's name was on the list which documented: Sacrum stage IV (4) POA (present on admission), Right ischium FA (facility acquired), Left heel FA. Surveyor review of R13's medical record revealed the following pressure injuries: Sacrum stage 4 POA 6/8/21, Left plantar FA SDTI (suspected deep tissue injury) identified 6/21/23. R13 underwent a transmetatarsal amputation of his toes. R13 subsequently developed a FA Left plantar SDTI identified on 10/24/23, FA Right lateral and right medial gluteal fold stage 4's identified on 11/7/23 and a FA Left heel SDTI identified 1/9/24. On 5/8/24 at 9:40 AM, Surveyor noted R13 was not in his room, the nurse reported he was getting a shower. On 5/8/24 at 10:25 AM, Surveyor observed R13 was back in his room, lying in bed which had an air mattress. Surveyor spoke with R13. R13 reported he gets out of bed for a couple hours a day which is all he is allowed because of a big sore on his butt. R13 reported he has had the pressure sore for at least 3 years, prior to admission to the facility. R13 reported the wound is slowly getting better, the facility is doing a good job, but it takes a long time to heal. Surveyor observed R13 had a right leg amputation. Surveyor observed R13's left heel resting directly on the mattress, not offloaded. Surveyor observed a mepilex dressing on his left heel. Surveyor asked R13 if he wears anything on his foot for protection when in bed. R13 stated, No, but they usually put my leg on a pillow. R13 was observed not wearing a heel suspension boot according to facility policy (for stage 3, 4, unstageable, or deep tissue injury) and his heel was not offloaded according to his care plan. Surveyor noted R13's care plan interventions of a heel lift cushion placed between foot board and patient's feet, soft boot left foot on in bed at all times, and float heels when in bed were not observed as implemented. On 5/9/24 at 9:00 AM, Surveyor observed R13 lying in bed on his back, watching TV. The head of bed was elevated 30 degrees. Surveyor observed R13's left heel wrapped with Kerlix gauze dated 5/9. Surveyor observed R13's left heel resting directly on the mattress, not offloaded. Surveyor asked R13 how he thought his wounds developed. R13 stated, Well, I'm paralyzed from the waist down, so I'm not really able to move much. Surveyor noted grab bars on both sides of the bed and a trapeze. Surveyor asked R13 if he was able to use the trapeze. R13 stated, Yeah, I can grab it to boost myself up a little. Surveyor asked R13 if he can turn and reposition himself with the grab bars. R13 stated, No, I'm not strong enough to turn myself all the way over on my side. Surveyor asked if staff offers to turn and reposition him. R13 stated, No, I don't know why. Surveyor asked R13 if he asks to be turned and repositioned. R13 stated, No, but I probably should. Surveyor asked R13 if he is able to move his leg or lift his leg off the bed. R13 reported he cannot lift his leg off the bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R13 was observed not wearing a heel suspension boot according to facility policy (for stage 3, 4, unstageable, or deep tissue injury) and his heel was not offloaded according to the care plan. Surveyor noted R13's care plan interventions of a heel lift cushion placed between foot board and patient's feet, soft boot left foot on in bed at all times, and float heels were not observed as implemented. On 5/9/24 at 11:00 AM, Surveyor observed R13 lying in bed on his back watching TV. Surveyor noted the bed was tilted downward on an angle with his head higher than his legs. Surveyor observed R13's left heel resting directly on the mattress, not offloaded. Surveyor observed several dried dark stains on the sheet in the area where R13's left heel would rest, indicating the heel was previously resting on the mattress. R13 was not wearing a heel suspension boot according to facility policy (for stage 3, 4, unstageable, or deep tissue injury) and his heel was not offloaded according to his care plan. Surveyor noted R13's care plan interventions of a heel lift cushion placed between foot board and patient's feet, soft boot left foot on in bed at all times, and float heels were not observed as implemented. On 5/9/24 at 12:54 PM, Surveyor observed R13 sitting up in his wheelchair watching TV. R13 was wearing a gripper sock on his left foot. Surveyor noted a blue pad covering R13's wheelchair footrests. R13's heel was resting directly on the blue pad. There was no pillow under his leg and his heel was not offloaded. R13's care plan intervention to elevate feet while in wheelchair was not observed as implemented. On 5/13/24 at 9:14 AM, Surveyor observed R13 lying in bed on his back with the head of bed elevated, watching TV. Surveyor observed R13's left heel offloaded on a pillow. Surveyor observed a Mepilex dressing peeling halfway off the heel. Surveyor observed dark drainage on the dressing which was dated 5/12. Surveyor noted dried dark stains on the sheet in area where R13's heel previously rested, indicating the heel had previously been resting directed on the mattress. Review of R13's medical record documented: The facility's initial wound assessment dated [DATE] documents: Left lateral foot pressure 2.5 x 2.6 x 0.2 cm (centimeters) unstageable. 100% eschar. Resident exhibits two or more conditions that increase the likelihood of the development of an unavoidable wound? NO. R13's pressure injuries to be followed by Wound Doctor-I. The left foot plantar pressure injury subsequently healed. Surveyor was advised Wound Doctor-I stopped working for the facility in December 2023, and wounds were then followed by Director of Nursing (DON)-B. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/14/24 at 11:01 AM, Surveyor met with RN (Registered Nurse) Consultant-C. She reported having spent the whole weekend reviewing R13's medical record which revealed R13 admitted in 2021 with a right gluteal fold stage 3 pressure injury and vascular wound left lateral foot. IV (intravenous) antibiotics were ordered for osteomyelitis of the left foot and ankle. The gluteal fold did progress to a stage 4 and did eventually heal. In August 2021, the left gluteal opened related to wound vac tape, and eventually healed. Surveyor reviewed Wound Doctor-I's documentation regarding R13's current gluteal pressure injuries. Surveyor asked why the wounds were staged as stage 4. RN Consultant-C reported Wound Doctor-I had been following R13 for years, at another facility prior to admission. Wound Doctor-I advised once a wound is staged, like a stage 4, if it heals and re-opens at any time, it is then still staged at a stage 4. DON-B (present in room) stated, I guess I can understand that logic, but his assessment and documentation indicates stage 3, but that's why he classified it as stage 4. The facility's weekly skin assessment dated [DATE] documents: Sacrum, right thigh (rear,) Left heel - tx (treatment) continues. Surveyor noted there was no documentation of an assessment or measurements of a left heel wound and no treatment implemented on 1/3/24. The left heel SDTI was not documented as identified until 1/9/24. On 1/9/24, R13 developed a Facility Acquired SDTI on his left heel. The initial wound assessment documents: Left heel pressure 2.0 x 2.0 x 0 cm. Suspected Deep Tissue Injury. Area has 2 small discolored areas inside of it. Resident exhibits two or more conditions that increase the likelihood of the development of an unavoidable wound? Yes. Resident exhibits the following conditions (check all that apply) - Diabetes, Severe PVD. Surveyor reviewed R13's medical record, including the face sheet, hospital discharge summary, and History and Physical. Surveyor located no diagnosis of Diabetes in R13's medical record. R13's prior assessment of the left lateral foot pressure injury dated 6/21/23 of resident exhibits two or more conditions that increase the likelihood of the development of an unavoidable wound documented No. Subsequent documentation and weekly measurements of the left heel: 1/16/24 3 x 2 x UTD (unable to determine) SDTI 1/23/24 2.8 x 2.0 x 0 SDTI 1/30/24 2 x 2 x 0 SDTI. Area has become 1 area but is not open 2/6/24 3.8 x 2 x UTD unstageable. DTI reabsorbed 2/13/24 2.5 x 1.5 unstageable. 100% eschar. 2/20/24 2 x 1 x 0 SDTI 100% eschar 2/27/24 4 x 1 unstageable 100% eschar 3/5/24 4 x 1 SDTI 100% eschar 3/12/24 2 x 2.2 unstageable, 100% eschar (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3/19/24 2 x 1.5 SDTI 100% slough 3/26/24 2 x 1 SDTI 100% slough 4/2/24 1.8 x 1.8 unstageable 100% slough 4/9/24 1.5 x 1.8 unstageable 100% eschar 4/16/24 2 x 3 unstageable 100% slough 4/23/24 3 x 3.5 unstageable - no percentages documented 4/30/24 4 x 2.5 stage 3 75% granulation, 25% slough 5/7/24 2.4 x 3.5 unstageable 75% granulation, 25% slough Surveyor noted inconsistent and/or inaccurate documentation of staging and wound characteristics. Documentation varies from week to week, indicating SDTI 100% eschar, then unstageable 100% eschar, then SDTI 100% slough. A SDTI would not include slough. When the wound progressed to stage 3 with 75% granulation and 25% slough, which indicates only 25% of the wound is obscured with slough, no depth is measured or documented. On 5/14/24 at 9:10 AM, Surveyor spoke with RN (Registered Nurse)/MDS (Minimum Data Set) Coordinator-D who reported she was the prior DON (Director of Nursing.) Surveyor advised of observations of R13's heels not offloaded while on survey. RN/MDS Coordinator-D rolled her eyes and stated OK, that's a problem. On 5/14/24 at 10:41 AM, Surveyor observed R13's wound care with Assistant Director of Nursing (ADON)-J. Surveyor noted several dark stains on R13's sheet in area where his heel would rest, indicating the heel was previously resting directly on the mattress. Surveyor noted no wound or discoloration to the left foot plantar area. R13's left heel revealed a stage 3 pressure injury approximate size of a half dollar. The center of the wound was necrotic surrounded by a rim of slough, surrounded by maceration. R13's entire heel was reddened. There was no active drainage or odor noted. On 5/14/24 at 11:30 AM, Surveyor advised DON-B of the concern that R13 admitted to the facility with pressure injuries and a long history of wounds, including RLE amputation. Weekly skin checks were implemented, however, although R13 had current pressure injuries and was at increased risk, daily foot checks were not implemented until after R13 developed a facility acquired pressure injury on his foot. Surveyor advised of multiple observations R13's care plan interventions, including offloading of heels, which were observed to not be implemented while on survey. On 5/14/24, during the daily exit meeting with the facility, DON-B voiced she did not agree with recommended citation for R13's heel pressure injury. DON-B reported the reason the heel wound was staged as stage 3 is because it was an SDTI and, there is no way to know how deep it would be, it could go as deep as the bone, therefore stage 3 would actually indicate healing. Surveyor advised DON-B Surveyor would be happy to review any additional information the facility chooses to provide. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	RN Consultant-C then reported the facility has evidence from the doctor that the pressure injury was unavoidable. This was the first time the facility alleged the pressure injury was unavoidable. Surveyor had asked previously if there was any documentation as such, and was not provided any information. Surveyor reminded the facility of multiple observations on survey of care plan interventions not implemented and R13's heel not offloaded. After Surveyors left the facility, the facility provided a form titled Community Acquired Pressure Injury Investigation Form. The form did not document anything about R13's FA left heel pressure injury or that it was specific to said pressure injury. At the bottom of the form was a typed statement with a check mark: Based on this review, it is unavoidable. Unavoidable, per NPUAP means that the individual developed a pressure injury even though the community had evaluated the individual's clinical condition and pressure risk factors, defined and implemented interventions that are consistent with the individual's needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions and revised the approach as appropriate. If unavoidable, has the physician documented this? (Check mark next to yes). Surveyor noted the form was dated 2/23/24 and signed by a physician (not Wound Doctor-I.) Surveyor located no evidence or other documentation by a physician that indicated the pressure injury was unavoidable.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16584 Based on record review and staff interviews, the facility did not always ensure that , based on a comprehensive assessment, provided the appropriate treatment and services to restore continence , to the extent possible, for 1 out of 2 residents (R19) reviewed for bowel and bladder incontinence. This is evidenced by: Policy Review: Incontinence Date implemented: (blank), Date Reviewed/ Revised (blank). Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines: (includes) 1. The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. R19 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes, Morbid Obesity, Chronic Obstructive Pulmonary Disease, Spinal Stenosis, Anxiety Disorder, Hypertension, and Major Depressive Disorder. A review of the Admission assessment dated [DATE] documents: Clinical Summary: Resident (R19) arrived to facility via wheelchair. Resident was admitted to hospital for generalized weakness and diagnosed with PE to lower left lobe. Full code, split to right wrist but refuses to wear, regular diet, thin liquids, room air, glasses, upper and lower dentures, incontinent of bowel and bladder, last BM (bowel movement) 3/12/2024, transfers pivot with gait belt and walker, excoriation under breast and abdomen, open area to left shin, AxO (Alert and Orientated) x4, lives at home with caregivers assisting during the day. The Admission/ Readmission/ Routine Head to Toe evaluation, dated 3/14/24, indicates that R19 is continent of bowel. The last bowel movement was noted on 3/13/24, Frequency of bowel movements is every other day. No indication that a plan of care is to be developed. The assessment also states that R19 is incontinent of bladder and has been incontinent longer than 1 month, less than 1 year. Goal is to have R19 be / remain free form skin breakdown due to incontinence and brief use through the review date. A review of the physician's order's for R19 dated 3/14/24 documented: : Record bowel movements every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission/ full MDS (minimum data set), dated 3/20/24 indicates that R19 has a BIMS score of 13 (cognitively intact). *Section H0200 Urinary Toileting Program: A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/ entry or reentry since urinary incontinence was noted at facility. Answer- No. *Section H0300- always incontinent of urine *Section H0400- always incontinent of bowel *Section H0500 Bowel Toileting Program Is a toileting program currently being used to manage the resident's bowel continence? ? Answer- no *Section H0600 Bowel Patterns: Constipation Present- answer no. Surveyor conducted a review of the CAA (care area assessment) for Urinary Incontinence and Indwelling Catheter. Analysis of findings: Resident (R19) is always incontinent of bladder. Needs assist with toilet transfer and toileting hygiene. Type of incontinence is not indicated. Care Plan considerations: Avoid complications. Will be addressed in the care plan. On 4/10/24, the facility completed a Bowel evaluation - full assessment. Does the resident have a history of Bowel Incontinence? - yes. Was the resident continent of bowel on admission?- No. Resident is frequently incontinent since admission. Resident can communicate need to defecate. Mental Status- alert and orientated. Last Bowel Movement is- unknown. Bowel Status- incontinent. Resident is not appropriate for training due to - resident is totally incontinent Surveyor conducted a review of the plan of care for R19. The plan states : The resident (R19) has mixed bladder incontinence r/t decreased mobility, nerve damage. Date initiated: 3/14/24. Revision : 3/30/24. oThe resident will remain free from skin breakdown due to incontinence and brief use through the review date. + oClean peri-area with each incontinence episode. oMonitor/document for s/sx UTI (Urinary Tract Infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Further review of the plan of care for R19 does not show that a plan was developed for R19's bowel incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's nursing notes document: 4/17/2024 1:59 p.m. Nurses Note Text: MD (medical doctor) and resident consulted regarding resident bowel patterns, resident noted to go days without BM. MD suggests increasing senna, resident is not agreeable to change. Resident states at home she typically had 1 bm a week, states she has been complaint with taking 1 senna but does not want any more. MD aware of resident refusal for change. 4/19/2024 9:00 p.m., Nurses Note Text: 24-hour report board. Resident is being monitored D/T (due to) No BM Q4 (every four days) days, refused a suppository again. Will pass onto next shift nurse. No issues with resident at this time. No pain noted. Resident is safe and continue to observe. 4/26/2024 2:34 p.m., Nurses Note Text: Pt continues to be monitored for no bowel movement within 3 days. Pt alert and oriented x4, able to make all needs known. Active BS x4. Abd (abdomen) soft, non-tender. Pt continues to refuse stool softeners. Will continue to monitor closely. On 05/13/24 at 03:28 p.m., Surveyor interviewed RN Consultant-C regarding R19's comprehensive assessment for bowel and bladder incontinence. Consultant RN-C stated that there should be patterning for bowel and bladder for R19, and she will provide a copy of this information. On 5/14/24 at 8:00 a.m., Surveyor conducted a review of the information provided by RN Consultant-C for R19. The 3-day bowel and bladder tracker, dated 3/14/24 - 3/18/24 documented findings at time of toileting, wet or dry. The tracker did not indicate if R19 was incontinent of bowel or bladder. RN- Consultant-C also provided a document stating that the facility will be starting a 3-day assessment for prompted toileting schedule starting 5/13/24. The facility's assessment of R19's bowels indicated that although R19 is incontinent of bowel, R19 can communicate the need to defecate. Surveyor noted that the facility did not comprehensively assess R19's bowel incontinence to help maintain or restore as much bowel continence as possible. The facility also did not comprehensively assess R19's urinary incontinence by trying to determine the type of incontinence and to develop a pattern. The facility did not provide services to try to maintain or restore as much bladder incontinence as possible for R19. No additional information was provided as of the time of exit.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation, interview, and record review the Facility did not ensure a Resident with a gastrostomy tube received the appropriate care and services for 1 (R60) of 3 Residents with gastrostomy tubes. *R60's water flush bag and tube feeding was not labeled for two days during the survey process. R60's tube feeding pump had not been calibrated to ensure proper flow rate. Findings Include: Surveyor reviewed the facility's undated Care and Treatment of Feeding Tubes policy and procedure and notes the following: 10. Direction for staff regarding how to manage and monitor the rate of flow will be provided: a. Use of gravity flow b. Use of a pump c. Periodic evaluation of the amount of feeding being administrated for consistency with practitioner's orders d. Calibration of enteral feeding pumps to ensure that pump settings accurately provide the rate and volume consistent with the Resident's care plan. e. Periodic maintenance of feeding pumps consistent with manufacturer's instructions to ensure proper mechanical functioning. 12. The Resident's plan of care will direct staff regarding proper positioning of the Resident consistent with the Resident's individual needs. R60 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction due to Unspecified Occlusion, Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Dominant Side, Type 2 Diabetes Mellitus, End Stage Renal Disease, and Major Depressive Disorder. R60 has an activated Health Care Power of Attorney (HCPOA). R60's Quarterly Minimum Data Set (MDS) dated [DATE] documents R60's Brief Interview for Mental Status (BIMS) score to be a 13, indicating R60 is cognitively intact for decision making. R60 has no mood issues and R60 can have verbal behaviors 1-3 days. R60 has range of motion (ROM) impairment on 1 side of both upper and lower extremities. R60 is dependent for upper and lower dressing and transfers. R60 requires substantial to max assist for mobility. R60's MDS documents that R60 is receiving tube feeding. Surveyor reviewed R60's comprehensive care plan for tube feeding/nutrition related care plans: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident requires tube feeding r/t dysphagia 12/11/23 The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. 12/11/23 The resident needs the HOB elevated 45 degrees during and thirty minutes after tube feed. [CNA,LPN,RN] 12/11/23 Monitor/document/report PRN any s/sx of: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. [LPN,RN] 12/11/23 Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. [LPN,RN] 12/11/23 Provide local care to G-Tube site as ordered and monitor for s/sx of infection. [LPN,RN] 12/11/23 RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. [LPN,RN] 12/11/23 Surveyor reviewed R60's current physician orders and notes the following: -140 ml peg flush every 2 hours every shift, Monday, Wednesday, Friday effective 8/30/23 -Check residual from PEG tube every 4 hours. Return aspirate. If >300 ml hold tube feeding and recheck residual in 1 hours. If residual <300 ml resume tube feeding at previous rate three times a day effective 12/19/23 -Oral Feeding: Pureed Diet; Nectar Liquids. Only feed when alert/awake. Sit upright when feeding. effective 8/15/23 -Head of bed elevated 45 degrees at all times every shift for tube feedings effective 8/12/23 -Nepro 1.8@45 ml/hour continues with 120 ml flush every 2 hours every shift every Tues, Thurs, Sat, Sun effective 11/18/23 -Nepro 1.8@70 ml/hr x 12 hours (1900-0700) with 145 ml FWF (free water flush) every shift every Mon, Wed, Fri effective 4/24/24 (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's Nutritional Evaluation dated 5/8/24 documents that R60 is on a renal, puree, nectar diet and tube feeding in April was changed to Nepro 1.8@70 ml/hours 12 hours with 145 ml FWF every 2 hours x 24 hours. The evaluation stated R60 has had goo intake and has not had a significant weight loss in the past 3 months. Surveyor had the following observations during the survey process: On 5/9/24 at 8:33 AM, Surveyor observed R60's tube feeding is not dated or initialed. R60's flush bag is dated 5/8/24. On 5/9/24 at 1:41 PM, Surveyor observed R60's tube feeding is not dated or initialed. On 5/13/24 at 8:48 AM, Surveyor observed R60's tube feeding and flush is not dated or initialed. On 5/13/24 at 11:19 AM, Surveyor observed R60's tube feeding and flush is not dated or initialed. On 5/13/24 at 1:01 PM Surveyor spoke to Registered Dietitian (RD-S) who stated that R60 eats 3 meals a day, and R60 has been switched to night tube feedings. R60 has had no issues with dehydration. RD-S stated the goal is to transition R60 off of the tube feeding in order to discharge to the community. The night tube feeding has been switched on April 22, 2023. RD-S confirmed that the tube feeding and flush should be dated and initialed. RD-S is not sure who calibrates the tube feeding pump. On 5/13/24 at 3:20 PM, Surveyor shared the concern with Administrator (NHA-A) and RN Consultant (RNC-C) that R60's tube feed and flush has not been dated or initialed during the survey process. RNC-C stated the expectation is that when the tube feed and flush is hung both should be dated and initialed. No further information was provided by the facility at this time. On 5/14/24 at 7:30 AM, RNC-C shared that the pump should be calibrated every 2 years and confirmed this has not been done. RNC-C stated that it is getting calibrated today. On 5/14/24 at 9:23 AM, Registered Nurse (RN-E) confirmed that tube feeding and flushes are supposed to be dated and initialed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037 Based on interview and record review, the Facility did not provide dialysis services consistent with professional standards of practice for 1 (R321) of 1 Residents reviewed for dialysis. * R321 receives dialysis three times per week. R321's dialysis center communication records are not being completed by Facility nurses. Findings include: 1. R321 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, diabetes mellitus and encephalopathy. R321 is dependent upon renal dialysis and attends dialysis three times per week. On 5/9/24, Surveyor reviewed R321's medical record, including physician's orders and comprehensive care plans. Surveyor was unable to locate any dialysis communication forms for R321 in R321's medical record. On 5/9/24 at 12:45 PM, Surveyor requested R321's dialysis communication forms that are to be completed on R321's dialysis days. On 5/9/24 at 2:25 PM, Nurse Consultant-C approached Surveyor for interview. Nurse Consultant-C told Surveyor that the facility had not been sending any Dialysis communication forms to dialysis centers on days residents receive dialysis. Nurse Consultant-C provided Surveyor with a PIP (Performance Improvement Plan) related to the facility's failure to communicate with dialysis centers for residents receiving dialysis care. On 5/9/24 at 2:45 PM, Surveyor shared concerns with Nursing Home Administrator (NHA)-A related to lack of dialysis communication records completed by facility on R321's dialysis days. No additional information was provided as to why the facility did not provide dialysis services consistent with professional standards of practice for R321.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on observation, interview, and record review the facility did not have evidence that it attempted appropriate alternatives prior to installation of bed rails, did not have evidence it assessed residents at risk of entrapment from bed rails prior to installation, did not have evidence the risks and benefits of bed rails were discussed with the Resident and/or resident representatives and that informed consent was obtained prior to installation for 7 (R32, R36, R60, R371, R44, R12, and R52) of 7 Residents reviewed for repositioning bars. *R32 has a physician order dated 3/14/23 for bilateral quarter side rails. R32 did not have an assesment completed and consent discussing risks and benefits signed prior to installation. *R33 has a physician order dated 5/16/23 for bilateral 1/2 side rails. R60 did not have an assesment completed and consent discussing risks and benefits signed prior to installation. *R60 has a physician order dated 8/21/23 for bilateral enabler bars. R32 did not have an assesment completed and consent discussing risks and benefits signed prior to installation. *R371 had no comprehensive assessment prior to use of enabler bars and had no signed consent for enabler bars. *R44 had no signed consent for enabler bars. *R12 had no signed consent for enabler bars. *R52's care plan indicates padded 1/4 side rails added on 2/13/23, consent from representative explaining risks and benefits was not obtained until 5/13/24. Findings Include: Surveyor reviewed the undated facility's Proper Use of Bed Rails policy and procedure and notes the following applicable: .Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. Resident Assessment 1. As part of the Resident's comprehensive assessment, components will be considered when determining the Resident's needs, and whether or not the use of bed rails meets the needs. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the Resident's assessed needs. 3. The Resident assessment must also assess the Resident's risk from using bed rails. 4. The Resident assessment should assess the Resident's risks of entrapment between the mattress and bed rail or in the bed rail itself. 5. The facility will assess to determine if the bed rail meets the definition of a restraint. A bed rail is considered to be a restraint if the bed rail keeps a Resident from voluntarily getting out of bed in a safe manner due to his/her physical or cognitive inability to lower the bed rail independently. If it is determined to be a restraint, the facility will follow their procedures related to physical restraints. Informed Consent 6. Informed consent from the Resident or Resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. 7. The information that the facility should provide to the Resident, or Resident representative includes, but is not limited to: a. What assessed medical needs would be addressed by the use of bed rails b. The Resident's benefits from the use of bed rails and the likelihood of these benefits c. The Resident's risks from the use of bed rails and how these risks will be mitigated d. Alternatives attempted that failed to meet the Resident's needs and alternatives considered but not attempted because they were considered to be inappropriate. 8. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail. Appropriate Alternatives 9. The facility will attempt to use appropriate alternatives prior to installing or using bed rails. 10. Alternatives that are attempted should be appropriate for the Resident, safe and address the medical conditions, symptoms or behavioral patterns for which a bed rail was considered. 11. If no appropriate alternatives are identified, the medical record should include evidence of the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful b. Assessment of the Resident, the bed, the mattress, and rail for entrapment risk c. Risks and benefits were reviewed with the Resident representative, and informed consent was given before installation or use Ongoing Monitoring and Supervision 15. The facility will continue to provide necessary treatment and care to the Resident who has bed rails in accordance with professional standards of practices and the Resident's choices. This should be evidenced in the Resident's records, including their care plan, including, but not limited to, the following information: a. The type of specific direct monitoring and supervision provided during the use of the bed rails, including the documentation of the monitoring b. The identification of how needs will be met during use of the bed rails, such as for re-positioning, hydration, meals, use of the bathroom and hygiene c. Ongoing assessment to assure that the bed rail is used to meet the Resident's needs d. Ongoing evaluation of risks e. The identification of who may determine when the bed rail will be discontinued f. The identification and interventions to address any residual effects of the bed rail 16. Responsibilities of ongoing monitoring and supervision are specified as follows: a. Direct care staff will be responsible for care and treatment in accordance with plan of care. b. A nurse assigned to the Resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of of bed/mattress/rail c. The interdisciplinary team will make decisions regarding when the bed rail will be used or discontinued, or when to revise the care plan to address any residual effects of the bed rail . On 5/13/24, Director of Nursing(DON-B) provided documentation of an audit dated 5/2/24 that had been initiated to define what Residents had enabler bars or quarter rails. DON-B also provided documentation of correction education dated 5/9/24 which included the following: -Any Resident that has enabler bars/side rails must have a safety evaluation completed -Therapy should be notified to screen/eval for bed mobility (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Any Resident with a Enabler Bar/Side Rail must have a Consent for Use of Assistive Devices/Physical Restraints form completed explaining the Risk and Benefits of the device used The Consent for Use of Assistive Devices/Physical Restraints documents the following: The use of assistive devices/physical restraints presents benefits to the Residents as well as potential negative outcomes. In accordance with the facility policy, an assessment will be performed to determine the least restrictive device/physical restraint, deemed appropriate related to the Resident's medical condition and to attain or maintain the highest practicable level of physical and psychosocial well-being. A physician order will be obtained, and a personalized care plan/service will be developed. The form includes a list of potential benefits and potential negative outcomes. 1) R32 was admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy, Type 2 Diabetes Mellitus, Hypo-osmolality and Hyponatremia, and Gastro-Esophageal Reflux Disease. R32 has an activated health care power of attorney(HCPOA). R32's Significant Change Minimum Data Set(MDS) dated [DATE] documents R32's Brief Interview for Mental Status(BIMS) score to be a 0 indicating R32 demonstrates severely impaired skills for daily decision making. R32 has no behaviors documented. R32's Patient Health Questionnaire(PHQ-9) score is 8 indicating mild depression. R32 has no range of motion(ROM) impairment on upper extremities, and does have ROM impairment on bilateral lower extremities. R32's MDS documents R32 is dependent for dressing, mobility and transfers. R32's Certified Nursing Assistant(CNA) card documents that R32 has enabler bars times 2 with positioning and bed mobility. R32's physician orders document that R32 has had 1/4 side rails times 2 for positioning effective 3/14/23. Surveyor reviewed R32's comprehensive care plan and notes the following about R32's 1/4 side rails: R32 has Impaired Mobility due to weakness, metabolic encephalopathy Initiated 1/13/22 Interventions Include: Bed mobility/Repositioning: Assist 2 and 1/4 side rail x2 1/13/22 Therapy to screen/eval for needs 1/13/22 Transfers with assist of 2 and HOYER. Full body sling / Large sling 1/16/22 Update MD prn 1/13/22 On 5/8/24 at 9:25 AM, Surveyor observed R32 in bed, head of bed elevated and quarter side rails on both sides of R32's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/9/24 at 1:00 PM, Surveyor observed R32 in bed with quarter side rails on both sides of R32's bed. R32 informed Surveyor that R32 uses them to turn over. On 5/9/24 at 1:40 PM. Surveyor is unable to locate R32's side rail assessment or consent in R32's electronic medical record(EMR). At this time, Surveyor requested additional information in regards to a side rail assessment and consent for R32's quarter side rails. On 5/13/24 at 8:06 AM, the facility provided Surveyor with a side rail assessment dated [DATE] and a verbal consent obtained from R32's representative dated 5/12/24. 2) R33 was admitted to the facility on [DATE] with diagnoses of Quadriplegia, Human Immunodeficiency Virus, Unspecified Cirrhosis of Liver, Restlessness and Agitation, and Anxiety Disorder. R33 is his own person. R33's primary language is Spanish. R33's Quarterly Minimum Data Set(MDS) dated [DATE] documents R33's Brief Interview for Mental Status(BIMS) score to be a 15, indicating R33 is cognitively intact for daily decision making. R33's MDS also documents that R33 has range of motion impairment on both upper and lower extremities on both sides. The MDS documents that R33 is dependent for upper and lower body dressing, mobility, and transfers. R33's Certified Nursing Assistant(CNA) card documents that R32 has enabler bars times 2 with positioning and bed mobility. R33's physician orders document that R33 has had 1/2 side rails times 2 to aide in positioning effective 5/16/23. Surveyor reviewed R33's comprehensive care plan and notes the following about R32's 1/4 side rails: Self care deficit r/t generalized weakness, impaired cognition, quadriplegia Initiated 4/8/20 Interventions Include: L LE PROM, AARM R LR 10-15 reps, 1-2 sets daily 7/6/20 ASSIST OF 1 WITH ADLs 4/8/20 Assist of 1 with bed mobility and 1/2 side rails x 2 4/8/20 Assist of 2 transfer with Hoyer. Full body sling / Xlarge. No Ambulation, High back W/C with mobility. 4/8/20 Bathing: A1 4/8/20 Dressing: Assist x1 with UB and LB dressing and grooming 4/8/20 Eating: tray table appropriate height to keep hand from sliding, tray close to him, scoop/divider plate, vertical fork and spoon, cup with handle/lid/straw if having difficulty, dicem under plate/bowl, no small bowls 4/8/20 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	High back w/c, chair slightly reclined, should not be upright, foot drop shoes on while in W/C and foot rests on. 4/8/20 Soft touch call light, pinned to bed near right hip 4/8/20 Toileting: Assist x2 using Hoyer Lift to and from bed and W/C with toileting, Assist x1 with hygiene 4/8/20 On 5/8/24 at 9:43 AM, Surveyor observed 1/2 siderails on both sides of R33's bed. Head of bed elevated more that 45. Bed in regular position. On 5/9/24 at 1:39 PM, Surveyor is unable to locate a side rail assessment and consent for R33 in R33's EMR. At this time, Surveyor requested additional information in regards to a side rail assessment and consent for R33's 1/2 side rails. On 5/13/24 at 8:06 AM, Surveyor received R33's side rail assessment dated [DATE] and a consent form with no date. 3) R60 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction due to Unspecified Occlusion, Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease Affecting Left Dominant Side, Type 2 Diabetes Mellitus, End Stage Renal Disease, and Major Depressive Disorder. R60 has an activated Health Care Power of Attorney(HCPOA). R60's Quarterly Minimum Data Set(MDS) dated [DATE] documents R60's Brief Interview for Mental Status(BIMS) score to be a 13, indicating R60 is cognitively intact for decision making. R60 has no mood issues and R60 can have verbal behaviors 1-3 days. R60 has range of motion(ROM) impairment on 1 side of both upper and lower extremities. R60 is dependent for upper and lower dressing and transfers. R60 requires substantial to max assist for mobility. Surveyor requested R60's Certified Nursing Assistant(CNA) card but the facility did not provide. R60's physician orders document that R60 has had enabler bars times 2 for assist with self positioning effective 8/21/23. Surveyor reviewed R60's comprehensive care plan and notes the following about R60's enabler bars: Self care deficit r/t CVA with deficits - left-sided weakness Initiated 7/2/23 Interventions put into place on 7/2/23: Assist x1 Dressing: Assist x1 with UB and LB dressing and grooming enabler bars x 2 to enable independent repositioning/assist with repositioning. Assist x2 with bed mobility Encourage resident to complete as many ADL's for self as is able (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Personal Hygiene - A1 set up for meals: set up/ can feed self need encouragement Toileting: has colostomy, can use urinal with assist - urinates rarely due to dialysis Transfers with Hoyer Assist of 2 Large/ Full Body. No Ambulation, Assist with W/C mobility, On 5/9/24 at 8:30 AM, Surveyor observed R60 in bed, eating breakfast with enabler bars on both sides of the bed. On 5/9/24 at 1:04 PM, R60 informed Surveyor that R60 uses the enabler bars for repositioning. On 5/9/24 at 1:47 PM, Surveyor was unable to locate an enabler bar assessment or consent in R60's EMR. At this time, Surveyor requested additional information in regards to a side rail assessment and consent for R60's enabler bars. On 5/13/24 at 8:06 AM, Surveyor received R60's enabler bar assessment and consent both dated 5/9/24. On 5/13/24 at 9:54 AM, Director of Nursing(DON-B) informed Surveyor that an audit was completed on 5/2/24 to identify what Residents had side rails or enabler bars. DON-B stated an education on side rails and enabler bars was completed on 5/9/24. On 5/13/24 at 3:20 PM, Surveyor shared the concern with Administrator(NHA-A) and RN Consultant(RNC-C) the concern that R32, R33, and R60 did not have a side rail/enabler bar assessment completed prior to placing on the bed and there was no consent signed prior to placement which explained the risks/benefits of the devices. No further information was provided by the facility at this time. On 5/14/24 at 9:23 AM, Registered Nurse(RN-E) confirmed that R32, R33, and R60 use their bars on the bed to help turn and reposition. 16584 4.) R52 was readmitted to the facility on [DATE] with diagnosis that included Cerebral palsy, asthma, blindness right eye, major depressive disorder, bipolar disorder, developmental disorder, anxiety, seizures. R52 was originally admitted to the facility on [DATE]. Surveyor conducted a review of R52's plan of care that indicates R52 has the potential for falls, accidents and incidents due to immobility, impaired cognition, unaware of safety needs. Interventions included padded side rail to prevent bruising to extremities from swatting/ hitting when anxious. The need for padded side rail was added on 8/10/23. The plan of care also states that R52 has self- care deficit due to cognitive deficits, disease process/ progression due to his cerebral palsy, blind in both eyes. Interventions include that R52 needs the assist of 1 for bed mobility. Also the use of 1/4 side rails to aide in positioning was added to the plan of care on 2/13/23. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission/ readmission/ routine head to toe evaluation, dated 3/2/24, description quarterly' states that R52 uses an enabler/ assistive device that assists in the improvement in the resident's functional status. This is not considered a restraint for R52. The physician order reflecting the device, medical symptoms, and timeframe to be used is completed along with the consent and enabler/ assistive device care plan. On 5/13/24 at 3:15 p.m., Surveyor requested to review information for the use of the enabler bars for R52. This was to include the consent for the use and comprehensive assessment. Additionally, Surveyor shared observations of R52's enabler bars that were connected to the right and left side of the bed. The bars had foam taped to the bars with duct tape . There were many areas in which the duct tape was torn and the foam was not fastened to the enabler bar. On 5/14/24 at 8:00 a.m., Surveyor was provided with a copy of the consent form for the use of enabler bars for R52, dated 5/13/24. The consent was received via telephone from R52's Guardian. RN- Consultant- C stated that therapy will be evaluating R 52's enabler bars and will be replacing then with something that is padded. The foam was used originally because R52 had some bruising believed to be from the enabler bars. 49011 5.) R371 was admitted to the facility on [DATE] from the hospital with a primary diagnosis of paraplegia, complete; and other diagnoses which include, in part, morbid obesity, chronic respiratory failure, local infection of the skin and subcutaneous tissue, fibromyalgia, and osteoarthritis. R371's Admission Minimum Data Set (MDS) with an assessment reference date of 5/5/24 indicated R371 had a Brief Interview for Mental Status score of 15 (fully intact memory). R371 is able to make decisions for themselves. R371's MDS showed that upper extremities have no impairment and lower extremities have impairment on both sides. R371 uses a wheelchair for mobility. R371 has a physician order for enabler bars to assist with self positioning dated 4/29/2024. On 05/08/24 at 09:49 AM Surveyor notes observing enabler bars on R371's bed. On 5/9/2024 at 10:32 AM Surveyor reviewed a Screening Tool form completed by Evolve Therapy Services with a note stating Patient does have ability to utilize assist bar on bed to improve bed mobility. Surveyor notes this was completed on the same day that the assessment information was requested from the facility, 10 days after physician order and admission. On 05/13/24 at 08:29 AM Surveyor reviewed the signed Consent for Use of Assistive Devices/Physical Restraints form provided by the Facility. The form was signed by R371 on 5/12/2024. Surveyor notes that this is after the date (5/9/2024) this was requested from Facility by Surveyor. On 05/13/24 at 03:19 PM Surveyor informed Nursing Home Administrator-A and Regional Nurse-C of the above concerns. No further information was provided. 6.) R44 was admitted to the facility on [DATE]. R44 has a primary diagnosis of type 2 diabetes mellitus; and other diagnoses which include, in part, chronic kidney disease and dementia. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R44's Quarterly Minimum Data Set (MDS) with an assessment reference date of 4/27/24 indicated R44 had a Brief Interview for Mental Status score of 00 (severe cognitive impairment). R44 is not able to make decisions for themselves. R44's MDS showed that upper extremities and lower extremities have no impairment on both sides. R44 uses a wheelchair for mobility. R44 has a physician order for 1/4 side rails x2 to assist with self positioning dated 2/13/2023. On 05/08/24 at 02:02 PM Surveyor notes observing side rails on R44's bed. On 05/13/24 at 08:29 AM Surveyor reviewed the signed Consent for Use of Assistive Devices/Physical Restraints form provided by the Facility. The form was signed by R44 on 5/12/2024. Surveyor notes that this is after the date (5/9/2024) this was requested from Facility by Surveyor. Surveyor notes that R44 has an activated health care power or attorney and is not able to make decisions for self. On 05/13/24 at 03:19 PM Surveyor informed Nursing Home Administrator-A and Regional Nurse-C of the above concern. No further information was provided. 7.) R12 was admitted to the facility on [DATE] with a primary diagnosis of stroke. R12's Quarterly Minimum Data Set (MDS) with an assessment reference date of 5/1/24 indicated R12 had a Brief Interview for Mental Status score of 01 (severe cognitive impairment). R12 is not able to make decisions for themselves. R12's MDS showed that upper extremities and lower extremities have impairment on both sides. R12 has a physician order for 1/2 side rail x1 to aid in positioning dated 5/15/2023. On 05/08/24 at 01:43 PM Surveyor notes observing side rail on R12's bed. On 05/13/24 at 08:29 AM Surveyor reviewed the signed Consent for Use of Assistive Devices/Physical Restraints form provided by the Facility. The form shows telephone consent was given by R12's Power of Attorney on 5/12/2024. Surveyor notes that this is after the date (5/9/2024) this was requested from Facility by Surveyor. On 05/13/24 at 03:19 PM Surveyor informed Nursing Home Administrator-A and Regional Nurse-C of the above concern. No further information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38146 Based on interview and record review the pharmacist recommendations made during the monthly record review were not reported to the attending physician and were not acted upon for 1 of 5 (R37) residents reviewed for unnecessary medications. R37's pharmacy recommendations were not acted upon by the physician. Findings include: The facility policy titled Medication Regimin Review (not dated) documents (in part) . .The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. 1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication erros, or other irregularities. 4. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. 5. The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facily's Medical Director, and the Director of Nursing. 7. Timelines and responsibilities for MRR: a. The consultant pharmacist shall schedule at least one monthly visit to the facility, and shall allow for sufficient time to complete all required activities. b. The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 7:30 AM, the facility provided Surveyor the Pharmacy recommendation printed 4/19/24 which documented: Current order Meloxicam 15 mg (milligrams) TID (three times daily) increased from 15 mg qd (daily) on 9/20/23 in hospital. Manufacturer max dose is 15 mg/day. Manufacturer states not recommended for mod/severe renal impairment. Recommendation: Please evaluate current therapy and indicate below the appropriate option for this resident. ( ) A benefit/risk analysis of current therapy warrants continuation at the present dose above manufacturer max dose. ( ) Reduce dose to Meloxicam 15 mg qd per manufacturer guidelines. ( ) Please consider increase in Pantoprazole from 40 mg every other day to daily. Surveyor noted no check marks or orders to indicate the physician response. R37 has current physician orders for Meloxicam 15 mg give 1 tablet by mouth three times a day for pain. On 5/14/24 at 8:09 AM, Surveyor asked Director of Nursing (DON)-B who was responsible to ensure physician follow up on pharmacy recommendations. DON-B reported the recommendations are faxed to the doctor. We had to call yesterday to ask for it. He marked to reduce the dose, but the resident does not agree, so he's going to discuss it with the NP (Nurse Practitioner). Surveyor asked, so there was no follow up on the recommendation until yesterday? DON-B stated: Apparently not. On 5/14/24 at 8:43 AM, RN (Registered Nurse) Consultant-C advised Surveyor there was a new pharmacist last month who did not know she needed to send the recommendations to the physician and thought they just get sent out automatically, that's why there was no follow up. No additional information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38146 Based on interviews and record review the facility did not ensure that residents are free of any significant medication errors for 2 of 2 (R3 and R37) residents reviewed. Morning medications are not administered within timeframe specified and are often administered after 11 AM along with noon medications. The facility policy titled Medication Administration (not dated) documents (in part) . .10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. On 5/8/24 at 9:43 AM, during initial interview, R3 reported the Assistant Director of Nursing (ADON) is an idiot because she has only 1 nurse for wings 1 and 2. R3 stated: Sometimes I don't get my 8 AM (morning) meds (medications) until 2 PM (afternoon) and sometimes I don't get my noon meds at all. On 5/8/24 at 2:31 PM, during initial interview with R37 reported there is only 1 nurse for 2 wings. R37 reported he often gets his 8 AM medication around noon. R37 reported he is supposed to get pain meds every 4 hours, but never gets them on time because there's only 1 nurse and she's too busy. R37 stated: Everyone is complaining, including the nurses. People are calling in all the time because they're sick of it. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/24 at 11:30 AM, Surveyor spoke with Licensed Practical Nurse (LPN)-F who reported he is an agency/contract nurse that has worked for the facility since February 2024. LPN-F reported he works the front units 1 and 2. Surveyor asked LPN-F since he has worked for the facility, has he always been assigned to both units. LPN-F stated No, there used to be 1 nurse on each side, but (Director of Nursing-B) made a lot of changes with staffing recently. LPN-F confirmed he is responsible for passing meds to all residents on both sides 1 and 2, which is 28 residents. Surveyor asked LPN-F if he is able to pass the 8 AM meds in the allotted time. LPN-F stated: Well, it depends on the day, if there's a fall or change in condition or emergency. On a good day, with nothing else happening, I finish about 11 AM. Surveyor asked what time he starts passing meds in the morning. LPN-F reported 7 AM. Surveyor asked: When you say you finish at 11 AM, do you mean you finish the passing the 8 AM morning meds at 11 AM? LPN-F replied yes. Surveyor asked: So depending on which resident you start with, some residents won't get their 8 AM meds until 11 AM or later. LPN-F stated: Yes. It's a lot of residents and a lot of meds, I do what I can. Surveyor review of the facility schedule from 4/30/24 to 5/7/24 confirmed only 1 nurse scheduled on units 1 and 2. Of note, Surveyor review of the schedule on 5/13/24 and 5/14/24 while Surveyors were in the building and survey was in process, the schedule listed 2 nurses on units 1 and 2. On 5/13/24 at 2:19 PM, Surveyor spoke with DON-B. Surveyor asked: When meds are ordered for example, for anxiety or pain BID (twice daily), TID (three times daily) or QID (four times daily) how does the facility determine the times they are administered. DON-B reported the doctor sometimes determines the times based on the residents need or targeted times for behaviors. Surveyor asked what if the times are not specified. DON-B stated: Then, for like anxiety or pain, we will schedule times so they receive a continued amount of medication throughout the day. Like Morphine ER BID - we'd do 12 hours apart so they get a continuous dose of the medication. Surveyor asked: What about anti-anxiety meds ordered TID. DON-B stated: The same, we'd separate it to every 8 hours so they get a continuous dose throughout the day. Surveyor confirmed: So TID would be every 8 hours and BID would be every 12 hours unless the doctor specifies times. DON-B stated: Basically. Surveyor review of R3's Medication Administration Record (MAR) included the following: Risperdal 1 mg (milligram) - Give 1 tablet by mouth one time a day for psychosis. Takes 1 mg in AM and 2 mg in HS (hour of sleep). Times: 8 AM and 8 PM. Acetaminophen 500 mg - Give 2 tablets by mouth two times a day for pain. Times: 8 AM and 5 PM. Hiprex Tablet (Methenamine Hippurate) - Give 1 gram by mouth two times a day for Prophylaxis UTI (urinary tract infection) with meals indefinitely. Times: 8 AM and 4 PM. Lyrica Capsule 50 mg - Give 50 mg by mouth two times a day for Pain. Times: 8 AM and 5 PM. Savella Tablet 100 mg - Give 1 tablet by mouth two times a day for pain. Times: 8 AM and 8 PM. Baclofen Tablet 10 mg - Give 0.5 tablet by mouth three times a day for spasms related to spastic quadriplegic Cerebral Palsy. Times: 8 AM, 12 PM and 4 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to interview with both R3 and LPN-F, 8 AM meds are often not given until 11 AM or later, thus R3 would not benefit from the effect of the medications throughout the day. For example, R3's Baclofen which is to be given at 8 AM and 12 PM for spasms, could potentially be administered at the same time or within an hour of each dose. Surveyor review of R37's MAR included the following: Bupropion HCl (Hydrochloride) 100 mg - Give 1 tablet by mouth two times a day related to major depressive disorder. Times: 8 AM and 5 PM. Morphine Sulfate ER (extended release) 30 mg - Give 30 mg by mouth two times a day for pain. Times: 8 AM and 8 PM. Gabapentin Capsule 300 mg - Give 1 capsule by mouth three times a day for neuropathy. Times: 8 AM, 2 PM and 8 PM. Hydroxyzine HCl 25 mg - Give 25 mg by mouth three times a day related to anxiety disorder. Times: Midnight, 8 AM and 4 PM. Klonopin 1 mg (Clonazepam) - Give 1 mg by mouth three times a day for anxiety disorder and insomnia. Times: 12:30 AM, 8:30 AM and 4:30 PM. Meloxicam 15 mg - Give 1 tablet by mouth three times a day for pain. Times: 8 AM, 2 PM and 8 PM. Methocarbamol 500 mg - Give 2 tablet by mouth three times a day for Spasms. Times: 8 AM, 2 PM and 8 PM. Baclofen 20 mg - Give 1 tablet by mouth four times a day related to paraplegia. Times: 8 AM, 2 PM 6 PM and 10 PM. Oxycodone HCl 20 mg - Give 1 tablet by mouth every 4 hours for pain. Times: Midnight, 4 AM, 8 AM, 12 PM, 4 PM and 8 PM. According to interview with both R37 and LPN-F, 8 AM meds are often not given until 11 AM or later, thus R37 would not benefit from the effect of the medications throughout the day. For example, R37's Morphine extended release for pain is ordered 12 hours apart, Gabapentin, Meloxicam, Methocarbamol, Baclofen for pain and/or spasms are ordered at 8 AM and 2 PM, could potentially be administered at the same time or within a 2 hours of each dose. In addition, Oxycodone for pain, which is ordered to be given at 8 AM and 12 PM could potentially be administered at the same time. On 5/14/24 at 9:30 AM, Nursing Home Administrator (NHA)-A was advised of the above concerns. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20025 Based on observation, interview and record review the facility did not ensure 3 of 3 medication carts had insulin vials dated with the open date and insulin pens that have expired after being open removed from the medication cart. This affected 4 residents (R35, R30, R56 and R29) On [DATE] Surveyor observed medication carts from 200, 300, and 400 hall. The 200 hall had insulin vials opened and not dated. The 300 hall had an insulin pen that expired after it was opened on [DATE]. The 400 hall had an insulin pen that expired after it was opened on [DATE]. Findings include: On [DATE] at 8:55 a.m. Surveyor observed the 200 hall medication cart. Surveyor observed R30 humalog insulin vial opened but not dated. Surveyor also observed R35 lispro insulin vial opened but not dated. Surveyor showed RN(Registered Nurse)-G the insulin vials open and not dated and asked what is the facility's policy regarding insulin vials. RN-G stated once an insulin vial is opened it is dated with the date it was opened and only good for 28 days. On [DATE] at 9:08 a.m. Surveyor observed the 300 hall medication cart. Surveyor observed R56 lispro insulin pen dated with an open date of [DATE] in the cart. Surveyor showed the insulin pen to LPN(licensed practical nurse)-F and asked after the lispro insulin pen is open how long can it be kept in use. LPN F stated that was a good question and stated he wasn't sure how long. On [DATE] at 9:11 a.m. Surveyor observed the 400 hall medication cart. Surveyor observed R29 lispro insulin pen with an open date of [DATE] in the cart. Surveyor showed the insulin pen to RN-E and RN-E stated she will get rid of it. Humalog, the makers of the lispro pen, indicate once the pen is opened it can be stored at room temperature for no more than 28 days and then must be discarded. On [DATE] at 12:42 p.m. Surveyor interviewed DON (director of nursing)-B. Surveyor explained the observations regarding the insulin vials opened and not dated and the lispro pens opened and left in the cart past the 28 days. DON-B confirmed that the insulin vials need to be dated when opened and the lispro insulin pens need to be discarded after 28 days after it has been opened. No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49011 Based on record review, observation and interview the facility did not distribute and serve food in a manner that prevents foodborne illness to 74 out of 74 (census 76, 2 NPO) residents who receive their meals from the main serving kitchen. *Cook-K was observed grabbing ready to eat food with gloved hands, after touching non-sanitized food surfaces, and placing the ready to eat food on plates for residents to eat. *Dietary Aide-M was observed touching nose with gloved hands while transferring yogurt from large container to individual service containers. Findings include: The facility policy titled, Food Safety-Food Handling with revision date, 7/20/2019, states in part: Purpose To ensure food handling practices are consistent with USDA Food Code guidelines. To comply with federal and state regulations governing food safety and prevention of foodborne illness and to comply with state and local ordinances governing food safety. Policy 1. Food handling practices shall be completed in a manner to protect food safety and avoid cross contamination. 2. Safe food practices shall be consistent with the USDA Food Code and shall include the following: . c. proper handwashing and correct use of gloves; d. proper handling of dishes and equipment; . The facility policy titled, Food Safety Requirements with revision date, 1/2024, states in part: Policy: .Food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: .d. Distribution and service of food to the resident, including transportation, set up, and assistance. .f. Employee hygienic practices . Example 1 On 05/09/24 at 12:00 PM Surveyor observed Cook-K wearing gloves on both hands, grab the metal food cart, open door then touch the top of the cart and plate lids. Using same dirty gloves, did not wash hands, grabs ready to eat biscuit and places it on plate for resident to eat. On 05/09/24 at 12:01 PM Surveyor observed Cook-K wearing same gloves on both hands, grab the metal food cart, and grab plate lids. Using same dirty gloves, did not wash hands, grabs ready to eat biscuit and places it on plate for resident to eat. On 05/09/24 at 12:02 PM Surveyor observed Cook-K wearing same gloves on both hands, grab the metal food cart, open door then touch the top of the cart and plate lids. Using same dirty gloves, did not wash hands, with right and left gloved hands grabs two ready to eat biscuits and places on plates for residents to eat. On 05/09/24 at 12:03 PM Surveyor observed [NAME] wearing same gloves on both hands, grab the metal food cart. Using same dirty gloves, did not wash hands, grabs ready to eat biscuit and places it on plate for resident to eat. On 05/09/24 at 12:03 PM Surveyor observed Cook-K wearing same gloves on both hands, touching food lids, using same dirty gloves, did not wash hands, with right and left gloved hands grabs two ready to eat biscuits and places on plates for residents to eat. On 05/09/24 at 12:03 PM Surveyor asked Food Service Director-N if all food served for the entire facility comes from this steam table and it was confirmed that all food served comes from this steam table. On 05/09/24 at 12:06 PM Surveyor observed Cook-K wearing same gloves on both hands, grab a new metal food cart and using same dirty gloves, did not wash hands, with right gloved hand grabs ready to eat biscuit and places it on plate for resident to eat. On 05/09/24 at 12:08 PM Surveyor observes as Cook-K continues using same gloves, grabs ready to eat biscuit with right dirty gloved hand and places on plate for resident to eat, did not wash hands or put on new gloves. On 05/09/24 at 12:10 PM Surveyor observed Cook-K wearing same gloves on both hands, grab the metal food cart door, wipe nose with right gloved hand and using same dirty gloves, did not wash hands, with right and left gloved hands grabs two ready to eat biscuits and places them on plates for residents to eat. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/09/24 at 12:12 PM Surveyor observed Cook-K wearing same gloves on both hands, grab a metal food cart door and using same gloves, did not wash hands, with right dirty gloved hand grabs ready to eat biscuit and places on plate for resident to eat. On 05/09/24 at 12:14 PM Surveyor observed Cook-K continue using same gloves, grabs ready to eat biscuit with right dirty gloved hand and places on plate for resident to eat, did not wash hands or put on new gloves. On 05/09/24 at 12:16 PM Surveyor observes as Cook-K continues using same gloves, grabs ready to eat biscuit with right dirty gloved hand and places on plate for resident to eat, did not wash hands or put on new gloves. On 05/09/24 at 12:19 PM Surveyor observed Cook-K remove gloves. On 05/09/24 at 12:20 PM Surveyor observed Cook-K put on new gloves, but did not wash hands. On 05/09/24 at 12:21 PM Surveyor observed Cook-K remove gloves and wash hands before carrying plates of ready to eat food to dining room. Surveyor noted that Cook-K did not wash hands or change gloves after touching non-sanitized food surfaces and prior to touching ready to eat food. Dietary Aide-M Observations On 05/09/24 at 11:55 AM Surveyor observed Dietary Aide-M scooping yogurt from a larger container into small plastic containers, Dietary Aide-M was wearing gloves on both hands. Surveyor observed Dietary Aide-M wiping nose with gloves while scooping the yogurt then continue scooping, did not remove gloves or wash hands. On 05/09/24 at 11:56 AM Surveyor observed Dietary Aide-M wipe nose again without changing gloves or washing hands. Surveyor noted that Dietary Aide-M did not wash hands or change gloves after touching nose. On 05/14/24 at 09:18 AM Surveyor interviewed Food Service Director-N regarding staffing. It was stated that staffing in kitchen is usually made up of 2 dietary aides and 1 [NAME] for both morning and second shift. Food Service Director-N stated no staffing issues observed or identified on survey. On 05/14/24 at 09:23 AM Surveyor informed Food Service Director-N of observations with Dietary Aide-M and Cook-K touching/handling ready to eat food with gloves after wiping nose and touching non-sanitized food surfaces. When asked if they should be washing hands or using utensils to handle ready to eat food, states staff is expected to use tongs and utensils to handle ready to eat food, should be washing hands and changing gloves. Surveyor asked how many people are served out of the kitchen steam table, Food Service Director-N states all in census minus 2 who are NPO. States going forward will work to ensure that staff are using utensils to handle ready to eat food. No further information was provided as to why the facility did not ensure that food was distributed and served in accordance with professional standards for food service safety.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and interviews, the facility did not ensure hospice services providing end of life were coordinated for 1 (R32) of 3 sampled Residents receiving hospice services. *R32 was admitted on hospice on 4/8/24. R32's hospice binder did not have a physician certification of terminal illness, physician orders, documentation of visits, schedule of hospice visits with hospice team listed, and the facility did not designate a specific individual of the facility's interdisciplinary team to act as a liaison between the facility and the hospice provider. Findings Include: Surveyor reviewed the facility's Hospice Program policy and procedure and notes the following applicable: .Policy Interpretation and Implementation 9. In general, it is the responsibility of the hospice to manage the Resident's care as it relates to the terminal illness and related conditions, including: a. Determining appropriate hospice plan of care b. Changing the level of services provided when it is deemed appropriate c. Providing medical direction, nursing and clinical management of the terminal illness d. Providing spiritual, bereavement and/or psychosocial counseling and social services as needed e. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms 10. In general, it is the responsibility of the facility to meet the Resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual Resident's needs. d. Communicating with the hospice provider(and documenting such communication) to ensure that the needs of the Resident are addressed and met 24 hours per day. 12. Our facility has designated _____ Name_____ Title to coordinate care provided to the Resident by our facility staff and the hospice staff. He or she is responsible for the following: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for Residents receiving these services (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the Resident and family. d. Obtaining the following information from the hospice 1. The most recent hospice plan of care specific to each Resident 2. Hospice election form 3. Physician certification and recertification of the terminal illness specific to each Resident 4. Names and contact information for personnel involved in hospice care of each Resident 5. Instructions on how to access the hospice's 24-hour on-call system 6. Hospice medication information specific to each Resident 7. Hospice physician and attending physician(if any) orders specific to each Resident 13. Coordinated care plans for Residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility(including the responsible provider and discipline assigned to specific tasks) in order to maintain the Resident's highest practicable physical, mental and psychosocial well-being. Surveyor also reviewed the Hospice-Nursing Facility Services Agreement effective on the 20th day of March, 2023 between Hospice and the Facility: 2. Responsibilities of Facility (e) Coordination of Care i. General-Facility shall participate in any meetings, when requested by Hospice, for the coordination of services provided to Hospice Patients. ii. Design of Hospice Plan of Care-In accordance with applicable federal and state laws and regulations, facility shall coordinate with hospice in developing a hospice plan of care for each hospice patient that is consistent with the hospice philosophy and is responsive to the unique needs of each hospice patient and his or her expressed desire for hospice care. v. Designated Facility Member-Facility shall designate a member of facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to each hospice patient provided by facility and hospice. Facility's designated interdisciplinary team member shall be responsible for: 1. Collaborating with hospice representatives and coordinating facility's participation in hospice's care planning process for hospice patients (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consult with physician and Social Services to have Hospice care for resident in the facility [LPN,RN] 4/8/24 Encourage resident to express feelings, listen with non-judgmental acceptance, compassion. [LPN,RN] 4/8/24 Encourage support system of family and friends 4/8/24 On 5/9/24 at 2:17 PM, Surveyor completed a record review of R32's hospice binder located at the nurse's station. Surveyor notes there is a hospice care plan in place as of 5/2/24. There is a list of staff on the outside of the binder and the phone number of hospice and details of when to contact. A Hospice Election of Benefit Statement signed 4/8/24 by R32's activated HCPOA. The following items were not located in R32's hospice binder: 1. Physician certification of terminal illness 2. Schedule of when designated hospice care providers coming in to care for/visit R32 3. Any physician orders 4. Any documentation or communication from each hospice visit On 5/13/24 at 8:57 AM, Surveyor asked R32 how things were going with the care provided by hospice. R32 responded, I don't know, are they supposed to see me?. On 5/13/24 at 3:20 PM, Surveyor shared the concern with Administrator(NHA-A) and RN Consultant(RNC-C) that R32's hospice binder did not contain the required documentation that should have been obtained from hospice by the facility. Surveyor also shared there is no documentation of communication between the facility and hospice representatives to collaborate in providing care to/for R32. No further information was provided by the facility at this time. On 5/14/24 at 7:30 AM, RNC-C informed Surveyor that social services is auditing all hospice binders to make sure all required information and documentation is in the binder. Surveyor asked RNC-C who is the designated liaison from the facility responsible for the coordination of care between the facility and hospice. RNC-C does not know. On 5/14/24 at 1:53 PM, NHA-A informed Surveyor that R32's hospice provider was in the facility and updating R32's hospice documentation. No additional information was provided as to why the facility did not ensure hospice services providing end of life were coordinated for R32.

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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. 49011 Based on observation, interview, and record review, the facility did not implement effective infection prevention measures. This included observation of a nurse touching medications with bare hands during medication pass on two occasions. Observation of two residents having their catheter bag on the floor multiple times during the survey affecting 2 of 4 residents sampled with catheter bags. * The facility did not ensure R371 and R372's catheter bags were maintained in a sanitary manner. Findings include: The facility policy titled, Indwelling Catheter Use and Removal, with no implementation or revision date, states in part: Compliance Guidelines: .4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures . .7.e. Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the bladder . Surveyor notes no further infection prevention guidelines in policy. 1) .On 05/08/24 at 09:44 AM Surveyor interviewed R371 and learned they have had a catheter since 2019. Bag was hanging on bed frame with no privacy cover over. On 05/09/24 at 01:30 PM Surveyor observed R371 in their room. R371 was in bed and the catheter bag was laying on the floor. On 05/13/24 at 03:19 PM during the end of day meeting with Nursing Home Administrator (NHA)-A and Regional Nurse-C Surveyor shared concerns regarding observation of R371's catheter bag laying on the floor while in bed. On 05/14/24 at 07:56 AM Surveyor observed catheter bag laying directly on the floor again and asked Director of Nursing (DON)-B to come take a look at something. DON-B saw the problem and commented that the bag was directly on the floor. On 05/14/24 at 10:31 AM DON-B approached Surveyor and stated that the reason the bags have been touching or on the floor is that the beds have nowhere to hang them, they will need to find a solution. Surveyor notes having seen bag hanging from bed frame on separate observations. 2.) On 05/08/24 at 09:21 AM Surveyor observed R372 in bed sleeping, catheter bag laying on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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 - Few	On 05/08/24 at 09:54 AM Surveyor checked back and R372 was still sleeping and the catheter bag remained on the floor. On 05/08/24 at 09:57 AM Surveyor spoke with the agency registered nurse in the hallway and was told that R372 has a groin abscess and a foley is in use because of abscess. On 05/09/24 at 08:41 AM and 1:30 PM Surveyor observed the catheter bag off floor, hanging from bed frame. On 05/13/24 at 03:19 PM during the end of day meeting with Nursing Home Administrator (NHA)-A and Regional Nurse-C Surveyor shared concerns regarding observations of R372's catheter bag laying on the floor while in bed. On 05/14/24 at 07:56 AM Surveyor observed catheter bag hanging on bedframe, bottom of bag touching the floor and asked Director of Nursing (DON)-B to come take a look at something. DON-B saw the problem and commented that the bag was touching the floor. On 05/14/24 at 10:31 AM DON-B approached Surveyor and stated that the reason the bags have been touching or on the floor is that the beds have nowhere to hang them, they will need to find a solution. Surveyor notes having seen bag hanging from bed frame on separate observations. No additional information was provided. 20025 3.) The facility's medication administration policy (undated) indicate: Policy explanation and compliance guidelines: . 14. Remove medication from source, taking care not to touch medication with bare hand. On 5/14/24 at 8:00 a.m. Surveyor observed LNP (licensed practical nurse)-F administer medication to R64. LPN-F proceeded to dispense the pills out of the medication bubble pack into his bare hands then place the pills into a medication cup. LPN-F proceeded to dispense the medication in this manner for 4 different pills. On 5/14/24 at 8:06 a.m. Surveyor observed LPN-F administer medication to R42. LPN-F proceeded to dispense the pills out of the medication bubble pack into his bare hands then place the pills into a medication cup. LPN-F proceeded to dispense the medication in this manner for 6 different pills. On 5/14/24 at 8:14 a.m. Surveyor interviewed LPN-F. Surveyor asked LPN-F if there was a reason why he dispensed R64 and R42 medications into his hands then place them in the medication cup. LPN-F told Surveyor he should have dispensed the medication in the medication cup. On 5/14/24 at 12:42 p.m. Surveyor interviewed DON-B. Surveyor explained the observation of LPN-F dispensing medications into his hands then placing them in the medication cup. DON-B stated there have been many inservices regarding infection control procedures during medication pass. DON-B stated she understood the concern and had no addition information.