STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525488	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Black River Falls	1311 Tyler St Black River Falls, WI 54615

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not formulate an advance directive for the resident. Resident (R) 236 did not have orders for the advanced directive they elected for on file, or in a place for emergency personnel to retrieve the information if needed. This had the ability to effect 1 of 12 residents surveyed (R236). Findings include: The facility policy, entitled Advanced Directives, dated [DATE], states: Documentation . 1. Copied of any advanced directives are maintained in the residents clinical record. 2. The facility must document in a prominent part of the residents clinical record whether the resident has issues an advanced directive R236 was admitted on [DATE] to the facility and is able to be understood by peers and understands. On [DATE] at 1:39 PM, record review of R236's hard charts and electronic record could not produce an order for a Cardiopulmonary Resuscitation (CPR) or Do - Not - Resuscitate (DNR). Surveyor could not find a provider order related to advanced directives. On [DATE] at 1:40 PM, Surveyor interviewed Licensed Practical Nurse (LPN) L regarding the process for determining a resident's advanced directives. LPN L stated they would first look at the electronic record; below the resident's picture there should be a gray area that states Do Not Resuscitate or Full Code. The other place they look is in the Post Book which has advanced directive documentation organized by room location. On [DATE] at 1:50 PM, Surveyor reviewed the hard charts again and did not find any advanced directive designations. Surveyor did not find the advanced directive documentation in the books by the nurses station either. On [DATE] at 2:00 PM, Surveyor asked LPN H to look and see if Surveyor had missed the advanced directive documentation in the books at the nurses station. LPN H did not see documentation and directed the Surveyor to another staff member whose role was to put the directives in the book. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:07 PM, Surveyor interviewed Medical Records (MR) C regarding hard copies of advanced directive notification. MR C said they could not initially find the yellow form, but normally they would expect the form to be placed in the advanced directive book at the nurses station immediately. On [DATE] at 2:35 PM, Surveyor interviewed Chief Nursing Officer (CNO) M regarding procedure for advanced directives. CNO M stated they would expect there to be doctor orders, face sheet documentation in the electronic medical record, and a Physician Orders for Scope of Treatment (POST) sheet located at the nurses station. CNO M further mentioned they also looked and could not find the items required for R236's advanced directives in the proper places.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47657 Based on observations, interviews, and record reviews, the facility did not consult with a physician for 1 of 3 residents (R) R26 who had experienced a significant weight gain. This is evidenced by: The facility policy entitled Change in Condition Policy: dated August 2024 states: The purpose of this policy is to ensure the facility promptly consults the physician when there is a change requiring notification. Procedure - .The physician will be notified when there has been a change that is marked a difference in usual sign/symptoms. Specific information that requires prompt notification include . significant weight change gain or loss of 5% or more in the past 30 days, 7.5% or more in past three months, or 10% or more in the past six months. R26 was admitted to facility on 11/15/23, and has diagnoses that include Alzheimer's disease, hypertension, and chronic pain. R26 has a BIMS of 7, indicating moderately impaired cognitive level. R26's Quarterly Minimum Data Set (MDS) with target date of 05/23/24, Section K: weight 178#. R26's MDS with target date of 08/23/24, Section K: weight 189#. indicating a weight gain not on a physician prescribed weight gain regimen. R26's care plan dated 09/22/24, with a target date of 11/15/24, states: Resident has nutritional problem or potential nutritional problem d/t risk for variable intakes r/t Alzheimer's disease and chronic pain. Goal: Resident will maintain adequate nutritional status as evidenced by no significant weight changes. R26's physician orders dated 07/10/24 states: Weights weekly on shower day, every Sunday. On 10/07/24 at 12:40 PM, Surveyor reviewed R26's weight record which showed on 08/02/2024, the resident weighed 178.6 lbs and on 09/04/2024, the resident weighed 191.4., indicating R26 had a weight gain of 7.2% in one month. The facility was aware of the weight changes, as the record provides information of the percentage of weight changes as weights are entered into facility computer system. On 08/22/24 at 1:14 PM, R26's weight was recorded as166.6#, but was stricken out on 08/26/24 at 3:30 AM, by Nursing Home Administrator (NHA) A due to Data Entry Error. On 8/22/2024 at 1:17 PM, facility entered a Nursing Progress New order resident to have daily weights x 5 days to get an accurate weight. Resident showing weight loss. Primary Care Provider (PCP) updated with findings and to be updated after the 5 days of weight. Of note, R26's previous weight prior to PCP being updated was documented on 08/02/24 at 178.6#. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26's weights for the 5 days recorded shows: 8/23/2024 - 189.2 lbs 8/24/2024 - 190.4 lbs 8/25/2024 - 190.2 lbs 8/26/2024 - 191.8 lbs 8/27/2024 - 191.4 lbs On 10/07/24 at 12:40 PM, Surveyor reviewed R26's medical record and was unable to locate documentation to support PCP was updated of weight results. On 10/07/24 at 2:53 PM, Surveyor interviewed Assistant Director of Nursing (ADON) G regarding R26's significant change in weights from 09/08/24 - 09/20/24. ADON G, stated, I know, - the physician order to obtain weights for 5 days, was obtained due to weight discrepancies between 08/22/24 to 08/25/24. ADON G stated the PCP was not updated regarding weight gain after the 5 days per order. On 10/08/24 at 6:25 AM, ADON G reported to Surveyor that PCP was updated on 10/07/24 regarding R26's weight gain and is awaiting response.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observations, interviews and record review, the facility failed to ensure each resident is free from physical restraints that are not required to treat the resident's medical symptoms for 1 of 1 resident reviewed for restraints (R3). R3 had a lap belt in his wheelchair without a physician order for use, the medical symptom the lap belt was being used to treat, or an assessment to determine appropriateness of its use. The device was not indicated in R3's care plan. This is evidenced by: The facility's policy titled Restraint Management, read in part .If indicated, the least restrictive restraint is used for the least amount of time. In cases where restraints are implemented based on the resident's assessment, the facility will make reasonable efforts to reduce their use systematically and gradually. Physical restraints include, but are not limited to, leg restraints, arm restraints, soft ties, lap cushions, and lap trays the resident cannot remove easily. Also included as restraints are facility practices that meet the definition of restraint, such as .Using devices in conjunction with a chair, such as trays, table, bars or belts, that the resident cannot remove easily that prevent the resident from rising. Use of restraint upon admission. If the resident is admitted with orders for a restraint, the staff may accept the order for up to 72 hours pending completion of the Pre-Physical Restraint and Reduction Evaluation in the electronic medical record, provided that: the licensed nurse has consulted with the physician and documented the resident's history and the appropriateness of the restraint. The resident and/or his or her representative's authorization was received and documented, and the risks associated with restraint usage were reviewed. The reason for the restraint use was documented on the Nursing Initial Plan of Care. R3 was admitted to the facility on [DATE]; diagnoses included paralysis of left side of body following a stroke, inability to speak following a stroke, and dependence on wheelchair. The most recent Minimum Data Set (MDS) assessment competed on 07/15/24, confirmed R3 was unable to complete Brief Interview for Mental Status (BIMS), as he is rarely understood by others. Staff assessment for mental status was completed indicating R3's cognition was severely impaired. R3's Family Member (FM) E, is his activated Power of Attorney (POA). R3's MDS assessment indicated restraints were not used. R3 was dependent on staff for all activities of daily living (ADLs). R3's physician orders did not include an order to use a restraint. R3's care plan did not include use for a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's electronic record did not include an assessment for indication for use of a restraint. On 10/06/24 at 1:41 PM, Surveyor interviewed R3 and FM E. Surveyor observed R3 sitting in a positioning wheelchair and wearing a seatbelt or lap belt across his waist. The belt was secured into a latch plate, similar to a seatbelt in a vehicle. FM E stated R3 received his wheelchair prior to being admitted to the nursing home. FM E stated the seatbelt was used, Because it came with the wheelchair, we just got in the habit of using it. I don't think he really needs it. Surveyor asked R3 and FM E if he was able to remove the seatbelt on his own. FM E prompted R3 to unlock the seatbelt. R3 moved his right hand towards the seatbelt but did not attempt to unlock or remove the device. On 10/07/24 at 12:12 PM, Surveyor interviewed Certified Nursing Assistants (CNA) I and CNA J. CNA I and CNA J reported they do use the seatbelt when placing R3 in his wheelchair. CNA I and CNA J were unable to report why R3 needed a seatbelt in his wheelchair. CNA I and CNA J stated R3 was able to release the seatbelt at one time, but R3 had not been able to do this for a while. On 10/07/24 at 1:26 PM, Surveyor interviewed Assistant Director of Nursing (ADON) G. ADON G reported the facility should be restraint free. If a resident did require a restraint, the resident should be assessed for use of the restraint, daily monitoring should be completed in the resident's treatment administration record, and re-assessments should be completed at least quarterly. ADON confirmed there was no documentation in R3's record to support the use of a restraint. ADON stated she assessed R3 and removed the restraint from his wheelchair, as R3 did not require the use of the restraint.

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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. 47657 Based on interview and record review, the facility did not report an incident of potential misconduct to the state agency immediately upon learning of the incident and did not submit the 5-day investigation within 5 days as required. The facility practice had the potential to affect 1 of 2 residents (R) reviewed for abuse (R187). This is evidenced by: The facility police entitled Abuse prevention Facility Procedures Training Program and Staff Materials defines Neglect: Means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, or mental anguish. Neglect is the intentional carelessness, negligence, or disregard of policy or care plan which could cause or could be reasonably expected to cause pain injury or death. Section VII. External Reporting. 1. Initial Reporting of Allegations. When an allegation of abuse exploitation neglect, mistreatment or misappropriation of resident property has been made the administrator or designee shall complete a submit and submit a DQA form (F-62617), notifying DQA that an occurrence of potential abuse neglect exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. This report shall be made immediately. The term immediately as it is used in this policy in relationship to reporting abuse, neglect, exploitation, mistreatment, misappropriation of resident property, and suspicion of a crime shall be defined as following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the resident or residents involved or not later than two hours after forming the suspicion, if the events that caused the suspicion result in seriously bodily injury, or not later than 24 hours if the events that caused suspicion do not result in serious bodily injury. 2. Five-day Final Investigation Report. Within 5 working days after the report of the occurrence, the administrator or designee shall complete and submit a misconduct incident report form (F-62447) notifying the Regulatory agency of the conclusion of the investigation.: R187 was admitted to facility on 08/22/24 at 5:30 P.M. escorted by Adult Protective Service (APS) following being placed into Emergency Protective Placement on 08/21/4 at 3:57 PM while at hospital. R187 had diagnosis' of: encephalopathy, unspecified amnesia, disorientation, acute abdomen, calculus of gallbladder without cholecystitis, alcohol use, unspecified in remission following elopement from hospital. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/24 at 1:47 PM, Surveyor requested investigation of reported incidents of R187's elopements from facility. The facility provided a soft file investigation of R187's elopements from the facility on 08/23/24, documented that for 2 of the 3 elopements, R187 was away from the facility for a considerable amount of time, involved several law enforcement personnel including a K-9 unit, numerous staff members, a trip to the hospital emergency room , and R187 was physically stopped from jumping off a bridge that was approximately 1.7 miles from the facility. Summary of elopement events from facility: 1st elopement: On 08/23/24 at 4:30 AM, R187 exited the employee door, alarm sounded and Certified Nursing Assistant (CNA) N responded. CNA N exited building with R187. Resident was aggressive and agitated. CNA N redirected and was able to escort R187 into center after approximately 5 minutes. 2nd elopement: On 8/23/24 at 4:44 AM, R187 exited an emergency alarmed door (less than 9 minutes after 1st elopement) and was unable to be located. Staff and law enforcement were involved in the search. R187 was found 2 blocks from facility by law enforcement who brought R187 back to facility at 7:30 AM. On 08/23/24, R187 was seen in emergency room from 8:37 AM to 9:08 AM for evaluation. 3rd elopement: On 08/23/24 at 7:00 PM, R187 exited an emergency alarmed door and several staff chased after R187 to a bridge where a civilian stopped R187 from jumping off bridge. R187 was taken to emergency room at 8:30 PM. On 10/08/24 at 3:18 PM, Surveyor interviewed with Chief Nursing Officer (CNO) M regarding lack of reporting of elopements of R187. CNO M confirmed events were not reported and is unaware of the reason why it wasn't reported. On 10/08/24 at 3:27 PM, Surveyor interviewed Nursing Home Administrator (NHA) A who stated the elopements were not submitted to DQA, as NHA A talked with corporate office and was told to keep a soft file.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on record review and staff interview, the facility did not ensure 3 of 12 sampled residents (R11, R28, R20) reviewed for hospitalization s, received the proper notice of transfer, reason for transfer and location of transfer. Findings: Example 1 and 2 R11 was hospitalized on [DATE] and was not provided with a written notice of transfer. R28 was hospitalized on [DATE] and was not provided with a written notice of the transfer. R28 was hospitalized on [DATE] and was not provided with a written notice of transfer. 51095 Example 2 On 10/08/24, Surveyor reviewed R20's record. Record review identified R20 had a change in condition on 08/05/24. R20 was transferred to the emergency room and later admitted to the hospital with a diagnosis of a complicated urinary tract infection (UTI) with chronic indwelling Foley catheter. R20 remained in the hospital until 08/08/24. On 10/08/24, Surveyor requested written notice of transfer from facility administration and no notice of transfer was received. Surveyor was unable to find evidence that a written notice of transfer was provided to R20's representative. On 10/09/24 at 2:15 PM, Surveyor interviewed Medical Records C. Medical Records C reported the facility does not have a process for providing a written notice of transfer when a resident is hospitalized .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on staff interview and record review, the facility did not ensure 2 of 12 sampled residents (R28 and R20) reviewed for hospitalization , received notification of the facility's bed hold policy when they were transferred to the hospital. Findings include: The facility's policy titled, Bedhold Notification, read in part, When a resident is transferred to a hospital or requests a therapeutic leave, the center will provide written notice to the resident and/or resident representative regarding the resident's bed hold rights and the centers bed hold policy. When hospitalization or a therapeutic leave is necessary, the Resident's bed will be held automatically for 15 days at a rate of 100% of the Resident's current daily rate, unless the Resident or Resident Representative notifies the Facility's Business Office or Social Work Department or unless a condition of involuntary removal has been met. A statement will be given to the Resident outlining the Facility's bed hold policy at the time of transfer to the hospital or at the beginning of a leave. Example 1 R28 was admitted to the facility on [DATE]. R28 was his own decision maker. R28 was admitted to the hospital on 03/25/24 for acute kidney injury, dehydration, and urine retention. R28 was admitted to the hospital on 05/03/24 for inflammation of the gall bladder. On 10/07/24, Surveyor was unable to find evidence R28 was notified of the facility's bed hold policy at the time of his hospitalization s. 51095 Example 2 On 10/08/24, Surveyor reviewed R20's record. Record review identified R20 had a change in condition on 08/05/24. R20 was transferred to the emergency room and later admitted to the hospital with a diagnosis of a complicated urinary tract infection (UTI) with chronic indwelling Foley catheter. R20 remained in the hospital until 08/08/24. On 10/08/24, Surveyor requested written notice of facility's bed hold from facility administration and no bed hold was received. Surveyor was unable to find evidence R20's representative was notified of the facility's bed hold policy at the time of the hospitalization . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/24 at 1:00 PM, Surveyors requested bed hold notifications for R20 and R28. Surveyor interviewed Social Services Director (SSD) D. SSD D reported she was unable to locate bed hold notifications for the hospitalization s requested.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on record review and interview, the facility did not complete a Significant Change in Status Assessment (SCSA) for 1 resident (R11) of 12 sampled residents. R11 experienced a significant change in physical condition and cognition, identified on 09/12/24; the facility did not complete a SCSA for R11. This is evidenced by: According to the Resident Assessment Instrument (RAI) manual, a significant change is defined as: -A decline or improvement that will not resolve itself without staff intervention or standard clinical interventions. -A change that affects more than one area of the resident's health. -A change that requires a revision or interdisciplinary review of the care plan. Examples of a significant change in the resident's status include, in part: -A decline in two or more areas. -A decline in an Activities of Daily Living (ADLs) physical functioning. -A new pressure ulcer at Stage II or higher. -The resident's condition deteriorates overall. -The resident receives more support. -The resident develops a condition or disease that makes them unstable. The facility policy titled Change in Condition Policy, states in part, Changes in condition will be evaluated for the need to complete a Significant Change in Condition MDS 3.0/RAI Assessment. The care plan will be updated as necessary. R11 was admitted to the facility on [DATE]; diagnoses included history of a heart attack, Chronic Obstructive Pulmonary Disease (COPD), type 2 diabetes mellitus, obesity, and chronic kidney disease. R11's Minimum Data Set (MDS) Assessment, completed on 07/29/24, confirmed R11 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R11 was able to make his own decisions. R11's MDS assessment confirmed R11 required substantial assistance with toileting, bathing, dressing, repositioning, and transferring. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/24/24, R11's progress notes indicated he began hallucinating. On 08/26/24, R11 was hospitalized for respiratory failure, exacerbation of COPD, and urinary tract infection. On 08/28/24, R11 was readmitted to the facility, and progress notes indicated he continued with delusions. On 09/03/24, R11's progress notes indicated he continued with hallucinations. On 09/06/24, R11's PCP was updated R11 was experiencing increased carbon dioxide levels and continued with hallucinations. On 09/12/24, R11's progress notes reported the following: IDT reviewed resident during At Risk. IDT discussed resident's recent change of condition. Resident's cognition has declined and will be evaluated for incapacity. Resident has been seeing other individuals in his room, talking non sensical, and overall, not being able to follow a conversation. Resident does not feel safe getting up or attempting to walk with staff assistance. Resident's overall physical condition has declined since being transferred from the CBRF to the SNF. Resident has also had several physical health setbacks since the transfer. IDT will continue to monitor resident and his well-being. On 09/25/24, the facility requested an order for R11 to have a psychiatric evaluation related to continued hallucinations. On 09/26/24, R11's progress notes read . Being followed r/t hallucinations, has referral for neuro psych. Has pressure ulcer Left upper buttock and right upper thigh stage II. Currently on-air mattress. New order for PT, Treatment order. On 10/07/24 at 8:53 AM, Surveyor observed R11 was covered with a sheet up to mid-chest, with no upper clothing on. R11 stated this is his preference, since he does not get out of bed. Surveyor interviewed R11. R11 answered questions appropriately, reporting he requires staff assistance with repositioning in bed, transfers, toileting, bathing, and dressing. R11 states he prefers to stay in bed, stating he used to sit on the edge of the bed, but he can no longer do that. R11 stated he gets out of bed for his appointments. R11 confirmed he does not complete twice daily lymphedema treatments as ordered. During interview, Surveyor asked R11 questions to determine when he began refusing treatments and cares, and to determine his prior level of functioning. R11 refused to answer most questions stating, I am not going to tell you about that. It's done and over. On 10/07/24 at 10:01 AM, Surveyor observed Licensed Practical Nurse (LPN) H and Certified Nursing Assistant (CNA) I complete incontinence care for R11. LPN H and CNA I reported R11 has been refusing to reposition in bed, sit on the edge of the bed, get out of bed, or complete twice daily lymphedema treatments. (continued on next page)

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	525488	A. Building B. Wing	10/16/2024

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Meadowbrook at Black River Falls	1311 Tyler St Black River Falls, WI 54615

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/07/24 at 10:13 AM, Surveyor interviewed Nursing Home Administrator (NHA) A. NHA A reported the Assistant Director of Nursing (ADON) G and the Director of Nursing (DON) B were recently hired approximately two weeks ago. NHA A stated because of their new positions it is likely they were unaware of R11's change in condition. NHA A reported Medical Records (MR) C was working on scheduling psychiatric evaluation for R11. NHA A confirmed R11 met the criteria to complete a SCSA, and this had not been completed timely. On 10/07/24 at 10:59 AM, Surveyor interviewed MR C. MR C reported the facility was attempting to obtain two physician signatures for a determination of R11's capacity to make health care decisions. MR C verified R11's provider had evaluated and signed, confirming R11 lacked capacity to make decisions. MR C reported R11 would be having a psychiatric evaluation, and a determination for capacity would be confirmed at this appointment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on interview and record review, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 1 of 12 sampled residents (R11). The facility did not follow hospital discharge orders to complete laboratory testing five days after R11 discharged from the hospital. The facility did not follow hospital discharge orders to complete a sleep medicine evaluation to determine possible interventions related to R11 refusing to wear continuous positive airway pressure (CPAP) device. Findings: R11 was admitted to the facility on [DATE]. Diagnoses included dependence on supplemental oxygen, shortness of breath, obstructive sleep apnea, history of nicotine dependence, chronic obstructive pulmonary disease (COPD), respiratory failure with hypercapnia (elevated carbon dioxide levels), and respiratory failure with hypoxia (low levels of oxygen in the body's tissues). R11's Minimum Data Set (MDS) assessment, completed on 07/29/24, confirmed R11 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. On 08/24/24, R11's progress notes indicated he began hallucinating. R11 was admitted to the hospital from 08/26/24-08/28/24 with diagnoses of respiratory failure. During his hospitalization , R11's diagnostic testing revealed the following, confirming R11 was experiencing respiratory failure and required non-invasive ventilation (BiPap): -Elevated arterial blood gases (ABG), indicating lung or kidney dysfunction, and/or metabolic disorders. -Elevated carbon dioxide (CO2), indicating lung or kidney dysfunction or electrolyte imbalances. -Decreased oxygen (O2) saturation, indicating chronic lung disease, acute lung disease, or sleep apnea. During R11's hospitalization , laboratory testing revealed the following: -Elevated white blood count (WBC), indicating an infection or inflammation. -Decreased hemoglobin levels, indicating anemia. -Decreased platelets, indicating difficulty for the blood to clot. -Elevated sodium level, indicating electrolyte imbalance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Decreased potassium, indicating electrolyte imbalance. -Elevated bicarbonate level, indicating electrolyte imbalance. -Increased creatinine, indicating kidney dysfunction. R11's hospital records confirmed diagnoses of obesity hypoventilation syndrome ([NAME]), indicating high CO2 levels in the blood, and obstructive sleep apnea (OSA). Hospital records report it was noted R11 was confused. During R11's hospitalization , he reported he does not tolerate his continuous positive airway pressure (CPAP) device and does not wear it when he is at the nursing home. R11 reported he preferred the BiPap. On 08/28/24, R11's discharge instructions included: repeat laboratory evaluation in five days including creatinine and electrolytes, and sleep medicine evaluation for possible interventions related to OSA. On 09/12/24, the facility determined R11 had a change in condition related to continued hallucinations, resident does not feel safe getting up or attempting to walk, and overall physical decline. The facility did not complete a comprehensive assessment of R11's change in condition. Note, R11 is being referred for a psychiatric evaluation and determination of capacity to make daily decisions, related to continued hallucinations. His current BIMS of 15/15 may not be accurate. On 10/06/24 at 3:12 PM, Surveyor interviewed R11. R11 confirmed he was recently hospitalized but was unable to provide details related to when or why. On 10/07/24 at 10:59 AM, Surveyor interviewed Medical Records (MR) C. MR C is responsible for scheduling appointments. MR C stated when a resident admits, re-admits, or returns from an appointment, the nurse working at the time the resident enters the facility is responsible to review any instructions, enter orders, and place follow-up appointment documentation in a designated location. MR C collects the documentation and schedules any follow-up appointments. MR C was not aware if R11's labs or sleep evaluation were scheduled. On 10/08/24 at 10:27 AM, Surveyor interviewed MR C. MR C reported R11's labs were completed on 09/19/24, 22 days after he was discharged from the hospital. MR C provided Surveyor with email correspondence on 10/08/24, indicating a sleep study would be scheduled for R11 on 10/21/24.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47657 Based on record review and interview, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 5 residents (R187) reviewed for accidents. R187 had an elopement from the hospital prior to admission and, following admission here, eloped from the building on 3 separate occasions. On the second elopement, R187 was missing for 2.5 hours, which required police and a K9 search to find R187. On the third elopement, R187 traveled 1.4 miles to a bridge, running through busy traffic, and attempted to jump off the bridge. Facility failure to provide adequate supervision created a finding of immediate jeopardy that began on 08/23/24. Nursing Home Administrator (NHA) A was notified of the immediate jeopardy on 10/09/24 at 1:00 PM. The immediate jeopardy was removed on 08/26/24 and corrected on 08/27/24. This is being cited as past noncompliance. Findings: The facility policy titled Elopement dated June 2023, states, It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual care plan. The facility policy titled Elopement Management dated June 2023, states, Each resident is assisted in attaining or maintaining his or her highest practicable level of function by providing the resident with adequate supervision, activity/functional programs as appropriate, and safety interventions to minimize elopement risk. Signaling devices may be used if able and determined to be an appropriate intervention. The goal of the elopement management system is to identify residents with potential exit seeking behavior to assure the care plan and Kardex reflect effective and consistent interventions and safety measures and to assure staff are educated regarding the elopement management system and the resident's specific interventions. Practice guidelines: -Residents assessed on admission with the risk for elopement will have a. Interventions implemented to promote safety; and preventative measures implemented to mitigate elopement risk. R187 was admitted to the facility on [DATE] at 5:30 P.M. escorted by Adult Protective Service (APS), after being placed into Emergency Protective Placement on 08/21/24 at 3:57 PM while at the hospital. While waiting for treatment at the hospital, R187 had eloped. On 10/08/24 at 1:47 PM, Surveyor reviewed hospital emergency room documentation dated 08/21/24 which states in part, At 1453 the patient has eloped from the ER. Police called at 1554. Adult protective serves will be re-contacted. Per police report for hospital elopement, resident was located on [NAME] Street and complied with return to hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R187 had diagnoses of encephalopathy, unspecified amnesia, disorientation, acute abdomen, calculus of gallbladder without cholecystitis, alcohol use, unspecified in remission following elopement from hospital. Facility was unable to obtain a Brief Interview for Mental Status (BIMS) on admission as R187 refused to answer questions. Hospital records, dated 8/22/24, indicate the Montreal Cognitive Assessment (MoCA) (screening test for cognitive impairment) was given and R817 scored a 4. Less than 10: Indicates severe impairment. On 8/22/2024 at 11:40 PM, the facility documented a clinical admission note for R187 that states in part: -Admission Details: Arrived by - Other: Protective Services -Admission mode: walker. -Mental Status: Resident is experiencing signs of short-term memory loss. Oriented to person. Oriented to place. -Short-term memory loss: Unknown. -Level of cognitive impairment: Mild impairment (some confusion). Resident is coherent. Speech is clear. Language barrier: No. Resident makes self-understood. Resident understands others. -Mood and Behavior: Mood is pleasant, no unwanted behaviors witnessed. -Safety: Call light is within reach. -Physical restraints - none. -Able to move all extremities. Upper extremity ROM: No impairment. Lower extremity ROM: No impairment. -Gait is steady. -Balance is WNL (within normal limits). -Screening: Does the Resident currently or have a history of a substance use or been diagnosed with substance use disorder: No. -Education/Notification: Safety concerns - note: Elopement attempts while in hospital. On 8/22/2024 at 11:40 PM, the facility entered a nursing progress note that states in part: Screening: Resident has not faced a traumatic event or experience in the past. On 08/23/2024 at 12:04 AM, the facility completed an Elopement Evaluation, which showed a score of 5.0 (score above a 1 is at risk) based on answering Yes to the following questions: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Does the resident have a history of elopement or an attempted elopement while at home? -Does the resident have a history of elopement or attempted leaving the facility without informing staff? -Is the wandering behavior a pattern, goal directed i.e. specific designation in mind, going home, etc.? -Is the residence wandering behavior likely to affect the safety or well-being of self or other? -Has the resident been recently admitted or readmitted within the past 30 days and is not accepting the situation? Of note, the elopement assessment and wanderguard were not placed until over 6 hours after admission, putting R187 at risk of successful elopement during this time. Surveyor reviewed a nursing progress note from 8/23/2024 at 9:00 AM. Note Text: NEW ADMISSION: Res was awake all night. He couldn't rest early on the night shift and was coming to the window of the nurses station and asking questions with difficulty word finding, and word salad. One time wondered about sugar and diabetes. Another time said I am just going to my room, and I will die. Writer redirected res with conversation and a snack. Given a sandwich, and a soda and bag of chips. Res sat in lobby area, eating his snack. No further mention of death or dying. Res was concerned that he was not eating food away from staff or any others. Both staff left resident in lobby area eating, as he was content at approximately 0425. On 10/08/24 at 10:38 AM, Surveyor interviewed Dietary Manager (DM) F about R187's time at the facility and his elopements. DM F indicated on 08/23/24 at 4:30 AM, R187 was observed by DM F walking out the employee entrance which is off a hallway with administrative offices. Certified Nursing Assistant (CNA) N responded immediately and was able to convince R187 to return into facility and the incident was reported to NHA A at 4:43 a.m. On 10/08/24 at 1:47 PM, Surveyor requested from NHA A the facility's investigation for R187's elopements on 08/23/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NHA A, provided a soft file investigation/conclusion summary dated 08/23/24 - 08/26/24 and signed by NHA A, regarding the second elopement, that states under the sections Conclusion/Root cause Summary: [R187] was admitted on [DATE] at approximately 4:30 PM. [R187] placed in room mid hallway from either exit door. On 08/23/24 at 4:30 AM, [R187] exited the employee door and an alarm sounded. [CNA N] responded and [CNA N] exited building with [R187]. [DM F] outside in parking lot when [R187] exited. [R187] aggressive and agitated. [CNA N] redirected and was able to escort [R187] into center after approximately 5 minutes. [R187] escorted to lobby for close supervision and wanderguard placed [CNA N] contacted [NHA A] via telephone. Television was on for [R187]. [R187] went to room stating was tired. [RN X] witnessed [R187] ambulating in hallway to room on hall 200. [R187] bypassed room and attempted to push open door at end of hall 200; however, it alarmed and [R187] closed door and retreated. [RN X] was in a resident's room and observed [R187] ambulating quickly toward hall 300. Hall 300 door sounded at approximately 5:30 AM. Staff responded to door. [CNA N] went out the door at end of hall 300 and began search for [R187]. [CNA N] on phone with [NHA A] during this time. Police contact immediately. [LPN K] updated resides local [DM F] took vehicle to begin neighborhood search for [R187]. Other managers contacted to come to center to assist. Police came to center within two minutes of calling. Police suspected [R187] was hiding in bushes as they responded within minutes. [R187] located two blocks from center near the church/courthouse. [R187] was sitting on the steps of the church police brought [R187] to the center. [R187] assessed by nurse. No injuries noted. [R187] taken to hospital by maintenance supervisor for further evaluation. [R187] returned to center approximately 1-1.5 hours later at approximately 10:30 AM. hospital emergency room for evaluation following elopement. Surveyor did not find any documentation in R187's medical record regarding the first and second elopements or evidence of increased supervision or additional interventions after the first and second elopement. Surveyor received and reviewed a written statement and signed event dated 8/23/24 by Registered Nurse (RN) X. RN X only worked this one shift for the facility. RN X's statement read: Approximately 4:30 AM, heard wanderguard alarm go off. [CNA N] and [RN X] both on Aspen wing ran to get alarm when [R187] exited the building and came back with [CNA N]. [RN X] was looking out windows and doors to see if [CNA N] needed help returning [R187] to facility. [RN X] was unable to see well, so opened emergency wing door at the end of Birch Hall. [CNA N] came to help [RN X] to shut off alarm as were looking for a key to silence the loud alarm. At opposite end of wing staff heard [R187] yelling out something about a fire but alarm was so loud not really able to hear [R187] who was walking very fast as [R187] went by the wing from [NAME] way toward lobby. Staff not sure when [R187] exited second time as the alarms were so loud and we were trying to silence them. We are also not sure what door [R187] exited. [CNA N] called NHA A at 4:43 AM to inform of inability to find resident [R187]. At this time [RN X], [CNA N] and [DM F] involved looking for resident soon another staff member [LPN K] came from other building to help look. [Assistant Director of Nursing (ADON) G] was phoned at 5:04 AM and asked for help. Maintenance man arrived and shut off alarm at 5:19 AM. Staff and police continually searching for [R187] outside of building as it was confirmed [R187] was not inside the building. At 7:10 AM by police staff noted when returned [R187] did not have the wanderguard on left wrist. [R187] did have wanderguard on left wrist when [R187] was eating sandwiches at 4:25 AM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor interviewed DM F regarding R187's second elopement. DM F indicated that at approximately 4:44 AM on 08/23/24, R187 attempted to elope out of 200-wing setting off emergency door alarm. R187 walked back toward nurses' station and DM F was asked by CNA N to assist RN X to shut off the 200-wing emergency door alarm as CNA N went to conduct morning cares on another resident. DM F returned to the nurses' station as was unable to assist shutting off 200 wing emergency alarm. RN X continued to attempt shutting off alarm. DM F then heard the 300-wing emergency door alarm activate and responded along with CNA N. Both quickly conducted a search inside the building and were unable to locate R187. Both DM F and CNA N notified RN X who called the police and then started looking outside and around the building to locate resident. CNA N contacted NHA A via telephone at 4:43 AM. Police were contacted at 4:49 AM by RN X. Maintenance was contacted and was able to shut off door emergency alarm at 5:19 AM. Of note, the nurse on duty was an agency nurse who was working her first shift and was not knowledgeable in how to operate the alarms. DM F indicated she got into car and drove around neighborhood on 08/23/24 from 4:45 AM to 7:18 AM but was unable to locate R187. On 08/23/24 at approximately 7:30 AM, police department brought R187 back to facility as R187 was found approximately 0.7 miles from facility sitting on church steps. R187 would need to cross several roads to get to the church. Weather was low of 63 degrees and R187 was dressed in hospital gown, underwear, and shoes. On 10/08/24 at 12:14 PM, Surveyor interviewed CNA O, who stated on 08/23/24 she came on shift at 6:00 AM. CNA O was told that a new admission came in on 08/22/24 and was missing for hours and around breakfast time police brought R187 back to facility. CNA O stated R187 did not have a wanderguard on nor was he on 15-minute checks. On 10/09/24 at 6:49 AM, Surveyor interviewed CNA N who indicated RN X was overwhelmed as it was the first time RN X has worked for facility. CNA N indicated R187 was a little restless during the shift and he heard the wanderguard alarm by employee entrance so CNA N went out and redirected R187 back into facility. CNA N indicated while that was happening RN X went down the 200 hall, as RN X thought R187 went out the emergency door which set off the emergency alarm. R187 became agitated and freaking out there was going to be a fire. We got R187 to remain calm. CNA N indicated he went to see if the emergency alarm would stop, but it needed a key. R187 then went out 300 hall door, setting off another emergency alarm which made the noise louder while CNA N was on the phone with NHA A and RN X was freaking out. The police arrived and searched for R187. CNA N indicated prior to R187 arriving to facility, staff were informed he was an elopement risk and stated there was definitely not enough staff, normally we have 2 CNAs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor received and reviewed a written statement and signed event dated 8/23/24 by CNA N, who wrote a statement of the two elopements on the morning of 8/23/24. Surveyor reviewed the facility soft file which included the written statement of CNA N which stated, statement taken via phone: 4:30 AM [CNA N] heard the wander alarm go off. [CNA N] went to check the front door and saw [R187] walking down the management hallway. [CNA N] turned to follow [R187] out the employee exit. [R187] was very upset agitated and almost combative. [CNA N] was able to deescalate [R187] into coming back to the facility. Upon entering the building [CNA N] asked [R187] to sit in the lobby in a recliner while [CNA N] silenced the wander alarm. [CNA N], then saw [R187] get up and walking go towards [R187's] room. At 5:30 AM [CNA N] heard the door emergency alarm go off on the 200 hall. [CNA N] went to look down that hall then heard the 300-door emergency alarm go off [CNA N] walked out those doors and did a search around the building . On 10/08/24 at 11:08 AM, Surveyor interviewed Licensed Practical Nurse (LPN) K, regarding R187's 2nd elopement attempt. LPN K indicated they were called in by NHA A on 08/23/24 at approximately 5:00 AM, as a department head to come to facility to assist with a missing resident. LPN K indicated that during search for R187, LPN K ran into 2 deputies from the [NAME] County Police station who were also looking for resident and were able to locate R187 and brought R187 to facility. LPN K indicated hearing that R187 had another elopement episode but was not involved in that event. On 10/14/24 at 12:45 PM, Surveyor interviewed Police Officer Q, via telephone, who returned R187 through the front door of the nursing home after 2nd elopement from facility on 8/23/24. Surveyor asked if officer was aware of R187 wearing a wanderguard bracelet or if alarms sounded when going through the front. Police Officer Q stated there was no alarm sounding when they brought R187 back into the facility at 7:30 AM. R187 was missing from facility for 2.75 hours. Surveyor reviewed the police report for the second elopement that included in part: On Friday, August 23, 2024, Reported 4:49 AM. The notes were as follows: [R187], PATIENT ABSCONDED, LOOKING FOR ASSIST WITH LOCATING [R187]. UNKNOWN WHICH DOOR LEFT OUT OF FACILITY WEARING A PATIENT GOWN, 6'. [Deputy T] indicated the subject, [R187], had dementia, was possibly placed at the nursing home through social services and left agitated thinking the building was going to blow up. The information from August 21, 2024, indicated [R187] was supposed to be at the Black River Memorial Hospital under the care of Adult Protective Services. [Deputy U] Supplemental Report: K9 report: It should be noted that while enroute to the call, I came upon the missing person. This report is a summary of those events. Initial: On Friday, August 23, 2024, at approximately 6:43 AM, I, [Deputy V]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	While enroute to the call, I noted a person matching [R187's] clothing description near the intersection of [NAME] Street and N 5th Street, in the City of Black River Falls, [NAME] County, Wisconsin. I notified dispatch and made contact with the party who verbally identified self as [R187]. [R187] began to repeatedly ask me about a wallet that was lost. [R187] initially appeared agitated, so I began to ask [R187] about the wallet to calm [R187] down. Eventually [R187] calmed down at sat by the curb. I explained to [R187] that we were looking for [R187] and asked [R187] if we could give [R187] a ride back to the nursing home. [R187] agreed to this. [R187] eventually was picked back up by [Officer L], which ended my contact. At this time R187 was taken to the emergency room for evaluation. Emergency notes states: -Discharge Disposition: Patient will return to Meadowbrook facility where has been placed under and adult protective hold by adult protective services for [NAME] County. Patient has been medically cleared to return to that facility. Electronically signed 08/23/24 at 9:08 AM. On 08/23/24 at 9:48 AM, the facility entered a nurse's note that states in part, Wanderguard applied to resident's right wrist after returning from ER for eval. On 08/23/24, (no time stamp), a care plan was initiated which states, Focus: The resident is an elopement risk/wanderer. Disoriented to place, has a history of attempts to leave facility unattended, and has impaired safety awareness. Resident is protectively placed through [NAME] County due to emergency incapacitation from hospital. Adult protective services involved. Goal: the resident will not leave facility unattended through the review date. On 08/23/24 at 3:00 PM, treatment order for monitoring wanderguard was placed into chart for monitoring every shift of placement. Intervention/Tasks: Wander Alert - Wanderguard. Wanderguard will be checked every shift per MAR/TAR. On 08/23/24, the facility initiated 15-minute checks on R187 signed and time stamped by facility staff from 10:30 AM to 6:45 PM. Of note, R187's second elopement took place within 9 minutes from returning to building after the first elopement. The 15-minute check intervention had already proven to be an ineffective intervention for increased supervision to prevent R187 from eloping. 3rd elopement: On 8/24/2024 at 1:50 AM, a nurse's note was entered stating, Approximately 7:00 PM, [R187] walked out of room door; turned right; and walked through the alarmed door at the end of the 200 wing. Staff [CNA N] ran out the door following [R187] down the street. Another staff [DM F] got in car and followed [R187]. [NHA A] was called, as well as law enforcement since [R187] was not willing to come back with staff. Law enforcement took to HospitalER on a 72-hour hold. Protective Services was updated by law enforcement. Of note, ER states R187 presented to ER following event at 8:30 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/08/24 at 12:14 PM, Surveyor interviewed CNA O regarding the third elopement. CNA O indicated later that evening on 8/23/24, she received a phone call at home from CNA P who was following R187 on foot. CNA P informed CNA O that R187 eloped and is really fast. CNA O got in car to assist in locating R187. CNA O stated R187 was observed weaving in and out of traffic on Main Street and was found at bottom of the Black River bridge. CNA O stated Civilian Z happened to be driving on the bridge and got out of car as well as CNA O. They approached R187 who was hanging onto bridge rails looking over into water and stated, If I jump here, I will survive, and making other comments about wanting to jump over bridge. Civilian Z scooped R187 up and moved R187 away from railing. Civilian Z and CNA O were able to calm R187 down and have him sit. Police arrived and took R187 to hospital. On 10/08/24 at 12:55 PM, Surveyor interviewed CNA P regarding the elopement event on the evening of 08/23/24. CNA P stated R187 was on 15-minute checks, not on 1:1 or line of sight that evening. CNA P stated she had clocked out of 12-hour shift (6:00 AM to 6:30 PM) but clocked back in because replacement CNA I, scheduled for 2:00 PM, had not yet shown up yet. When CNA I arrived at facility, CNA P saw R187 exit 200 wing emergency door and she followed R187 from the nursing home to the bridge on foot, while CNA I followed in car. R187 was running ahead of staff, dodging in front of cars, trying to get into parked cars, and walking down the middle of the road. On 10/15/24 at 1:54 PM, Surveyor interviewed CNA P via telephone regarding following R187 from facility to bridge. CNA P stated she was approximately a half block away from R187 and she was unable to prevent R187 from dodging between cars, attempting to get into cars or stop R187 from getting to the bridge. Police report for third elopement: On Friday, August 23, 2024, at approximately 7:08 PM, I, [Deputy V], was dispatched .for a report of a male party who had walked away from the nursing home. This male party was later identified as [R187]. It should be noted that I had previously dealt with [R187] earlier in the day when I was requested to come in and attempt a K9 track on [R187] as had left Meadowbrook Nursing Home but was later found. Dispatch advised Meadowbrook had called again stating had walked away from the building While enroute to the call, I heard [Trooper Y] advised was out with the [R187] near the intersection of Main Street and North Water where [R187] had attempted to jump off the bridge. Contact with [CNA O] and [CNA P]: Arrived at the above location and observed [R187] being held on to by [Trooper Y] and [Civilian Z]. During this time several unidentified individuals were on scene as well. I then asked to speak with [CNA P] who worked at the nursing home. [CNA P] explained to me that earlier in the day, [R187] had absconded from the nursing home which I was aware of. [CNA P] stated that evening, she went to go take care of another patient and saw [R187] just got up and took off. [CNA P] further stated that she then followed [R187] to where we currently were. I asked [CNA P] about [R187] jumping off the bridge to which she told me that [R187] kept saying that was going to do that and had attempted to do so. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I asked [CNA O] if there were any locked doors or if [R187] could just walk out to which she told me [R187] could just walk out. I later learned [R187] had an alert bracelet that would alert staff if [R187] left the facility however, they would not physically stop a patient. [CNA O] stated that the facility did not have the manpower to deal with [R187] constantly running away. I asked [CNA O] where [R187] was before their facility to which she told me the hospital and [R187] had left there twice. Contact with [Civilian Z] I then spoke with retired officer [Civilian Z] who followed [R187] all the way from Falls Florists near South 7th Street and followed [R187]. [Civilian Z] stated as [R187] came near the intersection of Main and Water, [R187] then went into the oncoming lane and started making statements was going to jump off the bridge. [Civilian Z] stated since the nursing home staff was not close enough to stop [R187], [Civilian Z] intervened and stopped [R187] before [R187] made it over to the railing. [Civilian Z] stated once grabbed a hold of [R187] who stayed still. R187 was taken to the hospital at this time and did not return to the facility. On 10/09/24 at 6:43 AM, Surveyor toured the route as given per staff interviews and made these observations on what route R187 would have taken: R187 ran from the facility towards the bridge that overlooks the local river, approximately 1.4 miles from the facility. R187 would have been subject to traffic dangers as well, as this is a busy intersection with a three way stop and no stop-sign for vehicles leaving the downtown area. R187 made it to the bridge. The road is called I-94 alternative (intersection for state road 54 and 12 and is 40mph over the bridge and 25mph in the downtown area). The bridge overlooks the Black River and is over three stories high. The ground under the bridge is very rocky with a shallow river that comes from the Black River dam. The railing for the bridge is about 3' high and can easily be climbed over. There are no safety nets or high fences to prevent jumping. On 10/09/24 at 8:22 AM, Surveyor interviewed Chief Nursing Officer (CNO) M who first stated that facility was not aware that R187 eloped at the hospital prior to admission. At 9:10 AM, CNO M clarified the hospital referral paperwork indicated R187's elopement from the hospital. CNO M stated she had no idea why they accepted this resident. It was the job of DON AA to look at the acceptance paperwork, and DON AA left three days later; CNO M's assumption was that the acceptance paperwork was not looked at well. Surveyor asked CNO M if R187 had a wanderguard in place during the first and second elopements. CNO M stated that RN X referenced a wanderguard in written statement. Surveyor reviewed RN X's written statement. RN X's statement located in the facility soft file stated: Resident returned to facility at 7:10 AM, by police. Staff noted when returning to facility at 710 AM, by police, staff noted when returning he did not have the wanderguard on L wrist. [R187] did have wanderguard on L wrist when [R187] was eating sandwich at 4:25 AM. CNO M further indicated that RN X was new to the facility and when RN X heard the wanderguard, RN X was not aware where to look. CNO M indicated the facility should not have taken R187, as they did not have the staff to do 1:1 observations, which is why they did implement the 15-minute checks after the second elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/16/24 at 2:44 PM, Surveyor interviewed Medical Director (MD) S, who has been the facility's medical director for the past [AGE] years. MD S stated has not been made aware of any resident elopements within the past few months. MD S stated would anticipate that the facility would work with the resident's primary physician to determine interventions in order to keep a resident safe. On 10/14/24 at 4:01 PM, Surveyor interviewed DON B regarding expectations of process to be completed upon becoming aware a resident is an elopement risk. DON B stated that when the facility is made aware of an elopement risk, especially when the Director of Nursing at the time was aware of R187's elopement attempts prior to admission, would expect an assessment would immediately be completed, a wanderguard placed on resident, documented in resident's chart, treatment record updated for every shift monitoring, physician made aware along with resident and/or representative, and would expect a baseline care plan developed that includes triggers and interventions. The facility's failure to ensure a resident with a known history of elopements had the supervision to prevent accidents created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy that began on 08/23/24. On 08/26/24, the facility identified the deficient practice that occurred when the facility staff did not provide increased supervision after a resident eloped from the building. The facility took steps to correct the deficient practice and ensure compliance starting on 08/26/24. The immediate jeopardy was removed on 08/26/24 and corrected on 08/27/24 when the facility completed the following: The immediacy was removed on 8/26/24 when all staff education was provided that included the following: When a resident displays exit seeking behavior, supervision should be provided. Supervision includes: -resident being assisted to a common area. -resident engaged in activities of interest. -resident provided psychosocial support. -resident family contacted and included if able. -increased visits from facility managers. -staff coordination on who will be providing the increased supervision and for how long and when to provide relief. -if resident behaviors continue increased 1:1 support may be needed per staff discussion which includes DON/NHA/designee. Wanderguard does not replace supervision. Staff should be proactive and increase supervision as needed when resident displays exit seeking behavior. Staff should contact DON/NHA/designee for additional support and guidance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All elopement risk assessments were updated. All elopement residents' care plans were updated. Based on this determination, the citation is being issued as past non-compliance

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47657 Based on record review and interviews, the facility did not ensure acceptable parameters of nutritional status, such as usual body weight or desirable body weight range by obtaining routine weights routinely for 1 resident (R26) who had a significant weight gain. This is evidenced by: The facility policy entitled Weight Management dated September 2024 states: Resident's nutritional status will be monitored on a regular basis to aid in the maintenance of acceptable parameters, such as body weight, unless the resident's clinical condition demonstrates that this is not possible. Accurate weights are obtained by having staff follow a consistent approach to weighing and by using an appropriately serviced and functional scale. Weight can be a useful indicator of nutritional status when in evaluated within the context of the individual's personal history and overall condition. Significant unintended changes in weight loss or gain, may indicate a nutritional problem. Practice Guidelines: Weights will be obtained by nursing staff using the following process: Identify a consistent day for obtaining weekly weights. as residents are weighed, staff can compare current weight to previous weight. Significant weight variance is defined as: 5% in one month or 30 days; 7.5% in three months or 90 days;10% in six months or 180 days. The director of nursing or designee will notify the attending physician of significant weight changes and document in the resident progress notes. The attending physician will be notified of recommendations of the Interdisciplinary Team (IDT) and orders obtained if indicated. The assigned IDT member will communicate with the resident, resident's representative, and staff regarding interventions to be implemented. R26 was admitted to facility on 11/15/23, and has diagnoses that include Alzheimer's disease, hypertension, and chronic pain. R26 has a BIMS of 7, indicating moderately impaired cognitive level. R26's Quarterly Minimum Data Set (MDS) with target date of 05/23/24, Section K: weight 178#. R26's MDS with target date of 08/23/24, Section K: weight 189#, indicating a weight gain not on a physician prescribed weight gain regimen. R26's care plan, dated 09/22/24, with a target date of 11/15/24, states: Resident has nutritional problem or potential nutritional problem d/t risk for variable intakes r/t Alzheimer's disease and chronic pain. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Resident will maintain adequate nutritional status as evidenced by no significant weight changes. R26's physician orders dated 07/10/24 states: Weights weekly on shower day, every Sunday. On 10/07/24 at 12:40 PM, Surveyor reviewed R26's weight record which showed on 08/02/2024, the resident weighed 178.6 lbs and on 09/04/2024, the resident weighed 191.4., indicating R26 had a weight gain of 7.2% in one month. The facility was made aware of the weight changes, as the record provides information of the percentage of weight changes immediately as weights are entered into facility computer system. On 08/22/24 at 1:14 PM, R26's weight was recorded of 166.6# but was stricken out on 08/26/24 at 3:30 AM, by Nursing Home Administrator (NHA) A due to Data Entry Error. On 8/22/2024 at 1:17 PM, facility entered a Nursing Progress New order resident to have daily weights x 5 days to get an accurate weight. Resident showing weight loss. Primary Care Provider (PCP) updated with findings and to be updated after the 5 days of weight. Of note, R26's previous weight prior to PCP being updated on was documented on 08/02/24 at 178.6#. R26's weights for the 5 days recorded shows: 8/23/2024 - 189.2 lbs 8/24/2024 - 190.4 lbs 8/25/2024 - 190.2 lbs 8/26/2024 - 191.8 lbs 8/27/2024 - 191.4 lbs On 10/07/24 at 2:53 PM, Surveyor interviewed Assistant Director of Nursing (ADON) G regarding R26's significant change in weights from 09/08/24 - 09/20/24. ADON G stated the Medical Doctor was not updated regarding weight gain after the 5 days per order.

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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** 47807 Based on interview, observation and record review, the facility did not ensure that a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding. The facility did not follow current standards when checking feeding tube placement for 2 of 3 residents (R) investigated for feeding tube use (R24, R13). Findings Include: Example 1 The facility policy, entitled Care and Treatment of Feeding Tubes, dated April 2024, states: 6. In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube): . a. Tube placement will be verified before beginning a feeding and before administering medications. Of note: Nowhere in facility policy does it note that auscultation is no longer recommended for checking placement of the feeding tube. Movement of air would likely be heard whether the tube was in the correct or incorrect location. R24 was admitted to the facility on [DATE] and had diagnoses that include hypo-osmolality and hyponatremia, cervical disc disorder at c4-c5 level with myelopathy, type 2 diabetes, insomnia, gastro-esophageal reflux disease without esophagitis, unspecified symptoms and signs involving cognitive functions and awareness. R24's Minimum Data Set (MDS) assessment, dated 09/06/24, indicates that R24 has a Brief Interview for Mental Stats (BIMS) score of 03 indicating cognitive impairment. On 10/08/24 at 11:01 AM, Surveyor observed R24's tube feeding start up with Registered Nurse (RN) R. RN R moved the bed into an upright position for the feeding and then proceeded to check placement of feeding tube using auscultation method. RN R used a sterile syringe and pushed a small amount of air into the feeding tube and used a stethoscope to listen and confirm placement. On 10/08/24 at 11:13 AM Surveyor interviewed RN R regarding proper procedure for checking feeding tube placement. When asked if the facility expects them to use the auscultation method, RN R said yes. RN R has checked placement using residual in other facilities they have worked, but at this facility they are told to use the auscultation method. On 10/09/24 at 11:25 AM, Surveyor interviewed Chief Nursing Officer (CNO) M and Director of Nursing (DON) B regarding expectations for checking G-Tube placement prior to residents starting tube feeding. DON B was under the understanding the checking for tube placement using the auscultation method was still ok, but CNO M corrected DON B and said it was a more recent policy change and the facility should be using the residual method to check for feeding tube placement. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51095 Example 2 R13 was admitted to the facility on [DATE] with the following diagnoses, in part, moderate protein-calorie malnutrition, traumatic subarachnoid hemorrhage, epilepsy, alcoholic cirrhosis of the liver with ascites, dysphagia, oropharyngeal. R13's orders include enteral feed, one time a day pump feeding bag system, regular diet, mechanical soft texture, regular (thin) liquid consistency, mechanical soft solids with bite sized meat. Swallowing impairment requires R13 to receive 26-50% of cal. /501cc or more average intake of fluids per tube feeding. On 10/07/24 at 8:37 AM, Surveyor observed Licensed Practical Nurse (LPN) H administer medications to R13. After appropriate hand hygiene and donning of PPE, LPN H used a stethoscope to check for placement by listening for air. LPN H did not check for residual fluid or inquire if R13 was experiencing any gastric discomfort prior to administering medications and flushing with water. On 10/07/24 at 8:41 AM, Surveyor asked LPN H how she checked for placement of R13's G-tube and LPN H replied, By listening for air. On 10/09/24 at 7:30 AM, Surveyor interviewed LPN H, who reports she has not received any training on tube feeding from the facility since starting in her position as an LPN.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, interview and record review, the facility did not ensure that 2 of 2 residents (R11 and R29) reviewed for respiratory care were provided care consistent with professional standards of practice. R11 and 29 require oxygen and have a physician's orders to change oxygen tubing weekly. These were not changed as ordered. This is evidenced by: Example 1 The facility's policy titled Liquid Oxygen Use, read in part, Residents are to be provided with an oxygen concentrator whenever possible for the purpose of maximizing mobility and overall consistency in regulation of oxygen administration. Tubing should be changed weekly. Nasal cannula tubing may need to be changed more frequently. R11 was admitted to the facility on [DATE]. Diagnoses included dependence on supplemental oxygen, shortness of breath, obstructive sleep apnea, history of nicotine dependence, chronic obstructive pulmonary disease (COPD), respiratory failure with hypercapnia (elevated carbon dioxide levels), and respiratory failure with hypoxia (low levels of oxygen in the body's tissues). R11's Minimum Data Set (MDS) assessment, completed on 07/29/24, confirmed R11 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R11's physician orders included: -Keep oxygen saturation levels between 89-92% -Oxygen for portability 3-4 liters/min. 24 hours per day. -Change oxygen tubing and all other oxygen set up every Friday. -Head of bed elevated: Resident is unable to lay flat due to COPD. Head of bed elevated or elevated with two pillows to alleviate shortness of breath or difficulty breathing when lying flat. -Incentive spirometer for patient to use twice per shift as needed. -Albuterol Sulfate Inhalation. Two puffs inhale every six hours, as needed for COPD. R11's care plan included the following: -Self-care deficit. Fatigue and respiratory impairment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: 1/2 side rail for repositioning. Bariatric shower chair. Prefers shower. Check nail length and trim. Assist one for dressing. Independent with personal hygiene. Therapy evaluations per orders. -Potential for altered respiratory status related to difficulty breathing, anxiety, sleep apnea, and COPD. Interventions: Administer medications as ordered. Head of bed elevated. Monitor changes in condition. Monitor for signs and symptoms of respiratory distress. Oxygen via nasal cannula 3-4 liters continuous. On 08/26/24, R11 was hospitalized for respiratory failure. On 09/12/24, the facility determined R11 had a change in condition requiring evaluation of his capacity to make his own medical decisions. On 10/07/24 at 7:28 AM, Surveyor observed R11's oxygen tubing was initialed and dated 06/09/24. Surveyor reviewed R11's treatment administration record and noted licensed nursing staff were documenting weekly changes of R11's oxygen tubing. On 10/07/24 at 10:01 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H. LPN H stated oxygen tubing is changed once weekly, on Fridays. Surveyor asked LPN H to verify the date on R11's oxygen tubing. LPN H confirmed R11's oxygen tubing was dated 06/09/24. LPN H stated she would change R11's oxygen tubing right away. 47807 Example 2 On 10/07/24 at 11:02 AM, Surveyor entered R29's room to check the labeling on the oxygen tubing that R29 used regularly. Upon entering, Surveyor encountered Assistant Director of Nursing (ADON) G with new oxygen tubing in hand and R29 still using the original tubing. Surveyor asked ADON G if the tubing that R29 was currently using was labeled to which ADON G stated no it was not, this is why I decided to change the tubing. Surveyor then asked if they would expect there to be a label on R29's oxygen tubing to which ADON G said yes, they would expect that to be completed every time there is an oxygen tubing change.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51095 Based on interview and record review, the facility did not have a reliable system to account for the receipt, usage, disposition, and reconciliation of controlled medications for 4 out of 4 residents (R) reviewed and receiving controlled medications (R29, R1, R31, R286). Record review of the Controlled Substance Logs identified the logs were not accurate, as the quantity remaining of controlled medications was not accurately recorded. Sufficiently detailed records of receipt and disposition of controlled medications were not maintained to enable accurate reconciliation. Findings include: The facility's policy titled, Controlled Substance Management, dated January 2023, that states in part, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure F. ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. On 10/09/24 at 9:55 AM, record review of the facility's Controlled Substance Logs identified the following inaccuracies: On 7/31/24 at 9:00 PM, R286 was given MSSL 0.25 ml. Prior to administration, the quantity was 3.0 ml left and after providing 0.25 ml, it was documented that 2.5 ml remain. On 10/1/24 at 1:15 AM, R1 was given morphine 0.25 ml. Prior to administration, the quantity was 29.5 ml left and after providing 0.25 ml, it documented that 29 ml remain. On 10/4/24 at 9:00 PM, R31 was given morphine 0.25 ml. Prior to administration, the quantity was 10.5 ml left and after providing 0.25 ml, it documented that 10 ml remain. On 10/4/24 at 9:40 PM, R31 was given morphine 0.25 ml. Prior to administration, the quantity was 10 ml left and after providing 0.25 ml, it documented that 9.5 ml remain. On 10/5/24 at 2:00 AM, R31 was given morphine 0.25 ml. Prior to administration, the quantity was 9.5 ml left and after providing 0.25 ml, it documented that 9 ml remain. On 10/5/24 at 6:00 AM, R29 was given morphine 0.5 milliliters (ml). Prior to administration, the quantity was 12 ml left and after providing 0.5ml, it documented that 11 ml remain. On 10/5/24 at 6:00 AM, R31 was given morphine 0.25 ml. Prior to administration, the quantity was 9 ml left and after providing 0.25 ml, it documented that 8.5 ml remain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525488	A. Building B. Wing	10/16/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 9:59 AM, Surveyor interviewed Licensed Practical Nurse (LPN) H and requested clarification of narcotic count sheet. LPN H reported narcotic count book is kept on the medication cart and at the beginning and end of a shift two Licensed Nurses do a count of narcotics to verify accuracy. Surveyor showed LPN H the inaccuracies found. LPN H stated she does not know why they have incorrect counts. LPN H was not able to identify the initials where the mistakes were made. On 10/09/24 at 11:01 AM, Surveyor interviewed Director of Nursing (DON) B, who understood the concerns and agreed the entries shown to her in the Controlled Substance Logs were incorrect and did not add up correctly. DON B stated, Those books are one of the things I plan on changing and getting rid of these types of narcotic books.

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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. 51095 Based on observation, interview and record review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and did not ensure expired medications and biologics were removed from stock supply in the medication storage room. This occurred for 1 of 3 medication carts/storage rooms observed. An opened multidose medication/solution in the medication storage room refrigerator was not labeled with an opened date and stocked biologics located in the medication storage room were expired. Findings include: The facility's policy entitled Medication Storage dated January 2023, states in part, .all medications housed on our premises will be stored in the pharmacy and /or medication rooms according to the manufacturers' recommendations . The facility's guidelines entitled Medication Storage Guidance dated 2021, states in part, Tuberculin Tests: Aplisol Injection; Tubersol Injection- Store in refrigerator at 36 degrees to 46 degrees. Protect from light. Do not freeze. Date when opened and discard unused portion after 30 days. On 10/09/24 at 8:55 AM during the tour of the medication storage room with Licensed Practical Nurse (LPN) K, Surveyor observed two bottles, stamped with expiration dates of 9/22, of Breeza (a beverage used for neutral abdominal imaging) in general stock. On 10/09/24 at 9:03 AM, Surveyor observed an opened multidose vial of Tuberculin Test, Tubersol Injection without an opened date written on the vial or the box it was kept in. On 10/09/24 at 8:57 AM, Surveyor interviewed LPN K regarding expectations for the expired biologic. LPN K stated, Those are really old and should be thrown out. LPN K removed the two bottles of Breeza from the medication stock shelf. On 10/09/24 at 9:04 AM, Surveyor interviewed LPN K regarding expectations when opening multidose vial of Tuberculin Test. LPN K stated, It doesn't have a date on it and it should have been written on it when it was opened. On 10/09/24 at 11:01 AM, Surveyor interviewed Director of Nursing (DON) B who agreed the expired biologics should have been thrown out and the opened vial of Tuberculin Test should have been marked with a date when it was opened.

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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. 51095 Based on observation, interview and record review, the facility did not ensure the safety of food handling in accordance with professional standards for food service safety. Milk and juice, placed in the walk-in-cooler, had been opened but were not labeled with an opened date or use by date. Daily temperature logs for recording refrigerator and freezer temperatures had missing entries, resulting in the potential for foodborne illness to spread. This had the potential to affect 31 out of 32 residents that eat orally. Findings include: The facility's policy entitled Storage, Prepare, Distribute and Serve Food dated April 2020, states in part, 1. Temperatures a. Refrigerator/Freezer Temperature Log (FS-04/A) must be completed and reviewed on a daily basis . 3. Storage (Refrigerated) .c. All refrigerated and prepared food must be covered, labeled, and dated with a use-by date that is the maximum of 7 days from date of preparation. Label must include the name of the food and the date by which it should be used. On 10/06/24 at 10:33 AM during initial kitchen tour with Dietary Manager (DM) F, Surveyor observed two, gallon containers of opened milk and two, gallon containers of opened juice on a serving cart in the walk-in cooler. The milk and juice containers had not been labeled with an opened on or use by date by kitchen staff. On 10/06/24 at 10:42 AM, Surveyor requested to see the refrigerator/freezer logs. Upon review Surveyor noted that freezer entries for the dates of 10/05/24 were missing for freezer #1 and freezer #2. On 10/06/24 at 10:38 AM, Surveyor interviewed DM F regarding expectations for the opened milk and juice in the walk-in cooler. DM F said they would expect that milk and juice to be labeled with the used by date when it was opened, and the facility has stickers which they use to write used by dates on and stick on food when it is opened. On 10/06/24 at 10:45 AM, Surveyor interviewed DM F regarding temperature log expectations. DM F stated the expectation is that the temperatures of the refrigerators and freezers are recorded twice a day and that was not being done.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Staff did not wear proper personal protective equipment for enhanced barrier precautions (EBP) when providing care. This had the potential to affect 2 of 12 residents (R) observed for infection control practices (R24, R27). Findings include: Example 1 The facility policy, entitled Enhanced Barrier Precautions, dated September 2024, states: 3. Implementation of Enhanced Barrier Precautions . b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. wound care: any skin opening requiring dressing On 10/08/24 at 10:59 AM, Surveyor observed that R24's room had a sign on the door indicating that residents residing in the room would be on Enhanced Barrier Precautions. The sign indicated that staff interacting with residents would be required to wear gown and gloves. On 10/08/24 at 11:01 AM, Surveyor observed R24's tube feeding start with Registered Nurse (RN) R. RN R moved the bed into an upright position for the feeding and then proceed to check placement of feeding tube. At no time during the tube feeding process did RN R wear a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/24 at 11:13 AM, Surveyor interviewed RN R regarding proper procedure for EBP when accessing R24's G-tube for feeding purposes. Surveyor asked if they have been told to utilize a gown as well for a resident who is on enhanced barrier precautions. RN R said that they have trained and they realize now they should have worn more than just gloves. RN R also knew that the signs on the doors would indicate the proper PPE to wear; they just missed it this time. On 10/09/24 at 11:25 AM, Surveyor interviewed Chief Nursing Officer (CNO) M and Director of Nursing (DON) B regarding expectations for PPE for residents who are on EBP. Both CNO M and DON B would expect staff to wear both gown and gloves when starting tube feeding for a resident. 51095 Example 2 Resident (R) 27 was admitted to the facility on [DATE] with a diagnosis including, in part, type 2 diabetes mellitus with foot ulcer. On 10/06/24 at 2:55 PM, Surveyor observed R27 was wearing a protective boot with bandage underneath on left foot and had two adhesive bandages on top of his right foot. Progress note dated 10/5/24 - Received fax back from Provider, Dressing and ace wrap is to remain in place until next appointment. R27 is on an antibiotic for osteomyelitis. Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate) Give 1 tablet by mouth two times a day related to OSTEOMYELITIS, UNSPECIFIED (M86.9) until 10/16/2024 23:59 Give 1 tab BID x's 2 weeks. On 10/07/24 at 7:42 AM, interviewed Licensed Practical Nurse (LPN) H and asked why a bandage was placed on right outer foot. LPN H showed Surveyor wound under bandage (square 3x3 white bandage). Surveyor noted an approximately .2 cm sized skin lesion; skin was red surrounding the area and slightly raised. LPN H stated in part, I'm sure it's from pressure from the boot, and reported a plan to call podiatry. On 10/07/24 at 7:50 AM, Surveyor observed Certified Nursing Assistant (CNA) I assist R27 with cares. CNA I put on R27's socks, assisted him to a sitting and then standing position with use of gait belt to sit in a wheelchair. CNA I did not use protective personal equipment (PPE) and there was no EBP signage on the door or entry of R27's room. On 10/09/24 at 10:00 AM, Surveyor interviewed LPN H, who reported it would be the nurse's responsibility to place R27 on EBP, and that R27 has not been on EBP because they had not been doing dressing changes on his foot. Surveyor asked about the open skin area and dressing changes on the right foot, his diagnosis, and antibiotic use. LPN H stated that R27 should be on EBP and, I will put him on it today, as soon as I'm done with this. On 10/09/24 at 11:01 AM, Surveyor interviewed Director of Nursing (DON) B, who reported the staff responsible to place a resident on EBP would be the nurses. DON B stated it would be the expectation that a resident on an antibiotic with open wounds would be on EBP.