STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525493	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health Services	3540 S 43rd St Milwaukee, WI 53220

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 20483 Based on interview and record review the Facility did not ensure 1(R1) of 5 Resident's reviewed resident representative was notified when a new treatment was ordered. R1's POA (power of attorney) was not notified when a CBC (complete blood count) and urinalysis was ordered for R1 on 4/7/24. Findings include: The Change in Condition of the Resident policy last revised 9/20/22 under Policy documents A facility should immediately inform the resident; consult with the resident's physician' and notify, consistent with his or her authority, the resident representative(s) when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Under Policy and Compliance Guidelines documents 4. Notify resident's family/responsible party as applicable and in accordance with resident's wishes. R1's diagnoses includes Alzheimer's disease, depression, anxiety disorder, and dementia. R1's power of attorney for healthcare was activated on 4/27/22. The annual MDS (minimum data set) with an assessment reference date of 2/7/24 has a BIMS (brief interview mental status) score of 7 which indicates severe impairment. The nurses note dated 4/7/24, at 13:13 (1:13 p.m.) documents Resident is 15 min (minute) checks 2 [nd] shift she is very verbal name calling writer got order for CBC (complete blood count) UA/C&S (urinalysis/culture and sensitivity) urine (urine) picked up 4/7/24 at about 12:30 CBC will be drawn 4/8/24. This note was written by LPN-N. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/24, at 4:27 p.m., Surveyor called R1's POA and asked R1's POA if he was notified the physician ordered a CBC and UA/C&S on 4/7/24 for R1. R1's POA informed Surveyor he was not informed of the CBC and only knew about the UA after the fact. R1's POA explained he found out when he was called about R1's injury. R1's POA explained he was told they had done a UA because they thought R1 might have a UTI for her behavior which made sense. R1's POA stated no didn't know about the CBC and UA after the fact. On 4/23/24, at 9:25 a.m., Surveyor met with RN/ADON (Registered Nurse/Assistant Director of Nursing)-O to discuss R1. Surveyor informed RN/ADON-O Surveyor was unable to locate when R1's POA was notified of the CBC and UA/C&S was ordered for R1 on 4/7/24. Surveyor asked RN/ADON-O to look into this and get back to Surveyor with any information regarding notification. No information was provided to Surveyor regarding notification to R1's POA.

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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** 20483 Based on interview and record review the Facility did not ensure quality of care was provided for 1 (R1) of 5 Residents. R1 sustained a fracture of the left forearm after hitting her elbow on the head board of the bed. The Facility did not consistently monitor R1's left arm and did not implement a care plan regarding R1's fracture. R1 was identified with a concern to the right middle toe which was documented as being purple & painful. There was no monitoring of this toe. Findings include: R1's diagnoses includes Alzheimer's disease, depression, anxiety disorder, and dementia. The annual MDS (minimum data set) with an assessment reference date of 2/7/24 has a BIMS (brief interview mental status) score of 7 which indicates severe impairment. The nurses note dated 4/7/24 at 15:36 (3:36 p.m.) documents Resident hurt her elbow on the head board while flailing her arms and hit her left elbow on head board while writer was attempting to straight cath her while staff helped, she c/o (complained of) pain to the area writer called on call [Medical group's name] DOC (doctor) or NURSE practitioner she stated give some resident Tylenol. This nurses note was written by LPN (Licensed Practical Nurse)-N. The SBAR (situation, background, assessment, recommendations) note dated 4/8/24 at 00:33 (12:33 a.m.) documents Situation: Left elbow painful, shiny brown and swollen. Right foot middle toe, purple, painful when moved. Urinalysis positive, C&S (culture and sensitivity) pending. Background: Res (Resident) with behavioral issues since Thursday, Verbally abusive towards staff and residents, physical at times. Assessment (RN) (Registered Nurse)/Appearance (LPN) (Licensed Practical Nurse): Res up again start of night shift, belligerent, complaining. Finally stated she was tired. CNA helped her to bed. Noted elbow, res crying, limited ROM (range of motion), brown in color, swollen. Tylenol given and ice applied. Further investigation, bruising on arms from holding for straight cathing, tender. Noted right foot middle toe is purple, pain with PROM (passive range of motion). Recommendations: 0030, On call at [Medical group name] [Name], aware, New order for X-ray of elbow in AM (morning), cont (continue) to monitor toe, wait for C&S results Response: [Medical group name] on call, [Name] updated. Res calm at this time, remaining in bed. This SBAR noted was written by LPN-S. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 4/8/24, at 06:08 (6:08 a.m.), documents Res has remained in bed this night. Lab was here to draw blood, res was cooperative. Res took AM Thyroid med (medication). No adverse behaviors as yet. X-ray to be done today. Fluids to be encouraged. Urine C&S pending. This nurses note was written by LPN-S. The nurses note dated 4/8/24, at 12:36 (12:36 p.m.), documents X-RAY to L (left) elbow completed today. Res has been resting affected arm. X-RAY results pending. This nurses note was written by DON (Director of Nursing)-B. Physician-W's note dated 4/9/24 under subjective includes documentation of Patient is sitting in the chair, with no complaints of pain. Left arm has ecchymosis, slightly decreased ROM (range of motion) at the wrist, otherwise she is using the arm and hand to propel her walker. She refusing any intervention and refusing to see any doctor. Reports no shortness of breath or cough. No chills, nausea, vomiting, chest pain or chest tightness. Plan of care discussed with nursing staff with no additional concerns. Under assessment and plan includes Left forearm fracture. No vascular compromise seen. Slight deformity and tenderness and decreased ROM. Patient refusing interventions. POA (power of attorney) aware. Patient to see Ortho on 15th. Surveyor notes R1's care plan was not revised to include R1's left forearm fracture and right middle toe which was identified as being purple and painful. The nurses note dated 4/9/24, at 18:38 (6:38 p.m.), documents [Physician-W] in to evaluate resident earlier in shift. Per Physician-W request resident able to move fingers/wrist and arm without difficulty. Grimacing noted with movement CMS (circulation, motion, sensation) WNL (within normal limits). CRT (capillary refill time) less than 3 secs. (seconds). Purplish/bluish/reddish discoloration noted entire forearm. Resident continue to refuse ice pack and Tylenol when offered. This nurses note was written by LPN-U. The nurses note dated 4/10/24, at 02:40 (2:40 a.m.), documents Pt (patient) with fracture to proximal ulna. Pt propelling self about unit for a couple of hours using both arms. No c/o pain or discomfort. Pt with sensitivity pending on urine culture. No c/o dysuria. Pt was verbally hostile towards staff calling staff, stupid and lazy. Multiple attempts to redirect pt to her bedroom. About 2am pt finally went to bed. This nurses note was written by RN-Y. The nurses note dated 4/10/24, at 20:22 (8:22 p.m.), documents left elbow tender to touch, prn (as needed) Tylenol administered for reports of pain. Left ue (upper extremity) is bruised and red in color. In bed this shift resting, had visit with son this afternoon. No distress or behaviors this shift. This nurses note was written by LPN-T. The nurses note dated 4/11/24, at 05:53 (5:53 a.m.), documents Res has remained in bed this night shift. She is still being verbally belligerent, stated to writer to leave, she does not have nor never has had a urinary infection. You don't know what you're talking about. Res did take abt (antibiotic) and thyroid med earlier this AM when half asleep. Left arm remains bruised, elbow area swollen. Grimaces with movement. Denied need for meds. No new issues. This nurses note was written by LPN-S. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 4/11/24, at 14:17 (2:17 p.m.), documents Monitoring q (every) shift resident is on ABT no adverse reactions. This nurses note was written by LPN-N. The nurses note dated 4/11/24, at 22:36 (10:36 p.m.), documents Resident alert and responsive. Resident refused cares, meds, and vital signs this pm (evening) shift. Resident striked out at writer after attempting to assess vital signs. This nurses note was written by LPN-X. The nurses note dated 4/12/24, at 12:38 (12:38 p.m.), documents ABT/UTI monitoring with treatment for UTI has confusion talking a lot. This nurses note was written by LPN-N. The nurses note dated 4/12/24, at 21:15 (9:15 p.m.), documents Resident refused all medication, spitting them out saying that she cannot tolerate the medication. Tried a number of methods to get resident to resident to take her medication but resident still refused and wouldn't comply. Resident did not receive any ABT this PM shift. This nurses note was written by LPN-DD. The nurses note dated 4/13/24, at 12:36 (12:36 p.m.), documents Residents was very quiet and slept a lot this AM shift, was able to get resident to take medications without any issue, resident did not complaint of pain or discomfort. This nurses note was written by LPN-DD. The nurses note dated 4/14/24, at 19:07 (7:07 p.m.), documents Resident stable, however resident still refusing to take medication and refusing to eat, resident had visit from son, resident talk about making peace with God and wanting to die, son attempted to give resident meds she refused it from him as well. Resident did not complain of any pain or discomfort this AM shift. This nurses note was written by LPN-DD. The general note dated 4/15/24, at 13:47 (1:47 p.m.), documents Resident elbow propped up in wheelchair. Resident denied pain to writer and refused Tylenol with the nurse. This note was written by NHA (Nursing Home Administrator)-A. The nurses note dated 4/16/24, at 04:59 (4:59 a.m.), documents Pt refusing medications. To receive IM (intramuscular) ABT therapy for UTI. Pt is afebrile. No c/o pain or discomfort. Sleeping well throughout the night. This nurses note was written by RN-Y. The nurses note dated 4/16/24, at 15:54 (3:54 p.m.), documents Resident is on ABT/UTI resident refuses to take her meds q shift she does take them far and in between for pain to left elbow [NAME]. (Tylenol). This nurses note was written by LPN-N. Surveyor reviewed the Facility's 24 hour sheets from 4/7/24 to 4/16/24. Surveyor did not note any monitoring of R1's left arm bruising & swelling or the right middle toe on these 24 hour sheets. On 4/16/24 R1 was discharged to the hospital. The hospital ED (emergency department) not dated 4/16/24 at 4:40 p.m. under physical exam for Musculoskeletal documents General: Normal range of motion. Cervical back: Normal range of motion and neck supple. Comments: Old bruising of the left forearm. Left elbow has swelling and tenderness. During R1's record review Surveyor was unable to locate consistent monitoring of R1's left arm after R1 sustained a fracture and monitoring of R1's right foot middle toe which was documented as being purple & painful on 4/8/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/24, at 9:25 a.m., Surveyor asked RN/ADON (Registered Nurse/Assistant Director of Nursing)-O who is responsible for revising care plans. RN/ADON-O replied the IDT (interdisciplinary team). I play a role as well as [First name of DON (Director of Nursing)-B] and [First name of LPN (Licensed Practical Nurse)-H] does also. Surveyor informed RN/ADON-O Surveyor was unable to locate a care plan after R1 fractured her arm. Surveyor asked RN/ADON-O where Surveyor would be able to locate assessments, monitoring. and the plan for treating of R1's arm after R1 was diagnosed with the fracture. Surveyor asked RN/ADON-O if she could look into this and get back to Surveyor. On 4/23/24, at 12:14 p.m., RN/ADON-O informed Surveyor in regarding to R1's fracture there were no other MD (medical doctor) orders other than the order for Tylenol which was a previous order. The nurse had contacted the MD and they said to give Tylenol. RN/ADON-O informed Surveyor maybe now going forward she could push for a brace or ice. On 4/23/24, at 1:42 p.m., Surveyor met with NHA-A and DON-B regarding R1. Surveyor informed NHA-A and DON-B Surveyor had noted a nurses note dated 4/9/24 indicating the NP was aware of R1's fracture and there was a new order for ortho consult. Surveyor informed NHA-A and DON-B Surveyor did note there is not a care plan for the fracture, there was no plan on how to consistently monitor R1's left elbow bruising & swelling and no monitoring of the right middle toe which was purple & painful. Surveyor was not provided with any additional information regarding R1's left elbow and right middle toe On 4/23/24 at 2:34 p.m. Surveyor asked Physician-W's what interventions was she referring to in her note dated 4/9/24 that R1 was refusing. Physician-W informed Surveyor when she came she noticed swelling and the nurse was offering ice, trying to hold on to it. Physician-W indicated she asked if she can help, had to talk to R1 like she was a child and tried tying the bandage to keep the ice in place. Physician-W informed Surveyor she literally took two steps and the ice was off R1's arm. Physician-W indicated she asked R1 what happened and R1 replied I don't need this crap. Physician-W informed Surveyor R1 was propelling her chair with her arm so she guessed it wasn't painful.

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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** 38829 Based on observation, interview, and record review, the facility did not ensure 1(R2) of 1 Resident was as free of accident hazards as is possible and that R2 received adequate supervision and assistance devices to prevent accidents, resulting in a fall from bed *On [DATE] at approximately 1:07 PM, R2 was found on the floor next to R2's bed on the right side unresponsive and with no pulse. The medical examiner's (ME) preliminary autopsy report dated [DATE] documents that R2 suffered possible positional asphyxia, small epidural hemorrhage of spinal cord and hemorrhage of posterior right neck soft tissue which resulted in R2's death. The report documents that R2 was found lying prone on the floor of R2's room upon first observation of the ME. R2's head was tucked under R2's chest and was bent at an extreme angle. The weight of R2's upper body was on R2's head. R2's Kardex and comprehensive care plan documented that R2 required to be in a low bed due to being a fall risk. Based on interviews and police body camera images, R2's bed was not in the low position and the head of the bed was elevated at ,d+[DATE] degrees or more at the time of the incident. Surveyor notes that several staff members knew R2 leaned to the right when in bed. Surveyor was informed that R2 had no trunk support so if leaning to the right, R2 would have been unable to re-position R2's self or stop from rolling. Surveyor notes that there were no interventions put into place to create a barrier so R2 would be less likely to roll out of bed. Staff were aware that R2 was to be in a low bed, but needed it elevated to watch television which R2 liked to do. Surveyor notes there was no environmental adjustments with positioning and level of R2's television so R2 could safely watch television. Failure to follow the care plan and to provide an environment that was free of accident hazards based on R2's positioning needs created a finding of Immediate Jeopardy (IJ), which began on [DATE]. NHA (Nursing Home Administrator)-A , DON (Director of Nursing)-B were notified of the immediate jeopardy on [DATE] at 12:55 P.M. The immediate jeopardy was removed on [DATE]. However, the deficient practice continues at a severity/scope level of an E as the facility continues to implement their action plan. Findings Include: Surveyor reviewed the facility's Fall Prevention and Management Guidelines reviewed/revised [DATE] policy and procedure provided on [DATE] at 1:48 PM and notes the following applicable: Policy: Each Resident will be assessed for fall risk and will receive care and services in accordance with their individualized plan of care to minimize the likelihood of falls to reduce the possibility/severity of injury. Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a Resident's fall risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ii. Increased frequency of rounds iii. Increased supervision, if indicated iv. Medication regiment review v. Low bed vi. Alternate call system access vii. Scheduled ambulation or toileting assistance viii. Family/caregiver or Resident education ix. Therapy services referral x. Scheduled rest periods xi. Environmental modifications(s) including furniture, e.g. recliners. 6. Each Resident's risk factors and environmental hazards will be evaluated when developing the Resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed and should be communicated to the staff, Resident, and Resident's family/responsible party. R2 was admitted to the facility on [DATE] with diagnoses of Hypertensive Heart Disease, Type 2 Diabetes Mellitus, Anemia, Chronic Atrial Fibrillation, and Vascular Dementia, Moderate with Mood Disturbance. R2 was her own person while at the facility. On [DATE], R2 discharged to the hospital with a UTI (urinary tract infection). R2 returned to the facility on [DATE] with a diagnosis of Sepsis. A Brief Interview for Mental Status (BIMS) was completed on [DATE] upon return from the hospital. R2 scored an 8 indicating R2 demonstrated moderately impaired skills for daily decision making. Surveyor reviewed R2's most recent quarterly Minimum Data Set (MDS) dated [DATE]. R2's BIMS was a 3 indicating R2 was demonstrating severely impaired skills for daily decision making. R2's MDS documented no behaviors. The following is documented for R2's level of physical assistance: Upper dressing-substantial/maximum assist Lower dressing-dependent (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Left to Right roll in bed-substantial/maximum assist Lying to sitting-dependent Transfers-dependent R2's Usual/Customary Functional IDT Summary-Discharge assessment dated [DATE] documents that R2 required the following physical assistance: Mobility- Substantial/Maximum Assist Sit to lying-Dependent Transfers-dependent Eating-set-up R2's Readmission Evaluation assessment dated [DATE] documents that R2 now required the following physical assistance: Bed Mobility-Total assist of 2-staff uses muscle-R2 does not help Transfers-total assist of 2- staff uses muscle-resident does not help Eating-extensive assist of 1-staff uses muscle-resident helps Ability to change and control body position-completely immobile-does not make even slight changes in body or extremity position but unable to make frequent or significant changes independently. R2's Kardex dated [DATE] documents that R2 was an assist of 1. R2 required a hoyer lift for transfers. The Kardex documents bed in low position and was a fall risk. R2 required assist of 1 for personal hygiene and to turn and reposition R2 every,d+[DATE] hours when in bed. R2 was assist of 2 for bathing/showering and was assist of 1 for toileting. R2 was set up for eating. R2's comprehensive care plan had the following focused problems: 1. At risk for falls due to decreased mobility-Initiated [DATE] Interventions all on [DATE] -bed in low position -encourage to transfer and change positions slowly -fall risk -have commonly used articles within easy reach (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-reinforce need to call for assistance 2. ADL self-care deficit as evidenced by: weakness related to:CVA-Initiated [DATE] Interventions all on [DATE] -ambulation/locomotion: with device wheelchair -bathing showering: assist of 2 -bed mobility: assist of 1 -personal hygiene-assist of 1 -toileting: assist of 1 -transfer: mechanical lift xlarge sling 3. At risk for loss of range of motion due to prior CVA-Initiated [DATE] Interventions established on [DATE]: -administer analgesia per physician's orders -therapy evaluation and treatment as ordered. Surveyor notes that R2 had an alternating pressure reducing mattress. Surveyor notes that physician orders dated [DATE] upon return from hospital document R2 was to have an evaluation and treat as indicated for physical therapy, occupational therapy, and speech therapy. This evaluation did not occur. Surveyor reviewed the initial (Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report) facility reported incident dated [DATE] at 2:50 PM and the Misconduct Incident Report dated [DATE] at 3:38 P.M for R2 falling out of bed. The facility documents R2 was found on [DATE] at approximately 1:07 PM unresponsive and no pulse. The facility indicates the alternating air mattress was functioning correctly, there were no siderails or repositioning bars on the bed, and bed was in low position. The facility provided a timeline of events leading up to R2's death on [DATE]. The following is documentation of the timeline, and interviews obtained by Surveyor during the survey process. At 7:15 AM, Housekeeper (House-C) entered R2's room and observed R2 sleeping in bed per facility documentation. On [DATE] at 11:00 AM, Surveyor interviewed House-C over the phone. House-C stated House-C was in R2's room cleaning for about 15 minutes. House-C stated that R2 was in the middle of the bed, on R2's back like always. House-C stated R2 was in a low bed like usual and was sound asleep. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Between ,d+[DATE] AM, Certified Nursing Assistant (CNA-D) per facility documentation, entered the room and noted R2 seemed to be confused and was making statements about being robbed and waiting two hours for the police. CNA-D provided reassurance to R2 and reported R2's confusion to Licensed Practical Nurse (LPN-E). LPN-E received orders to obtain a UA, CBC, and BMP. On [DATE] at 11:35 AM, Surveyor interviewed CNA-D. CNA-D described R2 as quiet and a little stand offish. CNA-D stated that R2 did not move much. CNA-D stated R2 was a full assist with cares and mobility requiring 2 person assist. CNA-D informed Surveyor that R2 would frequently lean to the right side and would need to be repositioned. CNA-D stated that R2 never got out of bed per R2's choice and was alert to R2's needs. CNA-D stated that R2 had no bars on the bed and no mat on the floor next to the bed. CNA-D stated R2's bed was to be in the low position at all times. CNA-D stated the morning of [DATE], R2 was confused saying someone had robbed R2 and kept looking at the wall. CNA-D stated R2 appeared to be more confused than usual. CNA-D helped R2's roommate and told LPN-E about R2's confusion. CNA-D stated R2 was in a low bed and lying flat at this time. CNA-D confirmed that CNA-D responded to R2's incident. CNA-D observed R2 on the floor, R2's head was under R2's body. CNA-D stated the bed was at an angle and does not recall if the head of the bed was elevated. At 9:00 AM, LPN-E collected urine from R2's clean foley catheter bag and was noted to be sleeping in bed per facility documentation. At 11:00 AM, LPN-E and lab tech entered R2's room to obtain the blood samples for the labs that were ordered per facility documentation. On [DATE] at 9:17 AM, Surveyor interviewed LPN-E. LPN-E stated that R2 was confused and seeing things. Made delusional statements that men were chasing R2. LPN-E notified the physician on call and was instructed to get labs. LPN-E went to change the foley catheter bag to get clean urine. Collected the urine and gave R2 morning medications. About ,d+[DATE] hour later the lab came. The lab technician stated that R2 was not able to identify who R2 was so requested LPN-E go to the room with LPN-E to identify R2. LPN-E informed Surveyor that LPN-E verified it was R2 and left the room, not staying with the lab technician. LPN-E stated that after R2 was deceased , towards the end of LPN-E's shift is when LPN-E learned that the lab technician was not able to obtain the labs. LPN-E stated the lab technician alleges they told LPN-E but LPN-E does not remember this. LPN-E states LPN-E realized when another lab technician showed up later to obtain the labs. LPN-E stated that LPN-E observed R2 in bed, R2's right leg was hanging off of the bed. LPN-E stated that R2 would consistently lean to the right always. LPN-E stated that R2 was to be in a low bed and remembers R2's bed was elevated on [DATE]. LPN-E stated that R2 was confused that day, and who knows why R2 fell out of bed. At 11:00 AM, Activities Aide (ACT-G) entered the room to invite R2's roommate to church per facility documentation. On [DATE] at 1:20 PM, Surveyor interviewed ACT-G. ACT-G talked to R2's roommate and invited R2's roommate(R6) to church. ACT-G stated R2 was observed in bed flat, sleeping. ACT-G stated that R2's head of bed was not elevated and R2's bed was in a regular position, not a low bed. ACT-G thought the bed was parallel to the wall. ACT-G states ACT-G was in the room at 10:45 AM because church started at 11:00 AM. Surveyor notes that there is probability that the time of lab draw may not be accurate. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 12:30 PM, R2's roommate(R6) left the room to go to the dining room. A CNA had overheard R6 complaining about R2's behaviors and the CNA informed LPN-E. Staff were instructed to keep an eye on both. On [DATE] at 3:27 PM, Surveyor interviewed R2's roommate(R6). R6 stated R2's bed was against the wall and that R2 would always lean over to the right side. R6 stated R6 would always get help to reposition R2. R6 stated that R2 never moved. R6 stated R2 and R6 got along well. R6 stated the call light was never within reach of R2 so R6 would frequently get things for R2. R6 stated on [DATE], R6 recalls R2's bed being elevated but nothing else. Surveyor notes that R6's [DATE] quarterly MDS documents R6's BIMS to be a 15, indicating R6 is cognitively intact for decision making. The facility's timeline documents at 1:07 PM, CNA-F was passing meal trays and entered R2's room. CNA-F found R2 on the floor and immediately called for help. LPN-E responded first and called 911. R2 was noted to have apparent head/neck injury and was pulseless. Registered Nurse (RN-K) also responded. RN-K confirmed R2 was breathless and pulseless. On [DATE] at 12:48 PM, Surveyor interviewed CNA-F. CNA-F stated CNA-F did not take care of R2 on a regular basis but knew R2 was immobile and rarely moved. CNA-F stated that R2 never got out of bed. R2 would move R2's arms only and would feed R2's self. CNA-F stated that R2 was in a low bed with no bars. CNA-F stated that R2 did not use the bed remote and would like to lay flat. CNA-F stated the morning of [DATE], R2 did not appear to be in any distress. CNA-F provided cares about 10:00 AM on [DATE]. CNA-F stated CNA-F provided cares and did not have the assistance of any other caregivers. CNA-F was informed of the alleged roommate problem. CNA-F stated CNA-F went to give R2, R2's lunch tray and found R2 on the floor on the right side of the bed. CNA-F stated CNA-F could not find R2's head, looked like it was lost. CNA-F stated the bed at this time was not in low position and the head of the bed was elevated. CNA-F confirmed the air mattress was working. CNA-F informed Surveyor, I don't understand how this happened, especially if R2 doesn't move. CNA-F stated, never seen anything like this. The facility's summary provided by the facility only concludes there was no misconduct but does not give information that may establish what happened or why. Surveyor notes the interviews provided in the facility self report do not ask important questions like, exactly what did you do for R2, what did R2 say, what was the height of the bed when you saw R2, was the head of the bed elevated, was the call light within reach, were R2's items within reach. On [DATE] at 3:05 PM, the survey team met with Administrator (NHA-A) and Director of Nursing (DON-B). DON-B stated that caregivers would heighten a low bed to do cares. DON-B described a low bed as being close to the ground. NHA-A informed Surveyor that the facility cameras have not been working for about a month. Surveyor obtained other pertinent interviews in regard to R2's incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:50 PM, Unit Manager (UM-H) stated that R2 liked to lay in bed and watch TV. R2's bed was angled in the room. R2 could not sit up on own or move head. R2 could not move self in bed. UM-H stated that R2 was in a low bed meaning the bed should be lowest to the ground. UM-H stated R2 would lean more to the right side. UM-H indicated that R2's bed would be elevated to ,d+[DATE] degree angle when eating meals. UM-H stated that if R2 was flat R2 would not be able to see the television which R2 liked to do. UM-H stated that after R2's hospitalization from [DATE]-[DATE], R2 was more tired. UM-H was in shock to hear that R2 had rolled out of bed, On [DATE] at 7:45 AM, physical therapist (PT-I) stated that R2 had no range of motion (ROM) in both lower extremities. PI-I stated that R2's legs were stuck in a straight position. PT-I stated that R2 could not tolerate sitting. PT-I stated R2 had difficulty rolling side to side. PT-I talked about pillows and relied on R2 to educate the staff in regard to pillows. PT-I stated R2 was a fall risk due to lack of mobility. PT-I confirmed R2 had the potential to lean to 1 side or the other, most likely due to being weak. PT-I stated R2 was a heavy log roll and had no activation in legs. PT-I described R2 to be very rigid and stiff and very little activation in arms. PT-I stated would typically have 2 people if helping with changing R2. PT-I informed Surveyor that R2 was a potential for fall risk if elevated in bed because of no strength. PT-I confirmed that therapy did not evaluate or screen R2 upon return from hospital on [DATE] despite having physician orders to be evaluated and treated as indicated for physical, occupational, and speech therapy. On [DATE] at 8:25 AM, Surveyor interviewed LPN-J who is familiar with R2. LPN-J stated R2 barely got out bed and needed a lot of assistance. LPN-J stated, for some, 2 would assist with cares for R2. LPN- J stated R2 would frequently lean to the right side often. LPN-J stated R2's bed should be at low level. LPN-J stated, It was a surprise that R2 fell out bed. LPN-J stated maybe R2 rolled out of bed because the head of the bed was elevated and R2 didn't have upper body strength. On [DATE] at 9:56 AM, Surveyor interviewed RN-K who responded to the incident of R2 on [DATE]. RN-K stated R2 was in the corner between the wall and the bed. RN-K stated R2's bed was at a slant. When RN-K responded, RN-K observed R2's bed was at regular height and elevated ,d+[DATE] degrees. RN-K stated R2's head was tucked under R2's body. RN-K stated, Never want to see that again. It was very unnatural looking, freaky. R2's neck was clearly broken. Surveyor had RN-K set up R2's room as RN-K observed it on [DATE]. R2's bed was at an angle and the head of the bed was in the corner where the 2 walls meet. R2's TV was high on a armoire stand across from the bed. The bedside dresser was on the left of the bed. Surveyor notes that in all the interviews obtained, nobody was able to recall where the over bedside table was. Surveyor reviewed the documented police report dated [DATE]. Surveyor was also able to obtain the police body camera images. Surveyor viewed these images on [DATE] and notes the most remarkable images: -The first image is audio and you can hear someone say, oh shit, now I see it as the sheet is pulled off of R2. To the left of the screen, you can see the height of the bed which is clearly not in a low position and the head of the bed is elevated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The 2nd, 3rd, and 6th image you can see the height of the bed and that it is elevated at the head, and not in a low position. -7th image- You can't see R2's head, R2 is close up against the wall, right arm at side, palm up. -8th image-You can't see R2's head. -11th image-You can see the space between the bed and the height of the bed. On [DATE] at 10:22 AM, Surveyor spoke to the Medical Examiner (ME-L) over the phone. ME-L stated an autopsy was completed and the final report is pending toxicology results. ME-L informed Surveyor that R2 died from positional asphyxiation, small epidural hemorrhage of spinal cord, and hemorrhage of posterior right neck. Surveyor received the ME documented report on [DATE]. The report documents the following: R2 was found lying prone on the floor of R2's room upon first observation of the ME. R2's head was tucked under R2's chest and was bent at an extreme angle. The weight of R2's upper body was on R2's head. Contusions were noted to R2's anterior left arm near the antecubital fossa. Faint blanching purple-colored lividity was noted to R2's shoulders and forehead. R2's left eye was injected. The report also documents that the headboard of the bed was flush with the walls that formed the corner of the bedroom. R2 was lying on the floor parallel to the edge of the bed. R2's bed was measured to be 30 inches off the ground. Surveyor notes that several staff members knew R2 leaned to the right when in bed. Surveyor was informed that R2 had no trunk support so if leaning to the right, R2 would have been unable to re-position R2's self or stop from rolling. Surveyor notes that there were no interventions put into place to create a barrier so R2 would be less likely to roll out of bed. Staff were aware that R2 was to be in a low bed, but needed it elevated to watch television which R2 liked to do. Surveyor notes there was no environmental adjustments with positioning and level of R2's television so R2 could safely watch television. Surveyor also notes that R2 was being provided cares by 1 or 2 caregivers but was not consistently either way. DON-B stated the safest way to provide cares to R2 was a 2 person assist. On [DATE] at 9:07 AM, Surveyor asked CNA-M to demonstrate what a bed would like if a Resident's Kardex read low bed. CNA-M stated if there is a mat listed, the bed is put to the lowest to the floor. If a Resident does not need a mat, then CNA-M raised the bed. CNA-M demonstrated the level of the bed. Surveyor measured about 7 inches from the ground. On [DATE] at 10:10 AM, Surveyor had CNA-D demonstrate for Surveyor where a low bed should be. CNA-D stated for a low bed it goes all the way down to the ground right before the wheels touch the ground and demonstrated this for Surveyor. When the wheels drop the bed rolls easily. Surveyor asked CNA-D if everyone knows how to put a bed in low position. CNA-D stated, I assume if they are a CNA. On [DATE] at 2:27 PM, Surveyor had DON-B show Surveyor an alternating pressure mattress like what R2 had. Surveyor observed the bed the mattress was on and asked DON-B if this was what DON-B would consider a low bed. DON-B confirmed the bed was in a low position. Surveyor measured approximately 11 inches from ground. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor notes that the facility does not have a standard practice for what level from the ground is considered a low bed. Surveyor was shown from approximately 7 to 11 inches from ground for a low bed. Surveyor notes ME-L's written report documents the bed was measured at 30 inches. On [DATE] at 2:06 PM, Surveyor shared the serious concern of R2 falling out of bed which resulted in death with NHA-A and DON-B. Surveyor interviewed DON-B and asked what type of assistance did R2 require. DON-B stated that the CNAs would usually do 2 assist due to R2's weight. DON-B stated that would be the safest way to provide cares to R2. DON-B confirmed that R2 required a low bed. Surveyor shared the concern that the facility investigation summary did not indicate specific aspects of the bed as it looked on [DATE]. DON-B shared that R2 had to have the bed in a certain position to watch television. The facility stated they don't know what caused R2 to roll out of bed, but maybe it was R2's urinary tract infection or some other medical issue. No further information was provided by the facility at this time. Facility failure to address the positioning needs of R2 given that R2 would often lean to the right and given that R2 could not see the TV if lying flat and its failure to ensure that R2's bed was in the low position on [DATE] created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy. The facility removed the jeopardy on [DATE] when the facility implemented the following: Nursing staff will receive re-education on the Fall prevention and Management Guideline Policy. Education will include but is not limited to: - Each resident's risk factors will be evaluated when developing an individualized plan of care - Interventions will be monitored for effectiveness - Monitoring changes in residents condition including balance and positioning Re-education was initiated [DATE] and will continue prior to employees next shift to work. Staff will receive re-education on definition of low bed and bed in low position On [DATE] the ED, DON, and VPS reviewed the Fall Prevention and Management Guidelines policy and determined the policy identifies the compliance guidelines to provide services to minimize the likelihood of falls or reduce the possibility/severity of injury. No changes were required. Nursing management will re-evaluate residents with a care plan for bed in low position to determine if intervention is appropriate. Care plans will be updated based on the findings of the evaluations. DON and/or designee will complete audits on new admissions 5x weekly for 4 weeks and then 3x weekly for 4 weeks to ensure resident's at risk for falls have plans of care that are individualized and implemented by staff. DON and/or Designee will review 24 Hour Nursing Report/EMR Clinical Alerts 5x weekly for 4 weeks and then 3x weekly for 4 weeks to identify residents with a change of condition resulting in the need to re-evaluate fall risk and interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON and/or Designee will audit 5 Residents per week to determine if fall interventions are in place as per plan of care for 4 weeks and then 3 Residents per week for 4 weeks Results of the audits will be brought to QAPI for further review and recommendations. ADHOC QAPI held with IDT and Medical Director telephonically on [DATE].

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on interview and record review the Facility did not provide appropriate treatment and services for 1 (R1) of 1 resident with a diagnosis of dementia with behavioral symptoms to allow them to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. R1 has a diagnosis of Alzheimer's Disease and dementia. The December 2023, January 2024, February 2024, & March 2024 MAR (medication administration record) for daily behavior monitoring per shift does not document any behavior. On 4/4/24 R1's behaviors began & escalated. There was no comprehensive assessment with individualized interventions of R1's behaviors, the Facility did not assess the behavior change to identify the cause of R1's behavior, and the care plan was not revised until after R1 chased another Resident down the hall & ran over this resident's foot with her wheelchair. The Facility does not conduct dementia or trauma assessments. Failure to comprehensively assess R1's behavior and to conduct dementia & trauma assessments created a finding of Immediate Jeopardy (IJ), which began on 4/4/24. NHA (Nursing Home Administrator)-A , DON (Director of Nursing)-B, VP (Vice President) of Success-AA, and Operations-BB were notified of the immediate jeopardy on 4/24/24 at 12:55 p.m. The immediate jeopardy was removed on 4/25/24. However, the deficient practice continues at a severity/scope level of E (potential for harm/pattern) as the facility continues to implement its removal plan. Findings include: Although NHA-A informed Surveyor on 4/23/24 at 12:24 p.m. the Facility does not have a dementia care policy, on 4/24/24 at 1:48 p.m. NHA-A provided Surveyor with a dementia care policy. The Dementia Care policy dated 4/23/24 under policy documents It is the policy of this facility to provide the appropriate treatment and services for residents who display signs of, or are diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Under Policy Explanation and Compliance Guidelines documents: 1. The Facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. 2. The care plan goals will be achievable, and the facility will provide resources necessary for the resident to be successful in meeting their goals. 3. The care plan interventions will be related to each resident's individual symptomology. 4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. 5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. If needed, the environment will be modified to accommodate individual resident care needs. 7. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary. 8. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood, or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker). 9. Staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill sets to ensure residents' safety and help residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. R1's diagnoses includes Alzheimer's disease, depression, anxiety disorder, and dementia. R1's power of attorney for healthcare was activated on 4/27/22. R1's care plan documents cognitive loss as evidence by (specify) r/t (related to): Alzheimer's disease/dementia initiated & revised on 3/30/21 documents the following interventions: * Allow adequate time to respond. Do not rush or supply words. Initiated 3/30/21. * Approach/speak in a calm, positive/reassuring manner. Initiated 3/30/21 & revised 4/27/21. * Encourage low stress activities such as music, small group activities. Initiated 3/20/21. * Invite to participate in activities such as trivia, reminiscence, current events/newspapers. Initiated 3/30/21. * Repeat communication using more than one method (words, gestures, facial expressions). Initiated 3/30/21. * Use resident's name when addressing. Initiated 3/30/21. R1's care plan documents at risk for behavior symptoms r/t: (specify) Alzheimer's disease/dementia and depression. Resident can become angry with no provocation Swear at staff, Throw items at staff, Insult other Residents, Grab other residents clothing, Will use wheelchair to get to other residents and staff to antagonize care plan initiated 9/8/23 & revised on 4/7/24 documents the following interventions: * Administer medications per physician order. Initiated 9/8/23. * Attempt psychotropic drug reduction per physicians orders. Initiated 9/8/23. * Do not seat near Resident [first name of resident with last name's initial]. Initiated 9/8/23. * Re approach resident at a later time if she becomes verbally or physically aggressive towards staff. Initiated 1/6/24. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Use consistent approaches when giving care. Initiated 1/6/24. * When Resident experiences an episode of anger ensure surrounding residents maintain an appropriate distance from Resident. Initiated 1/6/24. * Resident can become easily triggered by other residents with dementia-please monitor environment when she is amongst peers. Initiated 3/7/24. * Room change on 3/1/24 for a quieter space. Initiated 3/7/24. * Staff to not allow res (resident) by [first name of resident with last name's initial]. Initiated 4/6/24. * When res in bed-staff to attempt to pad the bed with pillows to create border to protect from hard surfaces if res. allows. Initiated 4/7/24. R1's MAR (medication administration record) documents the following: Behaviors Monitor for the following: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cursing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. If any new behavior observed document in progress notes every shift for depression/medication. Surveyor noted during the months of December 2023, January 2024, February 2024, and March 2024 there are no behaviors documented. The annual MDS (minimum data set) with an assessment reference date of 2/7/24 has a BIMS (brief interview mental status) score of 7 which indicates severe impairment. R1 is assessed as not having any behaviors including refusal of care. R1 is assessed as being independent for eating and rolling left to right, and requires supervision or touching assistance for toileting, & chair/bed to chair transfer. Yes is checked for does the resident use a wheelchair or scooter and is assessed as being independent with wheeling the wheelchair. R1 is assessed as being frequently incontinent of urine and always incontinent of bowel. The cognitive loss/dementia CAA (care area assessment) dated 2/9/24 under nature of the problem/condition is blank. Under care plan considerations documents cognitive loss will be addressed on the care plan. Resident has a dx (diagnosis) of dementia. Interventions in place. The nurses note dated 3/1/24, at 22:29 (10:29 a.m.), created 3/2/24 at 00:32 (12:32 a.m.), document Res was found standing over roommate grasping roommate's gown by her neck. Roommate was screaming for help as 2 CNAs (Certified Nursing Assistant) came to separate the two residents. Res was taken out of room and monitored at nurses station for behaviors. Room to be changed when res to lay down. At this time res calm and sitting at nurses station. Roommate in room and asking for snacks. Res in good spirits at this time. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The psychosocial assessment dated [DATE] for Section B Mental Cognitive Status yes is answered for the question any psychosocial symptoms related to cognitive status. Under additional comments documents depression. Section C. Mood and Behavior Status for mood or behavior concerns since last assessment documents Res (Resident) acted out in physical aggression towards roommate. No is answered for is resident on any psychotropic medications and for mental health services Psychologist/other counselor involvement is checked. Under additional comments documents Res sees in house psych IPC (independent psychiatric consultant). Under Section D Psychosocial Status Check all those that apply: 1. Difficulty accepting placement and circumstances. 2. Difficulty with roommate. 3. Concerns with other Residents. 4. Concerns with Staff members. 5. Participates in Living Center Programs. 6. Pursues Independent Activities. 7. Maintains Supportive Relationships. 8. Has no Current Supportive Relationships. & 9. Grieving Loss of Loved One or Grieving Other Loss. Surveyor noted none of these are checked. Under Comments documents Res can often become agitated without warning. APNP (Advanced Practice Nurse Prescriber)-Z psych consult dated 3/6/24 under chief complaint documents f/u (follow up) Alzheimer's Dz (disease) Depression Dementia in other Dz classified elsewhere with Anxiety. Under narrative documents this is a f/u visit to assess pt meds and Dx as listed under Chief Complaint; Staff reports pt had aggressive encounter with peer - VPA (valproic acid) was started and pts (patients) separated to different rooms; At visit pt reports sleeps/eats good no pain why are you here-what do you want-am I in trouble-leave me alone. SSRI (selective serotonin reuptake inhibitor) recent GDR (gradual dose reduction). Under general appearance and manner documents pt up w/c - alert mild moody with mild anxiety - testy at visit. For thought process documents mod (moderate)-severe impoverished. Judgment and insight documents severe impairment. Mood and affect documents mild moody/mild anxiety. For major neurocognitive disorder Alzheimer's, moderate/severe, & without behavioral disturbances are circled. Under recommendations/plan of treatment documents Increase Lexapro back to 15mg (milligrams) q (every) day continue to monitor mood/anxiety - goal is to improve mood. The next nurses note Surveyor was able to locate regarding R1's behavior is dated 4/4/24. The nurses note dated 4/4/24, at 17:16 (5:16 p.m.), documents Describe Behavior/Mood: resident propelling self throughout hallway using profanity to all staff and residents. Unable to redirect, calling staff names, residents names. Was in the dining room for dinner and starting throwing meal and fluids. Refusing to take medications. Observed kicking and striking out at staff. Writer offered to call son and agreed, on the phone talking to son at this time. What was the resident doing prior to or at the time of behavior/mood: sitting in w/c (wheelchair) in common area. Interventions attempted: Redirected all shift, one on one with resident attempted but unsuccessful. Effectiveness of the interventions: Ineffective. This note was written by LPN (Licensed Practical Nurse)-T. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 4/4/24, at 21:23 (9:23 p.m.), documents Describe Behavior/Mood: Resident continues to use profanity at staff. Staff offered toileting, food and fluids. Resident declined all of above. Resident throwing items at peer, staff. Resident banging on windows in common area, bumping chair against wall, pushing empty w/c (wheelchair) towards staff. Unable to redirect. Resident propelling self in w/c taking items off of medication carts. Resident observed rolling in hallway B in and out of residents rooms and observed kicking door open after resident attempted to close door to keep resident out of their space. Following behind staff and calling staff names. Offered snack, but threw it at staff. What was the resident doing prior to or at the time of behavior/mood: sitting in w/c. Interventions attempted: Redirected resident not to throw items at staff or peers. Effectiveness of the interventions: Ineffective. This note was written by LPN-T. The nurses note dated 4/5/24, at 00:34 (12:34 a.m.), documents Res (Resident) remains up, belittling everyone she sees. Asked to speak to her son, so we called [Name] so she could talk to him. He will be in today. This note was written by LPN-S. The nurses note dated 4/5/24, at 05:38 (5:38 a.m.), documents Res has been up all night. Talking constantly!! Res is belligerent, condescending, sarcastic, downright nasty with her comments. She goes to each one of us, then to any other residents who are up. We are stupid, ugly, nasty, smell, etc., not worth her time. She is pushing carts around, chairs, throwing med (medication) cups on the floor and blaming us. Res refused morning Thyroid med, stating You don't know what you are doing, I wouldn't take anything from you!. This note was written by LPN-S. The nurses note dated 4/5/24, at 10:15 (10:15 a.m.), documents Late entry for 4/4/24, 0600-1400 (6:00 a.m. -2:00 p.m.) shift: resident refused to eat breakfast. Continued with verbal aggression: insulting staff and students calling to son of b_tch, ugly fat, liars etc. Also threatened to hit staff. Continues to wander up and down halls. This note was written by LPN-U. The nurses note dated 4/5/24, at 10:18 (10:18 a.m.), documents Resident continues to verbally abuse staff: called several staff members and students b__ches because staff tried redirecting her from leaving the unit. Resident scratch staff member on her arms during the redirecting process. Increase supervision provided Refused morning medications x (times) 3. Message left for [Name] NP (Nurse Practitioner). Per shift to shift report, resident son and MPOA (medical power of attorney) aware and will visit resident today. This note was written by LPN-U. The nurses note dated 4/5/24, at 12:37 (12:37 p.m.), documents Staff tried multiple times to administer medications. Son/NP aware resident continues to refuse medications. This note was written by LPN-U. The nurses note dated 4/6/24, at 20:36 (8:36 p.m.), documents Resident up calling staff names, using profanity, pushing over chairs, kicking medication cart. Resident rolling throughout hallway screaming, nobody is sleeping tonight. Resident kicked open door while male peer was undressed and getting washed up for bed. Resident threw shoe at staff, resident threw medications on floor. Resident offered snack and then threw on floor. Resident refused meal this shift, resident in w/c antagonizing staff. Resident observed pushing empty w/c towards staff. This note was written by LPN-T. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 4/6/24, at 21:38 (9:38 p.m.), documents Resident ran over right foot of peer while chasing peer down the hallway. Peer then observed hitting resident due to resident running over foot. Resident observed antagonizing peer. Resident continued to follow peer and call her names. Unable to redirect behavior. Resident continued to follow peer and propel self up and down hallway turning over chairs, pulling garbage out of medication cart and throw on the floor. Resident observed standing up several times this shift and turning around with no brief on and telling staff to kiss her _ss. Unable to assist resident with putting on undergarment due to behavior. Resident at this time banging on windows in common area. This note was written by LPN-T. The administration note dated 4/7/24, at 05:55 (5:55 a.m.), documents Restless, agitated cussing, psychotic, refusing care, condescending, spiteful, mean, belligerent, throwing things around, etc. This note was written by LPN-S. The nurses note dated 4/7/24, at 06:03 (6:03 a.m.), documents Res has been up all night in w/c. Res has been belligerent, sarcastic, mean, nasty, etc with the staff. She goes from one to the other and starts over again, non stop. We are all dumb, fat smelly, lazy b_tches. Res has been throwing things from the med carts, tearing up paper, pounding on the windows, throwing offered snacks and water on the floor. Res. going up and down halls, singing, wondering why no one was up. Needing to be removed from other rooms at times. Writer attempted to do pain assessment, but res uncooperative. Also uncooperative with skin assessment, although she did show me her _ss and stated I could kiss it. Res has red scratches on both buttocks, not new. Res nodded off about 20 minutes in w/c. Refused AM (morning) Synthroid med. This note was written by LPN-S. The nurses note dated 4/7/24, at 13:13 (1:13 p.m.), documents Resident is 15 min (minute) checks 2 shift she is very verbal name calling writer got order for CBC (complete blood count) UA/C&S (urinalysis/culture and sensitivity) urine (urine) picked up 4/7/24 at about 12:30. CBC will be drawn 4/8/24. This note was written by LPN-N. The nurses note dated 4/7/24, at 15:36 (3:36 p.m.), documents Resident hurt her elbow on the head board while failing her arms and hit her left elbow on heard sic (head) board while writer was attempting to straight cath (catheter) her while staff helped, she c/o (complained of) pain to the area writer called on call [medical group name] Doc (doctor) or nurse practitioner she stated give some resident Tylenol. This note was written by LPN-N. The nurses note dated 4/7/24, at 18:15 (6:15 p.m.), documents Resident continues to verbally abuse staff and residents. Resident continues to call staff fat _sses and b_tches. Resident continues to call other residents dumb_sses. Staff has attempted to redirect resident multiple times. Resident continues to harass residents and staff nonstop. This note was written by LPN-V. The psychosocial assessment dated [DATE] for Section B Mental Cognitive Status yes is answered for the question any psychosocial symptoms related to cognitive status. Under additional comments documents BIMS: 7 Resident diagnosed with Dementia and Alzheimer's Disease. Section C Mood and Behavior Status for 1. Mood or Behavior concerns since last assessment documents Resident sometimes acts out in physical aggression and swears at other residents and staff members. Resident can become agitated at times and confused. Resident recently had an altercation with another resident. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	For the question is resident on any psychotropic medications yes is answered. If yes to psychotropic medications, list psychotropic medications and target behaviors documents Escitalopram Oxalate Tablet Depakote Tablet Target Behavior 3: Depression/Sadness Intervention #1: Redirect as able. Intervention #2 One on one conversation. Intervention #3 Offer appropriate activities. For the statement if yes to psychotropic medication list resident non-pharmacological interventions utilized documents Non-pharm interventions for behaviors: 1. Address in a calm manner. 2. Attempt to orientate to place and time. 3. Allow resident to express feelings or frustrations and provide reassurance as needed. 4. Provide assistance as needed. 5. Family visits. 6. Offer activities of choice. 7. Provide emotional support to resident as needed. 8. Offer to close door and curtains to facilitate sleep. For mental health services Psychologist/other counselor involvement is checked. Under additional comments documents Resident is seen by psych in facility. Under Psychosocial Status the following are checked: 1. Difficulty accepting placement and circumstances. 3. Concerns with other residents. 4. Concerns with staff members. 5. Participates in Living Center Programs. 6. Pursues independent activities. and 7. Maintains supportive relationships. Under Comments documents Resident recently had altercation with peer. Resident observed by staff using foul language and calling staff/residents derogatory names. Staff attempted to redirect resident, but resident proceeded to approach peer which caused peer to become upset. Resident ran over peers toe with wheelchair and staff witnessed peer striking resident. Staff separated residents and continued to monitor. Writer followed up with resident today, who stated she has no concerns. DON (Director of Nursing), psych NP, and family notified. The change of condition note dated 4/8/24, at 00:33 (12:33 a.m.), documents Situation: Left elbow painful, shiny brown and swollen. Right foot, middle toe, purpose, painful when moved. Urinalysis positive, C&S pending. Background: Res with behavior issues since Thursday, Verbally abusive towards staff and residents, physical at times. Assessment (RN) (Registered Nurse)/Appearance (LPN): Res up again at start of night shift, belligerent, complaining. Finally stated she was tired. CNA (Certified Nursing Assistant) helped her to bed. Noted elbow, res crying, limited ROM (range of motion), brown in color, swollen. Tylenol given and ice applied. Further investigation, bruising on arms from holding for straight cathing, tender. Noted right foot middle toe is purple, pain with PROM (passive range of motion). Recommendations: 0030 (12:30 a.m.) On call for [medical group name], [Name] aware. New order for X-ray of elbow in AM (morning), cont (continue) to monitor toe, wait for C&S results. Response: [Medical group name] on call [Name] updated. Res calm at this time, remaining in bed. The nurses note dated 4/8/24, at 23:13 (11:13 p.m.), documents D/T (due to) res increased aggressive behaviors with dementia, [Name] Psych NP increased her Depakote to 250 mg (milligrams) BID (twice daily). Nursing to monitor. This note was written by DON (Director of Nursing)-B. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note dated 4/9/24, at 10:08 (10:08 a.m.), documents Writer updated POA with X-ray results indicating there is a fracture of the proximal ulna. POA would like resident to have a follow up/consult with ortho but unsure at this time if wanting surgical intervention if indicated. NP also made aware of results and NOR (new order received) to set up a consult with ortho. Will continue to monitor. This note was written by RN/ADON (Registered Nurse/Assistant Director of Nursing)-O. The nurses note dated 4/10/24, at 02:40 (2:40 a.m.), documents Pt (patient) with fracture to proximal ulna. Pt propelling self about unit for a couple hours using both arms. No c/o pain or discomfort. Pt with sensitivity pending on urine culture. No c/o dysuria. Pt was verbally hostile towards staff calling staff, stupid and lazy. Multiple attempts to redirect pt to her bedroom. About 2am pt finally went to bed. This note was written by RN-Y. The nurses note dated 4/11/24, at 05:53 (5:53 a.m.), documents Res has remained in bed this night shift. She is still being verbally belligerent, stated to writer to leave, she does not have nor never has had a urinary infection. You don't know what you're talking about. Res did take abt (antibiotic) and thyroid med earlier this AM when half asleep. Left arm remains bruised, elbow area swollen. Grimaces with movement. Denied need for meds. No new issues. This note was written by LPN-S. The nurses note dated 4/11/24, at 22:36 (10:36 p.m.), documents Resident alert and responsive. Resident refused cares, meds, and vital signs this PM shift. Resident strike out at writer after attempting to assess vital signs. This note was written by LPN-X. The administration note dated 4/12/24, at 01:15 (1:15 a.m.), documents agitation. This note was written by LPN-S. The administration note dated 4/12/24, at 01:16 (1:16 a.m.), documents restless, cussing, slurs, psychosis, aggression, refusing cares. The nurses note dated 4/12/24, at 06:24 (6:24 a.m.), documents Res has remained up in w/c, at desk, the entire night shift. Res has been talking non-stop to staff, or no-one, or Buddy about whatever is on her mind. How incompetent we are, dumb, fat, smelly, anything derogatory she can think of, over and over again. Refused cares, finally take water. Does not live here so she would not go to bed or lie down. Wanted to speak with the police. She would scream if we asked her to go away from the desk or be quiet. Refused AM med and offered analgesic. This note was written by LPN-S. R1 was discharged to the hospital on 4/16/24 for altered mental status and returned during the afternoon on 4/23/24. The hospital discharge summary dated 4/23/24 under the Admission Information section documents Reason for Admission: Closed Fracture of olecranon process of left ulna, initial encounter [S52.022A], Urinary tract infection without hematuria, site unspecified [N39.0] Dementia with agitation, unspecified dementia severity, unspecified dementia type (CMD) [F03.911]. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Under hospital course documents [R1's name, sex and age] with past medical history significant for CAD (coronary artery disease), sinus bradycardia, hypothyroidism, depression, Alzheimer's dementia who is living in nursing home and noted having more encephalopathic/combative than her usual. In the outpatient setting the patient had fallen, however there are inconsistent reports of the nature of the fall. Recently urine sample consistent with infection/UTI (urinary tract infection) and combative per the staff/son which is not her usual, and out of concern for recent fall as well as the concern of not receiving the appropriate medication, son brought her to ED (emergency department) at [Hospital name] . On 4/22/24 at 10:56 a.m. Surveyor spoke with NP (Nurse Practitioner)-CC regarding R1. NP-CC informed Surveyor R1 was confused, refused cares & medication, had behavior problems with psych involved. NP-CC informed Surveyor she was trying to get R1 to take her medication. Surveyor inquired when she was informed of R1's behaviors. NP-CC informed Surveyor she didn't know when but was aware. Surveyor asked NP-CC if she was notified of R1 refusing her medication. NP-CC replied yes, I was notified. NP-CC explained nursing would call her or would let her know when she was in the facility. NP-CC informed Surveyor some nurses were able to give R1 her medication and some weren't. Surveyor inquired when the last time she was notified of R1's medication refusals. NP-CC was unable to provide Surveyor the last time she was notified. Surveyor asked NP-CC about R1's fracture. NP-CC informed Surveyor RN/ADON-O informed her they were trying to straight cath R1 and R1 hit her elbow. NP-CC indicated she can't remember if it was on the wall or headboard of the bed. NP-CC informed Surveyor they got an X-ray and had an ortho appointment which R1 refused to go to. Surveyor asked NP-CC when was the last time she saw R1. NP-CC informed Surveyor 4/15. Surveyor asked NP-CC if she examined R1. NP-CC informed Surveyor she kind of went in she was trying to get R1's antibiotic switched. On 4/22/24, at 11:08 a.m., Surveyor asked CNA (Certified Nursing Assistant)-P to tell Surveyor about R1. CNA-P informed Surveyor before R1 went to the hospital she was acting anxious, had behaviors, was feisty, screaming out, cursing, getting up out of her chair & walking around. Surveyor asked CNA-P if she could redirect R1. CNA-P replied no. Surveyor informed CNA-P Surveyor had noted R1 was straight cath on 4/7/24 and asked if she was there during this. CNA-P informed Surveyor she and another CNA (CNA-M) tried helping R1 in getting R1 into bed. CNA-P explained she let R1 know the nurse was going to straight cath her. Surveyor inquired who the nurse was. CNA-P informed Surveyor the first name of LPN (Licensed Practical Nurse)-N. Surveyor asked if R1 let them put her in bed. CNA-P informed Surveyor she was feisty at first then calmed down. Surveyor asked CNA-P what she meant by being feisty. CNA-P replied yelling & screaming. CNA-P explained they let R1 know it was for her own good. CNA-P explained LPN-N tried putting the catheter in but couldn't get it. We had to try to redirect R1 and after she calmed down she told us to hurry up. CNA-P informed Surveyor LPN-N tried again to get the urine, R1's arm swung, hit the head board it was like a loud boom. LPN-N asked R1 if she could move her arm which R1 was able to. CNA-P indicated LPN-N never got the urine, they cleaned R1 and took R1 to the toilet. CNA-P informed Surveyor there was a hat in the toilet and they were able to get the urine. Surveyor asked while LPN-N was trying to straight cath R1 where was she. CNA-P informed Surveyor she was on one side of R1 and CNA-M was on the other side and they both were holding R1's arms so she wouldn't swing, she was like fighting. Surveyor asked CNA-P why they had to hold R1's arms. CNA-P informed Surveyor R1 was fighting & swinging. Surveyor asked CNA-P if she was ever involved with R1 being straight cath before. CNA-P replied no and explained R1 wasn't on her side. Surveyor asked CNA-P if she knew why R1 was fighting them. CNA-P replied no cause she normally not like that, normally a sweet little lady. (continued on next page)

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/22/24, at 12:09 p.m., Surveyor spoke with LPN-N on the telephone. Surveyor asked LPN-N what he could tell Surveyor about R1. LPN-N informed Surveyor R1 was confused, in a wheelchair and would roll around, talk with other residents & staff sometimes would say bad stuff other times good never would know what R1 was going to say. R1 recently had a UTI, at one time was taking her medications and then didn't take them. LPN-N explained when he came back from work R1 was diagnosed with a UTI, had me wondering if had a UTI as sometimes act normal then R1 got worse and went to the hospital. Surveyor asked LPN-N if he straight cathed R1. LPN-N informed Surveyor the names of CNA-M, CNA-P and CNA-Q. LPN-N informed Surveyor he told R1 okay [first name of R1] going to straight cath you and told her he had to do the procedure. LPN-N informed Surveyor he attempted to straight cath her and R1 was saying a bunch of stuff. LPN-N informed Surveyor no one was really holding her down because that's how she hit her arm. LPN-N informed Surveyor they had to hold her legs open but couldn't get it. LPN-N informed Surveyor he said lets put her on the toilet. They put R1 on the toilet, turned on the water and R1 said going to put on the water so I can pee. LPN-N informed Surveyor they were able to get the urine sample. Surveyor asked LPN-N if the CNAs had their hands on R1's arms. LPN-N replied no they weren't forcing her, R1 knew what they were going to do. They weren't holding her down that's why she hit her elbow if they were holding her down she wouldn't have been able to hit her elbow. Sometimes during the procedure she wasn't cooperative and other times she was. Sometimes she was kicking her legs and saying all kinds of stuff. Surveyor asked LPN-N how many times he attempted to straight cath R1 before placing her on the toilet. LPN-N informed Surveyor 3 or 4 times and was surprised he couldn't get R1's urine. LPN-N informed Surveyor he called DON (Director of Nursing)-B and [name of medical group] after R1 hit her elbow. On 4/22/24, at 1:20 p.m., Surveyor spoke with CNA-Q regarding R1. CNA-Q informed Surveyor R1 was a very sweet lady, has moods, gets depressed & sad, looking for her husband and son. Surveyor inquired if R1 had any behaviors. CNA-Q replied not on everyday basis. CNA-Q explained R1 stopped taking her medication, was hitting & fighting. CNA-Q informed Surveyor she thought R1's behavior was happening more frequently and she spoke with the night nurse who told her R1 was not sleeping, not taking her medication, stopped eating, and thought they were trying to kill her. Surveyor asked CNA-Q when R1 was having her episodes of behavior could she redirect R1. CNA-Q replied no and explained would get worse and call her fat a_s. CNA-Q informed Surveyor she would ask R1 what was wrong, if she wanted to talk with her son or if she was in pain. CNA-Q informed Surveyor R1's behavior just got worse & worse. Surveyor asked CNA-Q if she was working when R1 was straight cathed on 4/7/24. CNA-Q replied no was off that day. On 4/23/24, at 8:46 a.m., Surveyor spoke with CNA-M regarding R1. CNA-M informed Surveyor before R1 got sick she was a nice lady. They said she had an UTI. [TRUNCATED]

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	525493	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health Services	3540 S 43rd St Milwaukee, WI 53220

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on staff interviews, and record review, the facility did not ensure therapy services were provided in a timely manner for 1 Resident (R2) of 1 Resident reviewed for therapy services. *R2 was readmitted into the facility on [DATE]. R2 had physician orders dated [DATE] for evaluation and treatment as indicated and R2 was not evaluated and/or screened for speech (ST), physical (PT) therapy, and occupational (OT) therapy. R2's comprehensive care plan indicated R2 was at risk for loss of range of motion due to prior CVA (cerebral vascular accident) and the intervention established on [DATE] was for therapy evaluation and treatment as ordered. Findings Include: Surveyor was provided the facility's Rehabilitation Services Screening Policy and Procedure effective , d+[DATE] on [DATE] at 1:48 PM and notes the following applicable to R2: Policy . The purpose of the policy is to define the process and timing of Rehabilitation Services Resident screening completion. Procedure 1. Timing: a. Routine Screens* are completed on a quarterly basis b. On Demand Screens occur as a result of a Resident change in status that may require Rehabilitation Services Intervention i. A best practice is that Rehabilitations Services staff complete On Demand screens the same day the request is received whenever clinically appropriate and no later than 48 hours during regular therapy business hours. 2. Workflow: a. Routine Screens are initiated by the Resident Care Management Director (RCDM) with the Resident name, date, reason for screen and ADL (Activities of Daily Living) index range completed and provided to the Director of Rehabilitation (DOR) on a quarterly basis. Completed Routine Screens are reviewed in the facility morning meeting with the IDT (Interdisciplinary Team) at least weekly. Surveyor requested a policy and procedure for following physician's order and/or a policy for receiving Rehabilitation Services when ordered. Nursing Home Administrator (NHA)-A stated the facility had neither policy and procedure. R2 was admitted to the facility on [DATE] with diagnoses of Hypertensive Heart Disease, Type 2 Diabetes Mellitus, Anemia, Chronic Atrial Fibrillation, and Vascular Dementia, Moderate with Mood Disturbance. R2 expired in the facility on [DATE]. R2 was her own person while at the facility. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], R2 discharged to the hospital with a UTI (Urinary Tract Infection). R2 returned to the facility on [DATE] with a diagnosis of Sepsis. A Brief Interview for Mental Status (BIMS) assessment was completed on [DATE] upon return from the hospital. R2 scored an 8 indicating R2 demonstrated moderately impaired skills for daily decision making. Surveyor reviewed R2's most recent quarterly Minimum Data Set (MDS) dated [DATE]. R2's BIMS was a 3 indicating R2 was demonstrating severely impaired skills for daily decision making. R2's MDS documented no behaviors. The following is documented for R2's level of physical assistance: -Upper extremity dressing-Substantial/maximum assist -Lower extremity dressing-Dependent -Left to Right roll in bed-substantial/maximum assist -Lying to sitting-Dependent -Transfers-Dependent R2's Usual/Customary Functional IDT Summary-Discharge assessment dated [DATE] documents R2 required the following physical assistance: -Mobility- Substantial/Maximum Assist -Sit to lying-Dependent -Transfers-Dependent -Eating-Set-up assistance R2's Readmission Evaluation assessment dated [DATE] documents R2 required the following physical assistance: -Bed Mobility-Total assist of 2-staff uses muscle-R2 does not help -Transfers-total assist of 2- staff uses muscle-resident does not help -Eating-extensive assist of 1-staff uses muscle-resident helps -Ability to change and control body position-completely immobile-does not make even slight changes in body or extremity position but unable to make frequent or significant changes independently. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Certified Nursing Assistant (CNA) Kardex (instructions to care for residents) dated [DATE] documents R2 required an assist of 1 staff. R2 required a hoyer lift for transfers; bed in low position and was a fall risk; required assist of 1 staff for personal hygiene and to turn and reposition Q (every),d+[DATE] hours when in bed; assist of 2 for bathing/showering and assist of 1 for toileting; set up assistance for eating. R2's comprehensive care plan had the following focused problems: 1. At risk for falls due to decreased mobility-Initiated [DATE] Interventions all on [DATE] -bed in low position -encourage to transfer and change positions slowly -fall risk -have commonly used articles within easy reach -reinforce need to call for assistance 2. ADL self-care deficit as evidenced by: weakness related to: CVA-Initiated [DATE] Interventions all on [DATE] -ambulation/locomotion: with device: wheelchair -bathing showering: assist of 2 -bed mobility: assist of 1 -personal hygiene-assist of 1 -toileting: assist of 1 -transfer: mechanical lift xlarge (extra large) sling 3. At risk for loss of range of motion due to prior CVA-Initiated [DATE] Interventions established on [DATE] -administer analgesia per physician's orders -therapy evaluation and treatment as ordered. Surveyor notes R2 had an alternating pressure reducing mattress. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Physician Orders document the following: ST, PT, OT evaluation and treat as indicated dated [DATE]. On [DATE], at 3:05 PM, Surveyor requested therapy notes from Director of Nursing (DON)-B and Administrator (NHA-A) from the [DATE] evaluation order. On [DATE], at 7:45 AM, Physical Therapist (PT)-I provided documentation of a PT treatment encounter dated [DATE]. Within this documentation R2 is identified as bedbound and a fall risk. R2 was educated on proper ways to reposition and pressure spots that can be prone to sores. Surveyor interviewed PT-I and asked why R2 had not been evaluated based on the physician orders dated [DATE] for PT, OT, and ST evaluation and treat as indicated. PT-I stated PT-I was not aware of R2's physician orders from [DATE]. PT-I stated the Rehabilitation Director is responsible for the orders but is not available for interview. PT-I stated R2 should have been evaluated at minimum upon return from the hospital on [DATE]. Surveyor requested from PT-I any additional documentation identifying R2 has been evaluated or screened since [DATE]. Surveyor notes R2 had a decline in status related to bed mobility. On [DATE], R2's discharge assessment documented R2 required an assist of 1 staff and on [DATE], when R2 returns from the hospital, R2 requires an assist of 2 staff for bed mobility. Surveyor also notes per facility policy R2 should have been screened on a quarterly basis to identify a possible need for therapy services. Surveyor notes R2 should have been screened in [DATE] and January of 2024 and R2 was not evaluated per physician's order dated [DATE]. On [DATE], at 2:06 PM, Surveyor shared the concern with NHA-A and DON-B that R2 had not been screened at a minimum on a quarterly basis and that there is no documentation R2 had been evaluated per physician's order dated [DATE]. DON-B stated therapy orders automatically generate when a Resident returns from the hospital. DON-B understands the concern. No further information was provided at this time.